

DRUG POLICY IN THE UK AND ITS INTERSECTION WITH INTERNATIONAL HUMAN RIGHTS

Submission to the Office of the High Commissioner for Human Rights from Release

Release welcomes the opportunity to submit evidence to the Office of the High Commission of Human Rights (OHCHR) in pursuance of Human Rights Council Resolution A/HRC/28/L.22 which “Requests the United Nations High Commissioner for Human Rights to prepare a study... on the impact of the world drug problem on the enjoyment of human rights”¹.

Release is the UK centre of expertise on drugs and drugs law – providing free and confidential specialist advice to the public and professionals for over forty years. Release has been at the forefront of delivering accurate information to the public on drugs and drug policy for many years using a variety of media platforms. Release also aims to raise awareness of how UK drug policy and legislation impacts on those who use drugs in our society. The organisation advocates for changes to UK drug policy, based on our clients experiences, to bring about a fairer, more equitable and compassionate legal framework to manage drug use in our society.

The organisation delivers five key frontline services: legal outreach services; drug and alcohol counselling; expert witness testimony; a national advice service; and a youth stream which focuses on stop and search. Through the delivery of these services we hear directly from those most affected by the UK’s drug laws in particular those impacted by drugs policing, the criminal justice system more broadly and those who use drugs problematically. Often the perception is that the human rights abuses of people who use drugs is confined to certain parts of the world but in our view people in the UK who use drugs, particularly those whose use is considered problematic, are subject to high levels of discrimination and marginalisation. Below is detailed practices in the UK that engage a number of human right obligations including:

Right to Health (Constitution of the World Health Organisation (WHO) 144; Article 25 of the Universal Declaration of Human Rights (‘UDHR’); Article 12 International Covenant on Economic, Social and Cultural Rights 1966 (‘ICESCR’))

States party to the International Covenant on Economic, Social and Cultural Rights 1966 sign up to the ‘highest attainable standard of physical and mental health’ (Article 12). It is well evidenced that harm reduction interventions, including the provision of Opiate Substitute Treatment (‘OST’), are effective at reducing the harms associated with illicit drug use. Harm reduction is defined as ‘policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits people who use drugs, their families and the community’². The UK has a long tradition of delivering harm reduction based interventions with many citing the introduction of needle exchanges in the 1980’s as the reason we have one of the lowest rates of HIV

¹ http://ap.ohchr.org/documents/dpage_e.aspx?si=A/HRC/28/L.22

²Harm Reduction International, 2015, ‘What is Harm Reduction?’, <http://www.ihra.net/what-is-harm-reduction>

rates amongst people who use drugs (PWUDS). However in recent years this commitment to harm reduction, especially OST, has seriously diminished. The last Coalition Government, in particular the Conservative partners, introduced a new strategy that focused on abstinence as the goal of treatment at the expense of methadone maintenance treatment.

“Methadone maintenance treatment is the most researched treatment currently available for people who are dependent on opioids. Its use is supported by an evidence-base developed over almost 40 years and from across many different countries. It retains patients in treatment for longer than any alternative, non-replacement therapy, and has a superior effect on the reduction of heroin use and crime associated with opioid dependence. It is effective at reducing HIV risk behaviours and there is evidence that it also reduces the risk of mortality from opioid use.”³

Despite the evidence that methadone saves lives, is cost effective, reduces drug related deaths, reduces the transmission of blood borne viruses, and, when used as part of a holistic treatment approach, can stabilise someone, hence improving the quality of their life, the current UK drug strategy has moved away from this approach. In fact we would say that we are witnessing the politicisation of drug treatment.

The political environment has seen the issue of drug treatment polarised, with some policy makers and Government representatives pursuing an abstinence focused treatment system at the expense of evidenced harm reduction interventions. Release supports a treatment system that offers all options but that the decision as to what is the best treatment for an individual is one taken by that person and their clinician and not one that is driven by political imperative and ideology.

Repeatedly Ministers have asked the Advisory Council on the Misuse of Drugs (‘ACMD’) to consider the evidence for time limited methadone, and repeatedly the ACMD has said there is no evidence to support this approach.⁴ Despite this very clear statement from the ACMD Government Ministers have attacked their findings in the media, with one stating, “It remains that the culture of prescribing methadone has proved incredibly stubborn and difficult to break. There is still a huge amount more that Government must do, so that in practice treatment is about full recovery instead of maintenance”⁵.

This political ideology and rhetoric has had a direct impact on many drug treatment providers and commissioners of services and has been reflected in public health outcomes. The Public Health Outcomes Framework has only one indicator in relation to drug treatment and that is the ‘successful completion of treatment’ with no return within 6 months. The means many services are having to evidence their performance through this lens.

Through the services we provide at Release we have seen more and more punitive measures imposed on people, and whilst this is not the case in all areas, we are seeing a postcode lottery with some services moving away from a compassionate supportive treatment environment to one which is increasingly punitive. Punitive measures include:

³ Neil Hunt et al, 2003, Review of the Evidence-Base for Harm Reduction Approaches to Drug Use, at 3.2.12, <http://www.ihra.net/files/2010/05/31/HIVTop50Documents11.pdf>

⁴ ACMD, 2014, Time limiting opioid substitution therapy, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/371521/ACMD_RC_Time_limiting_OST_061114.pdf

⁵ <http://www.telegraph.co.uk/news/politics/conservative/11233664/Now-fight-the-methadone-industry-that-keeps-addicts-hooked-says-lain-Duncan-Smith.html>

- ‘therapeutic discharge’ where a client is suspended from a service for behavioural issues – often, these issues are very low level and can include simple disputes between the client and a member of staff - in many of these cases the client’s methadone prescription is also withdrawn, contrary to the Orange Guidelines (National Guidelines for OST) and National Institute of Clinical Evidence (NICE) TA114⁶.
- coerced reduction of prescribed methadone and buprenorphine dosage.
- methadone prescription being made conditional on engagement with other interventions.
- people being moved from weekly pick up of methadone to daily supervision regardless of the circumstances and in contravention of NICE TA 114.

This is all happening in the context of a 32% rise in heroin and morphine drug related deaths according to last year’s data from the Office of National Statistics on drug related deaths⁷.

In no other area of treatment would we see the choice of the individual to be able to access a widely available and evidenced treatment at the expense of political ideology. Unfortunately, this is the case in the UK and we would respectfully submit that this falls well below the required standard set by the ICESCR.

Another area of concern is the discrimination of people who use drugs resulting in the withholding of opiate based pain relieve medication. Reports from people who use drugs problematically, or who have a history of such use, highlights the stigma they suffer at the hands of medical professionals who are unwilling to provide appropriate and/or sufficient pain relief medication leading to unnecessary and distressing pain being suffered by the patient.⁸

Right to be Free from Discrimination (Article 7 UDHR; Article 26 of the International Covenant on Civil and Political Rights 1966; International Convention on the Elimination of All Forms of Racial Discrimination 1965; Convention on the Elimination of All Forms of Discrimination Against Women 1979)

Racial Discrimination in the under current UK Drugs Law /Policy

Release and the London School of Economics 2013 report ‘[The Numbers in Black and White: Ethnic Disparities into Policing and Prosecution of Drug Offences in England and Wales](#)’ highlighted how drugs policing and drugs prosecutions impacted disproportionality on Black Minority and Ethnic (‘BME’).⁹ The main findings of that report were:

⁶ NICE, 2007, Methadone and buprenorphine for the management of opioid dependence, <http://www.nice.org.uk/guidance/ta114>

⁷ ONS, 2013, Deaths Related to Drug Poisoning in England and Wales, <http://www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/england-and-wales---2013/stb---deaths-related-to-drug-poisoning-in-england-and-wales--2013.html>

⁸ <http://www.actiononaddiction.org.uk/Documents/The-Management-of-Pain-in-People-with-a-Past-or-Cu.aspx>

⁹ Eastwood, Shiner & Bear, 2013, The Numbers in Black and White, Release, <http://www.release.org.uk/publications/numbers-black-and-white-ethnic-disparities-policing-and-prosecution-drug-offences>

- In 2009/10 the overall search rate for drugs across the population as a whole was 10 searches per 1000 people. For those from the white population it was 7 per 1000, increasing to 14 per 1000 for those identifying as mixed race, 18 per 1000 for those identifying as Asian and to 45 per 1000 for those identifying as black.
- Black people were, in other words, stopped and searched for drugs at 6.3 times the rate of white people¹⁰, while Asian people were stopped and searched for drugs at 2.5 times the rate of white people and those identifying as mixed race were stopped and searched for drugs at twice the rate of white people. This is despite the fact that drug use is lower amongst both the black and Asian communities compare to the white community.
- The policing of drugs is driving racial disparities in stop and search across England and Wales. When drugs searches are removed from the data for all 'reasonable suspicion' searches, disproportionality for black people drops to 5 times the rate of white people (rather than 6.3 times for drugs). For the Asian community rates of disproportionality more than halve when drug searches are excluded.
- In London the Metropolitan Police Service ('MPS') carries out drug searches at a rate of 34 per 1000 across the population as a whole, rising to 66 per 1000 for black people.
- Black people in London are stopped and searched at nearly three times the rate of white people. Rates of disproportionality vary throughout the capital, with Kensington and Chelsea and Richmond reporting the highest rates (black people are stopped and searched at 5 to 6 times the rate of whites).
- Large numbers of young people are being subject to police stop and search for drugs. In 2009/10 half the 280,000 drug stop searches carried out by the Metropolitan police were on young people aged 21 years or below. Just over 7600 were of children aged 15 or below.
- Across England and Wales only 7 per cent or so of drug stop and searches end in arrest. As a result of almost 550,000 stop and searches for drugs in 2009/10, only 40,000 people were arrested.
- Black people are arrested for a drugs offence at 6 times the rate of white people and Asian people are arrested at almost twice the rate of whites.
- Across London black people are charged for possession of cannabis at 5 times the rate of white people. For cannabis warnings the rate is 3 times. This jump in disproportionality at the charge stage demonstrates that black people are more likely to receive a harsher police response for possession of cannabis.
- Black people in London who are caught in possession of cocaine are charged, rather than cautioned, at a much higher rate than their white counterparts. In 2009/10 the Metropolitan Police charged 78 per cent of black people caught in possession of cocaine compared with 44

¹⁰ In 2008/09 and 2009/10 black people were, respectively, 6.7 times and 6.3 times more likely to be stopped and searched for drugs in England and Wales than white people.

per cent of whites. Alternatively, 22 per cent of black people were given a caution compared with 56 per cent of whites.

- Black people are subject to court proceedings for drug possession offences 4.5 times the rate of whites; are found guilty of this offence at 4.5 times the rate; and are subject to immediate custody at a rate of 5.0 times that of white people.

(The above bullet points are taken directly from the Executive Summary of the Release/LSE report, 'The Numbers in Black and White: Ethnic Disparities into Policing and Prosecution of Drug Offences'¹¹)

Discrimination of Women under Current UK Drugs Law / Policy

In the UK the negative impact of general trends in drugs policy and law is clear. Particularly so with regard to women and their experiences in the criminal justice system. In 2013 4,475 drug cautions were given to women drug users and another 4,868 went on to be charged before a criminal court.¹² Of this last group, the largest percentage of sentences given fell in the 2 to 3 year custodial category.¹³ In contrast to this, a staggeringly low number of action plans or treatment orders were given.¹⁴ Indeed, the UN Committee on the Elimination of Discrimination against Women has made clear concerns it has, that are widely held, about incarceration or criminalisation for minor infringements of drugs laws.

The impact on the future of these women as a result of heavy-handed sentencing, as well as on secondary parties such as their children, cannot be underestimated. Not only is the situation women face prior to sentencing or cautioning unique, but once the sentence is served or the caution given, the effects of these criminalising measures also have a unique and far-reaching impact on the lives of women.

The criminal justice system in the UK does not seem to account for the often unique situation women drug users face. Often, they are socially and emotionally tied to a circle or relationship which not only exacerbates their drug use but can act as a form of direct or indirect duress in their drug using. In addition, these relationships can also present other additional problems – such as sexual and physical abuse, low self-esteem, lack of familial support or other supportive connections.

The UN Bangkok Rules (on the standards of treatment of women prisoners) state that, “[W]omen offenders shall not be separated from their families and communities without due consideration being given to their backgrounds and family ties.” It is evident this ideal has not been brought into practice enough. Though discrimination based on sex is generally prohibited in UK and international law, it is clear that there is a huge gap in the tailoring of drug policy towards the often unique situation of women, resulting in an indirect form of discrimination.

Other issues which engage international human rights are detailed in the table below:

¹¹ Ibid at 8

¹² Ministry of Justice, 2013, Criminal Justice System Outcomes by Offence, England and Wales, 2009 – 2013, <https://www.gov.uk/government/statistics/criminal-justice-statistics-quarterly-december-2013>

¹³ Ibid

¹⁴ Ibid

Human Right	International Human Rights Convention	Violation details
Social economic	<ul style="list-style-type: none"> • Article 22 Universal Declaration of Human Rights, 1948 • Article 6 & 7 International Covenant on Economic, Social & Cultural Rights, 1966 	<ul style="list-style-type: none"> • Proposed mandatory drug testing for welfare benefit recipients in the Welfare Reform Bill in 2009, which were removed • Probable Government proposals in 2015 (in light of Government Manifesto pledges) for benefits to be reduced if claimants refuse drug treatment • Closure of and eviction from homes where specified drug offences are alleged to have led to anti-social behaviour (Anti-Social Behaviour, Crime & Policing Act 2014) • Seizure of alleged proceeds of crime under the guise of disrupting supply chains, despite low value of assets
Privacy	<ul style="list-style-type: none"> • Article 12 Universal of Human Rights, 1948 	<ul style="list-style-type: none"> • Scale of stop and search – 50-75% of all stop and searches are for drugs depending on area. Her Majesty’s Inspectorate of Constabulary found that the majority are for low level offences (HMIC (2013) <i>Stop and Search Powers: Are the police using them effectively and fairly?</i> - https://www.justiceinspectors.gov.uk/hmic/media/stop-and-search-powers-20130709.pdf) • People can be detained and strip searched before arrest if the police have ‘reasonable suspicion’ that they are in possession of drugs. Some of those who are strip-searched are not always taken to a police station. A ‘designated area’ can suffice and this can include a tent or a police station that is no longer in use • Use of sniffer dogs is widespread, with positive indications creating sufficient reasonable suspicion for a search despite evidence showing lack of effectiveness http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3078300/ • Disclosure of medical records to employers, or other bodies, where drug use has been disclosed to a

		<p>Doctor (even where this is purely recreational use)</p> <ul style="list-style-type: none"> • Drug testing in the workplace for jobs which do not have a safety-critical element, and especially where testing is to determine presence of a drug in the system rather than if the employee is actually under the influence
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In addition to the above Release would like to highlight the unnecessary criminalisation of people who use drugs and disproportionate sentencing of drug offenders.

Unnecessary Criminalisation for Possession of Drugs

Every year approximately 70,000 to 80,000 people are criminalised for possession of drugs in England and Wales¹⁵. In the last 15 years we have criminalised over 1.5 million people¹⁶. This is despite the evidence supporting the fact that this is an unnecessary response and one that create greater harms for people who use drugs, including negative outcomes in relation to employment; education; relationships; and housing. In addition, initial contact with the criminal justice system – often a result of first time possession of drugs for personal use - increases the risk of recidivism and further contact with law enforcement.¹⁷

In 2012 Release published ‘A Quiet Revolution: Drug Decriminalisation Policies in Practice across the Globe’ which looked at 21 jurisdictions across the world that had adopted a decriminalisation¹⁸ model either in relation to all drugs or in relation to cannabis. Our analysis of those countries showed that the legal framework had little or no impact on the levels of drug use. This was also the finding of the European Monitoring Centre on Drug and Drug Abuse (EMCDDA) in their 2011 report which looked at the relationship between cannabis and changes in the penalties available¹⁹. Finally, the UK Home Office launched a report on 30 October 2014 which looked at 11 countries around the world that had adopted different approaches to tackling drugs, from Japan and Sweden which have harsh penalties for drug possession offences through to Portugal and Uruguay which do not criminalise use. The report found that there was "not ... any obvious relationship between the toughness of a country's enforcement against drug possession, and levels of drug use in that country."²⁰

¹⁵ Ibid

¹⁶ Ministry of Justice, 2013, Drugs: Police Cautions and Convictions, Answer to Parliamentary Question asked by Caroline Lucas MP (25 April 2013) <http://www.theyworkforyou.com/wrans/?id=2013-04-25d.150855.h>

¹⁷ McLaren J, Mattick RP, 2007, *Cannabis in Australia: use, supply, harms, and responses*. Sydney: National Drug and Alcohol Research Centre, University of New South Wales, p.560.

¹⁸ For clarity, the term ‘decriminalisation’ is generally accepted by those in the policy field as meaning that drugs are still illegal, but either the police decide not to enforce the laws (a de facto model) or that possession and use are dealt with through the civil system (a de jure model).

¹⁹ http://www.emcdda.europa.eu/attachements.cfm/att_143743_EN EMCDDA AR2011 EN.pdf

²⁰ Home Office, 2014, Drugs: International Comparators, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/368489/DrugsInternationalComparators.pdf

Lack of Proportionality in Sentencing

When comparing current sentencing levels for drugs, which are invariably crimes without a direct victim, against other offences disproportionate sentencing occurs. Considering the offence of importation clearly demonstrates this. Importation of 1kg of heroin or cocaine 'leading role' (directing or organising buying and selling on a commercial scale) results in a starting point of sentence of 11 years imprisonment, within a range of 9 – 13 years imprisonment. Whereas, for the humiliating offence of rape against an adult victim there is a starting sentence point of 8 years in custody within a range of 4 – 8 years. Similarly, Grievous Bodily Harm (s.20 Offences Against the Person 1861) with the greatest level of harm and a high level of culpability results in a starting point of 3 years within a range of 2 ½ - 4 years. Street robbery with serious physical injury resulting from significant force and/or weapon being demonstrated further disproportionality with a starting point of 8 years imprisonment, ranging from 7 – 12 years imprisonment.

In line with the concept of offence seriousness being one of the overarching principles of sentencing, seriousness should be assessed in relation to culpability and harm. In drawing comparisons with the starting points and ranges of other serious offences it is clear that sentencing guidelines for drug offences in England and Wales result in disproportionate sentencing. Each of the comparative offences above involves direct harm to an individual victim, including both physical and mental harm, but all result in much lower sentence starting points and ranges. It is outrageous that someone who subjects their victim to the humiliating experience of rape will receive a shorter sentence than someone who imports 1kg of heroin or cocaine. Whilst it can be argued that there is a risk of harm to the wider public in importation cases, this is a presumed harm in each instance rather than the direct proven harm in rape, GBH and robbery.

Conclusion

Release supports the International Drug Policy Consortium's recommendations in its submission of the ONCHR, namely:

"In preparation for the UNGASS on drugs in April 2016, the IDPC network has agreed a set of core policy asks:²¹

- 1. Ensure an open and inclusive debate – one inclusive of all UN agencies, civil society and affected populations, and one which considers all options and issues.*
- 2. Re-set the objectives of drug policies – focusing not on seizures, arrests and crop destruction, but instead on wellbeing, health, drug markets, development and human rights.*
- 3. Support policy experimentation and innovation – including the establishment of an Expert Working Group to further explore the existing tensions between the international drug conventions and other UN treaties (such as human rights law).*
- 4. End the criminalisation of people who use drugs and subsistence farmers involved in the cultivation of drug-linked crops.*
- 5. Commit to the harm reduction approach.*

We would also strongly recommend that OHCHR seeks to ensure, and plays a key role in, a formal human rights oversight mechanism of the existing drug control infrastructure – bridging the gap between Geneva and Vienna to guarantee greater system coherence and more humane drug policies."

²¹ <http://idpc.net/publications/2014/10/the-road-to-ungass-2016-process-and-policy-asks-from-idpc>