1. **Introduction:**

1.1 This literature review is in response to the Health and Social Care Committee inquiry on ‘Drugs Policy’ and aims to discuss the impact of Drugs Policy on Public Health in the UK.

1.2 This review discusses:
- Legislation on Drugs in the UK (para. 2)
- Penalties for Drugs in the UK (para. 3)
- Drugs Policy in the UK (para. 4)
- Drug Strategy in the UK (para. 5)
- Harm Reduction Services in the UK (para. 6)
- Crime Outcomes for Drug Offences in the UK (para. 7)
- Trends in the UK (para. 8)
- Conclusions (para. 9)

2. **Legislation on Drugs in the UK:**

2.1 Misuse of Drugs Act 1971: The Misuse of Drugs Act (MDA) [23] established controlled substances into Class A, Class B and Class C [1]. Class A drugs are considered to be most harmful, Class B drugs fall into an intermediate category and Class C drugs are considered to be least harmful. Consequently, Class A drugs carry the highest penalties and Class C drugs result in the lowest penalties (para. 3). Popular Class A drugs include crack, cocaine, ecstasy, heroin, methadone, LSD, magic mushrooms and methamphetamine (crystal meth) [2]. Popular Class B drugs include cannabis [2], synthetic cannabinoids such as Spice and Black Mamba [3], amphetamine (speed) [15], barbiturates, codeine, ketamine, synthetic cathinones such as mephedrone (m-cat) [16] and methoxetamine. Popular Class C drugs include anabolic steroids, benzodiazepines, GHB/GBL (G) [17] and khat [2].

2.2 Misuse of Drugs Regulations (MDR): The 2001 and 2018 Regulations [25,26] that extend to England, Wales and Scotland, have listed controlled substances in Schedule 1, Schedule 2, Schedule 3, Schedule 4 and Schedule 5 categories [4]. Schedule 1 substances are subjected to strictest level of control in terms of import, export, production, possession, supply and administration [4]. Consequently, possession, supply and production of Schedule 1 drugs carry highest penalties (para. 3). Schedule 1 is a category for substances believed to have no medicinal value [1] and require a Home Office licence for research purposes [1]. Popular Schedule 1 drugs include LSD and ecstasy [5]. Schedule 2 and Schedule 3 substances are legally available upon prescription for personal possession [5]. However, the difference between Schedule 2 and Schedule 3 substances is that Schedule 2 substances are most tightly regulated in terms of prescription requirements, record keeping, labelling, destruction, disposal and safe custody [1,4,5]. Popular Schedule 2 drugs include methadone and heroin [5] while popular Schedule 3 drugs include subutex and many barbiturates [5]. Schedule 4(i) substances can only be legally possessed upon prescription, while Schedule 4(ii) substances can be legally possessed if they are clearly intended for personal use [5]. Popular Schedule 4(i) drugs include benzodiazepines and popular Schedule 4(ii) drugs include steroids [5]. At the other end of the spectrum, Schedule 5 substances can be legally sold as over the counter medicines [5] and can be legally bought without a prescription. Thus Schedule 5 substances are subjected to least
stringent controls. These Regulations are devolved in Northern Ireland [27,28,29].

2.3 Psychoactive Substances Act 2016: The Psychoactive Substances Act (PSA) [24] came into force on 26-May-2016 [6,7]. The PSA was in response to the drawbacks of the Temporary Class Drug Orders (TCDO) that came into force on 15-Nov-2011 [8] to control New Psychoactive Substances (NPS) not belonging to any of the MDA Classes. However, the PSA does not make the TCDO invalid [6]. Under the TCDO, all NPS had to be assessed on a substance by substance basis or a group by group basis [9] in order to determine potential harms [8] of the NPS and the most appropriate classification [2] for the NPS. The PSA defined what constituted NPS [6] and made its production, supply, offer to supply, possession with intent to supply, import, export, distribution, and sale [9] an offence. While simply possession of a Temporary Class Drug was not an offence [10] under the TCDO, the possession of NPS in custodial institutions [9] became an offence under the PSA.

3. Penalties for Drugs in the UK:

3.1 Drugs commonly encountered and controlled under the Misuse of Drugs legislation are thus classified [11] into a Class (para. 2.1) and a Schedule (para. 2.2). Together it determines maximum penalties for possession, supply and production of drugs (strictest for MDR Schedule 1) depending on the MDA Class (strictest for MDA Class A).

3.2 Generally, the offence of possession [2] may result in a sentence of up to 7 years in prison for a Class A drug, up to 5 years in prison for a Class B drug, and up to 2 years in prison for a Class C drug; and/or an unlimited fine. No charges are made against possession of a Temporary Class Drug, but this drug may be confiscated. No charges are made against possession of NPS, unless the user is in a custodial institution in which case it may result in a maximum prison sentence up to 2 years [12] and/or a fine.

3.3 Generally, supply including possession with intent to supply, offering to supply [9] and production [2] of controlled drugs may result in a life sentence for a Class A drug, up to 14 years in prison for a Class B/ Class C/ Temporary Class drug, and up to 7 years in prison for NPS; and/or an unlimited fine.

4. Drugs Policy in the UK:

4.1 It is clearly evident (para. 2; para. 3) that the current Drugs Policy in the UK has a criminal justice-led approach with a tendency to criminalise drug users. The aim of the drug legislation is to reduce the supply of drugs, prevent the uptake of drugs, reduce the crime linked to drugs and increase the treatment uptake [13] of drug users. Opportunities exist for drug offenders to accept treatment instead of fines or cautions [13]. This approach essentially forms the basis of the Drug Strategy (para. 5) in the UK.

4.2 The criminalisation of drug users [14,30,31,33] means that no distinction [18] is made between drug use and abuse/misuse. Drug use is not a medical condition and may not even result in drug dependence [21]. This means that problematic abuse/misuse [18] resulting in personal harm, domestic violence, anti-social behaviour and drug related crime [14] is not distinguished from recreational [18] or medicinal [19] drug use. Drug users may do drugs as a lifestyle choice similar to the lifestyle choices of drinking alcohol or smoking tobacco, may not want treatment [20] or other medical interventions, or may wish to make an informed decision to opt-out of drug cessation programmes or to not opt-in to drug cessation programmes, in line with their human rights [21].

4.3 In cases where drug users discover that they want help and need treatment, the genuine fear [18] of receiving a criminal record [18] or incarceration [18], judgment [21] and stigmatisation [21] may prevent or delay them from accessing public services including healthcare and social
It was this fear of breaching a suspended jail term that stopped Broughton seeking medical assistance to save Louella Fletcher-Michie in the recent high-profile Bestival drugs death. Drug policy and strategy should be geared towards protecting the vulnerable and educating future generations about the dangers of drugs, while at the same time reassuring existing drug users that they can confidently and confidentially seek help without fear of retribution or incarceration.

5. Drug Strategy in the UK:

5.1 The UK Drug Strategy 2017 envisioned a national Recovery Champion and is built on reducing demand, restricting supply, building recovery and global action, with elements covering the devolved administrations. It refines the UK Drug Strategy 2010. The Substance Misuse Strategy for Wales, Scotland’s ‘Rights, Respect and Recovery’ refining ‘The Road to Recovery’, and Northern Ireland’s New Strategic Direction also apply to the corresponding devolved administrations. The strategies reflect the public health and human rights oriented approaches of UNGASS 2016.

5.2 It is clear that there is no intention of decriminalising drugs and the UK Drug Strategy 2017 asserts that it is overly simplistic to conclude that drug decriminalisation works. Proponents of drug prohibition argue that one can neither refute nor confirm that decriminalisation reduces drug use. At the same time, there is no evidence that incarceration acts as a deterrent for drug use.

5.3 The UK Drug Strategy has been criticised for not explicitly referencing harm reduction. However, in the UK, treatment and basic harm reduction services are available and neither criminalised nor prohibited by law. Thus, criminal justice responses aim to be proportionate to promote human rights and allows drug users to be referred to treatment.

6. Harm Reduction Services in the UK:

6.1 Needle and Syringe Programmes (NSPs): In the UK, NSPs are available in the community, but not in prisons. NICE recommends the use of custody centres to provide geographical and demographic coverage. The Government needs to expand coverage in prisons to ensure adequate provision. However according to Avert, the UK distributes more than the WHO recommended amount of sterile needles and syringes per drug injector per year. NICE recommends low dead-space syringes to reduce the risk of transmission of infections among people who may end up sharing needles.

6.2 Opioid Substitution Therapy (OST): In the UK, OST includes methadone, buprenorphine, heroin-assisted therapy (HAT) and may also include morphine and codeine. HAT is the prescription of diamorphine (medical heroin). HAT is highly effective in reducing the use of illicit heroin and adhering to OST. Despite all the progress made in the UK, the Global State of Harm Reduction 2018 report states that lack of commitment to a harm reduction framework is responsible for sub-optimal doses of methadone linked to opioid overdose deaths.

6.3 Naloxone: Naloxone acts as an opioid antagonist and reverses the effects of opioid overdose. It is available to medical personnel in the UK, in addition to take-home naloxone and peer-distribution of naloxone. However, the inadequate coverage of naloxone kits for every 100 users during 2016-2017 needs to be addressed by increasing the availability of naloxone.

6.4 Drug Consumption Rooms (DCRs)/ Supervised Injection Facilities (SIFs)/ Safe Injecting Sites (SISs): Extensive research shows that SIFs reduce overdose deaths, increase uptake of
treatment [66] and decrease anti-social behaviour. DCRs reduce the risk of sharing needles/injecting equipment [67] and increase the likelihood of safe disposal of used syringes. SIFs are projected to have huge health benefits and cost savings by avoiding hospitalisation, A&E visits and ambulance callouts [68]. Currently DCRs do not exist in the UK [40]. DCRs were not approved since they may appear to condone [18] drug use, support the illicit drugs market [18] and cannot guarantee safety [18] of drugs used. Consequently, users may inject adulterated drugs, and drugs of unknown composition and potency. The problem of the safety element may be overcome in the short term by integrating [40] drug-checking services (para. 6.5) into DCRs to allow users to make informed decisions [43]. On the other hand, regulating [18,60] the drugs market to tackle the problem of unknown drug composition, purity and potency, seems to be an unrealistic solution for the long term based on the current legislative framework. It is a myth [65] that DCRs encourage drug use. DCRs may be visualised as an extended form of harm reduction.

6.5 Drug-checking services: These services are available in the UK and usually exist on-site at parties and festivals to determine potency and adulteration [40] of drugs. The UK’s first Home Office licensed [42,43] drug-checking service pilot was launched in February 2019. Drug testing outcomes include users deciding not to take the substances tested, or taking less than originally planned, resulting in reduced harm.

7. Crime Outcomes for Drug Offences in the UK:

7.1 England and Wales: For drug offences recorded in the year ending March 2018 [34], 29.9% were charged/summoned; 0% were taken into consideration (TICs) by a court; 15.1% were out-of-court (formal) including caution - adults, caution - youths, and Penalty Notices for Disorder; and 28.6% were out-of-court (informal) including cannabis/khat warnings and community resolutions; among other outcomes.

7.2 Scotland: For people convicted of drug crimes during 2017-2018 [35], 16% ended up in custody; 24% received a community sentence; while 42% faced a financial penalty; among other outcomes.

7.3 Northern Ireland: For drug offences recorded during 2017-2018 [36], 44.9% were charged/summoned; 0% were taken into consideration (TICs); 12.6% were out-of-court (formal); and 29.4% were out-of-court (informal); among other outcomes.

7.4 Postcode lottery: Different police forces have different ways of using out-of-court outcomes. This essentially results in different outcomes for the same drug offence. For example, Lancashire, Leicestershire and Staffordshire police forces use community resolutions [34] rather than cannabis/khat warnings for possession offences.

8. Trends in the UK:

8.1 Drug offences: Drug use/possession offences [53] in the UK have seen an overall decrease, initially rising from 86,528 in 2006 to a peak of 100,722 in 2011, followed by a sharp decline to 73,180 in 2015. On the other hand, drug dealing/trafficking/production offences [53] have seen an overall increase from 20,954 in 2006 to 27,381 in 2015, although there was a gradual decline from 31,269 in 2012.

8.2 Drug use (lifetime prevalence rate): This has decreased only slightly [50] from 35.7% in 2006/2007 to 34.2% in 2016/2017 for England and Wales; from 33.5% in 2008/2009 to 29.5% in 2014/2015 for Scotland; and from 28.0% in 2006/2007 to 27.7% in 2014/2015 for Northern Ireland.
8.3 Drug-related deaths: There has been an overall rise in drug-related deaths [52] in the UK from 2,103 in 2004 to 3,070 in 2015; characterised by peaks and troughs, showing a sharp rise from 2,178 in 2012.

8.4 Drug-related infectious diseases:

8.4.1 Hepatitis C Virus (HCV): There has been an overall increase [54] from 46% in 2006 to 54% in 2016 in England; from 20% in 2006 to 52% in 2016 in Wales; and from 54% in 2008/2009 to 58% in 2015/2016 in Scotland. However, there has been an overall decrease from 32% in 2006 to 22% in 2016 in Northern Ireland.

8.4.2 Hepatitis B Virus (HBV): There has been an overall decrease [55] from 29% in 2006 to 15% in 2016 in England; from 23% in 2006 to 13% in 2016 in Wales; and from 8.9% in 2006 to 6.4% in 2016 in Northern Ireland. It was 9% for 2013/2014 in Scotland, below the average of 16% in England and 12% in Wales, and higher than the average of 7% in Northern Ireland, over the same 2013/2014 period. The overall decline may be due to the increased uptake of the Hepatitis B vaccine [50].

8.4.3 HIV: An overall decrease [56] is seen in England from 1.3% in 2006 to 0.85% in 2016; and in Northern Ireland from 1.8% in 2006 to 0.0% in 2016. This contrasts with an overall increase [56] seen in Wales from 0.0% in 2006 to 1.4% in 2016; and in Scotland from 0.3% in 2011/2012 to 1.9% in 2015/2016. The marked rise in HIV in Wales from 0.5% in 2013 to 1.1% in 2014 corresponds with a sharp decline in NSP distribution from 2013/2014 (5,242,420 needles/syringes) to 2014/2015 (3,141,442 needles/syringes) [57]. The fall to 0.77% in 2015 and the subsequent rise to 1.4% in 2016 [56] also corresponds with a slight increase in NSP distribution in 2015/2016 (3,398,314 needles/syringes) and subsequent decrease in 2016/2017 (3,100,009 needles/syringes) [57] for Wales. Although NSP distribution in Scotland [57] has increased from 2013/2014 (3,816,488 needles/syringes) to 2015/2016 (4,742,060 needles/syringes), the closure of one of the main NSP services in Glasgow [58] in 2017 may explain the HIV outbreak in Scotland.

8.4.4 PWID are also prone [50,59] to staphylococcal infections, invasive group A streptococcal infections, skin and soft tissue infections (SSTIs), wound botulism, tetanus, anthrax and tuberculosis, among other diseases.

8.5 Drug treatment: The percentage of adults completing treatment was higher in the community [49] at 48% compared to those in custody [48] at 31% in England (2017-2018).

8.6 Drug-related police encounters: In the UK, police encounters [62] include drug dog encounters (25.5%), stop and search (6.3%), warning (2.9%), fine (0.5%), offer of bribe (0.2%) and arrest (1.2%). Drug dog encounters may take place at a festival (72.8%), pub/club (34.0%), public transport (35.3%), or residential location (0.6%), among other (5.7%) locations. Drug consumption to avoid detection by sniffer dogs increases risk of overdose. Stop and search may violate human rights [63].

9. Conclusions:

9.1 The overall decrease in drug use/possession offences (para. 8.1) may indicate a shift towards human rights and public health.

9.2 Criminalisation has failed to achieve abstinence [21] from drug use (para. 8.2).

9.3 Drug law enforcement approaches have failed to prevent a rise in drug-related deaths (para. 8.3) and/or infections (para. 8.4).

9.4 Successful drug treatment outcomes are higher in the community than in custody (para. 8.5). Therefore, minor drug offences may be treated as administrative infractions [21] without resort to criminal sanctions if the end goal is successful treatment.
9.5 Criminal justice-led approaches instil fear, neither promote public health (para. 8.6) nor guarantee public safety (para. 4.3) [18] and may breach human rights.

9.6 Drug policy should be enshrined in public health rather than criminal justice [18,60].

9.7 The UK should improve harm reduction services (para. 6) by expanding coverage of NSPs to prisons and introducing DCRs integrated with drug-checking services.

9.8 Decriminalisation may be considered a harm reduction strategy as it minimises the harms of having a criminal record [61].

9.9 Liberalisation [61,64] of drug policy in the UK may help users confidently engage with health services.

9.10 Drug policy approaches should be based on principles of harm reduction, treatment, holistic recovery and human rights. The UK should lead globally in a public health oriented drugs policy.

Abbreviations/ Definitions

A&E Accident and Emergency
AIDS Acquired Immune Deficiency Syndrome
DCRs Drug Consumption Rooms
GBL gamma-butyrolactone
GHB gamma hydroxybutyrate
HAT Heroin-assisted therapy
HBV Hepatitis B Virus
HCV Hepatitis C Virus
HIV Human Immunodeficiency Virus
LSD Lysergic Acid Diethylamide
MDA Misuse of Drugs Act
MDR Misuse of Drugs Regulations
NHS National Health Service
NICE National Institute for Health and Care Excellence
NPS New Psychoactive Substances
NSPs Needle and Syringe Programmes
OST opioid substitution therapy
PSA Psychoactive Substances Act
PWID Persons Who Inject Drugs
SIFs Supervised Injection Facilities
SiSs Safe Injecting Sites
SSTIs skin and soft tissue infections
TCDO Temporary Class Drug Orders
TICs taken into consideration by a court
UK United Kingdom of Great Britain and Northern Ireland
UN United Nations
UNGASS United Nations General Assembly Special Session
UNODC United Nations Office on Drugs and Crime
US United States of America
WHO World Health Organization

References


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Resources


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About me

I am submitting this literature review in a personal capacity. I hold a BSc in Microbiology, then completed my MSc in Plant Genetic Manipulation (University of Nottingham) as I became interested in emerging technologies and my postgraduate thesis is available at http://webcat.warwick.ac.uk/record=b2217205~S1
I decided to return to Microbiology and achieved the equivalent of Distinction in my IBMS accredited BSc Biomedical Science modules at UEL. I have recently developed an interest in Public Health Policy.