Chapter 6 – Controlling illicit drug use

6.1 Introduction

This chapter reviews the current legal framework related to illicit drug use and examines the implications for society and for health professionals.

In considering the impacts of current drug policy and law, it is important to distinguish between harm associated with drug use per se and harm associated with, or created or exacerbated by, the legal/policy environment. The former are discussed in detail in **Chapter 3**. **Sections 6.2** and **6.3** of this chapter specifically explore the legal/policy aspects. This type of distinction may not always be clear in practice; while the health harms associated with drug use are relatively well understood,[a] the relationship between drug use, and the cultural/political response to the drug use, is complex. It is important to consider whether the same drug may cause different types of harm depending upon the sociocultural context and legal framework within which the drug use takes place.

The debate surrounding enforcement of drug policy is controversial, with strong feelings both for and against liberalisation. These arguments are discussed in **Section 6.5** and alternative approaches to drug control are presented in **Sections 6.6** and **6.7**.

6.2 Evaluating prohibition

Reviewing both the impact and effectiveness of the legal and policy environment relating to drug use is not straightforward and study conclusions must be interpreted with care. A wide variety of interest groups come to the drug policy debate, with different priorities and analytical perspectives, which can be shaped by personal, ideological, political or professional interests. Drug policy and law influence a broad range of social policy arenas, encompassing a range of different enforcement interventions that may deliver success on certain indicators, but prove counterproductive elsewhere. The choice and prioritisation of particular effectiveness indicators can lead to very different conclusions.

a Novel psychoactive substances are an important exception.

Separating out the impact of drug policy from the effects of wider social policy and non-policy exogenous variables that can also affect drug-using behaviours and drug markets[b] presents an additional challenge.

A key question is what the primary aim of drug policy and legislation should be. Specifically, should it be the reduction of illegal drug use through the use of prohibitive and criminal legislation? Or should it be, from the medical perspective, focused upon reducing public health and social harms? This dichotomy requires consideration of a complex array of social, health and human rights factors. The doctor's role is discussed in more detail in **Chapter 11**.

6.2.1 A global approach

Current drug policy is underpinned by the UN drug conventions (see **Box 2**, **Section 1.2**). Their founding principle is the need to address problems associated with drug use and is primarily concerned with protecting and improving public health. The consensus based on these conventions is to create a framework where supply and possession of listed drugs for non-medical/scientific use is made a criminal offence.

6.3 The benefits of a prohibitionist approach

6.3.1 Deterring use

While there is a voluminous literature on the deterrent effects of punitive enforcement on crime generally, there is comparatively little about how the threat of sanctions and law enforcement affects illicit drug use.[1] Existing research has tended to focus on the impacts of decriminalising, rather than criminalising, the possession and use of illicit drugs. The 2001 US National Academy of Sciences report, *Informing America's policy on illegal drugs: what we don't know keeps hurting us* recognised this evidential gap,[2] and called for more research into the deterrent effect, noting that '*a rational drug control policy must take appropriate account of the benefits and costs of enforcing sanctions against drug users*'. The gap was also identified in the 2006 Science and Technology Select Committee's report *Drug classification: making a hash of it?*[3] The report notes that while legal enforcement underpins the Government's policy on drug classification, the committee could find '*no solid evidence to support the existence of a deterrent effect*'. The UK Government responded by acknowledging the lack of evidence but stating that it '*fundamentally believes that illegality is an important factor when people are considering engaging in risk-taking behaviour*'.[4] The response also stated that '[T]*he Government will consider ways in which the evidence base in the context of the deterrent effect can be strengthened*',[4] but it has, to date, not published any such evidence.

b For example, demographic changes, cultural shifts, migration, medical advances, emergence of new drugs, recessions, wars, etc.

For crime more broadly, the literature indicates that generalisations about punishment and deterrence are not useful and a differentiated approach is necessary for different types of crimes.[5] Research that specifically studies deterrence and illicit drug use is urgently needed.

Studies that have focused on the deterrent effects of sanctions on users have produced mixed results. Some polling evidence, for example by The Police Foundation inquiry report *Drugs and the law* (1999),[6] suggests that, for some, illegality is a factor in their decision not to use drugs. The inquiry concluded that the evidence of a deterrent effect was '*very limited*' and found that health concerns and general disinterest played a much greater role. There is also some evidence showing that sanctions can reduce use of hard drugs among individuals already in the criminal justice system,[7] though Babor and colleagues caution against extrapolating these findings to more open systems.[8]

Comparative analysis between countries or jurisdictions with different levels or intensity of punitive user-level enforcement provides no conclusive support for a significant deterrent effect. A 2008 review, drawing on mental health surveys conducted in 17 countries across the world in conjunction with the WHO, concluded that global drug use is not simply related to drug policy, since '*countries with stringent user-level illegal drug policies did not have lower levels of use than countries with liberal ones*'.[9] As discussed in **Chapter 3**, the relative levels of harm for different drugs correlate poorly with their legal classification, and legal substances, such as alcohol and tobacco, have been found to be at least as harmful as commonly used illicit drugs (see **Figure 3**, **Chapter 3**).[10,11] Studies comparing levels of cannabis use in different states in both Australia and the USA have similarly failed to demonstrate any significant correlation between punitiveness of enforcement and prevalence of use.[12] Some of the groups that are most vulnerable to drug-related health harms are likely to be among those least deterred by punitive laws. These groups include young people with an inclination to take risks, dependent and problematic users, those from socially deprived backgrounds, those with existing criminal records, and those with mental health vulnerabilities (see **Chapter 4**). The impact of enforcement on overall harms for these groups is likely to be limited.[13]

There may even be perverse effects associated with criminalisation. The Home Office noted in its submission to the Home Affairs Select Committee in 2001: '*some people would seem to be attracted to experiment with controlled drugs because of their illegality (eg "forbidden fruits")*'.[14] Any such effects are hard to quantify.

Following their review of the existing evidence, Babor and colleagues report that the majority of interventions aimed at deterring drug use in the criminal justice system show '*modest effectiveness*'.[8] They go on to stress that the amount of research on this issue has been minimal, of varying quality, and concentrated in only a few countries.[8] A review published by the EMCDDA in 2010 also highlighted that the impact of legal changes on drug use has not been consistently evaluated.[15] At present, the evidence justifying the conclusion that criminal prohibition deters use is not strong (see **Chapter 7**).[16] While it would be wrong to discount the effect altogether, there is little evidence that punitive enforcement is significantly effective in 'sending a message' that will help reduce or eliminate drug use. It is argued that illegality can help young people in particular to 'say no to drugs': this is a credible proposition but it is hard to measure its efficacy with any accuracy. It is unclear whether comparable prevention efforts are more effective with illegal drugs than legal ones, ie whether the illegality itself is a key aspect of prevention effectiveness (see **Chapter 7**). In addition to legal sanctions, it is also important to consider the extent to which social, cultural and religious norms may condition and deter use. Writing in the journal *Science*, Jarvik suggests that religious convictions may account for the lower use of legal substances such as alcohol and tobacco in Amish and Mormon communities.[17] He goes on to hypothesise that such convictions, combined with the conspicuous stigmatisation of deviant behaviour, may deter illicit drug use more effectively than the threat of prison.[17]

6.3.2 Reducing use by reducing availability and increasing price

As discussed in **Section 4.5.1**, price appears to influence the use of drugs.

Availability

As discussed in **Section 4.5.2**, the physical availability of drugs refers to their proximity and accessibility. In an illegal market, it is difficult to establish reliable methods to measure availability. A series of proxy measures have been used by the UK Government, such as drug seizures, dismantling of criminal groups, and recovery of criminal assets. While these measures can indicate enforcement successes, they are not measures of availability.

The reduction of availability was a priority target in the 1998 and 2002 UK drug strategies,[18,19] and the 2010 strategy takes what it describes as an '*uncompromising approach to crack down on those involved in the drug supply both at home and abroad*'.[20] The strategies are not based upon an agreed definition of availability, and although the 2010 strategy focuses on process measures such as breaking up criminal gangs and seizing assets, it has not identified any targets or established measures of impacts on availability.[20]

Price

The role of supply-side enforcement in raising prices is unquestioned. Products like heroin and cocaine, which cost only pennies per gram to produce, frequently sell for £40 or more per gram by the time they reach consumers in the UK.[21] This process, which has been described as '*the alchemy of prohibition*',[22] turns low-value processed agricultural products into commodities that are literally worth more than their weight in gold.[23]

The impact of price on levels of drug consumption is discussed in detail in **Section 4.5.1**. Drugs of dependence have more complex economics than other products: drug use does not necessarily follow predictable economic patterns in a simple linear way, which makes generalised conclusions problematic. Levels of use can rise and fall independently of price[24] and there is some disagreement between commentators on the impact of price rises. Drawing on the work of Grossman[25], Babor and colleagues maintain that even users who are drug dependent cut back on their consumption when prices rise.[8] Other commentators argue that for those who are dependent, increases in price are unlikely to have a dramatic impact on use, particularly when compared to those whose use is more intermittent.

Enforcement can certainly create obstacles in terms of additional expense and inconvenience, and drug markets can be locally displaced and temporarily disrupted. There is no evidence from the experience of past decades to suggest they can be eliminated or significantly reduced in the long term while demand remains high. It is evident that criminal supply has been able to keep pace with rising demand. Inference from prevalence data (see **Chapter 2**), and survey data on '*drug offers*', indicate that drugs remain widely available to those who seek them.[26]

Supply and demand within a criminal market that is not regulated by the state still has a series of checks and balances. In a market that is primarily demand driven and supplied by profit-seeking entrepreneurs, prices are unlikely to rise to a level where demand dries up. Even if supply-side enforcement can successfully achieve a '*drought*' or push prices for a particular drug beyond the reach of most consumers, the effect is likely to be displacement to other more affordable drugs, or a drop in drug purity as a way of maintaining more consistent street prices.[21] Both these impacts have unpredictable health implications. For dependent users on lower incomes, demand may also be less price elastic (for an explanation of price elasticity, see **Section 4.5.1**), so that increasing prices lead to increased levels of criminal activities (see **Section 6.4.2**) to raise the necessary funds, rather than reduced use.[27]

All of these effects were observed during the 2000 Australian '*heroin drought*',[c,27] although it is not clear how much this was related to enforcement, and how much to external factors in global opiate production.[28]

6.4 The costs of a prohibitionist approach

In 2008, the executive director of the UNODC acknowledged the major negative '*unintended consequences*' of prohibition.[29] These included the creation of '*a huge criminal black market*'; '*policy displacement*', where '*public health, which is clearly the first principle of drug control …* [is] *displaced into the background*'; and '*the balloon-effect*', where enforcement activity in one area does not eliminate production, transit or use, but simply displaces it to another area.[29] Other bodies, such as the coalition of non-governmental organisations (NGOs) supporting the 2011 Count the Costs initiative,[30] have produced more detailed analyses. The key costs, or unintended consequences, of the prohibition approach are outlined next.

6.4.1 Increasing health risks associated with drug use

Prohibition has an impact on the type and quality of the specific products consumed and on consumption behaviours. This increases health risks in a number of ways.

- Illegally sourced drugs are of unknown quality, strength and purity, lacking the certainty of legal drugs or legally regulated equivalents for medical use. This point was emphasised by a recent NTA guide.[31] In addition to the health risks associated with illicit drug use, the uncertainty surrounding the quality and purity of illicit drugs creates or exacerbates risks. These include the risks of overdose, poisoning (from adulterants, bulking agents and other contaminants), and infection from biological contaminants among drug users who inject.[32]
- A fall in purity and/or rise in the cost of heroin (and some other powder-form drugs) can encourage injecting in preference to safer methods of use such as smoking/snorting, as a way of getting a greater effect for less money.[33]
- The economics of the illegal trade have tended to push markets towards increasingly potent or concentrated (but profitable) drugs and drug preparations associated with increased risks.[34]
- Criminalisation can increase risk by pushing use into marginal, unhygienic and unsupervised environments. This is particularly true for needle sharing among drug users who inject, in relation to transmission of HIV and hepatitis.[35,36] These infections are not a feature of injecting use in Swiss-style clinics, where injection of prescribed heroin is supervised (see **Section 6.6.4**).[37]

c The Australian 'heroin drought' was an unpredicted and abrupt reduction in heroin supply. The shortage was most marked in New South Wales, which witnessed increases in price, decreases in purity at street level, and reductions in the ease of obtaining the drug.

- Criminalisation of users can discourage them from approaching drug services, contacting paramedic services in emergency situations, or volunteering accurate or complete information to health professionals (see **Section 8.2**).

6.4.2 Fuelling crime

The causal links between drug use and crime are complex and contentious among criminologists.[d,13] There is a clear and demonstrable connection or nexus between supply-side criminalisation and actual acts of criminal behaviour.[30] Conflict between high demand for drugs and the laws that prohibit their production, supply and use puts pressure on supply in a market that is demand led. This inflates prices, which has two effects.

- The first is the creation of a lucrative opportunity for criminal entrepreneurs. To give an indication of scale, the Home Office has estimated the value of the UK illicit drug market at £4.6 billion a year,[38] while the 2005 UN *World Drug Report* estimated the global market at $332 billion (around £200 billion) at retail level.[39] There is cogent evidence that organised crime has exploited the opportunities created by drug prohibition. A growing illegal trade is associated with high levels of violence,[40] corruption and money laundering.[41,42]
- The second effect is that inflated prices encourage acquisitive crime among low-income dependent drug users fundraising to support their habits (see **Section 3.4.2**). While estimates are hard to formulate,[43] volumes of such offending are substantial (see **Section 3.4.2**).[44] The high cost of drug use also exacerbates the social harms discussed in **Section 3.4**. The specific role of illegality is underlined by an absence of evidence for acquisitive crime associated with dependent use of alcohol,[45,46] tobacco[47] or prescription drugs, which are all available legally.

6.4.3 Marginalisation of human rights

In many countries, drug enforcement has resulted in serious human rights abuses,[48,49] including torture and ill treatment by police, judicial corporal punishment for drug offenders, executions and extrajudicial killings, arbitrary detention, and denial of basic health services. Poorly scrutinised drug-enforcement practices can additionally exacerbate systematic discrimination against people who use drugs, impede access to essential medicines,[50,51] and prevent access to harm-reduction and HIV-treatment services for marginalised high-risk populations.

Many of these particular issues are of marginal or no relevance to the situation in the UK, where concerns centre essentially around access to HCV treatment for some people who inject drugs (see **Section 10.6**).[52,53] There is some evidence to suggest that UK drug users feel that they are negatively profiled by the police. Research examining drug

d Issues to consider include the influence of intoxication, and links to common exogenous variables such as social deprivation.

users' experiences of street policing in the UK found that the vast majority of the sample (*n*=62) were known to the police and were targeted for attention. Very few relayed stories about receiving help from the police: for most of the sample, contact was a negative experience involving routine '*stopping, checking, questioning, and moving persons on*'.[54] Those who were subjected to this practice tended to perceive it as an unwarranted imposition of authority and control. When conducted in a busy, public place, some of the sample also felt that police actions were intended to shame the user by exposing their drug use to others.[54] Stigmatisation of problematic/dependent drug users, particularly those who inject drugs, remains a serious issue (see **Section 8.2**), with a series of identified negative public health implications; this is made worse by the burden of criminalisation, in addition to the stigma relating to addiction to legal or prescription drugs.[35,55]

An additional human rights issue is the discriminatory use of police powers. White young people in an affluent neighbourhood in New York are many times less likely to be stopped, checked and arrested by police than Black young people in a poor neighbourhood in New York;[56] the same has been documented for California[57] and elsewhere in the USA.[58] Discriminatory stop-and-search patterns have also been well documented for the UK, particularly in London and the Midlands.[59]

6.4.4 Negative impacts on international development, security and conflict

Drug consumption in the developed west cannot be divorced from the regions in which many of the drugs are produced, or through which they are transported. The illicit drug trade has deleterious effects on development and security in many of the world's most fragile regions and states.[60,61] Illicit drug production and transit is naturally drawn to the most marginal and underdeveloped regions that already have poor infrastructure and weak governance. This ensures that the threat from enforcement can be kept to a minimum, public officials are relatively easily corrupted, and a ready supply of labour is available from impoverished populations.

The endemic violence and corruption that accompany large-scale illicit drug operations massively increases the challenges involved in bringing development to regions involved in drug production, such as Latin and Central America and Afghanistan,[62] or those involved in transit, such as the Caribbean and West Africa.[62] The resulting destabilisation has disastrous knock-on impacts on a range of public health, human rights and wider development goals, deterring investment, restricting activities of development agencies and NGOs, and diverting limited domestic or foreign aid resources into enforcement rather than public health and development initiatives.[62]

6.4.5 Financial costs

Expenditure on the UK's drug strategy is around £1.2 billion per annum, of which £300-400 million is on enforcement, with most of the rest spent on treatment.[63] This figure is understated, as it includes only direct, proactive, spending on supply-side enforcement, and does not include reactive spending dealing with drug-related crime across the criminal justice system, including police, courts, probation and prisons. When these costs are included, the total criminal justice expenditure is estimated at between £2 billion[64] and £4 billion[65] per annum. These criminal justice costs are in addition to the wider social and economic costs of drug-related crime itself (see **Section 6.4.2**), which have been estimated at around £16 billion a year in England and Wales.[24]

The overall spend (proactive and reactive) on drug law enforcement and dealing with the costs of drug-related crime is significantly greater than the amount spent on drug-related health interventions (see **Section 3.5**).

6.4.6 Consequences for health professionals

The existing legal framework can impact on the ability of health professionals to provide treatment for individuals who need medical intervention. It can, for example, make access to vulnerable populations more difficult and make problematic drug users reluctant either to come forward or to disclose information about their drug use (see **Section 8.2**). It can also create political or practical obstacles to providing certain treatments (eg for hepatitis or HIV) or harm-reduction interventions (eg needle exchange or methadone treatment), especially for individuals who are in prison (see **Section 10.6**).[51-53]

6.5 Debate on the need for reform

Calls for any form of liberalisation of policy, and especially moves towards legalisation and regulation of any currently illegal drug, remain controversial, with debate frequently being polarised. Proposals have increasingly moved into the mainstream political arena. The case in favour of maintaining the overarching prohibitionist status quo has also been put by a range of individuals and agencies.

6.5.1 Maintaining the status quo

The core of the arguments against law reform is that it threatens to reduce or remove existing barriers to availability and will thus lead to increased availability, use, dependence and related harms. It is additionally argued that the potential for increased use would be made worse by the removal of the deterrent effect of criminality and the 'wrong message' that any such reforms would send out, particularly to young people.[66-71] The experience with some legal drugs, specifically alcohol and tobacco, is often suggested as a potential indicator of where levels of use of currently illegal drugs could end up, without the restraining influence of prohibition.[66-71]

While the UK Government has generally refrained from engaging in the detail of this debate, the Home Secretary, writing in the foreword to the 2010 drug strategy, stated unequivocally that the '*Government does not believe that liberalisation and decriminalisation are the answer*', as they '*fail to recognise the complexity of the problem*'.[20]

Similar rejections of any liberalisation of UK drug laws are regularly issued by the Home Office in response to such calls. In 2010, for example, in response to the Government's drug strategy consultation paper, the ACMD recommended that:

> '[F]*or people found to be in possession of drugs (any) for personal use (and involved in no other criminal offences), they should not be processed through the criminal justice system but instead be diverted into drug education/awareness courses* […] *or possibly other, more creative civil punishments.*'[72]

While recognising the harms associated with drug use and the need to support '*those caught in the cycle of dependence*' to live drug-free lives, the Home Office rejected the ACMD's recommendation, stating that '*giving people a green light to possess drugs through decriminalisation is clearly not the answer*'.[73] A very similar response was given to the Global Commission on Drug Policy's report *War on drugs*.[74,75]

More detailed critiques of reform proposals have been made by academics [66,77] and NGO coalitions.[67,68] The UN drug agencies have also produced clear statements. For example, in the preface to the *World Drug Report* 2009, the UNODC Executive Director concludes that '*transnational organized crime will never be stopped by drug legalization*' and calls for '*more control on crime, without fewer controls on drugs*'.[69] The 1997 *World Drug Report* also presents a more nuanced discussion in a chapter dedicated to '*the regulation–legalization debate*'.[70] The US Drug Enforcement Agency has gone further, producing a detailed debating guide titled *Speaking out against drug legalization*.[71]

6.5.2 Changing the status quo

Those who argue that the status quo is not working believe that reform is needed and that the current punitive criminal justice approach to drug use has failed in its key aim of eliminating or substantially reducing the trade and use of illegal drugs and related health harms. They argue that the blanket prohibition of non-medical use of drugs encompassed by the three UN conventions (see **Section 1.2** and **Chapter 5**) has an effect on users' access to healthcare (see **Section 8.2**) and leads to additional social and health harms associated with the illegal drug trade (see **Section 3.4** for a discussion of part of this issue). These arguments are made

while accepting that criminalisation might have had some, positive, deterrent effect. The point is made that a modified and reformed system could be substantially more effective than the status quo. The point is also made that the options for reform are not binary: criminalisation or non-criminalisation. There is a spectrum of alternatives and permutations of alternatives that could be used to potentially improve upon the present system. There may well be some elements of criminalisation that should remain but that should be coupled to other non-criminal approaches.

These broad conclusions have been repeated in a series of UK reports produced in recent years, including those from the Police Foundation,[6] the Home Affairs Select Committee,[77] The Prime Minister's Strategy Unit,[24] the Royal Society for the encouragement of Arts, Manufacture and Commerce,[78] and the UK Drug Policy Commission (UKDPC).[79] They are also endorsed by the Vienna Declaration of 2010, which calls for evidence-based drug polices.[80]

A 2011 report from the Global Commission on Drug Policy, whose members included the former Secretary-General of the UN, Kofi Annan,[e] and a further five former heads of state, summarises the current situation.[74] It states that the vast expenditure and effort involved in enforcing prohibition has failed to curtail supply or consumption of illicit drugs. It cites the health and social harms that are linked to drug use and those that occur as a direct consequence of prohibition and suggests that Government expenditure on '*supply reduction strategies and incarceration displace more cost-effective and evidence-based investments in demand and harm reduction*'.[74]

Most recently, a 2012 report from the UKDPC, *A fresh approach to drugs*, identifies the need for a new approach to policy that changes the ways in which Government and society respond to drug problems, informed by a thorough analysis of the evidence for improvements to polices and interventions.[81]

It calls for *'a clear distinction between the overall goals of drug policy and the tools to deliver it'*, looking at ways to support responsible behaviour, while also focusing on ways in which *'society can enable and promote recovery from entrenched drug problems'*. The report advocates a 'wholesale review' of the Misuse of Drugs Act 1971 and the classification of drugs (see **Section 1.2**), with a commitment to ensuring a strong evidence base to inform all changes to policy.

e Following his appointment as Joint Special Envoy for Syria in April 2012, Mr Annan recused himself as a Commissioner of the Global Commission on Drug Policy, with immediate effect.

6.6 What are the options for an alternative legal framework?

There is a spectrum of alternative legal frameworks available, and a useful, if incomplete, body of evidence to draw on. This includes experience with other drugs, in other countries, and with approaches to regulation and control of other risky products or behaviours.[82]

The options for alternatives range from harshly enforced absolutist prohibition, through a series of regulatory market models, through to (effectively unregulated) free market models (see **Box 5**).[83] Between these extremes, there is a range of options for less punitive approaches, decriminalising drug users, and potentially regulating drug markets.

Box 5 – The range of regulatory market models

Prohibition/criminalisation

Prohibiting/criminalising non-medical production, supply, possession and use, with punitive sanctions. The intensity of enforcement and severity of penalties can vary. Decriminalisation (see **Glossary** and **Section 6.6.2**) of personal possession and use can operate within a prohibitionist framework.

- *Examples*: heroin, cocaine, cannabis, ecstasy
- *Market controller*: criminal entrepreneurs, corrupt officials

Regulated markets

A range of regulatory controls are deployed, covering drug production and trade, products, gatekeepers of supply and users. Some drugs, preparations and activities remain prohibited.

- *Examples*: prescription drugs, OTC drugs, alcohol, tobacco
- *Market controller*: moderate to intense regulation by Government agencies

Free market legislation or 'supermarket model'

Drugs are legal and available for essentially unrestricted sale in the 'free market', like other consumer goods.

- *Example*: caffeinated drinks
- *Market controller*: corporate/private enterprise, with minimal regulation by Government agencies and voluntary codes for retailers

Adapted from Rolles S (2009) *After the war on drugs: blueprint for regulation*. Bristol: Transform Drug Policy Foundation,[83] with the permission of Transform Drug Policy Foundation.

Within each of these of these broad categorisations, there exists a range of sub-options. As highlighted in **Box 5**, different drugs in the UK sit within all three categorisations. While illegal drugs obviously come under 'prohibition/criminalisation', the UK's approach could be described as intermediate between the most punitive and most tolerant of the prohibition models observed around the world.

As discussed in **Section 6.2.1**, the international consensus set out in the three UN conventions (see **Box 2**, **Section 1.2**) means that supply and possession of classified drugs is made a criminal offence. There are a number of legal and policy reforms that can take place within an overarching prohibitionist framework. These are explored below (see **Sections 6.6.1 and 6.6.2**) and can involve moves towards either more or less punitive approaches. Any options that involve legally regulated production, supply and availability of drugs that are currently illegal for non-medical use (see **Sections 6.6.3 and 6.6.4**) face more substantive legal, practical and political obstacles (both domestically and internationally), as they necessarily involve crossing the line established by the UN drug conventions that prohibits any such moves.[f,g,83]

6.6.1 Increasing the intensity or severity of enforcement

Relatively few policy makers, even those such as the UK and US Governments and UN drug agencies who argue against less punitive enforcement, call for increases in the intensity of enforcement against drug users, even if tough talking around drug trafficking remains a key element of the political narrative. In the USA, there has recently been a conscious effort to move away from the 'war on drugs' rhetoric of past decades.[84] Some UK commentators have argued that the evident failures of UK drug policy are not due to failure of the prohibition paradigm per se, but rather the failure to enforce the laws with sufficient vigour and resources. These include members of the police and academia and some media commentators and think tanks.[h,85]

f See *After the war on drugs*[83] Appendix 1 page 165.

g There is the option of denouncing the treaty, withdrawing from the convention, and requesting reaccession with a reservation.[12] Bolivia is part way through this process and has asked to be re-admitted if the UN removes the statute that classifies the coca leaf as illegal.

h Including the Social Justice Policy Group,[85] and the Centre for Policy Studies.

6.6.2 Sentencing reform, including options for non-criminal sanctions for certain drug offences

Various options exist for reforming sentencing for drug offences. The UK has recently concluded a consultation process and review of sentencing guidelines for drug offences under the auspices of the Sentencing Council. Its primary aim has been to improve guidelines to ensure consistency of sentencing, while leaving the average severity of sentencing unchanged.[86] Potential sentencing reforms beyond the remit of this review could consider the severity of sentencing more broadly and examine options for raising or lowering average penalties, or alternative non-criminal disposals for some offences.

This concept of maintaining certain drug offences but reforming sentencing to empower judges to impose more non-custodial sentences, or enabling law enforcement agencies to use administrative (non-criminal) sanctions, is usually explored in reference to possession of small quantities of drugs for personal use. Small-scale production, usually of cannabis, or not-for-profit supply among peer networks, is also occasionally included in such discussions. This is often referred to as **decriminalisation**, although the term is inaccurately and confusingly used in some of the literature.

'Decriminalisation' only describes a process, rather than an actual policy or legal framework, and it is often mistakenly either confused with **legalisation** (which usually includes **regulation**, see **Section 6.6.4**), or assumed to mean the removal of any sanctions, or removal of an offence from law entirely. These terms are defined in more detail in the **Glossary**.

Decriminalisation of use[i] is widespread across the world (see **Glossary** and below), and there is a clear trend of growing support and adoption for such approaches.[87,88] It is difficult to generalise about these experiences, as there are many variations between countries (and often between local Government jurisdictions within countries), as well as different legal structures and definitions of civil and criminal offences and sanctions.[89] There are also significant variations in the threshold quantities used to determine the user/supplier distinction,[90] as well as the non-criminal sanctions adopted. Variations include fines, warnings, treatment referrals (sometimes mandatory) and confiscation of passports or driving licences. The key point is that decriminalisation does not mean deregulation; it means adopting a different (and it is hoped), more effective response than the use of the criminal courts and process.

i Dutch coffee shops go beyond decriminalisation of use. They operate within a regime where a drug (cannabis) can be **purchased** within a highly regulated retail system, as well as used and possessed.[8] New legislation has been introduced prohibiting sales to non-Dutch residents; however, local authorities have been given the power to determine how the laws will be implemented/enforced. A number of cities have enforced the law (eg Maastricht and Tilburg), while others (including Amsterdam) have not.

A distinction is also made between *de jure* decriminalisation, which involves specific reforms to the legal framework, and *de facto* decriminalisation, which involves a similar outcome, but is achieved through 'turning a blind eye' tolerant policing – effectively non-enforcement of criminal laws that technically remain in force. Confiscation of drugs also characterises most decriminalisation policies, with the exception of discretionary approaches adopted by police under some of the more tolerant cannabis policy models (in the Netherlands, Belgium and Spain for example).[89]

There is considerable variation in the approaches operating within the regulatory framework in different countries. **Box 6** presents a list of countries that have adopted some form of non-criminal disposals for possession of small quantities of some or all drugs, and an example case study is set out below.

Box 6 – Countries that have adopted non-criminal disposals for possession of small quantities of drugs

Europe

Austria, Portugal, Spain and the Czech Republic have decriminalised all drugs (*de jure* decriminalisation), while the Netherlands and Switzerland effectively have similar but *de facto* decriminalisation policies. Luxembourg, Belgium and Germany have adopted similar approaches for cannabis (in some German Lander this is applied to all drugs).[91]

Latin America

Argentina, Mexico, Paraguay, Peru and Uruguay have decriminalised all drugs, Ecuador and Brazil have decriminalisation laws pending, Chile and Ecuador have partial decriminalisation, and in Colombia the Government and Supreme Court are involved in an ongoing legal and constitutional dispute over a 1994 decriminalisation law. [j,92,93]

Elsewhere in the world

Four Australian states and 14 US states have decriminalised cannabis possession. Russia has made possession of small amounts of any drugs for personal use an administrative offence, and Kyrgyzstan has administrative responses to small-scale possession offences.[94]

j A 1994 Supreme Court ruling effectively made criminalisation of possession unconstitutional. The constitution was amended in 2009 to recriminalise possession.[92] This has recently been challenged again in the Supreme Court.[93]

Case study: The Portugal experience

The publication in 2009 of a report by the US-based CATO Institute[95] on Portugal's 2001 decriminalisation policy has made the country a focus of global drug debate. The Portuguese policy decriminalised the possession of small quantities of any drug for personal use, alongside expanding drug-treatment and harm-reduction interventions.

The volume of data collected on numerous indicators over 10 years provides many useful lessons but has also provided scope for cherry-picking and filtering through different political and ideological perspectives.[96] Some of Portugal's prohibitionist 'antidrug' organisations, for example, present the data as indicating an unmitigated disaster,[97] in contrast to the arguably rose-tinted perspective of the libertarian-leaning CATO Institute report.[95]

A comprehensive academic study of the Portugal experience has now been published in a peer-reviewed journal. *What can we learn from the Portuguese decriminalization of illicit drugs?*[98] summarises that since decriminalisation, the following changes have been observed:

- small increases in reported illicit drug use amongst adults
- reduced illicit drug use among problematic drug users and adolescents, at least since 2003
- reduced burden of drug offenders on the criminal justice system
- increased uptake of drug treatment
- reduction in opiate-related deaths and infectious diseases
- increases in the amounts of drugs seized by the authorities
- reductions in the retail prices of drugs.

In conclusion, this publication notes:

> '[The Portugal experience] *disconfirms the hypothesis that decriminalization necessarily leads to increases in the most harmful forms of drug use. While small increases in drug use were reported by Portuguese adults, the regional context of this trend suggests that they were not produced solely by the 2001 decriminalization. We would argue that they are less important than the major reductions seen in opiate-related deaths and infections, as well as reductions in young people's drug use. The Portuguese evidence suggests that combining the removal of criminal penalties with the use of alternative therapeutic responses to dependent drug users offers several advantages. It can reduce the burden of drug law enforcement on the criminal justice system, while also reducing problematic drug use.'*

A more recent *Drug Policy Profile of Portugal* produced by the EU's European Monitoring Centre on Drugs and Drug Addiction has supported these conclusions.[99] It observed that the model might be best described as a public health harm-reduction policy rather than a first step towards legalisation of drug use.

6.6.3 Unregulated 'free market' model

While only advocated by a small group of free market libertarians, the free market model has remained a feature of the debate, although more as a thought experiment than a serious proposition. Under this model, a clear description of which can be found in Nadelmann,[100] all aspects of drug production and supply are legalised. Regulation is essentially left to market forces and self-regulation among vendors, with a minimal level of Government intervention (trading standards, contract enforcement and so on) that might be associated with standard consumer products available in a supermarket.[100] There is an argument that tax revenue from sales of drugs could be used to fund the public health costs associated with dependent drug use.[100]

Given the negative health outcomes that under-regulated markets for alcohol and tobacco have produced historically,[46,101] this is a model that is unlikely to be supported by health professionals working to proven public health principles.

6.6.4 Options for legal regulation of drug production and availability

While the UN conventions clearly mandate that the supply of drugs must remain an offence, this section examines models that cannot currently operate for use of drugs classified within this framework. In theory, the conventions can be revisited and changed; Room and colleagues identify four ways in which the 1961 Convention could be altered:

1. by amendment under Article 47. This Article states that *'[A]ny Party may propose an amendment to this Convention'* and requires either unanimous consent or the convening of a Conference of the Parties by action of the Economic and Social Council of the United Nations (UN ECOSOC)
2. by termination of the convention, resulting from a sufficient number of denunciations (withdrawals) from the convention to reduce the number of parties below 40
3. by removing particular drugs from any of the convention's schedules. This would have to be based on the recommendation of a WHO expert committee, and would require a majority vote in the Commission on Narcotic Drugs (CND), and in the UN ECOSOC if any party appealed the CND decision
4. the convention could theoretically fall out of use as conditions change, without any formal termination or denunciation.[12]

These methods highlight that there is scope – in theory at least – to change the drug conventions. Proposals for how post-prohibition models of drug market regulation (legalisation) could function have been published relatively recently.[102-104] In the UK, the Transform Drug Policy Foundation's 2009 *Blueprint for regulation*[83,105] presents a range of potential regulatory models for different drugs that are currently illegal. Options are explored for controls over:

- products (dose, preparation, price, and packaging)
- vendors (licensing, vetting and training requirements, marketing and promotions) and outlets (location, outlet density, appearance)
- who has access (age controls, licensed buyers, club membership schemes)
- where and when drugs can be consumed.[83]

Five basic models for regulating drug availability are proposed:

1. **a medical prescription model**: or supervised venues for the highest-risk drugs (injected drugs including heroin and more potent stimulants such as methamphetamine) and problematic users[k]
2. **a 'specialist pharmacist' retail model**: for moderate-risk drugs such as amphetamine, powder cocaine and ecstasy. A trained and licensed pharmacist would act as both gatekeeper and provider of health/risk information. Systems for named/licensed user access and rationing of volume of sales could be added
3. **licensed retailing**: including tiers of regulation appropriate to product risk and local needs. This could be used for lower-risk drugs and preparations such as lower-strength stimulant-based drinks
4. **licensed premises for retail and consumption**: similar to licensed alcohol venues and Dutch cannabis 'coffee shops', potentially also for smoking opium or drinking poppy tea
5. **unlicensed retail**: minimal regulation for the least risky products, such as caffeine drinks and coca tea.

In making the case for such an approach, Transform has additionally noted that:[83]

- rather than a universal model, a flexible range of regulatory tools would be available with the more restrictive controls used for more risky products and less restrictive controls for lower-risk products
- differential application of regulatory controls could additionally encourage use of safer products, behaviours and environments
- commercialisation of markets would be strictly controlled, with default bans on most or all forms of promotion, branding and marketing
- the oversight and enforcement of new regulations would largely fall within the remit of existing public health, regulatory and enforcement agencies. Activities that take place outside the regulatory framework would naturally remain prohibited and subject to civil or criminal sanctions
- such models would also need to be phased in cautiously over several years, under close evaluation

k Existing examples include Swiss-style heroin 'clinics' where prescribed heroin can be injected in a supervised quasi-clinical setting. UK law already allows for maintenance prescription of cocaine, (injectable) heroin, and amphetamines to dependent users, although only heroin and amphetamines are prescribed in practice (in a similar fashion to methadone) and numbers are small, around 400 and 2,000 individuals respectively.[37]

- the costs of developing and implementing a new regulatory infrastructure would represent a fraction of the resources currently directed towards supply. There would also be potential for translating a proportion of existing criminal profits into tax revenue. It is important to note that there is no clear assessment as to what level of revenue this could generate.[83]

6.7 Call to consider alternative options for drug policy

In 2010, Anand Grover, the UN's Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, presented a thematic report on drug policy to the UN Secretary-General.[106] As well as calling for the decriminalisation of possession and use of drugs, the report's concluding recommendation was to: '*Consider creation of an alternative drug regulatory framework in the long term, based on a model such as the Framework Convention on Tobacco Control*'.[107] This was attempted in 2010 by Room and colleagues who adapted the tobacco model and used it as the basis for a '*draft Framework Convention on Cannabis Control*'.[12]

The Framework Convention on Tobacco Control contains a series of UN-mandated recommendations specifically for the public-health-based regulation of a non-medical drug.[107] Transform has noted that this convention encompasses the same types of regulation proposed in its own blueprint,[83] and has a similar number of signatories (168) to the three UN drug treaties, '*which define parallel contrasting systems for the absolute prohibition of almost all other non-medical drug markets*'.[83]

As noted in **Section 6.5.1** the Government's ACMD has expressed interest in exploring non-criminal sanctions for drug possession[72] and many of the UK's leading drug service providers have expressed support for exploration and debate around the legal framework relating to drug use.[108-113] Internationally, support for such moves is far wider – as demonstrated by initiatives such as the Vienna Declaration in 2010[80] and the Beirut Declaration in 2011.[114] The UKDPC report in 2012, *A fresh approach to drugs*, proposes a new approach to the ways in which Government and society respond to drug problems.[81] It provides an analysis of the evidence for how policies and interventions could be improved, with recommendations for policy makers and practitioners to address the new and established challenges associated with drug use.

While support for moves in this direction has gathered increasingly mainstream intellectual, political and public support, the current legal framework presents an impassable obstacle. The law is absolutist in nature; it does not allow for experimentation with any forms of legally regulated non-medical drug production and supply.

6.8 Conclusions

This chapter highlights the shortage of robust evidence relating to the benefits of the present prohibitionist framework in terms of deterring use or reducing availability and presents some evidence that the effects are, at best, modest (see **Sections 6.2** and **6.3**). The evidence suggests that the costs of enforcement are high (see **Section 6.4.5**) and prohibition has created a range of unintended health, social and economic costs (see **Section 6.4**).

Some commentators have gone on to argue that the benefits of the UK's current system are questionable and that there is a pressing need to explore whether a new and/or modified legal and policy framework is required. The assumption is that a different policy framework holds the potential to be more effective than the status quo. Other commentators have been more cautious: for this group, the lack of research into the effects of criminalising illicit drug use and possession does not, in itself, lead to the position that new or amended regulations are required.

Doctors have a key role to play in taking this debate forward and this is discussed in **Chapter 11**.

Summary

- For the last half century, prohibition and criminalisation has been the dominant policy for drug control, both nationally and internationally.
- It is very difficult to separate the impact of drug policy from the wider effects of social policy and environmental factors on drug-using behaviour.
- Levels of drug consumption do not necessarily follow predictable economic patterns in a linear way, where an increase in price leads to decreased use.
- It is difficult to predict supply and demand of illicit drugs, as all trade is illegal; decreased availability of one drug may result in users turning to other drugs that are more readily available.
- Illegally sourced drugs are of variable quality and purity, with clear adverse health implications for users.
- Criminalisation increases the health risks of illicit drugs by encouraging use in unsafe environments and through dangerous methods of administration. It also deters users from approaching health professionals for treatment.
- A prohibitionist approach creates a lucrative opportunity for criminality and leads to high levels of acquisitive crime among dependent users.
- The stigmatisation of vulnerable populations of drug users also has significant public health implications.
- The illicit drug trade has deleterious effects on development and security in many of the world's most fragile regions and states.

- The national budget required for law enforcement, the criminal justice system and dealing with the costs of drug-related crime is several times higher than the amount spent on drug-related health interventions.
- The existing legal framework directly impacts on the ability of medical professionals to gain access to and treat problematic drug users.
- Debate on liberalisation of drug policy is contentious, with strong feelings on both sides of the argument.
- There is widespread confusion about the use of terms such as 'decriminalisation' and an insufficient understanding that criminalisation can operate in tandem with other forms of regulation, supervision and intervention.
- Alternative legal frameworks include decriminalisation (eg sentencing reform), regulation (within a legislative framework), and free market legalisation.
- There is a shortage of robust evidence relating to the benefits of the present prohibitionist framework in terms of deterring use or reducing availability.
- The evidence suggests that the costs of enforcement are high and that prohibition has created a range of unintended health, social and economic costs.
- While some commentators argue that the benefits of the UK's current system are questionable, and that there is a pressing need to explore whether a new and/or modified legal and policy framework is required, other commentators have been more cautious. Among this latter group of commentators, the lack of research into the effects of criminalising illicit drug use and possession does not, in itself, lead to the position that new or amended regulations are required.