The UK Drug Policy Commission

Evidence to the Home Affairs Committee inquiry into drugs

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The UK Drug Policy Commission (UKDPC) is an independent body providing objective analysis of evidence related to UK drug policy. It aims to improve political, media and public understanding of drug policy issues and the options for achieving an effective, evidence-led response to the problems caused by illegal drugs.

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UKDPC brings together senior figures from policing, public policy and the media along with leading experts from the drug treatment and medical research fields:

Summary

This submission is not an exhaustive summary of the evidence for all areas of drug policy, but rather our view of some of the key issues that require attention. We have extracted key points from our reports and submissions, which we have referenced and copies of which are supplied with this submission as appendices. We would be very pleased to add further detail to these areas or to respond on issues that we have not covered.

We have identified 13 key points for consideration:

Understanding the drug problem in the UK

1. Drug use is not a single coherent phenomenon: there are many different causes and experiences of use and this complexity needs to be reflected in the range of policy responses. As such, drug use should be seen as one aspect of social policy and not treated in isolation from other issues.

2. Drug policy interventions have harms and unintended consequences that are often not recognised and there is a need for more effort to be made to include these when designing and implementing interventions and overall policies and in evaluating their cost-effectiveness.

The overarching aims and approach to drug policy

3. The Strategy aim of enabling people with drug dependence problems to recover is welcomed but it is important that this is person-centred and encompasses a range of different pathways and support services.

4. It is also important to recognise and build on the successes of past strategies and the strong evidence underpinning some public health measures that tackle some of the harms associated with serious drug problems, such as through needle exchanges, substitute prescribing and blood-borne virus (BBV) immunisations.

5. The rapid introduction of PbR for funding treatment services has the potential to disrupt service delivery to vulnerable individuals and requires carefully phased introduction and evaluation with an emphasis on using evidence to design policy. Comparison with alternative models for incentivising recovery should be an important component of any evaluation programme.

6. The Drug Strategy should have two other overarching aims: one to improve the health and wellbeing of drug and other substance users and their families, the other to improve public safety in relation to the operation of drug markets.

Measuring impacts and effectiveness

7. Despite the explicit aim of basing the Drug Strategy on evidence, there are a number of parts of the strategy for which evidence is weak, in particular in the area

of enforcement. These gaps require mitigation by carefully targeted and well-designed trials of competing interventions.

8. We recommend the inclusion of a clear programme for research development and evaluation of drug strategies and policies alongside the promotion of evidence amongst professionals (ie a 'knowledge pillar') in future drug strategies.

Getting the legal frameworks right

9. The current legal control systems for psychoactive substances are inconsistent. The new psychoactive substances provide an opportunity to develop and evaluate new approaches to drug control. This could provide evidence to support a complete review of the legal framework for controlling all psychoactive substances.

Challenges of implementation

10. Disinvestment, fragmentation and marginalisation pose threats to the continued success of drug policies. It is important that drug issues continue to be highlighted and championed both at the national and local level, and that we deal with drug issues with a focused, integrated and evidence-based approach.

11. Stigma experienced by recovering drug users is a fundamental barrier to delivery of the Drug Strategy. A campaign should be developed to address this.

Rethinking how we make drug policy

12. The current system for provision of independent advice and analysis of the evidence for drug policy to inform the government, parliament and the public could benefit from review and reform.

13. National and international evidence indicates that the current system of drug control produces negative unintended consequences, and that realistic alternatives exist that have the potential to address these without leading to significant new problems. These alternatives, such as the replacement of criminal sanctions for personal possession of controlled drugs with a system of civil sanctions, are worthy of serious consideration.

Introduction

In responding to the inquiry, we have grouped the questions posed by the Committee into a number of broad themes and have addressed these questions and other relevant issues together under these broader headings. To assist the Committee in identifying the sections that have relevance to the different questions, we have placed the questions covered within each theme in italics at the start of the section. We have identified key points from a range of our reports and submissions, which we have referenced; copies of the full documents are appended with our submission. We would be very pleased to add further detail to these areas or to respond on issues that we have not covered within this submission

Understanding the drug problem in the UK

The comparative harm and cost of legal and illegal drugs

The links between drugs, organised crime and terrorism

1. Illicit drugs and their associated problems are often discussed in policy terms as if they were manageable as a single set of issues, with the term 'drug problem' synonymous with heroin or crack addiction, and any drug use seen as being qualitatively different from use of legal psychoactive substances, such as alcohol.
2. It is important to acknowledge that different drugs do not present the same level of potential harms, even if the relative rankings are the subject of debate.[1] While for many of the estimated 12 million or more people in the UK who report having used drugs at some time in their lives, such use will have been without serious consequences, there is a range of problems that may be associated with different types of use. For example, amongst 'recreational' users there is a strong overlap with alcohol use; there is a potential public health issue with the use of cutting agents which may affect both occasional and dependent users; and injecting drug use is still strongly associated with blood-borne virus infections.
3. The drivers for use are similarly varied and drug use is influenced by a wide variety of factors, including employment opportunities, inequality, social trends and other cultural influences. These factors also include the perceived benefits derived from use, which may include relief from mental or physical distress, cognitive enhancement, as well social benefits. People also vary in how they respond to drugs and in their ability to deal with any negative effects associated with use.
4. Given this variety amongst individual users, in the contexts of use, and among different drugs, there is a need for a more considered and nuanced policy response that recognises this diversity and goes beyond simply targeting drug-

[1] Nutt, D et al, *Development of a rational scale to assess the harm of drugs of potential misuse*, *Lancet* 369, 24 Mar 2007; Nutt et al. *Drug Harms in the UK: a multicriteria decision analysis*, *The Lancet*, 376, 1558-1565, 6 Nov 2010 and subsequent correspondence in *The Lancet*, 377, Pages 551-555, 12 Feb 2011.

consuming behaviours (eg seeking to restrict access to drugs). Recognising this allows us to identify a wider set of opportunities and levers that can be used in order to influence drug use. Drug use cannot be seen in isolation from other social and economic policy issues.

5. The 2010 Drug Strategy goes some way towards recognising this complexity, in that it seeks to address dependence on all drugs and recognises the overlaps between alcohol and drug dependence. However, it still emphasises the traditional responses that focus primarily on the drugs themselves rather than the drivers and contexts that are associated with harmful drug use. We should instead expect to take very different approaches to different kinds of drug issues.

6. The best estimate of the relative costs associated with drug misuse is £15.4 billion for Class A drug use in 2003/04[2] but there were many limitations to the data on which that was based, and some people think this is an overestimate. The estimates for alcohol also vary considerably for example, The Institute for Alcohol Studies has reported the estimated costs of alcohol misuse are in excess of £15bn in 2004[3] while a 2008 BMA report cited figures ranging between £20-50bn+[4].There are clear taxation and other economic benefits also associated with the alcohol trade which off-set some of these costs; these have been estimated at between £18 and £24 million.

7. The Impact Assessment for the Drug Strategy 2010 contained no figures for either the costs or benefits of the various interventions. It also made many assumptions about costs and benefits of policies that are not backed up by any evidence (eg the benefits of temporary banning powers for legal highs, an issue that is discussed in more detail below). Currently, there is a great deal of emphasis on the costs involved in drug use and the benefits in reducing consumption, but very little attention to the unintended harms incurred by interventions. There should be more effort made to calculate this, for example recognising the financial and opportunity costs of enforcement as well as the harms that misplaced enforcement can cause. It should also be recognised that many people perceive their own drug use to have a benefit that outweighs its potential harms, including in substitution for other more harmful drugs, as well as pleasure and cognitive enhancements.

8. In this submission we have not sought to analyse the link between drugs, organised crime and terrorism. The Home Affairs Committee explored some of this in its previous report about the cocaine trade and we anticipate organisations such as SOCA and Transform will provide additional information about the perceived links.

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[2] Home Office Online Report 16/06, *The economic and social costs of Class A drug use in England and Wales, 2003/04*

[3] http://www.ias.org.uk/resources/factsheets/economic_costs_benefits.pdf

[4] http://www.bma.org.uk/images/Alcoholmisuse_tcm41-147192.pdf

Key Point 1: Drug use is not a single coherent phenomenon: there are many different causes and experiences of use and this complexity needs to be reflected in the range of policy responses. As such, drug use should be seen as one aspect of social policy and not treated in isolation from other issues.

Key point 2: Drug policy interventions have harms and unintended consequences that are often not recognised and there is a need for more effort to be made to include these when designing and implementing interventions and overall policies and in evaluating their cost-effectiveness.

The overarching aims and approach to drug policy

The extent to which the Government's 2010 drug strategy is a 'fiscally responsible policy with strategies grounded in science, health, security and human rights' in line with the recent recommendation by the Global Commission on Drug Policy

The extent to which public health considerations should play a leading role in developing drugs policy

9. There have been some notable successes in UK drug policy over the years, for example: public health 'harm reduction' approaches have delivered rates of HIV among injecting drug users that are among the lowest in the world[5] and saved thousands of lives; different types of drug treatment services, whether provided through the criminal justice system or outside, have helped many people overcome dependency; more money has been invested in treatment capacity so that there has been an increase in the numbers of people accessing drug treatment with lower waiting times; and information about drugs and other substances has secured a place in the national curriculum, although the impacts of this are hard to ascertain.

10. Successive UK drug strategies have recognised the need for these to be evidence-based but in practice the extent to which this has been the case is patchy. Treatment for drug dependency and addictions has a robust international scientific evidence base to justify the provision of public expenditure and has proven efficacy.[6] [7] The use of methadone and other prescribed medications as part of a treatment package has substantial research evidence in support, including use in prisons. Regrettably, this evidence has become the subject of considerable and unwarranted misrepresentation by those seeking to promote their favoured interventions. On the other hand, it is in the

[5] Mathers et al 'Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review'. *The Lancet*, 372, pp 1733-1745, 15 Nov 2008

[6] National Audit Office, *Tackling problem drug use*, 4 Mar 2010

[7] National Institute for Health and Clinical Excellence: *Methadone and buprenorphine for the management of opioid dependence*, *NICE technology appraisal 114*. 2007; *Naltrexone for the management of opioid dependence*, *NICE technology appraisal 115*. 2007; *Opiate detoxification for drug misuse*. *Clinical Guideline 52*. 2007; *Psychosocial management of drug misuse*. *Clinical Guideline 51*. 2007.

area of enforcement of the law to tackle drug markets and those involved in them, where the scientific evidence base is most thin. This has been remarked upon by the NAO[8] and was highlighted by a review of the evidence base underpinning law enforcement drug policies undertaken on behalf of UKDPC in 2008.[9] Important questions remain unanswered, like: whether it is more efficient to invest in upstream efforts in other countries, border and organised crime interventions or local policing; whether asset seizure offers value for money in enforcement; and which of the different sentencing and justice approaches are most effective.

11. The focus on recovery in the 2010 Drug Strategy is welcomed as is the fact that this did not constrain treatment and recovery services to 'abstinent only' approaches, as the current evidence base does not support that. Abstinence-oriented interventions should play an important part in a balanced treatment and recovery system, along with self-help and mutual-aid groups. But current evidence suggests that recovery is as varied as the individuals who suffer from dependence and a range of recovery pathways and support services will be necessary. As we have noted, recovery is a process, not an end state.[10] Research to establish how best to deliver recovery-oriented services that are person-centred and respect the different circumstances and needs of individuals should be part of the knowledge development associated with the Drug Strategy. While there is a pilot and associated evaluation of Payment by Results for Drug and Alcohol Recovery, this is only one means for incentivising recovery and we have some concerns about the approach being adopted[11]. A wider research effort should be undertaken given the centrality of the concept of recovery to the strategy and the varied ways in which the principle of 'payment by results' is being implemented across many associated service delivery areas.

12. The 2010 Drug Strategy sets out as overarching aims to reduce illicit and other harmful drug use; and to increase the numbers recovering from their dependence. Unfortunately, the Strategy avoids identifying specific metrics by which success overall will be evaluated. UKDPC support both of the stated aims but would wish also to see a stronger emphasis on positive measures to improve the health and wellbeing of drug and other substance users and their families, along with an aim of improving public safety in relation to the operation of drug markets.

Key point 3: The Strategy aim of enabling people with drug dependence problems to recover is welcomed but it is important that this is person-

[8] National Audit Office, op cit

[9] Appendix 1: UKDPC, *Tackling Drug Markets and Distribution Networks in the UK*, Jul 2008 (http://www.ukdpc.org.uk/publications.shtml#drug_markets_report)

[10] Appendix 2: UKDPC, *The UK Drug Policy Commission Recovery Consensus Group: A Vision of Recovery* , Jul 2008 (http://www.ukdpc.org.uk/Recovery_Consensus_Statement.shtml)

[11] Appendix 3: UKDPC, *By their fruits… Applying payment by results to drug recovery*, Feb 2011(http://www.ukdpc.org.uk/resources/UKDPC_PbR.pdf)

centred and encompasses a range of different pathways and support services.

Key point 4: It is also important to recognise and build on the successes of past strategies and the strong evidence underpinning some public health interventions that tackle some of the harms associated with serious drug problems, such as through needle exchanges, substitute prescribing and blood-borne virus (BBV) immunisations.

Key point 5: The rapid introduction of PbR for funding treatment services has the potential to disrupt service delivery to vulnerable individuals and requires carefully phased introduction and evaluation with an emphasis on using evidence to design policy. Comparison with alternative models for incentivising recovery should be an important component of any evaluation programme.

Key point 6: The Drug Strategy should have two other overarching aims: one to improve the health and wellbeing of drug and other substance users and their families, the other to improve public safety in relation to the operation of drug markets.

Measuring impacts and effectiveness

The criteria used by the Government to measure the efficacy of its drug policies

The cost effectiveness of different policies to reduce drug usage

13. The collection and analysis of evidence should be central to the development of drug policy, and evaluation of policies should be built into the implementation process. This does not currently happen effectively in practice. For example, there is no clear linkage between the overarching aims of the current Strategy (to reduce illicit and other harmful drug use; and to increase the numbers recovering from their dependence) and any objective outcome measures. Nor is there any clear model (with underpinning knowledge base or knowledge development strategy) between the interventions identified and the aims of the Strategy. As discussed earlier, the 2010 Drug Strategy Impact Assessment was extremely limited and was insufficient for predicting its likely impact and effectiveness. It therefore provides no foundation for a thorough evaluation of the Strategy and the promised evaluation framework has yet to be published.

14. This absence of logic models and measurement frameworks is a problem that we have also identified with respect to individual enforcement interventions and is, at least in part, responsible for the lack of evidence of effectiveness for enforcement. We have suggested a framework for approaching enforcement that could help to address this problem[12]. We believe the UK has a unique opportunity internationally to become a beacon of developing practice around measuring the impact of supply side interventions, but this would require

[12] Appendix 4: UKDPC, *Refocusing Drug-Related Law Enforcement to Address Harms*, Jul 2009 (http://www.ukdpc.org.uk/publications.shtml#hre_report)

political will and resource to invest in opening up to scrutiny what is, effectively, a closed system.

15. While the commitment in the current Strategy to developing and publishing the evidence base on what works, to develop an evaluation framework to assess the effectiveness and value for money of the strategy overall, and to review it on an annual basis is welcome, it is not clear how this will be done given the lack of clear outcomes or a model for interventions, let alone the necessary spending on research and evaluation. To address the shortfall, we have recommended in the past that a 'knowledge pillar' should be included as part of future drug strategies.[13] This would encompass a clear commitment and programme to build a stronger evidence base through independent research and development, evaluation of interventions and a subsequent programme of evidence promotion and workforce development amongst relevant professionals in the treatment, recovery, prevention and enforcement fields. This should introduce a greater emphasis on respecting where the evidence is strong, and identifying where further work is needed to evaluate existing policies and identify promising alternatives. It should also include a commitment to cease doing things that have been shown not to work. In the United States, SAMSHA has created and supported a series of regional 'knowledge transfer centres' to spread knowledge and good practice in the addictions treatment field.[14] The Substance Misuse Skills Consortium in England offers a foundation on which to develop a new approach.

Key point 7: Despite the explicit aim of basing the Drug Strategy on evidence, there are a number of parts of the strategy for which evidence is weak, in particular in the area of enforcement. These gaps require mitigation by carefully targeted and well-designed trials of competing interventions.

Key point 8: We recommend the inclusion of a clear programme for research development and evaluation of drug strategies and policies alongside the promotion of that evidence amongst professionals (ie a 'knowledge pillar' in future drug strategies).

Getting the legal frameworks right

The relationship between drug and alcohol abuse

The availability of 'legal highs' and the challenges associated with adapting the legal framework to deal with new substances

16. The inconsistencies in the ways we control various psychoactive and harmful substances have been widely noted. This becomes particularly evident in our approaches to new psychoactive substances ('legal highs'), where the response

[13] Appendix 5: UKDPC, *A Response to Drugs: Our Community, Your Say Consultation Paper*, Oct 2007 (http://www.ukdpc.org.uk/resources/Drug_Strategy_Consultation_Response.pdf); Appendix 6: UKDPC , *A Response to the 2010 Drug Strategy Consultation Paper*, Sep 2010 (http://www.ukdpc.org.uk/resources/Drug_Strategy_2010_Consultation_Final1.pdf)
[14] See: http://www.attcnetwork.org/index.asp

in the Drug Strategy is to simply seek to place these within the controls of the Misuse of Drugs Act (MDA) as a precautionary measure without any robust evidence of harms or of the likely impact of these controls. Resorting to the use of the 'precautionary principle' may provide comfort to some politicians and sections of the media. But in practice it has little utility and should be avoided in the field of drug control. The current policy of introducing temporary banning powers under the MDA relies on an enforcement capacity that may not exist. It also fails to take account of the potential harms associated with such controls if people continue to use the drugs (as the evidence suggests they will), ie the shift of supply to organised criminal groups, the loss of any possibility of control over content and quality, and the potential for substitution of even more harmful substances. Criminalising suppliers also makes it difficult to collect the information needed for assessing the harms, providing advice to users and mounting credible prevention campaigns. It also does not acknowledge the potential positive aspects that may be associated with new drugs, such as that they may substitute for more harmful ones, as may have been the case for mephedrone for which it is plausible to suggest that the recent decline in cocaine deaths may have been, at least in part, a result of people substituting mephedrone for cocaine.[15]

17. These problems would also apply to the ACMD's proposed solution of analogue controls. There are other drawbacks with this solution, as identified by Dr Les King in his submission to this inquiry. [16]

18. As we highlighted in our recent project looking at so-called 'legal highs'[17], a fundamental concern with the current approach is that it appears neither to be targeting clear desirable outcomes nor to be based on evidence of effectiveness. As indicated above, criminalising supply of all new psychoactive substances is likely to have negative unintended consequences. An approach that targeted the outcome of reducing harms to young people might draw on other legal responses such as using enhanced consumer protection powers (eg trading standards) to regulate the availability and nature of certain new substances. Approaches taken in other countries and the experience of regulation under the Intoxicating Substances (Supply) Act 1985 indicate the potential for this approach of using the legal control system to improve health and wellbeing, and public safety.[18]

19. We feel there is a clear missed opportunity here to test alternative approaches to control of substances and to begin to develop a more coherent, staged approach to regulation of the whole range of harmful substances. This would

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[15] Bird, S, *Banned drug may have saved lives, not cost them*, *Straight Statistics*, 22 Nov 2010, www.straightstatistics.org/article/banned-drug-may-have-saved-lives-not-cost-them

[16] King, L, Submission to the Home Affairs Committee, Dec 2011

[17] Appendix 7: UKDPC/Demos, *Taking Drugs Seriously*, May 2011 (http://www.ukdpc.org.uk/publications.shtml#legalhighs)

[18] New Zealand Law Commission, *Controlling and Regulating Drugs – A Review of the Misuse of Drugs Act 1975*, May 2011; EMCDDA *Responding to new psychoactive substances*. *Drugs in focus*. 22. December 2011; Hughes & Blidaru *Legal Responses to New Psychoactive Substances in Europe* EMCDDA, 19 Feb 2009.

recognise that the evidence suggests that use of psychoactive substances will persist and that the freedom to use substances is best limited proportionately to the known harms they cause. In the longer term, we suggest there would be value in a complete review of the way we control all psychoactive substances, legal and 'illegal', in order to reduce the clear inconsistencies and anomalies in the way we treat them and to develop a coherent and effective substance control framework, such as a Harmful Substances Control Act.

Key point 9: The current legal control systems for psychoactive substances are inconsistent. The new psychoactive substances provide an opportunity to develop and evaluate new approaches to drug control. This could provide evidence to support a complete review of the legal framework for controlling all psychoactive substances.

Challenges of implementation

Whether drug-related policing and expenditure is likely to decrease in line with police budgets and what impact this may have

The impact of the transfer of functions of the National Treatment Agency for Substance Misuse to Public Health England and how this will affect the provision of treatment

Whether the UK is supporting its global partners effectively and what changes may occur with the introduction of the national crime agency

20. The amount of change to delivery structures at the local level is unprecedented and is taking place during a period of serious financial constraints. As the changes are currently on-going it is not yet possible to be certain of the impact but it is important to identify both potential threats and opportunities in order to mitigate the former as far as possible and try and ensure advantage is taken of the latter. To this end we are undertaking research which seeks to document these issues.

21. As powers are devolved and ring fences are removed from some funding, it is apparent that there is a risk that funding for drug services will be deprioritised. There is some evidence that services for young people with substance abuse problems have begun to be reduced, and UKDPC research has identified an expectation among police forces that they will have less funding and time to proactively address drug problems. Our report on this is appended.[19] At the heart of this is the risk that, without strong local leadership, drug-related issues will be considered a lower priority than more 'mainstream' concerns within public health and law enforcement. A further challenge is the growing difficulty, under increasing devolution and localism, of identifying costs and benefits of particular policies, when funding may be allocated in one area (eg public health) and benefits felt in another (crime reduction). Sharing of evidence to ensure

[19] Appendix 8: UKDPC, *Drug enforcement in an age of austerity*, Oct 2011 (http://www.ukdpc.org.uk/resources/Drug_related_enforcement.pdf)

efficiency and best practice also stands at risk in a fragmented and increasingly market driven economy. Improved practices do not simply happen by osmosis and competition.

22. A fundamental impediment to successful implementation of drug policies is the huge barrier of stigma experienced by recovering drug users and their families as they seek to turn their lives around. This stigma stops people seeking help, promotes feelings of hopelessness that act as a barrier to change, and makes it difficult for them to obtain the jobs and accommodation needed to sustain recovery. Wide-ranging research carried out by UKDPC (appended) illustrates the many examples of stigmatisation by professionals in services, employers, the media and the general public and the ways this stigma has an impact on recovery.[20] Addressing this is an important issue for sustaining more responsible behaviours and also touches on the human rights of those recovering from drug use. In value for money terms, the financial gains made through treatment will be lost if reintegration is not achieved.

23. To achieve the desired goal of increasing recovery it is vital to tackle this stigma through a wide-ranging anti-stigma campaign, such as that which has successfully changed attitudes to mental health. This will take time but will be essential for effective delivery of much of the Drug Strategy.

Key point 10: Disinvestment, fragmentation and marginalisation pose threats to the continued success of drug policies. It is important that drug issues continue to be highlighted and championed both at the national and local level, and that we deal with drug issues with a focused, integrated and evidence-based approach.

Key point 11: Stigma experienced by recovering drug users is a fundamental barrier to delivery of the Drug Strategy aims. A campaign should be developed to address this.

Rethinking how we make drug policy

The independence and quality of expert advice which is being given to the government

Whether detailed consideration ought to be given to alternative ways of tackling the drugs dilemma, as recommended by the Select Committee in 2002 (The Government's Drugs Policy: Is It Working?, HC 318, 2001–02) and the Justice Committee's 2010 Report on justice reinvestment (Cutting crime: the case for justice reinvestment, HC 94, 2009–10).

24. Concerns have been raised about the pressures experienced by the ACMD, particularly concerning the timeframes under which they are required to act, and the shortage of resources available to them. This notwithstanding, we have broader concerns about the lack of evidence-based advice available to the government on all aspects of drug policy, beyond the ACMD's expert and

[20] Appendix 9: UKDPC, *Getting Serious About Stigma: the problem with stigmatising drug users*, Dec 2010 (http://www.ukdpc.org.uk/publications.shtml#Stigma_reports)

scientific remit. The Omand Review of the ACMD in 2010 considered some of these issues, but we are concerned that it was limited by narrow terms of reference. It may also be noted that there appears to be a lack of responsiveness by governments to the advice that is received, whether provided by the ACMD (for example the rejection of advice about the classification of cannabis and ecstasy) or by other informed bodies. We note that many of the recommendations of the Home Affairs Committee's 2002 report on drug policy were not acted upon, and that there has been no explanation for why these were not taken up.

25. UKDPC has recently launched a review of the governance of drug policy; the findings from this will be available in autumn 2012. This study involves an international comparison of governance systems, in the UK countries and in a number of other countries. Our review covers such issues as: the nature and role of independent expert advice; the nature and contribution of the media and public engagement exercises; parliamentary accountability systems and the availability of robust evaluation, evidence and performance data.

26. We finish this submission with some reflections about the perennial debate as to whether the UK government should rethink its drug policy in more fundamental ways. Unfortunately this debate has become polarised, requiring people to be identified with one camp or the other. There has been much discussion and analysis in many countries about the wisdom of processing people who use or possess drugs for personal use though the criminal justice system. The UNODC and the EU have considered this and attention was drawn to various initiatives taken in such countries as Portugal, Czech Republic and the Netherlands to remove or relax the use of criminal sanctions for small amounts of drugs, both possession and production/supply. Some of the results have been disputed but at the least we draw one broad lesson from these developments, which is that change is possible without leading to significant increases in consumption or associated harms.

27. In the UK, warnings, cautions, small fines for small personal possession offences lower level penalties have been introduced in recent years, alongside the use of community justice interventions to steer those with drug-related offences into treatment programmes.

28. While the UK processes a substantial number of people for minor drug offences through the criminal justice system (there were just over 200,000 recorded drug possession offences in England & Wales in 2010/11,[21] the majority of which were cannabis warnings and cautions), given the scale and everyday prevalence of drug use (it is estimated that well over a million people in England and Wales used drugs at least once in the past year[22]) the risk of receiving any penalty is quite low. Nevertheless, the costs to individuals, their families and society, of

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[21] Chaplin et al *Crime in England and Wales, 2010/11(2nd edition)*. Home Office Statistical Bulletin 10/11, July 2011.

[22] Smith & Flatley *Drug Misuse Declared 2010-11,* Home Office Statistical Bulletin 12/11, July 2011.

applying these penalties are significant. It might be argued that the UK has been heading in the direction of decriminalisation for some time. Crucially, this has corresponded with a trend of overall reduced drug prevalence and especially of cannabis, along with a stabilisation of the numbers of those with drug dependency and addiction problems. We conclude this trend could be carried further with either the replacement of criminal penalties with civil sanctions or other actions for personal possession offences, as the ACMD has also suggested.

29. When it comes to examining whether to change control and regulatory systems for the production and supply of drugs, the evidence is much more ambiguous. There is no doubt, as the ex-head of UNODC has said, there are many unintended consequences that have stemmed from the international and parallel domestic drug control systems that have been built up over the past half-century. The costs of production and supply control are considerable and yet there remain vibrant and innovative drug markets. As with any market, supply and demand co-exist and normal economic rules apply. Strict control of supply through enforcement does place increased costs on illicit producers and suppliers and it is plausible that these additional costs reduce demand to some degree through the normal pricing mechanisms. This is as true for controlled drugs as it is for alcohol and tobacco. What is open to question is whether the public spending costs of this enforcement activity is balanced through benefits such as less demand on health care, improved productivity and tax receipts.

30. Unfortunately, there is little concrete evidence to support arguments on both sides. What must remain of concern is that the example of tobacco and alcohol control and regulation is not encouraging about what a possible increased commercialisation of production and supply could bring. Whether such a regime could be applied to very widely used drugs like cannabis remains unclear. At the moment, the only substantial example of change in the production and supply control regime is the case of the production and sale of medical marijuana through approved outlets in the US. As with decriminalisation of personal possession cases in other countries, we conclude that change is feasible and consumption does not appear to have gone out of control. As to whether such change to the control and regulatory system would prove cost effective, in the absence of more robust and reliable data, we remain cautiously agnostic.

Key point 12: The current system for provision of independent advice and analysis of the evidence for drug policy to inform the government, parliament and the public could benefit from review and reform.

Key point 13: National and international evidence indicates that the current system of drug control produces negative unintended consequences, and that realistic alternatives exist that have the potential to address these without leading to significant new problems. These alternatives, such as the replacement of criminal sanctions for personal possession of controlled drugs with a system of civil sanctions, are worthy of serious consideration.