Implementation of harm reduction strategies criminology essay

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The Central Intelligence Agency (CIA) identifies five categories for illicit drugs: narcotics, stimulants, depressants (sedatives), hallucinogens, and cannabis. These categories include many drugs legally produced and prescribed by doctors as well as those illegally produced and sold outside of medical channels (CIA World Fact Book, 2012). In the United Kingdom, the term ' illicit drugs' is used to describe those drugs that are controlled under the Misuse of Drugs Act 1971. Globally, the illicit drugs trade (also referred to as the illegal drugs trade or drug trafficking) is one of the largest businesses and some 210 million people use illicit drugs each year, and almost 200, 000 deaths can be attributed as a direct result of these drugs (UNODC, 2011). Illicit drugs are a substantial threat to the public good, not only because they adversely affect public health, but also because they can generate crime, disorder, family breakdown, and community decay (Strang et al., 2012). }

Proportion of 16 to 59 year olds reporting use of any drug by age group and sex in

the last year, 2010/11 BCS

CHAPTER 2 EPIDEMIOLOGY AND REIVEW OF THE LITERATURE

2. 1 Epidemiology of illicit drug use

Drug misuse is a global social problem and, along with poverty and infectious disease, is one of the most challenging issues for personal and community health in many parts of the world (Donmall, 2001). The task of drug abuse epidemiology is to better understand patterns and trends in drug use, such as the characteristics of persons abusing drugs and how this may change over time. Drug abuse epidemiology is one of the more challenging areas of

epidemiology. One of the basic reasons for this is the nature of substance use and the circumstances around it- the illegal nature of most drug abuse means that it remains hidden from view to some extent, and thus difficult to quantify (Donmall, 2001, WHO, 2000). Since the 1980s there have been major changes in trends and patterns of drug use including: global increases in the production and use of drugs; new forms of old drugs (eg. smokeable " crack" cocaine); changes in way drugs are taken (eg. transitions from opium smoking to heroin injection); and the introduction and proliferation of new drugs (eg. MDMA " ecstasy" and other amphetamine-type stimulants)(WHO, 2000).

Drug use behaviours range from occasional, sporadic or experimental use, through regular low risk recreational use, to high risk, daily dependence that is often associated with a variety of financial, health and social problems (Donmall, 2001). However not all drug use is equally harmful, just as not all drugs have the same negative effects. This creates another challenge for drug abuse epidemiology- not all behaviours or substances pose the same risk. However, it has been recognised that drug injection is of specific importance as it has become a major transmission route for HIV (WHO, 2000).

2. 2 Illicit drugs

In the United Kingdom, the Misuse of Drugs Act 1971, with amendments, is the main law regulating drug control UK. It divides controlled substances into 3 Classes (A, B, C) based on harm, with Class A being the most harmful. An

overview of the main drugs are found in table 1, along with their classification.

Table 1: Drug classification

Source: Home Office 2011

The detailed information on the different drugs found below is derived from the following sources: World Health Organisation's Guide to Drug Abuse Epidemiology (2000), DrugScope (2012) and the ' Talk to Frank' Home Office initiative (2012) to provide accurate and reliable information on drugs for young people (WHO, 2000, DrugScope, 2012, FRANK, 2012).

Cocaine

Cocaine and its derivative " crack" cocaine provide an example of both the globalization of

substance use and the cyclical nature of drug epidemics. Traditionally coca leaves have been chewed by people in the Andean countries of South America for thousands of years. The main alkaloid of the coca leave, cocaine, was isolated relatively recently in about 1860. Cocaine was then used in patent medicines, beverages and " tonics" in developed countries in Europe, North America and in Australia until the early 1900s. Laws restricting the availability of cocaine saw a decrease in consumption in these countries until the 1960s. From that time cocaine use became popular among certain groups of young people in some developed countries and in the producer countries of South America. Cocaine became

widely available in North America in the 1970s and Europe in the 1980s (WHO, 2000).

Ecstasy

Ecstasy is an illegally manufactured drug that usually comes in tablet or capsule form. The chemical name of pure ecstasy is 3, 4 methylenedioxymethamphetamine (MDMA) (DrugScope, 2012). Ecstasy is a stimulant drug which also has mild hallucinogenic effects. It has been described as being like a mix of amphetamine and a weak form of LSD. The effects of taking a moderate dose start after 20-60 minutes (longer if on a full stomach) and can last for up to several hours. Ecstasy was first made by two German chemists in 1912 and patented in 1914, in case it turned out to be a useful drug. It didn't. During the 1950s, the American military experimented with a whole range of drugs, including ecstasy, for use in chemical warfare, to extract information from prisoners and to immobilise armies. In the 1960s, the drug was rediscovered' by an American research chemist Alexander Shulgin who experimented with it on himself (DrugScope, 2012).

LSD

Lysergic acid diethylamide (LSD) is an hallucinogenic drug that is derived originally from ergot, a fungus found growing wild on rye and other grasses. It is a white powder, but as a street drug, it is a liquid either on its own or absorbed into paper sheets. The sheets are cut into tiny squares like postage stamps or transfers and often have pictures or designs on. LSD is also

sometimes dropped on to sugar cubes or formed into tablets or small capsules (DrugScope, 2012).

Magic Mushrooms

Psilocin-based ‘ magic’ mushrooms (PBMMs) in prepared forms (e. g. dried or extracted) have been illegal in the UK since the 1971 Misuse of Drugs Act. But fresh or unprepared PBMMs were legal to possess and traffic until the 2005 Drugs Act, UK (Riley, 2010).

Meth Methamphetamine (crystal meth) is a central nervous system stimulant with a high potential for misuse and dependence. A synthetic drug, it is closely related chemically to amphetamine (‘ speed’) but produces greater effects on the central nervous system.

Cannabis

Cannabis is a Class B drug derived from the cannabis plant, a bushy plant found wild in most parts of the world and easily cultivated in Britain. There are three varieties of the plant, Cannabis sativa, indica and ruderalis. In Western countries it is generally used as a relaxant and mild intoxicant. In the UK, cannabis is generally smoked with tobacco in a joint or spliff, but can also be smoked in a pipe, brewed into a drink or cooked into food (DrugScope, 2012).

Poppers

Poppers are usually found in the form of a liquid chemical (a nitrite) sold in a small bottle. Commonly, the chemical is alkyl nitrite. Other nitrites like amyl

nitrite (and butyl nitrite and isobutyl nitrite) have also used been used. Nitrites dilate the blood vessels and allow more blood to get to the heart ((FRANK, 2012).

Heroin

Heroin use has become increasingly common in North-America and Europe since the 1960s. Increases in heroin use are often cyclical in these countries. In the United Kingdom, for example, there was a well reported " heroin epidemic" in the mid-1980s, following a period in the 1970s when the heroin using population was generally stable and ageing (Power, 1994). The UK epidemic in the 1980s was in part the result of the availability of cheap, high purity heroin from South-west Asia notably Pakistan. This form of heroin could be smoked and became attractive to young non-injecting users (Pearson, 1987).(WHO, 2000)

Since heroin is commonly used by injecting, the health risks including that of HIV and hepatitis transmission are substantial.

A number of drugs used commonly for their therapeutic efficacy in health care are also being abused all over the world. These include barbiturates, benzodiazepines, other sedatives and some stimulant drugs . The epidemiology of this use is difficult to study, because of difficulties in distinguishing medical and non-medical use (WHO, 2000).

2. 3 Data on Drug users United Kingdom

In the United Kingdom, primary sources of information about prevalence of illegal drugs among the adult population are derived from representative

household surveys. In England and Wales, the British Crime Survey (BCS) has been a continuous survey since 2002 (EMCDDA, 2012). The BCS collects a rich set of information on the personal, household, area characteristics and lifestyle factors of respondents that can be used to explore differences in drug use. This information, together with other information from representative surveys feeds into the latest report on the statistics of drug misuse in England and Wales (NHS Information Centre, 2011). The following data is extracted from the 2011 report ‘ Statistics on Drug Misuse: England’ published by the NHS Information Centre and the 2011 Home Office report on Drug misuse in England and Wales (Home Office, 2011, NHS Information Centre, 2011). According to this report, the prevalence of ever having taken illicit drugs in England and Wales has increased from 30. 5% in 1996 to 36. 3% in 2010/11.

As can be seen in figure 1 in 2010/2011, 12 per cent of men, versus 5. 7 per cent of women reported using any type of drug in the last year. There is a clear downward trend in any drug use in the past year as age increases for all adults. Specifically for Class A drugs, there is a slight increase in use for the 20-24 age group, after which use decreases with age as well.

Figure 1: Proportion of adults reporting use of the most prevalent drugs in the last year, by

age, 2010/11 BCSBCR home office drugs. PNG

Source: Home Office 2011

A total of 8. 8 per cent of adults had used one or more illicit drug within the last year (figure 1), compared with 8. 6 per cent in 2009/10, which indicates a slight increase in any drug use for adults in the past year. However, as can be seen in figure 2, there has been a general downward trend in the use of any drug in the past decade, whereas there has been little change in the percentage of any Class A drugs used by adults in this same time period.

Figure 2: Proportion of 16 to 59 year olds reporting use of any illicit drug or any Class A drug

in the last year, 1996 to 2010/11 BCS

Source: Home Office 2011

drugs 2. PNG

The prevalence of young adults (16-24 years) ever having taken drugs has decreased from 48. 6 per cent in 1996 to 40. 1 per cent in 2010/11. Findings from the 2009/10 BCS suggest that falls in illicit drug use have occurred in the youngest age groups (16-29 year olds), where use is highest. For example, around one in three (31. 6%) of 16-19 year olds used an illicit drug in the last year in 1996 compared with around one in five (22. 3%) in 2009/10.

Figure 3: Proportion of adults reporting use of the most prevalent drugs in the last year, by

age, 2010/11 BCS

As can be seen in figure 3, in 2010/11 cannabis is the type of drug most likely to be used by adults (6. 8%) followed by powder cocaine (2. 1%), which is consistent with findings from previous years. Similarly, for young adults (16-24 years) cannabis is the most prevalent drug followed by powder cocaine and ecstasy.

The 2010/11 BCS reported that single adults had higher levels of any (18. 1%) or Class A (6. 5%) drug use in comparison with all other marital groups (for example, 2. 7% and 0. 6% were the equivalent figures for married adults). In addition, adults from a White ethnic group had higher levels of any (9. 4%) or Class A (3. 2%) drug use than those from a non-White background (that is, ethnic groups other than White; 5. 1%, any drug use; 1. 0% Class A).

Adults living in a household in the lowest income group (£10, 000 or less) had the highest levels of any drug use (12. 9%) compared with all other income groups (e. g. 7. 7% of adults living in a household with an income of £50, 000). In addition, a clear urban-rural disparity exists, with 9. 3 per cent of adults in urban areas had taken any illicit drug in the last year compared with 7. 0 per cent of those in rural areas. This was the case for both Class A drug use as well as any other drug use among adults (Home Office, 2011).

Similar to the data collected by the British Crime Survey , the NHS also collects data on smoking, drinking and drug use among secondary school pupils aged 11 to 15(NHS, 2011). Overall, this report shows that drug use has declined since 2001. In 2010, 18 per cent of pupils said they had ever

dused drugs, 12 per cent had taken any drugs in the last year and 7 per cent had taken drugs in the last month (compared to 29 %, 20 % and 12% respectively in 2001). This decreasing trend can be seen in figure 4. Girls were less likely than boys to have taken drugs in the last year (odds ratio= 0. 74), the odds of having taken drugs in the last year also increased with age (odds ratio= 1. 13 for each additional year) (NHS, 2011). In terms of ethnicity, pupils of Asian ethnicity were more likely to have taken drugs in the last year than white pupils (odds ratio= 1. 13). As is not unexpected, both smoking and drinking alcohol were associated with drug use in the last year.

When looking at the type of drugs used, cannabis is the most prevalent- 8. 2 per cent of pupils reported taking it in the last year. This compares with 8. 9 per cent in 2009 and continues the decline seen since 2001. As can be seen in figure 5, 3. 8 per cent of pupils reported sniffing collative substances such as glue, gas, aerosols etc, which shows a decrease from 5. 5 per cent in 2009. Sniffing poppers has fallen from a high in 2007 to 1. 5 per cent in 2010 (NHS, 2011).

Figure 4

Source: NHS 2011

Figure 5

Source: NHS 2011

A team of researchers recently found higher than expected rates of HIV and hepatitis C infection in a study in London. They suggested that this was due

to high risk injecting practices, associated with newer injectors and the injection of crack (Judd et al. 2005). 4 They found higher rates of hepatitis C in their sample than in many other cities internationally (Hope et al. 2001).

2. 4 Country comparison

Compared to Scotland, data from 2010/11 show that illicit drug use ever among 16-59 year olds was lower in Scotland (33. 5%) than in England and Wales (36. 4%). Whereas the percentage taking any illicit drug in Scotland in the last year (9. 8%) or last month (5. 8%) was higher than across England and Wales (8. 6% in the last year and 5. 0% in the last month.)

Another barrier to the accuracy of survey estimates is that household and school surveys are likely to miss those people who are amongst the heaviest users of illicit drugs: the homeless, prisoners and school truants. Dependent users of cocaine and heroin may also be of unstable residence, and less likely to be found in their residence at a given time (reuter).

2. 3 What is harm reduction

Three separate facets of physical harm can be identifi ed. First, acute physical harm-ie, the immediate eff ects (eg, respiratory depression with opioids, acute cardiac crises with cocaine, and fatal poisonings). Second, chronic physical harm-ie, the health consequences of repeated use (eg, psychosis with stimulants, possible lung disease with cannabis). Finally, there are specifi c problems associated with intravenous drug use.(Nutt et al., 2007)

Harm reduction refers to policies and programmes that aim to reduce the harms associated with the use of drugs (Power, 1994). One widely-cited conception of harm reduction distinguishes harm at different levels – individual, community and societal – and of different types – health, social and economic (Donmall, 2001). These distinctions give a good indication of the breadth of focus and concern within harm reduction. As such, harm reduction should not be considered as a service type, or something delivered within a single tier, but should be subject to a whole system approach to reduce or eliminate the harms associated with drug use (NHS, 2009/10).

Health related harm resulting from the use and abuse of drugs vary. This is dependent on the type of substance being used, its frequency, its dosage and circumstances of use (Department of Health and National Treatment Agency, 2011b, Department of Health and National Treatment Agency, 2011a). There is a wide-ranging group of health related harms associated with high levels of illicit drug use and misuse. These include, but are not limited to drug dependence (psychological and physical); withdrawal syndromes; tolerance; substance related deaths which can result from poisoning/overdose, violent attacks, and suicides; as well as the development of other medical illnesses such as HIV/AIDS or hepatitis (AGENCY, 2007, Equal Partners: Health and Human Rights, 2007). At the community level, drug use can cause nuisance as a result of people discarding drug related litter such as used needles and syringes (Power, 1994). High levels of drug use and drug dealing can contribute more generally to problems in neighbourhoods and communities with little cultural capital and high levels of poverty, and considerable affects crime levels

(Power, 1994). The economic burden of health harms related to drug use and misuse is alarming with the National Health Service (NHS) spending close to £500 million annually on drug misuse associated harms and drug related crime costing the country an estimated £13. 32 billion (Department of Health and National Treatment Agency, 2007).

Recent trends among drug users, particularly injecting drug users (IDU), suggest that drug-related harms have increased in recent years. The Health Protection Agency (HPA) report, ‘ Shooting Up: Infections among injecting drug users in the United Kingdom 2006, an update: October 2007’ (Pearson, 1987) describes the high levels (48%) of sharing injecting equipment amongst current injecting drug users, with mixing containers such as spoons being the most commonly shared items (NHS, 2011).

2. 4 What is health related harm

Some of the main concerns about health related harm and drug use related to blood borne viruses, such as hepatitis and HIV. Hepatitis C is the most significant infection affecting injecting drug users (IDUs) with 41% of IDUs having been infected. There is marked regional variation with a prevalence of 22% in the North East to a prevalence of 57% and 60% in London and the North West regions respectively. Alcohol use and misuse is the single biggest contributory factor to those with hepatitis C infection developing fatal liver disease (NHS, 2011, Pearson, 1987).

In the UK, hepatitis B is usually acquired in adulthood, with sexual activity or injecting drug use being the most commonly reported routes of infection. Infection with the hepatitis B virus typically causes an acute infection, with a

small number of those infected going on to develop chronic disease. Infection with hepatitis B is preventable using a safe and effective vaccine, but continues to cause serious ill health in IDUs and their communities. In 2005, the percentage of IDUs with evidence of past or current hepatitis B infection was 19% (613 of 3, 175), which is similar to rates since 1995. There is substantial variation between regions, with North West having the highest rates of 31% (221 of 777), and the lowest in the Yorkshire and the Humber region at 5. 5% (14 of 253) (NHS, 2011, Pearson, 1987).

HIV infection among drug users remains relatively uncommon in the United Kingdom but there is some evidence of both increasing prevalence and transmission. The prevalence of HIV infection in current IDUs in England and Wales in 2005 was 2. 1%, the highest prevalence ever seen. In London the prevalence in current IDUs was 4. 3%, which is similar to recent years, but elsewhere in England and Wales the prevalence in current injectors was 1. 6% which is more than double the prevalence in 2004 (Pearson, 1987, NHS, 2011).

In addition to the infectious diseases mentioned above, site infections are also considered health related harm. There are continuing problems with infections associated with injecting including tetanus and wound botulism. These can result from poor skin hygiene, environmental conditions, and/or poor injecting practice (NHS, 2011, Pearson, 1987).

2. 5 Role of community pharmacy and needle exchange

Open access drug services, such as needle exchange, can provide a crucial interface with drug users who are not currently engaged in structured drug

treatment and who are often, by definition, at greater risk of drug-related harm (NHS, 2009/10). For this reason, this aspect of drug-related harm reduction is highlighted here.

In recent years, there has been an increased awareness of the rising levels of hepatitis (B and C), thus increasing the recognition of the need for better distribution of clean injecting equipment (Matheson et al., 2007). The model of delivery for needle exchange (specialist centre based, detached, outreach or pharmacy-based) will vary according to locally defined need (NHS, 2009/10). Community pharmacists play an important role in the UK in the provision of harm reduction services and in the treatment of drug misusers. They distribute clean needles through exchange or sale and dispense substitute drugs (primarily methadone) for maintenance and detoxification, often supervising the self-administration in the pharmacy to ensure it is taken by the intended person (Matheson et al., 2007).

Participation in needle exchange at pharmacy level in Scotland has increased overall but more so in some NHS areas than others. It is still relatively low having only increased from 9. 7 to 12. 5% compared with England where 19% of pharmacies provide this service (Matheson et al., 2007, Sheridan J, 1996)

As discussed above, needle exchange and open access services offer an opportunity not only to provide access to safer injecting materials but also to engage with service users who are not in contact with more structured services. They provide health promotion advice, information and materials, brief interventions, healthcare checks, and referral on to other specialist

services (NHS, 2009/10). Increasing the number of pharmacy schemes is likely to offer the best opportunity for the rapid expansion of distribution sites, especially for out of hours cover, supported by robust local co-ordination and monitoring of needle and syringe exchange programmes (NHS, 2009/10).

Closely connected to such needle exchange programmes are community-based outreach programmes, with which they are sometimes linked. Without necessarily distributing needles and syringes, these aim to obtain face-to-face contact with IDUs, provide literature about HIV risk reduction, distribute condoms and bleach for disinfection of needles and syringes (especially where needle exchange programmes are not operating), promote teaching and modelling of HIV risk reduction by network leaders, referral to services, improve access to risk assessment and HIV testing, provide counselling and support community organising (Hunt, 2010). It has been shown that such community-based responses can be an effective component of the overall drug response (Hunt, 2010).

2. 6 Methadone and other replacement therapies

Methadone maintenance treatment is the most researched treatment currently available for people who are dependent on opioids. Its use is supported by an evidence-base developed over almost 40 years and from across many different countries. It retains patients in treatment for longer than any alternative, non-replacement therapy, and has a

superior effect on the reduction of heroin use and crime associated with opioid dependence (Power, 1994).

2. 7 Historical perspective and the policy development

The first controls of drug possession were introduced in the First World War, and in the Dangerous Drugs Act of 1920 (Stimson, 2010). At this time, prescribing heroin and morphine was considered legitimate medical treatment for people who would otherwise be unable to withdraw- a very similar concept to the harm reduction strategy known today- and thus helping the patient lead a useful and fairly normal life.

The harm reduction approach to drug use first developed among Dutch heroin users in the 1970s. The original " Junkiebond" (users' union) of Rotterdam spread fast into a national federation which successfully negotiated substantial decriminalization, the prescription of methadone, and the provision of clean needles and syringes. The new approach rapidly spread through Germany, Austria, Switzerland, the UK, France, and other northern European countries (Des Jarlais, 1993, Van Solinge, 1999, Gowan et al., 2012).

CHAPTER 4 POLICY ANALYSIS

4. 1 Drug Policy

Despite the long-standing political prominence of the problem, relatively coherent strategies and substantial investments, the United Kingdom has the highest level of dependent drug use and among the highest levels of recreational drug use in Europe (Reuter, 2007). There are vast arrays of different policies and programmes working towards solving problems related to drug use and drug related harm at all levels, and they vary considerably in

their effectiveness. In this chapter, policies in the United Kingdom in general and England in particular will be considered.

The United Kingdom consists of England, Wales, Scotland and Northern Ireland, within which England accounts for 85% of the UK population (Office for National Statistics, 2012). A number of powers have been devolved from the UK Parliament to Wales, Scotland, and Northern Ireland, but each has different levels of devolved responsibilities. The United Kingdom Government is responsible for setting the overall strategy and for its delivery in the devolved administrations only in matters where it has reserved power (Department of Health, 2011).

In the United Kingdom, illicit drug policy and attitude towards harm reduction strategies has shifted with government changes. Between 1987 and 1997, there was a public health approach. The aim was to help problem drug users to lead healthier lives, and to limit the damage they might cause to themselves or others (Stimson, 2000). Harm reduction developed in a context of a healthy policy – although there were hitches in getting it accepted, for the most part it was well integrated into an amenable existing framework (Stimson, 2000).

In 2002 the Liberal Democrats launched new drug policy in which it was proposed that imprisonment should no longer be a punishment option and cannabis should be legalised. The Lib Dem policies were evidence-based, rejecting artificial distinctions between the harm caused by legal and illegal drugs, and rejecting enforcement and prison as primary policy tools based on evidence of ineffectiveness. Unsuccessful in promoting their policies in

2002, in 2011, experts backed calls to be made at the Liberal Democrats conference for the decriminalisation of all drugs, saying it would not lead to a surge in drug use (Travis, 2011). This call came not long after the launch of a new drug strategy, launched in December 2010, replacing that of the previous Government. The 2010 strategy sets out a fundamentally different approach to preventing drug use in communities, and in supporting recovery from drug and alcohol dependence. Some of the main aspects include the responsibility it puts on the individual to seek help and overcome dependency as well as providing a more holistic approach, by addressing other issues in addition to treatment to support people dependent on drugs or alcohol, such as offending, employment and housing. The 2010 strategy aims to reduce demand and takes an uncompromising approach to crack down on those involved in the drug supply both at home and abroad. With the devolution of power, it puts accountability in the hands of local communities to tackle drugs and the harms they cause. The coverage of the new strategy is as follows:

- health, education, housing and social care – confined to England

- policing and the criminal justice system – England and Wales

- the work of the Department for Work and Pensions – England, Wales and Scotland

(Home Office, 2012)

The Scottish Government and Welsh Government’s national drug strategies were published in 2008 and all three strategies aim to make further progress

on reducing harm and each focuses on recovery (Department of Health, 2011).

The changes in the Government’s drug policies have not gone without remark. In response to the change in Government strategy, the recently published document ‘ Charting New Waters’ from the UK Drug Policy Commission examined potential threats to drug services. The radical shift from centralised oversight toward local control of commissioning services, raised concerns and questions about whether the changes will “ deliver the outcomes that people need” or help control public expenditure. The report concludes that the new policy is “ a major social experiment, the outcomes of which are uncertain” (O’Hara, 2012). Research by the UK Drug Policy commission has shown that in addition to the reforms to police, justice, health and local council services in England, these systemic changes together with the budget cuts risk reducing the ability of local areas to respond effectively to problems caused by illicit drug use (Beck 2012).

4. 2 UK policy approach

As is the case in most European countries, drug-related deaths, infectious diseases, co-morbidity and other health consequences are key policy issues within the United Kingdom’s drug strategies (EMCDDA, 2012). Interventions include information campaigns on the risks associated with drug use for different target groups, as well as information on safer injecting and safer sex practices, needle exchange schemes, infection counselling, support and testing, and vaccinations against hepatitis B.

In most parts of the United Kingdom, particularly in England, there is a four-tier system of treatment for drug abuse. Tier 1 refers to generic interventions such as information and advice, screening and referral to more specialist services. Tier 2 refers to open-access interventions, such as drop-in services providing advice, information and some harm reduction services such as syringe exchange. Tier 3 services are specialist community services and include prescribing services, structured day programmes and structured psychosocial interventions, such as counselling and therapy and community-based detoxification. Tier 4 services are inpatient services, including detoxification and residential rehabilitation. The majority of structured treatment is delivered at Tier 3, predominantly through community-based specialist drug treatment services (EMCDDA, 2012).

4. 3 Drugs and the law

The Misuse of Drugs Act 1971, with amendments, is the main law regulating drug control in the UK. Drug use per se is not an offence under the Misuse of Drugs Act 1971: it is the possession of the drug which constitutes an offence (EMCDDA, 2012). The Misuse of Drugs Act 1971 divides controlled substances into 3 Classes (A, B, C) based on harm, with Class A being the most harmful. The classification of a drug has several consequences, specifically in determining the legal penalties for importation, supply, and possession, as well as the degree of police effort targeted at restricting its use (Nutt et al., 2007). The actual classifi