Release's Written Submission to the Home Affairs Committee's Inquiry on Drugs

24th March, 2022

Release is the national centre of expertise on drugs and drugs law in the UK. The organisation, founded in 1967, is an independent and registered charity. Release provides free non-judgmental, specialist advice and information to the public and professionals on issues related to drug use and to drug laws. The organisation campaigns directly on issues that impact its clients - it is their experiences that drive the policy work that Release does and why Release advocates for evidence-based drug policies that are founded on principles of public health rather than a criminal justice approach. Release believes in a just and fair society where drug policies should reduce the harms associated with drugs, and where those who use drugs are treated based on principles of human rights, dignity and equality. Release is in Special Consultative Status with the Economic and Social Council of the United Nations.

Summary

This submission addresses the failures of UK drug policy and evidences the health and social harms, and social and racial inequity, that our current drug laws (and the enforcement of those laws) has fostered. Release highlight that the current classification system under the MDA 1971, and where drugs sit within this system, is challenged by existing evidence on the relative harms of those drugs. We demonstrate that our current criminal justice approach is *itself* a barrier to accessing treatment services, seeking emergency medical assistance, and the development of a range of evidence-based public health responses (including establishing overdose prevention centres (OPCs), expanding drug checking services, and providing harm reduction equipment).

Release outline a number of reforms that could be made *within* the current MDA 1971 framework - including the provision of guidance/clarification to enable the legal operation of OPCs, and amendments to expand the range of paraphernalia provided for safer drug consumption. However, we also stress the need for national reform via a no punishment model of decriminalisation in the UK *de jure* (in law), which would decriminalise the possession of all controlled drugs under the MDA 1971 and other personal use offences. Release explain that this *is* possible in the UK given that: (1) the UK already has an operational model for decriminalisation in terms of the possession of drugs controlled under the PSA 2016; (2) decriminalisation is supported by the UN, WHO, ACMD, and numerous Committees that have come before, tasked with examining UK drug policy; and (3) international evidence from the now over 30 jurisdictions that have decriminalised the possession and use of drugs demonstrates that decriminalisation, when executed well, can save lives, reduce health harms, and reduce offending. Finally, this submission explores reform occurring across the globe in terms of regulated supply models, starting with cannabis reform, and we present the need for principles of social equity and racial justice to be a *core* feature of any legal framework for a future UK cannabis market.

1. The UK drug framework

Effectiveness of the UK drug framework in dealing with drug use and dependency, drug related deaths and drug related offending (1a)

The UK's drug framework is ineffective and fails in its own stated aim to reduce or eliminate drug use (an aim articulated by nearly every Secretary of State for the Home Department in the foreword to the various Drugs Strategies over the last twenty years). One in three adults have reported using a controlled drug in their lifetime.[1] In 2020, nearly 10 per cent of 16 to 59-year olds reported using an illegal substance in the previous year, this rises to 20 per cent for young adults,[2] whilst the rates of heroin and crack cocaine use have increased by 5 per cent between 2010 and 2017.[3]

The UK takes a largely criminal justice approach to drugs, using the drug laws and drug law enforcement as mechanisms to punish drug use, and the threat of punishment as a tool of deterrence. Yet, the Home Office's own analysis of drug polices in fourteen countries found that "there is no apparent correlation between the 'toughness 'of a country's approach and the prevalence of adult drug use".[4] This experience is borne out by countries that have ended criminal sanctions for possession and use of controlled substances, where there is no statistically significant impact on prevalence as a result of a new policy direction being implemented.[5]

The ineffective impact of drug law enforcement on the supply of drugs is acknowledged in a 2017 Home Office evaluation of the 2010 Drug Strategy. This evaluation found that despite spending an estimated £1.6 billion on drug law enforcement in 2014/15 (the Black Review estimated the spend to be just over £1.41 billion in 2016/17),[6] there was "little impact on availability" of drugs, with the market being described as "resilient".[7] Whilst acknowledging the limited impact drug law enforcement has on the supply of drugs, the Home Office evaluation also identifies "unintended consequences" associated with drug interdiction, including: increased violence in the market place resulting from enforcement activities; criminalisation negatively impacting on employment prospects; and parental imprisonment, which can have dire consequences for children, increasing the risks of child offending, experience of mental health problems, and problematic drug use.[8]

Not only does the UK's drugs framework not succeed in its own aim to reduce or eliminate certain drugs, it exacerbates and creates a myriad of harms for individuals and communities:

- Health harms - Drug-related deaths are at an all-time high across the UK,[9] accounting for a third of such deaths across the whole of Europe.[10] Opioid deaths have increased by 75 per cent since 2012, and there has been a 131 per cent rise in heroin/morphine deaths in the same period. Similar increases have been experienced in Scotland and Northern Ireland, and the Scottish government have declared the situation as a public health emergency.[11]

  The drivers for these deaths are complex, with inequalities and cuts to drug treatment due to austerity being two of the main factors resulting in these tragic and avoidable deaths. In addition, the risk of criminalisation hinders people seeking the support they need, this applies both in emergency situations and in relation to accessing drug treatment services. A recent report from the Higher Education Policy Institution (HEPI) into illicit drug use amongst students found that 29 per cent feared punishment if they were to disclose their drug use to their institution. This report also cited one study where 16 per cent of students who experienced or witnessed a "scary experience" did not go to hospital or seek help.[12] For those who experience drug dependency, fear of criminalisation, or at the very least, being perceived as a criminal first and foremost (and the associated stigma that creates), can result in reluctance to access treatment services. It is estimated that 54 per cent of those who died from an opioid related death had not been in contact with drug services in the preceding five years.[13]

- Economic & Social Harms - Over the last decade, 584,883 people have been prosecuted for drug offences, two thirds of these prosecutions were for simple possession of drugs.[14] This number does not include the hundreds of thousands of people who will have been criminalised by way of a police caution over the same period. The crippling effect of a criminal record has a profound impact on employment and consequentially, income levels. One study estimated that "of the twenty-eight thousand cannabis arrestees in 2010 (with average annual earnings of roughly £21,500) - the total loss of earnings through this scarring effect [criminalisation] is predicted to be just over £100m".[15] The impact of a criminal record can also affect educational aspirations and choices, be grounds for an eviction from rented accommodation, and can limit a person's life choices - including their ability to travel to other countries. An Australian study[16] comparing the outcomes of people who were criminalised for possession of cannabis against those who were subject to civil sanctions, found that those who had been criminalised were at greater risk of [re]offending - 32 per cent of respondents reported further contact with the criminal justice system compared to zero per cent of

respondents who received civil penalties. These findings should be read across the experience of those who have been criminalised for any controlled substance.

The social harms of drug law enforcement are not limited to the experiences of those caught in possession of drugs or those who supply drugs. Drugs policing is one of the main drivers of disproportionately in the criminal justice system, with the majority of stop and searches carried out under section 23 of the MDA 1971. Over half a million people are subject to police stop and search every year in England and Wales, with 69 per cent of all searches under the main police powers in the year ending March 2021 (2020/21) being searches for drugs (and this will largely be for possession of drugs).[17] In 2019/20, people from minority ethnic backgrounds were stopped and searched at 4.1 times the rate of White people, for Black people this disparity rose to 8.9 times[18] - *despite* reported drug use being lower amongst those from these ethnicities.[19,20] Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) – who have called for "an evidence-based national debate on the use of stop and search in the policing of controlled drugs" - also found that when searched, the "find rate" (i.e. when drugs were actually found in the possession of the person) was higher amongst White people (26.1 per cent) than Black people (25.8 per cent). Figures on racial and age disparity are also revealing, with Black men aged 18-24 being 19 times more likely to be stopped and searched than the general population. Black children (aged 10-17) were also stopped and searched at significantly higher rates than White adults and White children.[21]

Policing under the first lockdown in March 2020 is a worrying insight into how the drug laws are used to target people of colour. In April 2020, a month into the first national lockdown, stop and searches in London increased by 26 per cent on the previous month – rising from 23,847 searches in March 2020 to 30,608 searches in April – 70 per cent of these searches were for drugs. By May 2020, the number of searches carried out by the Metropolitan Police had increased to 43,948, an 84 per cent increase on March's figures, and the highest number of monthly searches since January 2012.[22] The rate of searches of Black people increased from 7.2 per 1000 in March to 13.6 per 1000 in May, with Black people stopped and searched at 4.2 times the rate of White people. Disturbingly, the highest rate of searches occurred in boroughs suffering the highest rate of COVID-19 deaths.[23]

These experiences are far from unusual, the recent case of 'Child Q', who was subject to a police strip search in her school without an appropriate adult present after teachers called the police because they suspected that she might be in possession of cannabis, is just one horrific example of the harms we cause to young people and children in the name of the drug laws.[24] Research that Release is currently undertaking shows that an estimated 90 per cent of strip searches are for drugs, and as repeatedly highlighted, this research indicates that these types of searches disproportionally impact people of colour.

For those caught in possession of drugs – only 1 in 5 searches result in a controlled drug being found. The inequity that *begins* with stop and search continues, with Black people and those from other minorities more likely to be arrested and prosecuted for the offence compared to White people - who are also more likely to get an out of court disposal. Black people are nearly 12 times more likely to be sentenced for cannabis possession when compared to the White population.[25] The inequalities continue throughout the criminal justice system, from prosecution to sentencing.

Classification of drugs under the MDA 1971 and the impact of the Psychoactive Substances Act (PSA 2016) (1a continued.)

The current A, B, C classification system for controlled drugs under the 1971 Act is unhelpful, un-evidenced, and arbitrary. A study of drug harms, published by the Lancet in 2010, found alcohol to be the most harmful substance.[26] The *least* harmful of the 20 drugs ranked was mushrooms containing psilocybin – currently a Class A drug. The notion that a person decides whether to use a drug based on its classification is again, not grounded in evidence. Cannabis is consistently the most popular illegal drug and is controlled as a Class B substance, whereas the second most popular is cocaine, a Class A drug.[27] However, reform of the classification system is not what is necessary to ensure the UK drug policies reduce harms, rather that requires wholescale reform focused on principles of harm reduction and *decriminalisation* in the first instance.

In fact, we already have an operational model for decriminalisation in the UK. The PSA 2016 does not criminalise or punish possession of substances that fall under the remit of that Act, except in custodial institutions. The Advisory Council on the Misuse of Drugs (ACMD), in 2016, recommended that the Government decriminalise possession of drugs controlled under the 1971 Act to bring it in line with the PSA 2016. That advice has not been published to date, with the Home Office refusing to release the papers, however media reported on the situation in 2021.[28]

The fact the PSA 2016 has not criminalised possession is a positive element of the Act, but in relation to the framework for restricting supply through the criminal law it has created significant harms, similar to those we see under the MDA 1971. The potency of novel psychoactive substances has increased since the Act came into force, the market shifted to the traditional illicit model, new substances continued to be produced, prevalence fell but this could be linked to a shift to Class A drug use, and there continued to be high levels of use amongst vulnerable populations, mainly people in prison and people who are street homeless.[29]

Reforming the current framework (1b)

The current framework predominantly frames drug use as a criminal justice matter, contributing to many of the harms outlined. Importantly, a criminal justice approach restricts the development of a range of evidenced public health responses, including overdose prevention centres, expansion of drug checking, and the provision of harm reduction equipment:

- Overdose prevention centres (OPCs) - OPCs, a space where people can use their own drugs under supervision and where overdoses can be reversed with naloxone (a medication that reverses the effect of an opiate overdose), are vital for engaging people who are not in contact with treatment services. As highlighted above, a large percentage of those who are dying of drug related deaths have not been in contact with treatment services for the last five years. This is in addition to the shockingly high rate of drug related deaths amongst the homeless population, which have more than doubled in the last 6 years.[30] OPCs are one way to overcome this problem. There are over 120 of these facilities operating in 12 countries across the world, providing a wealth of evidence for the effectiveness of OPCs to engage with people who inject or smoke drugs.[31] OPCs not only reduce risk of overdose and BBV infections among people who use drugs, they also reduce public injecting and drug-related litter. These facilities can also provide pathways to treatment and healthcare services.[32]

  The Government has repeatedly stated that they will not give permission to an OPC operating in the UK, on the basis that they condone drug use and that these facilities are unlawful under the MDA 1971. In relation to the first argument, that establishing an OPC would condone drug use, there is no evidence that such facilities encourage people to start injecting drugs, these facilities are specifically aimed at those who are already injecting in largely unhygienic conditions, usually in public spaces. With regards to the legal barriers, it is correct that those who would be accessing OPCs would be in possession of a controlled drug contrary to the s5 MDA 1971, but this is something we already manage in relation to needle and syringe programmes. The Crown Prosecution guidance on charging drug offences states the following:

  "These schemes [NPS] *need police and CPS co-operation because those who run and use them will necessarily commit offences under the Act…**Simple possession cases that are based on police surveillance at or near exchange centres should not normally be prosecuted**. The need to prevent the spread of serious infections outweighs the normal requirement for prosecution."*[33]

  There is no reason why similar guidance in relation to OPCs could not be developed, given that it would not be in the public interest to prosecute people accessing OPCs, in order to prevent overdose and deaths.

  Beyond the issue of possession of a controlled drug, the Home Office has listed a number of offences under the MDA 1971 that would be committed by staff of an OPC but have not provided a legal analysis of how

these offences would apply. This information would provide greater understanding of how possible legal liabilities could be managed. Ultimately though, the Government is responsible for the legislative agenda of Parliament, and could legislate for the legal operation of OPCs to ensure that some of the most marginalised and excluded in society get access to facilities that not only keep them safe but also can address their wider health and social issues. OPCs are permissible under the international drug control framework, as confirmed by the International Narcotic Control Board.[34]

- Expansion of paraphernalia provided at NSPs - Another limitation in attracting people into treatment settings is the laws prohibiting the supply of paraphernalia under section 9A of the Misuse of Drugs Act 1971. The exemptions to the law allow for the provision of specific sterile injecting equipment, to reduce the risk of BBVs. However, the provision of crack pipes to encourage safer use and reduce respiratory harms[35] is illegal, as is the providing of intranasal equipment to promote less sharing of such paraphernalia. Essentially, there are limited reasons as to why someone using stimulants would engage with a needle syringe programme (NSPs) unless they inject opioids. Yet, NSPs are often the first point of contact for someone engaging in services, and are an opportunity to address other health issues they may be experiencing; providing a route for referrals. Therefore, we would recommend that s9A of the MDA 1971 is repealed to allow for effective harm reduction responses across a range of substances. The provision of such equipment is permissible under the international drug control framework.

At the core of what needs to be reformed, is the focus on criminalising people who use drugs, this is why the UK Government should decriminalise possession offences and other personal use offences:

- Decriminalisation of drug possession offences and other personal use offences - Release advocates for the ending of criminal sanctions for possession of controlled drugs and other personal use offences. This is especially important in light of the high rates of drug-related death, highlighted above, and the evidence from other jurisdictions on the positive impact of this approach. Research undertaken by Release analysed 25 jurisdictions that had ended criminal sanctions for possession of all drugs or for cannabis only, it is worth noting that in the vast majority of these countries the policy applied to all drugs.[36] None of the countries that have taken this approach experienced statistically significant increases in prevalence, in some countries it went up slightly in some it went down.[37,38,39] Decriminalisation has been associated with reduced rates of recidivism, lower rates of incarceration, reduced burden on police resources, and savings to the public purse related to social costs. By decriminalising the possession of controlled drugs for personal use, resources could be diverted from the criminal justice system into health and other services.

  Decriminalisation is not only permissible under the international drug control framework, it is the legal model which is supported by the United Nations System Chief Executives Board for Coordination (UNCEB)[40] who represent all 33 agencies of the UN.

Decriminalisation of all controlled drugs is fundamental to improving the lives of people who use drugs, and has broader benefits for communities and the State as outlined in Section 4, but it does leave the supply of drugs unregulated and uncontrolled.

It is important that any consideration of reforms includes a regulated supply model, especially given the fact that in relation to cannabis, Uruguay, Canada, Mexico and Malta - and over a third of US states - have legalised production, supply, and possession of this product. Germany and Luxembourg have also announced their intention to create legal frameworks for a cannabis market, whilst the Netherlands and Spain have been operating quasi-legal models for decades. This is a fast-growing industry, and it is inevitable that the UK will at some point legalise cannabis given the significant financial influence of market actors and the sheer amount of money that can be generated from tax revenue annually[41] - as evidenced in the US. This raises questions about how we should regulate and experiences from the US outlined at Section 4 are instructive: providing an opportunity to incorporate principles of social equity and racial justice into any new legal framework for cannabis has been a core feature of recent examples of US legislatures.[42]

Given that nearly half a billion people can now access legal cannabis for non-medical purposes globally, the issue of legalisation and regulation of cannabis has ignited a discussion about the international legal framework and treaty compliance. The fracturing of the international consensus is leading to greater pressure on the UN system to move towards reforming, or even rewriting, the relevant treaties - especially given that drug law enforcement has so starkly contributed to human rights abuses across the world, undermining the goals of other parts of the UN framework.

Enshrining a right to recovery in law (1c)

A right to the highest standard of attainable health is fundamental to all and we welcome a focus on ensuring people can access high quality treatment. Unfortunately, the recovery agenda in the drug treatment field has historically focused on *abstinence* as the main goal of treatment, and this was a particular focus of the Government ten years ago.[43] This had a real-life impact, with people on opiate substitution therapy being told they had to reduce their medication in order to achieve "recovery", which led to an ideological approach to treatment rather than a clinical approach based on the needs, and wishes, of the patient. Rather than focusing on recovery in this context, wider support for people to navigate their existing treatment through a rights-based approach and with advocacy support should be core. Moreover, a rights-based approach for people who use drugs needs to expand beyond health to incorporate social and economic rights, by ensuring people are protected from unfair practices, such as loss of employment or exclusion from educational institutions.

2. UK drug policy

Trends and patterns in drug use across the four UK nations (2a)

In relation to drug dependency, the drivers for this are the same across the four nations, and will often be to address trauma(s) that they have experienced, especially as children. Many will have experienced violence (sexual and/ or physical), abuse and neglect, attachment problems, bereavement, abandonment, been in care, or will suffer from mental health conditions. It is these lived experiences of trauma that leads people to 'self-medicate' through the use of controlled drugs for the ongoing pain they suffer. The impact of Adverse Childhood Experiences ('ACEs') has been acknowledged by the ACMD,[44] and addressing ACEs should be at the heart of any prevention strategy. As such, the focus must be developing and scaling up responses that can help people to deal with trauma and mental health issues, and this should include trauma-informed counselling in schools. The experience of drug dependency is exacerbated by deprivation, which is why it is no coincidence that we see the highest rates of drug related deaths in some of the poorest parts of the UK, whether that be Glasgow or Blackpool or other parts of the four nations that experience similar inequalities.

UK Government's 10-Year Drug Strategy for England and Wales (2b)

Whilst the additional funding of £780 million over three years for the treatment system is welcomed, this has to be looked at in the context of over ten years of austerity and savage cuts to the public health expenditure for drug treatment (adult services), with an estimated 26 per cent reduction in funding between 2014/15 and 2019/20.[45] It is much harder to rebuild a "world class treatment and recovery system" when there has been a significant loss in experienced staff and the sector has been left demoralized. We also welcome the commitment to investing in research to ensure the treatment provided really meets the needs of those accessing services, as this is core to ensuring treatment is attractive to people.

Ultimately though, the potential impact of the funding will be undermined by the tired "tough on drugs" rhetoric which focuses on a largely criminal justice approach to addressing drug use and drug supply. The targeting of "middle class/recreational drug use" is reminiscent of the failed 'Just Say No' strategies of the 1980s, and the notion of naming and shaming people who use drugs - when at the same time trying to encourage people to access support if they need it - is clearly counterproductive.

The absence of OPCs is hardly surprising, but it is still disappointing, particularly given Scotland's plan to open a facility.[46] The lack of inclusion of Heroin Assisted Treatment (HAT), given its efficacy and the fact it is mentioned in the Serious Crime Strategy 2018, is also a major flaw. HAT has long been shown to work well for those who have been failed by other medically-assisted treatments. The lack of political support will limit the expansion of this approach and will mean that some of the structural problems – including secure supply of diamorphine (there is currently a serious shortage across the UK) – will go unaddressed.

The Government's strategy does not address any of the harms outlined in Section 1, and it is likely that the negative experiences outlined for individuals and communities will continue to cause damage.

Policies effective at reducing drug use, drugs related deaths, and drug offending (2c)

Scotland's focus on addressing drugs through a health lens, scaling up funding and harm reduction responses - including a nationally funded media campaign to promote the use of naloxone - seems to be having initial positive results. Recent reports indicate that there has been an 8 per cent fall in drug related deaths in 2021 compared to 2020.[47] Scotland's Lord Advocate has also implemented a police warning scheme for all controlled drugs, meaning that people caught in possession of drugs will not be prosecuted but instead will receive police recorded warnings (this does not form a criminal record).[48]

Drug diversion schemes are also operating in over ten police forces across England and Wales. Local and international evidence suggests that police diversion schemes can effectively reduce harms experienced by people who use drugs and/or are involved in supply. Durham Police force's diversion scheme "Checkpoint", for example, is for a range of low-level offences, including drug possession and low-level supply offences where the offender is determined to be a user-dealer.[49] Initial findings found lower reoffending rates and re-arrest rates.[50] Participants in Checkpoint also reported improved outcomes in relation to: substance misuse; alcohol misuse; accommodation; relationships; finances; and mental health. Similar findings have been found in other forces who have adopted this approach.

It is important to note that these schemes operate because this is as far as the police can go in relation to reforms of the legal framework in the UK. It also leads to a postcode lottery where someone in one part of the country is not criminalised, but go over a county line and they would end up in court for the same offence. This is just one of the reasons behind the need for *national* reform.

3. The impact of drug use in the UK

The Black Review Phase 1 details much of the negative impact of drug use in the UK, although much of this is related to the *policy* environment. Section 1 of this submission highlights the ineffective nature of the framework and the impact of the current approach, including in relation to drug use.

4. International comparisons

Are there laws, policies or approaches adopted in other countries that have been effective? (4a)

Release has undertaken significant research into the decriminalisation of drug use and possession offences, this includes analysing 25 jurisdictions across the world that have adopted a non-criminal response to drugs (it is estimated that the number of countries that have decriminalised now exceeds 30).[51] As stated this policy/legal approach has little impact on prevalence, but can have significant and positive impacts on health, social, and economic outcomes.

- Decriminalisation can save lives and reduce health harms - Portugal ended criminal sanctions for possession of all controlled drugs in 2001, while also investing in harm reduction initiatives, treatment, and prevention. People caught in possession are instead referred to a dissuasion committee to see whether they need help to address their substance use – in over 80 per cent of cases proceedings are suspended.[52] The drug-related

death rate (aged 15-64 years) in Portugal was 8 deaths per million in 2018, which is considerably lower than the UK's 76 per million.[53] Czechia also decriminalised possession of controlled drugs, the most recent law reform was in 2010, and similarly to Portugal, it has a significantly lower mortality rate of 5 per million - 15 times lower than the UK's rate. In fact, all the countries in Europe that have some form of decriminalisation - including Spain, Germany, Italy, and the Netherlands - have a lower drug-related death rate than the UK. While the lower rates of drug-related death in these countries will not necessarily stem from the legal framework, it is noteworthy that all of these countries have ended criminal sanctions for drug possession offences under various models of decriminalisation. Evidently, better health outcomes can be achieved when drug dependency is viewed through the lens of public health, rather than criminal justice.

Portugal also experienced a number of other positive health outcomes in the 20 years since the policy was first implemented, including: decrease in drug dependency, a 40+ per cent reduction in the estimated numbers of people who inject drugs; increased treatment engagement; and significant decrease in HIV (5,085 reported cases in 1994 to 639 in 2007) and TB transmission.[54]

- Decriminalisation can produce better social and economic outcomes - as highlighted in Section 1a, research conducted in Australia compared the outcomes for individuals who had been criminalised for cannabis possession to those who had received civil sanctions. Of those criminalised, 32 per cent reported a negative impact on *employment* compared to 2 per cent of those who were given civil sanctions. In terms of impact on *accommodation*, 16 per cent of those criminalised reported an adverse impact versus 0 per cent of those receiving civil sanctions. Finally, a negative impact on *relationships* was reported by 20 per cent of those criminalised versus 5 per cent of those receiving civil sanctions.[55]

  Researchers in Portugal also found there was an 18 per cent decrease in the social costs of drug use in the first 10 years of decriminalisation, creating significant economic savings for the State.[56] The Portuguese also experienced a significant reduction in the percentage of the prison population sentenced for drug related offending, falling from 44 per cent to 21 per cent over a ten-year period.[57]

  Decriminalisation has also been shown to reduce police contact for Black and other ethnic minority communities. Studies from the US, in States that have decriminalised cannabis, have shown that the overall rate of arrests for African Americans falls from just under 700 per 100,000 of the population to 400 over a 20 year period (the fall in States that have regulated cannabis is far more pronounced, with a fall in the arrest rate from 500 per 100,000 of the population to just a handful of arrests).[58] That being said, racial disparities still persist, drug law reform will not solve the issue of structural and institutional racism, but it can remove *one* of the tools used by police to harass Black and Brown communities, and reduce the actual number of people coming into contact with the CJS.

Beyond decriminalisation is the growing number of jurisdictions that are regulating cannabis for recreational use. As highlighted above, it is Release's view that cannabis regulation is not a question of "if" but "when and how". The organisation launched a report in January 2022 highlighting the experience of other jurisdictions, including that of US states that have chosen to prioritise racial and social justice principles over the interests of corporations. These models include ensuring that possession of cannabis outside the legal market is not an offence, that criminal records are expunged, and that communities most harmed by over policing and over criminalisation in the name of cannabis prohibition, now benefit from the market through re-distribution of taxes and opportunities to participate in the new legal market. The report "Regulating Right, Repairing Wrongs: Exploring Equity and Social Justice Initiatives within UK Cannabis Reform" is supported by a number of civil society organisations.[59]

Could it reasonably be expected to work in the UK? (4b)

As highlighted, the UK already has a model of decriminalisation in the PSA 2016. There is no reason that this approach could not be *extended* to the MDA 1971 and this would, in fact, reflect the recommendations of the ACMD.

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