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United Kingdom Drug Situation

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UK Focal Point On Drugs

Annual Report to the European Monitoring
Centre for Drugs and Drug Addiction (EMCDDA)



United Kingdom Drug Situation: Annual Report to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2009

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The United Kingdom Focal Point on Drugs

The United Kingdom (UK) Focal Point on Drugs is based at the Department of Health and the North West Public Health Observatory at the Centre for Public Health, Liverpool John Moores University. It is the national partner of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and provides comprehensive information to the Centre on the drug situation in England, Northern Ireland, Scotland and Wales.

The Focal Point works closely with the Home Office, other Government Departments and the devolved administrations. In addition to this annual report, it collates an extensive range of data in the form of standard tables and responses to structured questionnaires, which are submitted regularly to the EMCDDA. It also contributes to other elements of the EMCDDA's work such as the development and implementation of its five key epidemiological indicators, the Exchange on Drug Demand Reduction Action (EDDRA) and the implementation of the Council Decision on New Psychoactive Substances.

Further information about the United Kingdom Focal Point, including previous annual reports and data submitted to the EMCDDA, can be found on the Focal Point website at www.ukfocalpoint.org.uk

The EMCDDA's website is www.emcdda.europa.eu

The Head of the United Kingdom Focal Point on Drugs is Alan Lodwick at the Department of Health (alan.lodwick@dh.gsi.gov.uk).

The structure and content of this report

The structure and content of this annual report are pre-determined by the EMCDDA to facilitate comparison with similar reports produced by the other European Focal Points. Ten chapters cover the same subjects each year, and three further chapters, giving in-depth information on selected issues, change from year to year.

Each of the first ten chapters begins with an **Introduction**. This sets the context for the remainder of the chapter, describing the main features of the topic under consideration within the United Kingdom. This may include information about the main legislative and organisational frameworks, sources of data and definitions used, the broad picture shown by the data and recent trends.

The remainder of each chapter is concerned with **New Developments and Trends** that have not been included in previous annual reports. Generally, this covers developments that have occurred in the second half of 2008 or the first half of 2009. Relevant data that have become available during this period will also be discussed although these will often refer to earlier time periods.

This report, and the reports from the other European countries, will be used in the compilation of the EMCDDA's annual report of the drug situation in Europe to be published in 2010.

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Summary

PART A: New developments and trends

Chapter 1. National policy and context

Legal Framework

The Welfare Reform Bill, proposing a new benefit and sanction system for drug users, is currently going through parliament.

Drug Classification

Cannabis was reclassified from Class C to Class B in January 2009 under *the Misuse of Drugs Act 1971*. The Government also proposes a generic control on synthetic cannabinoid receptor agonists as Class B. A number of other drugs are proposed for control under Class C including GBL, BZP and 15 anabolic steroids. Following an ACMD review of MDMA the Government's response included an undertaking to retain MDMA within its current Class A status.

The Drug Harm Index 2006

The third report on the Drug Harm Index developed to measure an earlier Public Service Agreement to 'Reduce the harm caused by illegal drugs' reported a fall of 11.7 points, or 14.5% since 2005.

Implementation of the 2008 drugs strategies

A new national indicator (NI) to measure action on the drug strategy in England, National Indicator 38: Drug-related (Class A) offending, has been published. The Scottish Government established the Scottish Drugs Recovery Consortium to promote the core aim of recovery. Drugs services in Scotland are now delivered by Alcohol and Drugs Partnerships. In Wales, the National Substance Misuse Strategy Implementation Board has been established to oversee strategy delivery.

Public expenditure

Labelled public expenditure on drugs in England and Wales for 2008/09 was €1,256.8 million (£998.4m).

Chapter 2. Drug use in the general population and specific groups

Latest survey data for England and Wales, from the *2008/09 British Crime Survey* (BCS), show that prevalence of recent (last year) drug use amongst the general population has risen slightly to 10.1% from last year's figure of 9.6% after having decreased year on year since 2003/04. Cannabis continues to be the most commonly used drug across all age groups, with prevalence rates close to those for use of any drug. Recent cocaine powder use has increased significantly since the previous survey from 2.3% to 3.0%. Although ecstasy use had remained relatively stable since 1996, there was a significant increase since the last survey from 1.5% to 1.8%. Recent use of ketamine, anabolic steroids and tranquilisers also increased significantly between 2007/08 and 2008/09 as did the use of any stimulant.

The *Northern Ireland Crime Survey 2007/08* reported that prevalence of recent drug use amongst adults aged 16 to 59 was 6.8%, a fall from 8.4% in 2006/07. Cannabis was again the most commonly used drug with cocaine and ecstasy being the next most commonly reported drugs for recent use. In general there has been a downward trend in recent and current use of drugs though recent cocaine use, increased significantly and there were also increases in the recent use of ecstasy and amphetamines. Further analysis of the *2006/07 Drug Prevalence Survey* in Northern Ireland has been published.

Drug use in the school and youth population

Results from two new surveys have been published this year: the 2008 school survey in England and the *Scottish Schools Adolescent Lifestyle and Substance Use Survey* (SALSUS) for 2008. A secondary analysis of the *Northern Ireland Young Persons' Behaviour and Attitudes Survey* (YPBAS) 2007 was also reported.

In England recent and current drug use continued to fall amongst the school population mainly accounted for by a fall in cannabis use. There was also a decrease in the use of volatile substances (recent and current use).

The latest results from SALSUS in Scotland show that recent drug use fell amongst 15 year olds 13 year olds since the last survey. However, current use (last month) remained relatively stable apart from a slight decrease amongst 13 year old boys

Recently published analysis from the Northern Ireland Young Persons' Behaviour and Attitudes Survey (YPBAS) 2007 examines changes between the 2003 and 2007 surveys and showed sizeable decreases in lifetime, last year and last month use of any drugs and of solvents.

Truants and excludées are more likely to report drug use than other pupils but the proportion reporting frequent use in England has fallen since 2003.

Chapter 3. Prevention

The Scottish Government, with the Scottish Local Authorities, published the early years framework: a set of guidelines for Government and local partners on support and early intervention for children and families.

Review of drugs education in schools

Following an evidence review of drug and alcohol education in England in 2008, the Government proposed that PSHE (Personal, Social, Health and Economic education) should become a statutory requirement in schools, with a public consultation on the matter ongoing.

A final evaluation report into the Blueprint Drug Education Research Programme in England reported a positive recall of drugs information from pupils and increased communication skills by parents.

Scotland has reformed its school curriculum and has published guidance on teaching and learning about substance misuse. A steering group has been established in Wales to monitor progress in drugs education.

Communities

The Positive Futures programme in England and Wales continues to provide diversionary activities to young people in socially disadvantaged areas. In 2007/08 around 60,000 young people took part in activities across 123 projects. In Scotland, through the 'CashBack for Communities' programme, 280 youth organisations ran activities for 100,000 young people with money recovered through the *Proceeds of Crime Act 2002*.

Selective prevention

The FRANK campaign in England issued guidance for foster carers to encourage dialogue about drugs with young people in their care and provide them with information on where to get further help.

Inspiring Scotland provided funding, activities and services for vulnerable young people in Scotland who, upon leaving school, may not be working or in further education and need extra support to prevent them from experiencing problems such as substance misuse in the future.

At-risk families

In England 'Family Intervention Projects' were piloted in ten areas. These provide intensive support to families affected by drug use by offering protection to children of drug users and help to improve parenting skills.

In Wales, the Strengthening Families Programme 10-14 was evaluated and it was reported that the programme has long term potential as a national primary drug prevention project by building skills within families and reducing risk factors associated with substance misuse.

National and local Media campaigns

During 2008/09 the Government spent €8.8 million (£6.97m) on the FRANK information campaign, with its main focus on major television campaigns about cannabis and cocaine.

In Scotland the Know the Score communication campaign focussed over the past twelve months on an 'Informing Parents' campaign, targeting parents and providing them with information to enable them to talk to their children about drugs.

Chapter 4. Problem drug use

Estimate of problem drug users

It is estimated that there were 328,767 Problem Drug Users in England in 2006/07 a rate of 9.76 per 1,000 population aged 15 to 64 suggesting that problem drug use has remained stable between 2004/05 and 2006/07. There was, however, an overall decrease in injecting between each sweep of the three-year study.

New estimates for Scotland and Wales were also published. In Scotland it was estimated that there were 55,328 problem drug users in 2006 a rate of 16.16 per 1,000 population aged 15 to 64. In Wales it was estimated that there were 19,394 problem drug users in 2006/07 a rate of 10.10 per 1,000 population aged 15 to 64. Combining the latest estimates from each administration it is estimated that for the UK as a whole there were 404,884 problem drug users a rate of 10.10 per 1,000 population aged 15 to 64.

Chapter 5. Drug-related treatment: treatment demand and treatment availability

Seven 'Drug System Change Pilots' began across England to test new approaches to treatment which aim to provide better end-to-end management of drug users' needs through the treatment system.

In Scotland a specific NHS target is to be set for drug treatment waiting times for the first time.

The National Audit Office is currently reviewing drug treatment commissioning and planning at the local level in England. Reviews for services in Wales and Scotland have been published, with variations in standards, local planning and accountability reported for both countries.

The National Treatment Agency in England has published a number of guidance documents for drug partnerships, treatment providers, clinicians and keyworkers. Also in England, a review was conducted on inpatient and residential rehabilitation service delivery, commissioning and responses to diversity. Guidance on Treatment Quality was published in Wales.

The Treatment Demand Indicator

Presentations for treatment as measured through the Treatment Demand Indicator (TDI) increased by three per cent in 2007/08 to 132,003 (from 128,208 in 2006/07). Opiates remain the most common primary drug accounting for 62% of all treatment presentations. Although numbers remain stable, the proportion of presentations for opiates continues to fall. Numbers of cannabis and cocaine powder presentations have increased, the latter by 22% since 2006/07. The proportion of heroin presentations reporting secondary use of crack cocaine continued to increase.

Forty per cent of those presenting for treatment in 2007/08 were aged between 25 to 34, and 28% were under the age of 25. Amongst first treatments, 40% were under the age of 25. Those presenting for cocaine powder use tended to be younger than opiate users and cannabis presentations tended to be younger still. The proportion aged over 34 years old increased from 29% in 2005/06 to 32% in 2007/08.

Seventy-three per cent of all presentations were by males. Just under half of those presenting for treatment were current (last four weeks) or former injecting drug users with 22% reporting current injecting. The vast majority of clients receive treatment through out-patient services (94%).

First treatment presentations accounted for 35% (46,601) of all presentations.

Clients in treatment

In 2008/09 in England there were 207,580 individuals aged 18 or over in contact with structured drug treatment services, 83% of whom were problem drug users. It is estimated that in 2006/07 45% of PDUs were in treatment. In Wales, 19,126 clients were in treatment, a rise of 50% since the previous year.

Substitution treatment

Data from NDTMS in England show that, in 2007/08, 131,468 individuals were receiving prescribing treatment, an 11% increase from 2006/07 and a 49% increase since NDTMS started collecting the data in 2004/05. In 2007/08 in Northern Ireland there were 507 individuals in contact with substitute prescribing services. In Wales in 2008/09 there were 2,617 referrals to agencies that provide substitute prescribing or prescribing services.

Chapter 6. Health correlates and consequences

Drug-related deaths

Using the EMCDDA definition, drug-related deaths in the UK increased by 13% in 2008 to 2,231. The increase was greatest in Scotland (26%) and amongst women (36%). The number of deaths in Wales fell. There have been large increases since 2003 amongst people in their forties and fifties.

Most deaths continue to be linked with the use of opiates. However there have been large increases in mentions of cocaine including a rise of 32% between 2007 and 2008.

Drug-related infectious disease

HIV prevalence amongst IDUs is similar to previous years at around 1.5%, although this is higher than it was in 2000. In London prevalence is 3.8% (compared to 1.0% elsewhere in England). Emerging evidence suggests a possible increase in transmission in recent years. In 2007/08 in Northern Ireland prevalence was 2.2% and in Wales 0.8%.

Prevalence of hepatitis C (HCV) is much higher than that for HIV, at around 40% of IDUs in England and Wales. In 2008 around 13% of current and former IDUs in England, Wales and Northern Ireland were currently or had previously been infected with hepatitis B, compared to 20% in 1999.

Co-morbidity

The English household survey of adult psychiatric morbidity in 2007 reported that 36% of respondents who were drug dependent (on drugs other than cannabis) were receiving treatment for a mental or emotional problem and that 14% of respondents who were dependent on cannabis only were receiving treatment for a mental or emotional problem.

Chapter 7. Responses to health correlates and consequences

Drug-related death

In England the 'Harm Reduction Works' information campaign was launched in 2008. The NTA has also published *Good Practice in Harm Reduction*.

In Scotland, a national database of drug-related deaths, which includes an examination of the circumstances behind them, has been launched.

Drug-related infectious disease

NICE has published guidance on the provision of needle exchange services.

The ACMD Prevention Working Group on hepatitis C prevention published *The Primary Prevention of Hepatitis C Among Injecting Drug Users* which makes recommendations on the need for synergistic approaches to hepatitis C prevention. The ACMD is about to undertake a review on the provision of foil as a harm reduction measure.

In Scotland, phase two of the *Hepatitis C Action Plan for Scotland* reported on year one progress. Treatment targets have been met and a new infrastructure to improve identification, diagnosis and treatment and support is under development.

In Wales a needle exchange services data collection system has been piloted and evaluated with a view to rolling it out nationally.

There have been various initiatives around take home naloxone in England, Scotland and Wales.

The National Collaborating Centre for Mental Health is developing clinical guidelines for the assessment and management of psychosis in conjunction with problematic substance misuse and have published a scope of the guidance.

The Department of Health is currently undergoing a consultation process on its *New Horizons: towards a shared vision for mental health* document which sets out cross-governmental proposals to develop and improve the delivery of mental health services, including those for dual diagnosis.

Chapter 8. Social correlates and social reintegration

Employment

The majority of clients entering treatment in 2007/08 in Scotland were unemployed (70%); only 16% were in employment. Similarly, in Northern Ireland only 17% were employed.

A benefit sanction system is to be piloted in England which aims to encourage problem drug users claiming benefit to enter treatment. The UK Drugs Policy Commission published research on this and improving access to employment. A network of Jobcentre Plus Drug Co-ordinators has been established to support this.

Housing

In Scotland in 2007/08, 16% of clients entering drug treatment were homeless. It is reported that stable housing is frequently regarded as a pre-requisite for rehabilitation. Findings from the DORIS study in Scotland (which took place between 2001 and 2004) reported that for drug users with children there was a positive association between home ownership/tenancy and not having their children taken into care.

Findings from the Drug Interventions Programme (DIP) in England report that a stable home is crucial in preventing relapse and re-offending and numerous joint local projects with treatment and homeless services have been reported in the previous 12 months. There has also been an increase in drug users receiving 'Supporting People' housing support in England between 2006/07 and 2008/09 (from 4,589 to 5,435).

Social correlates and social reintegration

There have been various estimates of the 'hidden' population of children of drug using parents published. In Scotland, 33% of new clients entering treatment in 2007/08 had dependent children under 16. Also in Scotland, it was reported that amongst the DORIS cohort 20% had at least one child living with them (after eight months in treatment) and that there was a positive association between retaining children (not going into care) and methadone maintenance therapy.

In the North West of England it was estimated that between three per cent and five per cent of under 16 year olds in the areas of analysis were children of drug using parents.

In response to the issue of children of drug using parents, examples of several local family based interventions and initiatives were reported in 2008/09. An Action Plan on 'Hidden Harm' was published in Northern Ireland.

Youth Crime Action Plan

A progress update one year on from the launch of the Youth Crime Action Plan has reported that the plan had reduced drug consumption amongst young people, increased support provision and that a greater number were involved in positive activities.

Chapter 9. Drug-related crime, prevention of drug related crime and prison

Drug offences

There were 288,390 recorded drug crimes in the UK in 2008/09, an increase of six per cent on the previous year. In 2007/08 arrests for drug offences rose by 17% while the number found guilty or cautioned for drug offences increased by nine per cent in 2007 to 134,920. There has been a large increase (24%) in the number of convictions for cocaine powder offences. Cannabis warnings accounted for around two-thirds of recorded drug offences in England and Wales in 2008/09.

Guidance has been published on the new escalation policy for cannabis possession offences.

Crime and drug use

In Scotland results from the DORIS study reported that increased levels of drug consumption were associated with increased acquisitive crime committed by drug users.

Other research has shown a relationship between drug use and crime influenced by social and cultural settings, with PDUs more likely to commit burglary and shoplifting offences and non-PDUs more likely to be involved in violent crimes and offences under the *Misuse of Drugs Act (1971)*.

Interventions in the Criminal Justice System

Intensive Alternative to Custody (IAC) pilots are running in several areas of England and Wales as an alternative to short custodial sentences.

A consultation process, managed by the Sentencing Advisory Panel, is in progress (in England) to consider proposals which include a reduction in the length of custodial sentences for drug dealing and increased emphasis on criminal asset recovery.

In England and Wales the Youth Rehabilitation Order will have a treatment and support requirement attached to it.

In Scotland, central funding was withdrawn from June 2009 from the mandatory drug testing on arrest pilots. This was following the results of an independent evaluation which reported much lower than anticipated treatment referrals.

Prison and drug use

In England & Wales 7.8% prisoners tested positive for drugs in 2008/09 (a decrease from 9.1% in 2007/08 and from 24.4% in 1996/97)

In Scotland in 2007/08, 64% of prisoners tested positive for drugs on entry; 26% tested positive on exit and 26% of prisoners self-reported last month use whilst in prison.

In Northern Ireland in 2007/08 around 29% of prisoners who took Voluntary Drug Tests (VDT) tested positive.

Guidance for joined-up treatment for prisoners '*Continuity of care for drug users in prison*' has been jointly published by the NTA, Ministry of Justice and the Home Office.

The National Offender Management System (NOMS) drug strategy and action plan was published.

The NTA announced an additional €3.3 million (£2.9 m) funding for drug treatment in prisons in 2009/10. Funding for the Integrated Drug Treatment System (IDTS) is now available to all English adult prisons. Its aims are to enhance treatment within the prison setting and continuity of care in the community. In England, the NDTMS is being developed for use in prison.

In Scotland the responsibility for health care in prisons has been transferred to the NHS and the Scottish Prison Service substance misuse strategy is under development. A pilot scheme of a new model of care in prisons to support recovery will be evaluated with a view to national roll out.

Chapter 10. Drug markets

Availability

Despite reports of the ready availability of drugs, the proportion of school children reporting that drugs are easy to obtain has fallen in both England and Scotland since 2003.

Seizures

In England and Wales the number of seizures in 2007/08 increased by 17% on the previous year (216,792 compared to 186,028). There has been an upward trend since 2004.

The quantities of heroin and cocaine seized remained stable. The quantity of cannabis (resin and herbal) seized fell but the number of plants seized increased by 48%.

In Northern Ireland there were a total of 3,198 seizures in 2008/09, an increase of eight per cent (2,968).

Price

Data from law enforcement agencies show that the price of heroin and cocaine powder has again fallen, whilst prices for other drugs remain stable. The price of cocaine, when adjusted for purity, increased until 2005, and has since stabilised.

Purity

A large range of purities across all drugs was reported. The purity of heroin has fallen slightly but is still higher than in 2003/04; cocaine powder purity continues to fall, the mean purity being 29% in 2008, with some reports of purity as low as nine per cent.

PART B: Selected Issues

Chapter 11. Cannabis markets and production

Estimates of the size of the cannabis market in the United Kingdom range from around 250 to 450 tonnes of cannabis used yearly equating to a monetary value between €578 million (£400m) and over €5 billion (£3.5bn).

The cannabis market in the United Kingdom had been dominated by imported cannabis but since the early 1990s domestic cultivation has grown and large scale cultivation of cannabis in the UK in so-called 'cannabis farms' has increased considerably since 2004.

It is reported that cannabis farms are often operated by organised gangs with links to other serious criminal activities such as people trafficking. It is thought that South East Asian gangs run many of the large scale growing operations and White British criminals are involved in distribution at a local level. However, there are intelligence gaps in how national level distribution is organised.

Imported cannabis resin was for a long time the most common type of cannabis in the United Kingdom, but some reports now suggest that skunk cannabis accounts for anywhere between 38% and 81% of the domestic market with statistically significant differences reported by the Home Office across the regions of England and Wales. Seizure statistics from both police and customs seem to suggest a large reduction in cannabis resin seizures.

A recent online survey amongst frequent cannabis users found that availability was the most important factor in choosing what kind of cannabis to buy.

Street-level cannabis prices have remained stable over recent years at around £20 for an eighth of an ounce of skunk cannabis (3.54 grams) with less potent strains of cannabis such as resin or traditional herbal cannabis around half the price of skunk.

It has been suggested that most people access the drug from their social circle and usually buy cannabis from a friend/relative/partner rather than on the street or through formal illicit markets.

Chapter 12. Problem amphetamine use

In the past ten years in the United Kingdom there has been reduced focus on amphetamine use due to an increase in the use of other stimulant type drugs like ecstasy and cocaine powder. Despite concerns about methylamphetamine use there appears to be little evidence to suggest anything more than sporadic small-scale use in the United Kingdom.

There has been a significant decrease in recent and last month use of amphetamine between 1996 and 2008/09. A large majority (92%) of recent amphetamine users aged 16 to 59 reported using at least one other drug in the last year (70% cocaine powder and 62% ecstasy).

Just under one per cent of 16 to 59 year olds (0.9%) reported lifetime use of methylamphetamine in 2008/09 with only 0.1% reporting recent and current use. Amongst 16 to 24 year olds, lifetime use was 0.8%, recent use 0.2%, and current use 0.1%.

There were 4,416 presentations to treatment for primary amphetamine use in 2007/08 (3.5% of all presentations) and 1,976 first presentations (4.4%). There were marked differences between countries in the United Kingdom with amphetamine accounting for only 0.8% of first presentations in Northern Ireland compared to 3.3% in Scotland, 4.5% in England and 7.7% in Wales. In 2007/08, 57% of primary amphetamine clients were polydrug users.

It is suggested that the majority of amphetamines in the United Kingdom are produced in the Netherlands and Belgium in collaboration with British organised criminals. Some amphetamines are being manufactured in the United Kingdom but this is on a relatively small-scale and there has been a decline over the past 20 years in the number of illicit laboratories discovered in the United Kingdom.

In the United Kingdom guidelines on clinical management of drug misuse and dependence suggest that the mainstay of treatment for stimulant users including amphetamines users should be psychosocial and non-pharmacological.

Chapter 13. Treatment and care for older drug users

The United Kingdom has an ageing population and there is emerging evidence to suggest that drug use amongst the older general and treatment population is increasing.

Latest BCS data show a significant increase in last year use of any drug in the 45 to 54 year old age group between 1996 and 2008/09 (from 2.0% to 3.1%). Last year use of Class A drugs has also increased significantly between 1996 and 2008/09 for the 35 to 44 year old age category.

The proportion of all clients entering treatment in the 40 and over age group has shown a steady increase between 2003/04 and 2007/08 (from 12% to 17%) and over this time period the numbers in the 40 to 49 age group have nearly doubled. The proportion of older drug users in treatment in the United Kingdom has increased steadily since 2004 for all drugs (except cannabis). The proportion of clients over 40 reporting heroin as a primary drug has shown the largest proportional increase (of 7.1%) between 2003/04 and 2008/09.

In England in 2008/09, data from the NDTMS showed that there was a 20% increase in the proportion of new treatment presentations for heroin and crack cocaine by clients aged 35 and over between 2005/06 and 2008/09. In 2008/09, 24% of clients in contact with structured treatment were aged 40 and over (compared to 22% in 2007/08 and 20% in 2006/07). The average (median) age of clients has increased to 33 years in 2008/09 from 31 years in 2006/07.

Using the EMCDDA definition for drug-related deaths, the proportion of drug-related deaths (DRD) amongst the 40 and over age group in the United Kingdom has increased steadily between 1996 and 2007. It is reported that mortality rates are between 12 and 22 times higher in older drug users than in the general population.

Common health problems related to ageing can start at an earlier age amongst older drug users and drug use can accelerate the speed at which these problems worsen. Complications associated with long term drug use include: hepatic damage due to hepatitis B or C; HIV infection; chronic airways disease and lung damage; chronic venous and/or arterial damage; cardiac valve destruction; risk of drug interactions; alongside other diseases common in older adults such as hypertension, diabetes and memory loss.

There are examples of specific clinical guidelines and action plans in the UK for older drug users but further research and the development of tailored support and service provision has been recommended in several studies.

Technical notes

Standard Tables

References in the text to Standard Tables (sometimes abbreviated to ST01, ST02 etc) are to standardised reporting formats specified by the EMCDDA. All National Focal Points provide data using these Standard Tables in order to facilitate the collection of information in a consistent and comparable format across Europe. The tables provided to the EMCDDA by the UK Focal Point are available on the Focal Point website (www.ukfocalpoint.org.uk).

The standard tables usually include the source of the data and details of methodology. A list of standard tables referred to in this report is included in Part C of the document.

Exchange Rates

All monetary values in this report are provided in both Euros (€) and Pounds Sterling (£). Euro values have been derived using the annual average spot exchange rate published by the Bank of England for the most appropriate calendar year. For example, for 2007/08 financial year values the exchange rate for 2007 has been used. For 2009 the annual rate has been estimated from the first three quarterly average rates published at the time of writing and by assuming that the fourth quarter rate is the same as that prevailing in the third quarter. The 2009 rate has been calculated as the average of these four quarterly rates.

Exchange rates used in the text are shown in the table below.

| YEAR | EURO RATE (£1 =) |
|------|----------------------|
| 2003 | 1.4456 |
| 2004 | 1.4739 |
| 2005 | 1.4629 |
| 2006 | 1.4670 |
| 2007 | 1.4619 |
| 2008 | 1.2588 |
| 2009 | 1.1291 |

There have recently been considerable changes in the Sterling/Euro exchange rate. This means that care must be taken when interpreting trends in values given in Euros.

References to Specific Drugs

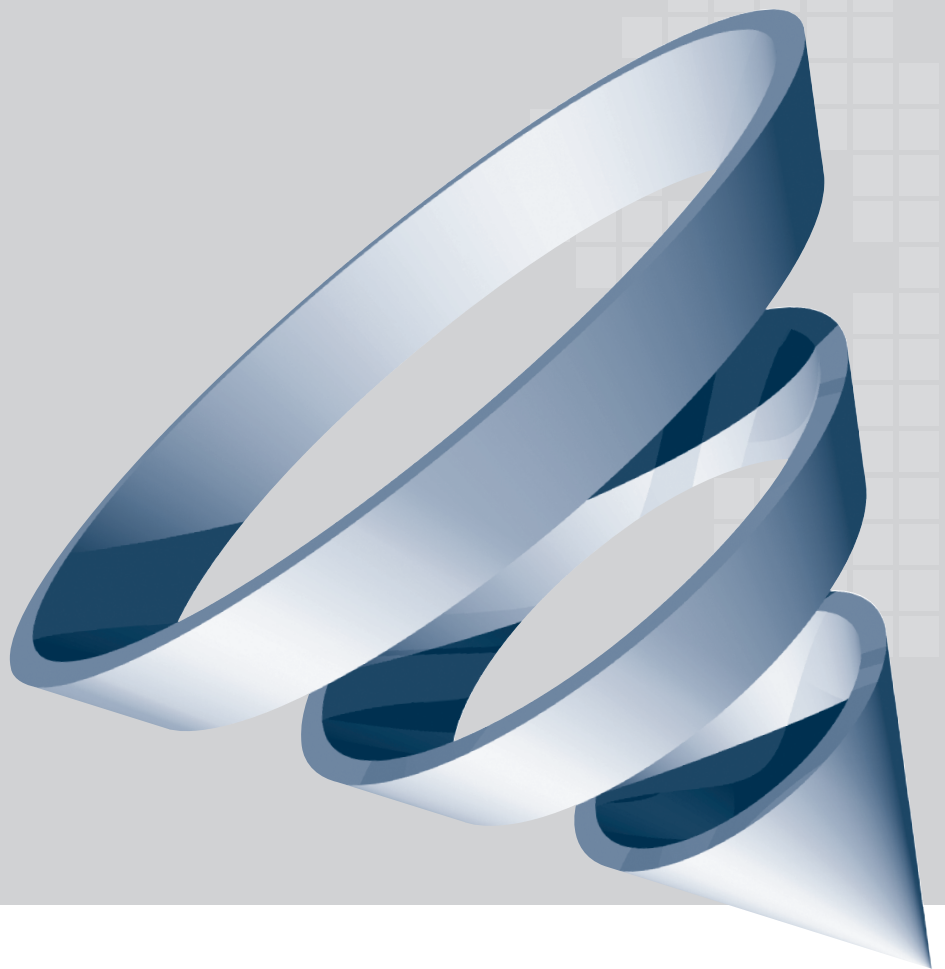
Cocaine. Where appropriate, this report distinguishes between 'cocaine powder' and 'crack cocaine'. When the word 'cocaine' is used it should be interpreted as meaning both forms of the drug.

Amphetamine(s) The term used in the text is the same as that used in the survey or study being described. In the UK methylamphetamine is the term used in legislation for what is more generally known as methamphetamine.



The United Kingdom population was estimated to be 61.4 million in the middle of 2008. 84% (51.4 million) live in England, eight per cent (5.2 million) in Scotland, five per cent (3.0 million) in Wales and three per cent (1.8 million) in Northern Ireland.

Part A: New Developments and Trends



1. National policy and context

1.1 Introduction

The United Kingdom consists of England, Wales, Scotland and Northern Ireland. England accounts for 84% of the UK population¹. A number of powers have been devolved from the United Kingdom Parliament to Wales, Scotland, and Northern Ireland, but each has different levels of devolved responsibilities.

The Misuse of Drugs Act 1971 is the principal legislation in the United Kingdom with respect to the control and supply of drugs that are considered dangerous or otherwise harmful when misused. This Act divides such drugs into three Classes (A, B and C) to reflect their relative harms and sets maximum criminal penalties for possession, supply and production in relation to each class. Drugs in Class A include cocaine based drugs, ecstasy, LSD, magic mushrooms, heroin, methadone and injectable amphetamine. In addition, methylamphetamine was reclassified from Class B to Class A in January 2007. Class B drugs include amphetamine and since January 2009, cannabis. Class C drugs include anabolic steroids, tranquillisers and ketamine. *The Drugs Act 2005* amended sections of *The Misuse of Drugs Act 1971* and *The Police and Criminal Evidence Act 1984*, strengthening police powers in relation to the supply of drugs.

The United Kingdom Government is responsible for setting the overall strategy and for its delivery in the devolved administrations only in the areas where it has reserved power. A new United Kingdom Drug Strategy was launched in February 2008; within it, policies concerning health, education, housing and social care are confined to England; those for policing and the criminal justice system cover England and Wales.

The Scottish Government and the Welsh Assembly Government (WAG) also launched new strategies in 2008, the latter combining drugs, alcohol and addiction to prescription drugs and over-the-counter medicines. All aim to make further progress on reducing harm and each looks towards a greater focus on recovery. All three strategy documents are accompanied by an action or implementation plan, providing a detailed set of objectives; actions and responsibilities; expected outcomes and a corresponding time scale (HM Government 2008a; HM Government 2008b; Scottish Government 2008a; WAG 2008a; WAG 2008b). Each plan reflects the devolution of responsibilities to the national government. Northern Ireland's strategy for reducing the harm related to alcohol and drug misuse, the *New Strategic Direction for Alcohol and Drugs (NSD)*, was launched in 2006. The NSD contained actions and outcomes, at both the regional and local level, to achieve its overarching aims (DHSSPSNI 2006). The UK strategies are also underpinned by performance management frameworks including Public Service Agreements (PSAs) and associated sets of performance indicators which progress is measured against.

The economic and social costs of Class A drug use in England and Wales combined are estimated to have been around €22.2 billion (£15.4bn) in 2003/04 (Gordon et al. 2006). Using a similar methodology, it is estimated that the economic and social costs of illicit drug use in Scotland was €5.1 billion (£3.5bn) in 2006 (Casey et al. 2006).

¹ See: <http://www.statistics.gov.uk/pdffdir/pop0809.pdf>

1.2 Legal framework

Welfare Reform Bill

The Welfare Reform Bill (House of Commons Library 2009) is currently going through parliament. It contains proposals to pilot a new benefit and sanction regime for drug users ² (see section 8.3.3).

Reclassification of cannabis

Following parliamentary approval, cannabis was reclassified from Class C to Class B in January 2009³. See also section 9.4.1 for information on penalty notices for disorder (PND) for cannabis possession offences.

ACMD review of MDMA

In a review of MDMA (ecstasy), the Advisory Council on the Misuse of Drugs (ACMD)⁴ concluded that on balance, the harms posed by it are commensurate to other drugs in the Class B category and recommended that it should be downgraded from its current Class A status (ACMD 2009a). Public health concerns regarding ecstasy use, largely due to the prevalence of use, were raised and a number of further, harm reduction recommendations were made in the report including:

- the promotion of public health messages to users, friends, parents and venues;
- credible and consistent advice about the risks of MDMA;
- improving data collection regarding the extent of MDMA use among under 16s;
- measurement of the relative risks of MDMA in comparison with other drugs and the attitude of the public towards it; and
- further research into MDMA in polydrug use and the effects of MDMA on the brain.

The Government accepted 11 of the ACMD's 13 recommendations but rejected the recommendations to downgrade MDMA to a Class B drug and to introduce a national scheme to enable testing of ecstasy tablets for personal use (Home Office personal communication).

Proposed classification of Gamma-butyrolactone (GBL) and 1,4-butanediol (1,4-BD)

Following a consultation carried out in 2009 (Home Office 2009a), the Government has announced that GBL (Gamma-butyrolactone) and 1,4-butanediol (1,4-BD) will be controlled under the *Misuse of Drugs Act 1971* as Class C drugs, when intended for human consumption⁵. This follows a provisional recommendation from the ACMD (ACMD 2009b) to subject the drugs to legal controls, with licensing arrangements made for their legitimate industrial use (as the substances are widely used in a range of legitimate products such as solvents; cleaning products; paints; rubber and plastics).

² See: <http://www.parliament.uk/commons/lib/research/rp2009/rp09-008.pdf> and <http://www.publications.parliament.uk/pa/ld200809/ldhansrd/text/91022-0015.htm>

³ The Misuse of Drugs Act 1971 (Amendment) Order 2008 (No. 3130). The UK Statute Law Database. Office of Public Sector Information. Available: <http://www.statutelaw.gov.uk/content.aspx?LegType=All+Legislation&PageNumber=1&NavFrom=3&activeTextDocId=3540710&parentActiveTextDocId=3540710&hideCommentary=0&showProsp=0&suppressWarning=0&showAllAttributes=1>

⁴ The Advisory Council on the Misuse of Drugs (ACMD) is an independent expert body that advises government on drug related issues in the UK.

⁵ See: <http://drugs.homeoffice.gov.uk/news-events/latest-news/legal-high-ban>

Proposed classification of 1-benzylpiperazine (BZP) and related compounds

Following advice from the ACMD (ACMD 2008a), and after a period of consultation in summer 2009 (Home Office 2009b), the Government announced its intention to subject BZP (and its related compounds) to control measures under the *Misuse of Drugs Act 1971*, as a Class C drug⁶. Generic controls against other chemically related compounds (such as mCPP, DBZP and TMPP) will also be implemented in order to prevent manufacturers diversifying and producing other substituted piperazines once BZP is a controlled substance⁷.

Proposed classification of 15 steroidal and two non-steroidal substances

It was reported in last year's Focal Point report that, following the advice of the ACMD (2008b), the Government intended to include a number of steroidal and non-steroidal substances as Class C drugs under the *Misuse of Drugs Act 1971*. After consultation (Home Office 2009b), in August 2009 the Government re-emphasised its intention to classify these substances as Class C drugs⁸.

The ACMD has set up an Anabolic Steroids Working Group which is currently in consultation with a range of experts who are closely considering the evidence regarding harm reduction and the risks associated with steroid use, with particular reference to young people. They are due to report in spring 2010 (ACMD 2009c).

ACMD report on the major cannabinoid agonists

Following reports across Europe of the marketing of a legal smoking mixture named 'Spice' which is sold as a legal alternative to cannabis, the ACMD has recommended that the active compounds (synthetic cannabinoid receptor agonists) of this substance and other similar 'herbal highs' should be subject to control measures. Results of forensic analysis have shown that these products are typically plant based mixes which appear to have been sprayed with synthetic cannabinoids and then marketed as a herbal product and sold online and in 'head shops'. Although the ACMD found that the evidence is presently not strong enough to establish the exact pharmacology of these products, existing research suggests that their harmful effects could mirror those associated with cannabis and they may be even more harmful. A generic control on synthetic cannabinoids has been proposed so that manufacturers are unable to diversify and produce different synthetic cannabinoids which are chemically and functionally similar once one becomes outlawed. Five substances are also recommended for specific control (ACMD 2009d). In response to this, the Government has announced its intention to control these substances as Class B drugs in line with the classification of cannabis⁹.

ACMD consideration of oripavine

At the request of the Home Office, the ACMD wrote to the Home Secretary in August 2009 regarding oripavine, an opiate derived from poppy straw of the opium poppy¹⁰. The ACMD report that only one company imports oripavine into the UK and there is no evidence at the moment to suggest that it is being used on its own within the UK. They go on to say that, whilst it has analgesic properties, it is also highly toxic and can cause seizures. Therefore the ACMD suggest that it should be placed in Class C alongside similar drugs such as buprenorphine as it does not have the same abuse potential as Class A opioids such as heroin and morphine¹¹. The Government accepted the ACMD's recommendation to control oripavine.

⁶ See: <http://drugs.homeoffice.gov.uk/news-events/latest-news/legal-high-ban>

⁷ See: <http://drugs.homeoffice.gov.uk/news-events/latest-news/legal-high-ban>

⁸ See: <http://drugs.homeoffice.gov.uk/news-events/latest-news/legal-high-ban>

⁹ See: <http://drugs.homeoffice.gov.uk/news-events/latest-news/legal-high-ban>

¹⁰ Oripavine can be easily converted into thebaine which is used in the production of buprenorphine.

¹¹ See: <http://drugs.homeoffice.gov.uk/publication-search/acmd/oripavine?view=Binary>

1.3 National action plan, strategy, evaluation and co-ordination

1.3.1 National action plans and strategies

Key indicators, relating to implementation of drug strategies and, in a number of instances, to expected outcomes of actions will be measured as reported in previous Focal Point reports.^{12 13 14}

England

Implementation of the drugs strategy

Key actions to tackle drug misuse in line with the drug strategy action plan (HM Government 2008b) in England are identified through Public Service Agreement (PSA) targets, and measured at local level through a set of National Indicators (NI)¹⁵. The original set of National Indicators (NI) for England was published in April 2008. At the time of publication, ten further indicators were delayed, one of which related to drugs: *National Indicator 38: Drug-related (Class A) offending*. Following a period of consultation, this has now been published (see section 9.3). A technical change to the way data is reported in measurement of progress against *NI 115: Substance misuse by young people*, has also been made (CLG 2009).

Following the United Kingdom strategy a number of key actions with respect to implementation have been set; these include the establishment of a Strategy Group and Delivery Group.

In April 2009 HM Government published *The 2008 Drug Strategy: One year on* (HM Government 2009a) which gives examples of the work being carried out under the new drug strategy. Future priorities include:

- more community engagement by the police to improve perceptions of drug use and dealing;
- enhanced drug treatment in prisons;
- implementation of a 'families at risk' programme;
- addition of a drug treatment/support requirement to Youth Rehabilitation Orders;

¹² In England this is identified through a number of Public Service Agreement (PSA) targets, specifically PSA 25 which aims to 'reduce the harm caused by alcohol and drugs' (HM Treasury 2007). Progress against this is measured through the following indicators: the number of drug users recorded as being in effective treatment; the rate of drug-related offending; and the percentage of the public who perceive drug use or dealing as a problem in their area.

¹³ The Scottish Government's National Performance Framework underpins the delivery of the Scottish Government's agenda, and contains 15 outcomes and 45 indicators which measure the progress of outcomes. 'Reducing the estimated number of problem drug users in Scotland by 2011' is one of these national indicators.

¹⁴ In Northern Ireland the Northern Ireland Executive programme for government 2008-2011 sets out the strategic priorities and key plans for 2008 to 2011 (Northern Ireland Executive 2008). Priorities are underpinned by a framework of 23 PSAs detailing actions, outcomes and targets to be achieved over the life course of the strategy. Included in this is Objective 3, of PSA 8: Promoting Health and Addressing Health Inequalities, which aims to reduce illicit drug use (and binge drinking) particularly among young people and vulnerable groups. Key targets are: five per cent reduction in the proportion of young adults taking illegal drugs within the previous month by 2010; and five per cent reduction in the number of children at risk from parental alcohol and/or drug dependency by 2011.

¹⁵ In England, Local Authorities and their Strategic Partnerships which include Primary Care Trusts (PCTs) are measured at the local level by a set of 188 National Indicators (NI) which relate to specific PSAs (CLG 2007; 2009). In each area, targets against the set of national indicators are negotiated through Local Area Agreements (LAAs). Each Agreement is expected to include up to 35 targets from the national indicators set which are measured by agreed data sources. As these indicators are based upon local need they may not necessarily include drug misuse indicators, except those relating to drug education. In addition, 'the number of drug users recorded as being in effective treatment' has been placed in Tier 2, of the Vital Signs indicator set, which is part of the Operating Framework for the National Health Service (NHS). This requires PCTs to submit a trajectory for this indicator as part of their operational plan. Performance management of PCT operational plans rests with Strategic Health Authorities (SHAs). See: http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_082560.pdf

- a public consultation on proposals to make PSHE (Personal, Social, Health and Economics) education statutory in all schools (see section 3.2.1); and
- piloting of recovery and reintegration focused programmes within drug treatment.

The Drug Harm Index 2006

A third report on the *Drug Harm Index (DHI)* has been published (Home Office 2009d)¹⁶. The DHI was developed to measure a PSA set for the previous Spending Review period 2005/06 to 2007/08 which aimed to:

'Reduce the harm caused by illegal drugs (as measured by the Drug Harm Index encompassing measures of the availability of Class A drugs and drug related crime) including substantially increasing the number of drug misusing offenders entering treatment through the criminal justice system'.

The latest report updates the DHI with data relating to 2006 and shows that the DHI fell by 11.7 points, or 14.5% since 2005. This is greater than the fall between 2004 and 2005, where the DHI fell by 5.7%. The fall is partly due to a large decrease in all types of recorded crime in 2006 (Home Office 2009d).

Scotland

Implementation of the Substance Use Action Plan

A progress report *The Road to Recovery: One Year On* (Scottish Government 2009a) was published by the Scottish Government to mark the first anniversary of the drugs strategy. The report sets out some of the key steps taken by the Scottish Government and other agencies to help deliver the strategy's objectives. The report states that there have been a variety of developments as part of the implementation of the substance use action plan, underpinned by an investment of €36.1 million (£32m). One such development is the establishment of the Scottish Drugs Recovery Consortium in order to fulfil the proposal in the drug strategy of setting up a 'drugs recovery network'. Its purpose is to promote the ethos of recovery as the core aim of drug services and to act as a figurehead in liaison with the media and policy makers (Scottish Government 2009b).

HEAT: Targets for waiting times in Scotland

From April 2010 the Scottish Government proposes to introduce targets on waiting times for drug treatment as part of wider 'HEAT' targets¹⁷ with the aim of speeding up access to treatment (measuring health improvement; efficiency and governance improvements, access to services, and treatment appropriate to individuals) as part of a total of €118.3 million (£94m) invested in treatment services between 2008 and 2011 (see section 5.2).

Framework for Local Partnerships on Alcohol and Drugs

The Scottish Government established the Delivery Reform Group¹⁸ in January 2008 to improve service delivery and outcomes for clients of drugs services (in line with the Concordat between the Scottish

¹⁶ For methodology see previous Focal Point reports or www.homeoffice.gov.uk/rds/pdfs05/rdsolr2405.pdf

¹⁷ HEAT targets are a core set of objectives, targets and measures for the NHS and are aligned with the Government's National Performance Framework and support the delivery of Single Outcome Agreements (between local authority areas and the Scottish Government). At the local level Local Delivery Plans reflect the HEAT Core Set (the key objectives, targets and measures that reflect Ministers' priorities for the Health portfolio), setting out a delivery agreement between the Scottish Executive Health Department and each NHS area Board. See: <http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/17273/targets>

¹⁸ See: <http://www.scotland.gov.uk/Topics/Health/health/alcohol/resources/deliveryreformgroup>

Government and the Convention of Scottish Local Authorities (CoSLA))¹⁹. A new framework for delivering local drugs and alcohol partnerships in Scotland has been launched following recommendations made by this group (Scottish Government 2009c) and also those made by Audit Scotland in their report on drug (and alcohol) services. The Delivery Reform Group reported that in the past delivery of drugs services was not subject to an effective accountability structure and therefore recommended that a key future objective should be clear and focused accountability between the Government and local partners and a framework which ensures that future outcomes from service delivery can be measured.

In response to this, the new framework involves a partnership between the Scottish Government, CoSLA and NHS. It outlines their responsibilities and clarifies the lines of accountability between the Scottish Government and Community Planning Partnerships on the delivery of outcomes for alcohol and drugs misuse, which will be measured through Single Outcome Agreements and NHS Board performance management arrangements.²⁰

From October 1st 2009, delivery of drugs services in each local authority area in Scotland became the responsibility of Alcohol and Drugs Partnerships (ADPs), replacing the former Alcohol and Drug Action Teams. They are part of a wider community planning process for each area (which include decision-making and accountability systems such as Single Outcome Agreements and NHS performance management). They are responsible for developing local drug (and alcohol) strategies in response to local need. It is stipulated that development of these strategies should involve a 'transparent, evidence-based process for agreeing how funds should be deployed; and a clear focus on the outcomes that this investment is achieving within their communities' (personal communication - Scottish Government).

Delivery Reform Group outcomes toolkit

The new delivery framework is accompanied by an outcomes toolkit which has been developed to support ADPs and enable them to deliver services in an 'outcomes based environment'. It contains a range of outcomes²¹ set out under the themes of recovery, prevention, children affected by parental substance misuse and enforcement and availability. It is envisaged that the toolkit will demonstrate to services the potential impact they can make to the communities they serve (which in turn feed into national aims); ensure evidence based decisions and needs assessments are made by services; enable adequate performance management to be undertaken; and encourage services to publicise the impact they make on communities.

Drugs Strategy Delivery Commission

The Scottish Government has established a Drugs Strategy Delivery Commission (DSDC) which is a successor to the Scottish Advisory Committee on Drug Misuse (SACDM). The new delivery Commission which will include expert stakeholders from across all sectors in Scotland will meet for the first time in December 2009. The Scottish Government has established the DSDC to provide independent expert advice and challenge for Scotland's National Drug Strategy.

Reviewing the evidence base

A review of the drugs evidence base against the requirements of Scotland's drug strategy has been commissioned in order to identify where the strengths in the current evidence base lie and to identify areas where further knowledge is needed in order to implement the strategy. The aim is to develop a

¹⁹ A partnership between the Scottish Government and local government, established in November 2007, which involved new ways of delivering local services. It underpins the funding to be provided to local government over the period 2008-09 to 2010-11.

²⁰ See: <http://www.scotland.gov.uk/News/Releases/2009/04/20130938>

²¹ Drug outcomes listed in the toolkit are: 'reduction in drug-related morbidity, mortality and deaths; less drug-related crime – acquisitive, violent, organised; safer and happier families and communities; a reduced number of children looked after and accommodated/separated from parents; increases in young people completing school, college or training; a reduction in children's exposure to substance misuse; increased productivity in the workplace; a reduction in adults on benefits due to drug/alcohol-related incapacity; and less absenteeism/lost productivity caused by drug use/alcohol consumption in the workplace and educational establishments'.

research framework which will set the agenda for future government funded research and influence externally funded research projects.

Wales

The National Substance Misuse Strategy Implementation Board, referred to in the Welsh substance misuse strategy, has now been established.

The Substance Misuse Strategy for Wales identified the need to strengthen service planning and performance management and secure further improvements in services. The reconfiguration of the NHS in Wales to seven Local Health Boards (LHB) has provided the opportunity to do this and seven new Substance Misuse Area Planning Boards are to be established aligned with these new LHB areas.

Establishment of these new Boards will commence in October 2009 and will combine resources for the development and management of services across Community Safety Partnership (CSP) areas. The Boards will bring existing members of Community Safety Partnerships (Police, Local Authorities, Local Health Boards) together with Probation services, the Drug Interventions Programme (DIP), Public Health Wales and the voluntary sector.

A key role for the Boards will be to take decisions on the allocation of resources for substance misuse services that form part of NHS funding. The Boards will also be responsible for taking decisions on how substance misuse capital funding and the Home Office Drug Interventions Programme funding are allocated and encourage other partners to pool and align their budgets where appropriate to do so. Guidance is currently being developed to support the development of the new Area Planning Boards, and set out minimum standards for substance misuse in Wales and models for integrated care pathways.

A set of key performance indicators (KPIs) covering substance misuse services are already in place against which CSP performance is monitored. The budget holders within the new Area Planning Boards are all tied into the achievement of these KPIs through their organisation's role within CSPs. The Welsh Assembly Government plans to reinforce this by including relevant substance misuse indicators in the new NHS performance framework, local authority performance frameworks and the priorities set for Public Health Wales.

Northern Ireland

Two Action Plans to support the ***New Strategic Direction (NSD)*** have been developed and launched; one looking at tackling young people's drinking and the other looking specifically at addressing the 'hidden harm' for children affected by parental substance misuse (DHSSPSNI 2008) (see section 8.3.4).

Currently, work is underway to produce a mid-term update of progress against the NSD, both in terms of indicators and actions against relevant outcomes. This is likely to be published in late 2009/early 2010.

1.3.2 Commentary on current drug policy

Devolution and British drug policies

McCambridge (2009) examined 2008 British drug policy post-devolution for England, Scotland and Wales. Looking at the different countries' drug strategy documents the author found that each strategy was developed to respond to the different profiles of drug use in each country. While England continued on the trend of previous strategies with a more specific focus on children and families, Wales combined drugs and alcohol for a more integrated approach to substance misuse, and Scotland focused on the recovery of their drug using population. The author proposes evaluation of drug strategies using a 'quasi-experimental approach' to compare the strategies over time and build a comprehensive evidence-base from which to measure effectiveness.

Reuter and Stevens (2008) conducted an examination of UK drugs policy from the criminal justice perspective. The authors concluded that there is little evidence that drug policy can influence the number of drug users or dependent users. Evidence shows that drug treatment has an impact upon the amount of drugs used by an individual and the number of offences committed although the authors suggest that the cost-benefit argument for treatment has been overstated. Despite this, the article concludes that treatment is the best option available for controlling drug-related crime particularly as efforts to limit drug supply and prevent drug use have not produced discernible impacts on levels of use or offending.

United Kingdom Drug Policy Commission (UKDPC): Law enforcement with harm reduction focus

In a consideration of current law enforcement policy, the UKDPC suggested that although the current policy of restricting supply is effective up to a point, it does not necessarily follow that more enforcement activity will lead to less supply as established drug markets are often resilient. Supply side activities can disrupt existing markets to a certain extent but they are usually replaced quickly by new dealers waiting to step in and in some cases, can even lead to further unintended problems such as geographical or substance displacement. This review proposes that since not all drug markets are equally harmful, enforcement activity may be more effective if in future it focused on those markets that cause the most harm and on reducing harms more generally. The authors point out that it is possible to reduce the harms associated with drug supply without necessarily reducing the size of the drugs market. The study recommends a very broad view of harms, including those to families, communities and institutions as well as those experienced by drug users. In developing a framework for consideration of harms throughout the enforcement process based on current enforcement practice, it identifies three main approaches that could deliver gains in terms of harm reduction, specifically by targeting:

- particularly harmful or 'noxious' individuals (e.g. getting PDUs and/or prolific offenders into treatment; or targeting specific individuals or organised crime groups who cause most harm);
- areas where the most damage is caused (in particular, by developing multi-agency approaches within the community); and
- behaviours which cause drug nuisance (for example, by deterring specific behaviours by the use of ASBOs and other civil powers).

It is reported that the research for this study was restricted by a dearth of evidence regarding the effectiveness of current enforcement activities and if a new approach such as the one proposed is adopted, it should also be accompanied by a thorough evaluation of its outcomes (UKDPC 2009).

UKDPC review of getting problem drug users (back) into employment

Research commissioned by the UKDPC and conducted by the University of Manchester reviewed the evidence related to the legislation and benefits system and its implications for getting problem drug users into work (UKDPC 2008) (see section 8.3.3).

1.3.3 Research developments

The Medical Research Council (MRC) (the main funding body for medical research in the UK) has published an *Addiction and Substance Misuse Research Strategy* which aims to encourage cross-disciplinary communication and collaboration (MRC 2009). The MRC is working in partnership with the Office for Strategic Co-ordination of Health Research (OSCHR) and the Economic and Social Research Council (ESRC) (the main funding body for economic and social research in the UK). A national network of experts has been established in interdisciplinary addiction research clusters. Together the MRC and ESRC have made available €5.1 million (£4.5m) to fund these research clusters.²²

²² See: <http://www.mrc.ac.uk/Fundingopportunities/Initiatives/Addictionresearch/Addictionresearchclusters/index.htm>

1.4 Economic analysis

1.4.1 Budget and public expenditure

England

Table 1.1 shows labelled drug expenditure for England from 2006/07 to 2008/09 by the United Nations Classifications of Functions of Government (COFOG).²³ Data differ from previous UK Focal Point Reports as the methodology for collecting expenditure information has changed. While the data appear to show a reduction in the drug budget for social protection (COFOG 10), the change is due to the mainstreaming of drug specific funding. For example the Drug Strategy Partnership Support Grant, which provided funding to local partnerships to increase capacity to deliver the Drugs Strategy was mainstreamed into a wider non-labelled grant known as the Area-based Grant in 2007/08. The Young People's Substance Misuse Grant became part of the same grant in 2008/09 further reducing labelled spend within that category, despite funding levels remaining stable. A detailed breakdown of both labelled and unlabelled spend for England and the devolved administrations for 2006/07 and 2007/08 can be found in the Standard Table on Public Expenditure (STPE).

Table 1.1: Public expenditure by COFOG category in England, 2006/07 to 2008/09

| COFOG CATEGORY | 2006/07 | 2007/08 | 2008/09 |
|------------------------------|---------------|---------------|---------------|
| | (£/€ million) | (£/€ million) | (£/€ million) |
| 01 – General public services | £78.8 | £70.1 | £73.2 |
| | €115.6 | €102.5 | €92.1 |
| 03 – Public order and safety | £275.7 | £254.9 | £268.6 |
| | €404.5 | €372.6 | €375.9 |
| 07 – Health | £601.6 | £611.2 | £644.9 |
| | €882.5 | €893.5 | €811.8 |
| 09 – Education | £5.4 | £4.2 | £4.1 |
| | €7.9 | €6.1 | €5.2 |
| 10 – Social protection | £37.7 | £22.9 | £7.6 |
| | €55.3 | €33.5 | €9.6 |
| Total | £999.2 | £963.3 | £998.4 |
| | €1465.8 | €1408.3 | €1256.8 |

Source: Government departments (see technical notes for information on exchange rates used)

Northern Ireland

Approximately €6.3 million (£5m) was spent on the implementation of the Northern Ireland alcohol and drug strategy in 2008/09. A further €1.3 million (£1.033m) was spent on substitute prescribing. Overall expenditure was €10.3 million (£8.19m) (Table 1.2).

²³ See: <http://unstats.un.org/unsd/cr/registry/regcst.asp?Cl=4>

Table 1.2: Public expenditure in Northern Ireland, 2008/09

| | £/€M |
|------------------------------------------------------------|--------------|
| Allocation to Drug and Alcohol Co-ordination Teams (DACTs) | £0.74 |
| | €0.93 |
| Allocation to implement the national strategy across DACTs | £5.04 |
| | €6.34 |
| Substitute prescribing allocation to Health Boards | £1.03 |
| | €1.30 |
| Policy development/research | £0.20 |
| | €0.25 |
| Public information campaigns | £0.44 |
| | €0.55 |
| Needle and Syringe Exchange Scheme | £0.14 |
| | € 0.18 |
| National Strategy implementation expenditure | £0.60 |
| | €0.76 |
| Total | £8.19 |
| | €10.3 |

Source: Department of Health, Social Services and Public Safety, Northern Ireland

Scotland

Funding to NHS boards for drug treatment for 2009/10 has increased by 13.5% in Scotland from 2008/09. Across Scotland, the ring-fenced budget for Health Board drugs services will amount to €35.2 million (£28.0), up from €31.1million (£24.7m) in 2008/09²⁴. Money from the Justice Directorate budget is allocated for Drug Treatment and Testing Orders (DTTO) and Drug Courts amounting to €10.7 million (£9.4m) in 2009/10. A further €27.9 million (£24.7m) has been allocated from the Justice Directorate budget to support the Scottish Crime and Drug Enforcement Agency in 2009/10. Other funding includes €3.1 million (£2.8m) for Alcohol and Drug Action Team support and €18.2 million (£16.1m) to support the *Hepatitis C Phase 2 Action Plan* (Scottish Government 2008b).²⁵

In addition, local authorities and Health Boards provide additional funding from their unified budgets on services for those affected by drugs and/or alcohol. Audit Scotland identified additional expenditure of €81.9 million (£56m) by NHS boards on drug and alcohol services in 2007/08 and found that in 2006/07, €61.6 million (£42m) of Scottish Government funding to councils was spent on addiction services (Audit Scotland 2009).

²⁴ See: <http://www.scotland.gov.uk/News/Releases/2009/01/20101448>

²⁵ Scottish Executive Written Answers, 22nd June 2009 (S3W-24810)

Wales

The Substance Misuse Action Fund (SMAF) in Wales for 2009/10 stands at €32 million (£28.4m). This is supplemented further by ring-fenced resources in the Local Health Board budgets of €12.5 million (£11.1m). The bulk of the SMAF continues to be allocated to Community Safety Partnerships (CSPs) in Wales to deliver their local substance misuse action plans. Overall for the current financial year, CSPs have benefited from an increase of 9.3% compared to 2008/09 allocations. Additional funding of €8.1 million (£6.5m) is provided by the Home Office for the Drug Interventions Programme in Wales.

1.4.2 Social costs

Economic and social costs of drug use in Scotland

Based on the findings from a Home Office study on social and economic costs of drug misuse (Gordon et al. 2006) and applying Scottish problem drug use prevalence figures from 2003, Audit Scotland estimate the economic and social costs of drug misuse in Scotland to be €2.9 billion (£2.6bn) in 2003/04 (Audit Scotland 2009).

A further report, commissioned by the Scottish Government, and providing estimates of the economic and social costs of illicit drug use in Scotland was published in 2009 (Casey et al. 2009). The study provided costs for 2006 based partly upon the recently published Scottish problem drug use (PDU) estimates (see section 4.2.2). It was estimated that the social and economic cost of illicit drug use was €5.1 billion (£3.5bn) in 2006, half of which was made up of wider costs to society as a result of premature deaths and victim or other consequence of crime costs. It is estimated that 96% of the total social and economic costs relate to problem drug use with the remainder relating to recreational drug use. The study suggests that this equates to a cost of €89,051 (£60,703) per problematic drug user and €197 (£134) per recreational drug user.

Cost Benefit Analysis

Transform, a charity established to promote the legalisation of drugs, has published a cost benefit analysis comparing legal, regulated drug markets against the current prohibition framework. It claims that even if use doubled (which it claims is highly unlikely), overall costs of drug use would be reduced in a regulated market by €5.2 billion (£4.6bn). It calls for Government to produce a comprehensive impact assessment of current drug policy (Transform 2009).

2. Drug use in the general population and specific groups

2.1 Introduction

Estimates of the prevalence of drug use in the general population in England and Wales are provided by the *British Crime Survey*²⁶. Similar victimisation surveys are also undertaken in Scotland²⁷ and Northern Ireland²⁸. Having remained stable between 1998 and 2003/04 at around 12%, last year drug use amongst 16 to 59 year olds in England and Wales decreased year on year to under 10% in 2007/08 but this trend did not continue into 2008/09. For the United Kingdom, combining data from surveys undertaken in 2006/07, it was estimated that just over a third of the adult population aged between 16 and 59 had used an illicit drug in their lifetime.

Young adults under 35 are much more likely than older adults to use drugs, and amongst those who are under 25 years old, recent (last year) and current (last month) prevalence is higher still. In England and Wales, amongst these young adults, there has nevertheless been a steady decline in the recent use of any drug since 1998. The apparent increase between the 2007/08 and 2008/09 surveys was not statistically significant.

Males are more likely to report drug use than females but the difference varies according to age, tending to be more pronounced in the older age groups.

Amongst the school age population, surveys of drug use prevalence have been undertaken in each of the four administrations of the United Kingdom²⁹. In England, for which the longest time series are available, drug use increased between 1998 and 2003, but has fallen since then.

Cannabis continues to be the most commonly used drug across all age groups, with prevalence rates close to those for use of any drug. Use of other drugs is considerably lower. Since the mid 1990s the *British Crime Survey* shows that use of cocaine powder increased substantially with a corresponding decline in amphetamines over the same period.

²⁶ The British Crime Survey (BCS) is a victimisation survey which gathers information about experience of crime in England and Wales, and is designed to provide a complementary measure of crime to police recorded crime statistics. It also asks respondents aged 16 to 59 about their use of illicit drugs in a self-completion module. The BCS was first carried out in 1982 and since 2001/02 it has become a continuous survey.

²⁷ The Scottish Crime and Victimisation Survey (SCVS, previously the Scottish Crime Survey) is similar in scope and aims to the BCS. Surveys were carried out, as part of the British Crime Survey (BCS) in 1982 and 1988, as the independent Scottish Crime Survey in 1993, 1996, 2000, 2003 and as the SCVS in 2004 and 2006. Re-named the Scottish Crime and Justice Survey (SCJS), the latest survey was carried out in 2008 and results will be published in spring 2010.

²⁸ The Northern Ireland Crime Survey is also similar to the BCS. Surveys were carried out in 1994/95, 1998, 2001 and 2003/04 and the survey has been continuous since January 2005. The latest published results are for 2007/08. In addition, a Drug Prevalence Survey, based on the EMCDDA model questionnaire, was carried out in Northern Ireland in 2002/03 and 2006/07.

²⁹ Amongst the school age population, the main sources of information on drug use prevalence are surveys undertaken in schools. In England, a survey of the prevalence of drug use, smoking and drinking amongst young people (11 to 15 year old school children), has been undertaken annually since 1998. The Young Person's Behaviour and Attitudes Survey was undertaken in Northern Ireland in 2000 for the first time and repeated in 2003 and 2007. In Scotland, the Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) is undertaken every two years, the most recent in 2008. The Health Behaviour in School Age Children Survey (HBSC) provides data from Wales and is undertaken every four years with a two-year interim survey. The most recent survey was conducted in 2006.

2.2 Drug use in the general population

Since submission of the 2008 United Kingdom Focal Point report, results have been published from the *2008/09 British Crime Survey* (BCS) covering England and Wales; the *2007/08 Northern Ireland Crime Survey*; the *2007 Psychiatric Morbidity Survey* covering England; and further analysis of the *2006/07 Drug Prevalence Survey* in Northern Ireland.

2.2.1 England and Wales: the British Crime Survey

The latest findings from the *2008/09 British Crime Survey*³⁰ show that 36.8% of 16 to 59 year olds have used drugs in their lifetime (ever use), 10.1% used drugs in the last year (recent use) and 5.9% used drugs in the last month (current use) (Table 2.1). Cannabis was again the most commonly used drug across all recall periods followed by cocaine powder for recent and current use. Amphetamines were the second most common drug to be reported for lifetime use.

Table 2.1: Percentage of 16 to 59 year olds reporting lifetime, last year and last month use of individual drugs in England and Wales, 2008/09

| | LIFETIME USE | | | LAST YEAR USE | | | LAST MONTH USE | | |
|-----------------|--------------|--------|--------|---------------|--------|--------|----------------|--------|--------|
| | Male | Female | Total | Male | Female | Total | Male | Female | Total |
| Any drug | 42.3 | 31.3 | 36.8 | 13.2 | 7.0 | 10.1 | 8.2 | 3.7 | 5.9 |
| Amphetamines | 15.2 | 9.4 | 12.3 | 1.7 | 0.8 | 1.2 | 0.6 | 0.2 | 0.4 |
| Cannabis | 36.6 | 25.6 | 31.1 | 10.6 | 5.2 | 7.9 | 6.4 | 2.7 | 4.6 |
| Cocaine | 12.4 | 6.3 | 9.4 | 4.3 | 1.8 | 3.0 | 2.0 | 0.9 | 1.5 |
| Ecstasy | 11.5 | 5.8 | 8.6 | 2.6 | 1.1 | 1.8 | 0.9 | 0.3 | 0.6 |
| LSD | 8.0 | 3.1 | 5.5 | 0.3 | 0.2 | 0.2 | 0.1 | 0.0 | 0.1 |
| Magic mushrooms | 10.4 | 4.5 | 7.4 | 0.8 | 0.3 | 0.5 | 0.1 | 0.0 | 0.1 |
| Opiates | 1.3 | 0.4 | 0.9 | 0.2 | 0.1 | 0.1 | 0.1 | 0.0 | 0.1 |
| Base | 13,014 | 15,393 | 28,407 | 12,919 | 15,313 | 28,232 | 12,896 | 15,294 | 28,190 |

Source: Standard Table prepared for the United Kingdom Focal Point

As in previous years, males were more likely than females to report drug use across all recall periods and individual drugs.

³⁰ The fieldwork for the survey was carried out between April 2008 and March 2009. 28,538 individuals completed the drugs module of the 2008/09 BCS. The overall response rate for the survey was 76% and the response rate for the self-completion drugs module was 95%.

For six months of the 2008/09 BCS, the upper age limit for the drugs self-completion module was raised to 69 years old.³¹ Using these six months data, lifetime drug use amongst the 16 to 64 age group (which is closer to the European Model Questionnaire (EMQ)³² age range of 15 to 64) was significantly lower than that of the 16 to 59 age group, 35.0% compared to 37.2%. Whilst lifetime use amongst the 16 to 64 age group was lower for almost all individual drugs, the difference was only statistically significant for cannabis (31.3% compared to 29.3%) and cocaine (9.9% compared to 9.1%). No statistically significant differences were noted for last year or last month use. The analysis suggests that the standard 16 to 59 year old BCS figures are slight over-estimates of lifetime drug use prevalence in comparison to those European countries which have adopted the EMQ age range of 15 to 64.

Factors related to drug use

Multivariate analysis of the BCS was carried out showing a number of variables independently associated with illicit drug use (Hoare 2009). Marital status, particularly being single, was associated with higher drug use as was age (being young) and gender (being male). Respondents who frequently visited pubs and bars were more likely to report drug use as were those who had been a victim of crime in the past year. Other demographic variables were also associated with higher drug use such as employment status, household income and accommodation type but these were not independently associated. Drug use was more common in urban areas (10.7%) than rural areas (7.3%). Detailed data on demographic variations including regional breakdowns by individual drug are available in the published report.

Polydrug use

Polydrug use as measured by the BCS is defined as having taken two or more illicit drugs within the same time period e.g. last year.³³

In 2008/09, amongst adults aged 16 to 59:

- 21% reported taking more than one illicit drug (polydrug use) in their lifetime;
- four per cent reported recent polydrug use; and
- two per cent reported current polydrug use.

Fifty-seven per cent of respondents who had ever used drugs had used more than one drug in their lifetime with 40% of recent users reporting polydrug use in the last year and 28% of current users. The most common type of polydrug use was the use of cannabis plus another drug, as may be expected since cannabis is the most commonly used drug. Among recent stimulant users, most reported the use of another drug in the past year; only four per cent of ecstasy users, eight per cent of amphetamine users and 14% of cocaine powder users had not recently used another drugs. In contrast, over half of recent cannabis users (56%) had not used another drug. The majority of recent ecstasy users (75%) and recent amphetamines users (70%) had also used cocaine powder recently. However, recent cocaine powder users were less likely to report the use of ecstasy (45%) and amphetamines (28%).

Factors associated with polydrug use were similar to those for any drug use: age, sex, marital status, and pub visits in the last month. In addition the strongest independent association was the frequency of nightclub visits; 58% of recent drug users who visited a nightclub four or more times in the past month were recent polydrug users, compared to 34% who did not visit a nightclub. Drug users who described themselves as being of White ethnic origin were more likely to be recent polydrug users (41%) than those who described themselves as of non-White ethnic origin (22%).

³¹ Since October 2008 this has been lowered again to 59 years old due to low response and problems reported by the interviewers.

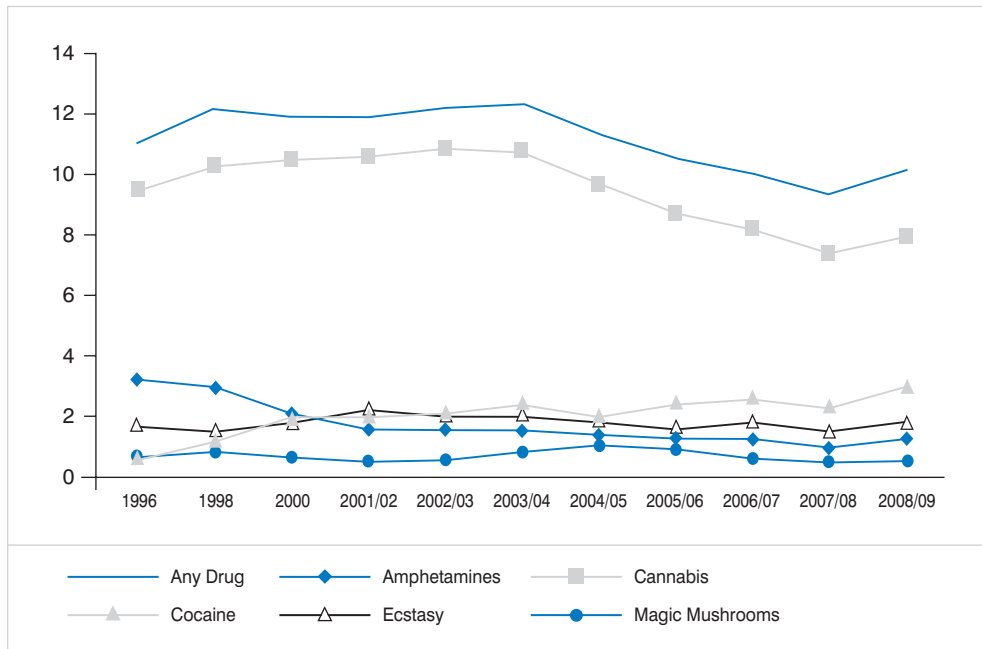
³² See: <http://www.emcdda.europa.eu/html.cfm/index58052EN.html>

³³ Does not necessarily mean on the same occasion.

Trends in drug use

Having remained stable between 1998 and 2003/04 at around 12%, recent drug use amongst 16 to 59 year olds in England and Wales decreased to 9.3% in 2007/08, with a parallel fall in cannabis use over the same period (Figure 2.1). The most recent BCS results for 2008/09 show an apparent increase in recent use of any drug to 10.1%, although this was not statistically significant. A general decline in amphetamine use and corresponding increase in cocaine powder use since 1996 is clearly seen. Recent cocaine powder use increased significantly since the previous survey to 3.0% (from 2.3% in 2007/08). Ecstasy use has remained relatively stable since 1996 although there was a statistically significant increase since the last survey from 1.5% to 1.8%.

Figure 2.1: Percentage of 16 to 59 year olds reporting having used drugs in the last year in England and Wales, 1996 to 2008/09



Source: Standard Table 01

Last year use of ketamine, anabolic steroids and tranquilisers also showed a statistically significant increase between 2007/08 and 2008/09 as did the use of any Class A drug or any stimulant drug³⁴ (Hoare 2009).

³⁴ A new composite group ('Any stimulant drug') includes drugs that are used for their stimulant properties and are more likely to be used interchangeably by the same people at similar times and in similar settings (cocaine powder, crack cocaine, ecstasy, amphetamine, amyl nitrite, methylamphetamine).

2.2.2 Northern Ireland Crime Survey 2007/08

Results from the *Northern Ireland Crime Survey* (NICS) 2007/08³⁵ have been published (Campbell and Wilson 2009). In 2007/08, amongst adults aged 16 to 59:

- 24.6% reported lifetime use of an illegal drug;
- 6.8% reported recent drug use; and
- 3.8% reported current drug use.

Cannabis was again the most commonly used drug; lifetime use was reported by 18.9% of respondents, recent use by 5.2% and current use by 3.0%. Cocaine powder and ecstasy were the next most commonly reported drugs for recent use (Table 2.2). There was once again a gender difference in recent drug use with 8.7% of males reporting recent drug use compared to 5.1% of females.

Table 2.2: Percentage of 16 to 59 year olds reporting lifetime, last year and last month use of individual drugs in Northern Ireland, 2007/08 by gender

| | LIFETIME USE | | | LAST YEAR USE | | | LAST MONTH USE | | |
|-----------------|--------------|--------------|--------------|---------------|--------------|--------------|----------------|--------------|--------------|
| | Male | Female | Total | Male | Female | Total | Male | Female | Total |
| Any drug | 29.5 | 20.5 | 24.6 | 8.7 | 5.1 | 6.8 | 5.5 | 2.4 | 3.8 |
| Amphetamines | 7.9 | 4.5 | 6.1 | 1.5 | 0.4 | 0.8 | 0.3 | 0.1 | 0.2 |
| Cannabis | 23.8 | 14.7 | 18.9 | 6.7 | 3.9 | 5.2 | 4.5 | 1.7 | 3.0 |
| Cocaine | 6.3 | 2.2 | 4.1 | 3.0 | 0.7 | 1.8 | 1.2 | 0.3 | 0.7 |
| Ecstasy | 8.9 | 5.2 | 6.9 | 2.1 | 1.1 | 1.5 | 0.4 | 0.2 | 0.3 |
| LSD | 5.3 | 2.5 | 3.8 | 0.2 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 |
| Magic mushrooms | 6.8 | 3.2 | 4.8 | 0.1 | 0.1 | 0.1 | 0 | 0 | 0 |
| Heroin | 1.1 | 0.4 | 0.7 | 0.1 | 0 | 0 | 0 | 0 | 0 |
| Base | 1,136 | 1,358 | 2,494 | 1,136 | 1,358 | 2,494 | 1,136 | 1,358 | 2,494 |

Source: Campbell and Wilson 2009

³⁵ The fieldwork for the survey was carried out between April 2007 and March 2008. The final sample size for the survey was 2,494 with a response rate of 91%. Results differ slightly from ST01 as this was provided on an EMCDDA basis and refers to 16 to 64 year olds. For comparison with results from previous surveys data for 16 to 59 year olds are quoted.

Trends in drug use

In general there has been a downward trend in recent and current use of drugs, as reported through crime surveys in Northern Ireland, particularly for last month use amongst females (Table 2.3).

Table 2.3: Percentage of 16 to 59 year olds reporting lifetime, last year and last month use of any drug in Northern Ireland, 2003/04 to 2007/08

| DRUG | LIFETIME USE | | | LAST YEAR USE | | | LAST MONTH USE | | |
|---------|--------------|--------|-------|---------------|--------|-------|----------------|--------|-------|
| | Male | Female | Total | Male | Female | Total | Male | Female | Total |
| 2003/04 | 31.6 | 23.7 | 27.4 | 11.5 | 8.1 | 9.7 | 7.4 | 5.1 | 6.2 |
| 2005 | 32.0 | 21.0 | 26.2 | 12.4 | 4.5 | 8.2 | 7.5 | 2.5 | 4.9 |
| 2006/07 | 31.5 | 23.4 | 27.3 | 10.6 | 6.4 | 8.4 | 5.4 | 3.3 | 4.3 |
| 2007/08 | 29.5 | 20.5 | 24.6 | 8.7 | 5.1 | 6.8 | 5.5 | 2.4 | 3.8 |

Source: Campbell and Wilson 2009

Recent cannabis use, having remained stable for the past two surveys, fell from 6.3% in 2006/07 to 5.2% in 2007/08. Recent cocaine use, having also been stable, increased significantly from around 1.0% in 2006/07 to 1.8% in 2007/08. There have also been increases in the recent use of ecstasy (0.9% in 2006/07 to 1.5% in 2007/08), and amphetamines (0.5% to 0.8%).

2.2.3 Further results from the Drug Prevalence Survey 2006/07 in Northern Ireland

Since the previous Focal Point report, further analysis of the *Drug Prevalence Survey* 2006/07 in Northern Ireland has been undertaken on cannabis use (NACD and PHIRB 2008), the use of sedatives or tranquillisers, anti-depressants (NACD and PHIRB 2009a) and polydrug use (NACD and PHIRB 2009b)³⁶. The cannabis analysis shows that, since the previous survey in 2002/03, lifetime use of cannabis significantly increased among all adults aged 15 to 64 from 16.8% to 24.7%. Similarly, increases were seen in recent use, from 5.4% to 7.2%. There was no increase in current use. With respect to sedatives, tranquilisers and anti-depressants, lifetime rates for older adults aged 35 to 64 were around twice those for young adults aged 15 to 34; 26% compared to 12% for sedatives or tranquilisers and 27% compared to 14% for anti-depressants. Females reported higher prevalence rates than males for lifetime and last month use of sedatives or tranquilisers, and across all time periods for anti-depressants.

Polydrug use analysis shows that amongst all adults, polydrug use involving any illegal drugs is low at only two per cent. However, current users of cannabis, amphetamine-type stimulants and cocaine powder are more likely to report drinking alcohol in the past month than other respondents.

³⁶ See: 2008 United Kingdom Focal Point report for information on methodology of the Drug Prevalence Survey.

2.2.4 The 2007 Adult Psychiatric Morbidity Survey (APMS)

Questions on drug use were asked of respondents to the *2007 Adult Psychiatric Morbidity Survey*³⁷. These included lifetime and last year drug use and questions designed to assess drug dependence (Fuller et al. 2009).

The findings show that:

- 25.7% of adults aged over 16 had ever taken drugs;
- 9.2% had taken drugs recently; and
- prevalence rates are highest for those aged 16 to 24 although prevalence is similar amongst men aged 25 to 34 (23.7% and 23.6% respectively)

While lifetime drug use is lower than in the 2007/08 BCS (35.8%), recent use is similar (9.2%) as is the recent use of all individual drugs.³⁸ Age-standardised rates of past year drug use were found to be highest amongst men describing their ethnicity as Black (21.8%) and lowest amongst South Asian women (0.8%). Women whose ethnicity is described as 'other'³⁹ were much more likely to report recent drug use (11.5%) than those who are of White (6.8%) or Black (5.6%) ethnic origin.

The majority of those assessed as having signs of drug dependence⁴⁰ were dependent on cannabis only. Those in the lowest age groups were the most likely to be assessed as having signs of drug dependence; 10.2% of 16 to 24 year olds and 6.3% of 25 to 34 year olds displayed signs of drug dependence. This is higher than in the 1993 survey (7.5% of 16 to 24 year olds and 1.7% of 25 to 34 year olds) but there was no change since 2000 (10.3% and 6.4% respectively). However, dependence on cannabis only amongst men aged 16 to 24 years old increased from 7.7% in the 2000 survey to 10.4% in the 2007 survey.

2.2.5 Other studies on drug use in the general population

Drug use and ageing

Beynon (2008), in a recent paper, suggests that both amongst the general population and amongst problem drug users, drug use is increasingly prevalent amongst those aged over 50. While biological systems and processes alter over time, the effect of drug use on these is not well understood. Given this, it is argued, such users may be characterised by considerable levels of morbidity (see section 13.1.1).

³⁷ The survey is the third survey of psychiatric morbidity amongst adults in private households. Previous surveys were carried out in 1993 and 2000. A stratified multi-stage random probability sample based on the Postcode Address File (PAF) was used and all adults aged 16 and over and resident in England were eligible. At phase one interview, which included a CASI drug use module, 57% of those eligible agreed to take part. 7,461 interviews were carried out.

³⁸ The age ranges used in the surveys are different. BCS includes adults up to the age of 59 while the APMS has no upper age limit.

³⁹ Includes Chinese and mixed ethnic groups.

⁴⁰ Drug dependence was measured through five questions based on the Diagnostic Interview Schedule covering: daily use for two weeks or more; a sense of need or dependence; an inability to abstain; increased tolerance; and withdrawal symptoms. A positive response to any of the items was used to indicate drug dependence.

In 2009 the Association of Public Health Observatories published the tenth report from the *Indications* series on the topic of drug use⁴¹ (Shaw et al. 2009). The report included data on drug use from initiation and use amongst young people and the general population through to the consequences of drug use such as treatment engagement, hospital admissions and rates of death. Data on each indicator were provided by English regions and differences between the regions were highlighted and discussed.

2.3 Drug use amongst young adults

Additional analyses have been undertaken from United Kingdom population surveys for the United Kingdom Focal Point to provide data for the 16 to 34 age group used by the EMCDDA. The surveys also routinely report data for 16 to 24 year olds.

2.3.1 England and Wales: the British Crime Survey 2008/09

Recent drug use is highest amongst 16 to 24 year olds at over twice the rate for adults aged 16 to 59 (22.6% compared to 10.1%). Respondents aged 16 to 34 were less likely to report drug use than those aged 16 to 24 mainly due to lower use of cannabis amongst 25 to 34 year olds. Use of cocaine was similar amongst both age groups (Table 2.4). Gender differences, although large, were less pronounced amongst 16 to 24 year olds than 16 to 34 year olds and 16 to 59 year olds.

Table 2.4: Percentage of 16 to 24 year olds and 16 to 34 year olds reporting last year use of individual drugs in England and Wales, 2008/09 by gender

| | 16-24 YEAR OLDS | | | 16-34 YEAR OLDS | | |
|-----------------|-----------------|--------|-------|-----------------|--------|-------|
| | Male | Female | Total | Male | Female | Total |
| Any drug | 27.2 | 17.9 | 22.6 | 23.0 | 13.1 | 18.1 |
| Amphetamines | 3.6 | 1.8 | 2.7 | 3.3 | 1.4 | 2.3 |
| Cannabis | 23.3 | 14.0 | 18.7 | 18.7 | 10.0 | 14.4 |
| Cocaine | 8.8 | 4.4 | 6.6 | 8.4 | 3.9 | 6.2 |
| Ecstasy | 6.0 | 2.8 | 4.4 | 5.3 | 2.4 | 3.9 |
| LSD | 1.0 | 0.5 | 0.8 | 0.7 | 0.4 | 0.5 |
| Magic mushrooms | 1.9 | 1.0 | 1.5 | 1.7 | 0.6 | 1.2 |
| Base | 2,556 | 2,872 | 5,428 | 4,260 | 5,329 | 9,589 |

Source: Standard Table 01

Polydrug use

Drug users aged between 16 and 34 were more likely to report the use of three or more illicit drugs in the last year than older drug users. Those aged 20 to 24 were most likely to report use of three or more illicit drugs in the last year (29%). Amongst 16 to 24 year olds, recent drug use was significantly higher for those who drunk alcohol; 6.1% of those who had not drunk alcohol reported recent drug use compared with 40.7% of those who drunk alcohol on three or more days a week (Hoare 2009).

⁴¹ The Indications series consists of reports commissioned by the Chief Medical Officer for England and published by the Association of Public Health Observatories. Previous reports have focused on public health topics including child health, ethnicity, mental health, sexual health and alcohol. See: <http://www.apho.org.uk/resource/view.aspx?RID=39296>

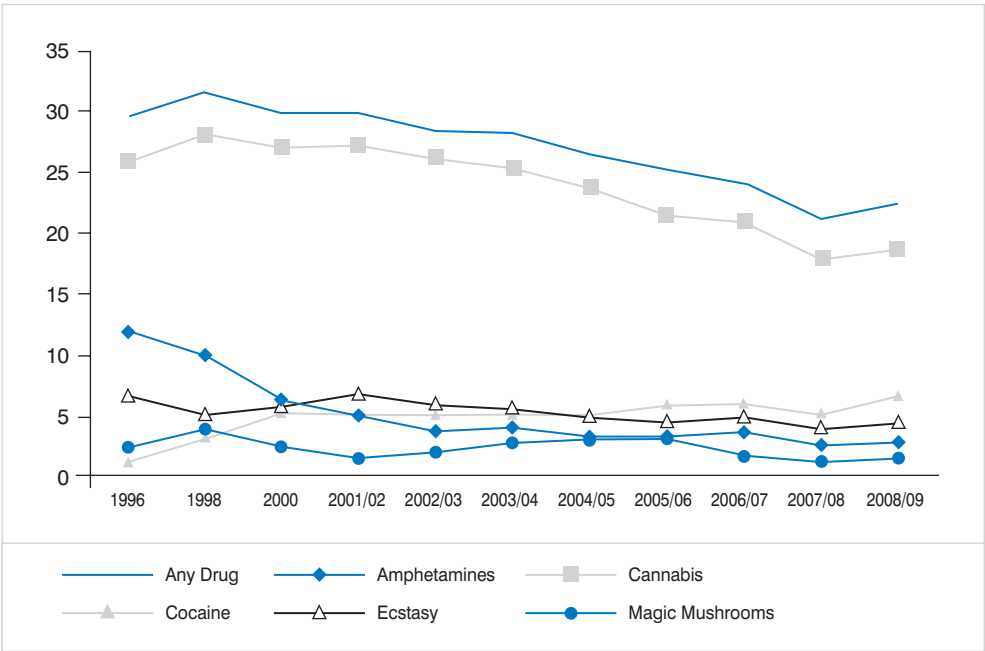
Frequency of drug use

Frequent use of any drug⁴² amongst 16 to 24 year olds was 7.6% in 2008/09, a significant fall from 11.6% in 2002/03 but no different than in 2007/08 (7.3%). Amongst drug users, cannabis users were most likely to report frequent use (36%) followed by cocaine powder users (27%) (Hoare 2009).

Trends in drug use

Recent drug use amongst 16 to 24 year olds has decreased significantly from 29.7% in 1996 to 22.6% in 2008/09, largely due to a fall in cannabis use over the same period from 26.0% to 18.7% (Figure 2.2). There have also been significant decreases in the long term trend for ecstasy, amphetamines and LSD use but an increase in cocaine powder use from 1.3% to 6.6%. Levels of recent drug use showed no change from 21.5% in 2007/08 to 22.6% in 2008/09; the apparent increase is not statistically significant. There has, however, been a statistically significant increase in the use of cocaine powder since the previous survey from 5.1% to 6.6% and in the use of ketamine (0.9% to 1.9%). The current use of these substances has also increased significantly since 2007/08, along with anabolic steroids, and a decrease in current use of amyl nitrite.

Figure 2.2: Percentage of 16 to 24 year olds reporting last year use of individual drugs in England and Wales, 1996 to 2008/09



Source: Standard Table 01

The trend for 16 to 34 year olds follows a similar pattern to that for 16 to 24 year olds with a decrease in drug use until 2007/08 and an apparent rise in 2008/09, which is not statistically significant (Figure 2.2).

⁴² Defined as use of any illicit drug more than once a month in the last year. Questions on frequency of use were first asked of 16 to 24 year olds in the 2002/03 BCS.

2.3.2 Northern Ireland Crime Survey 2007/08

Findings from the 2007/08 NICS (Campbell and Wilson 2009) show that:

- 34.9% of 16 to 24 year olds reported lifetime drug use, compared with 38.7% in 2006/07;
- 15.7% reported recent drug use, compared with 22.0% in 2006/07; and
- 10.7% reported current use, compared with 9.5% in 2006/07.

This is a decline in lifetime and recent use since the previous survey, but an increase in current use. However, due to the small numbers involved, caution should be taken when interpreting trends.

Drug use amongst 16 to 34 year olds was lower than amongst 16 to 24 year olds (Table 2.5).

Table 2.5: Percentage of 16 to 24 year olds and 16 to 34 year olds reporting last year use of individual drugs in Northern Ireland, 2007/08 by gender

| DRUG | 16-24 YEAR OLDS | | | 16-34 YEAR OLDS | | |
|-----------------|-----------------|--------|-------|-----------------|--------|-------|
| | Male | Female | Total | Male | Female | Total |
| Any drug | 17.2 | 14.5 | 15.8 | 16.6 | 9.2 | 12.6 |
| Amphetamines | 1.4 | 1.3 | 1.4 | 2.8 | 0.5 | 1.6 |
| Cannabis | 13.5 | 12.4 | 13.0 | 13.2 | 7.6 | 10.1 |
| Cocaine | 9.6 | 2.2 | 5.7 | 6.6 | 1.4 | 3.8 |
| Ecstasy | 5.4 | 2.2 | 3.7 | 4.8 | 2.2 | 3.3 |
| LSD | 0.0 | 0.4 | 0.2 | 0.4 | 0.2 | 0.3 |
| Magic mushrooms | 0.0 | 0.0 | 0.0 | 0.2 | 0.2 | 0.2 |
| Base | | | 315 | | | 604 |

Source: Standard Table 01

2.3.3 Other studies on drug use amongst young adults

The role of classical and contemporary criminological theory in understanding young people’s drug use

A review by Measham and Shiner (2009) suggests that the debate concerning the normalisation of recreational drug use amongst adolescents has polarised opinion within the field, with earlier work based on a rational action model of adolescent drug use, emphasising hedonism and consumption. However, they suggest that drug use is shaped by an interplay between social structure and human agency (the capacity for human beings to make choices), and that “normalisation is best understood as a contingent process negotiated by distinct social groups operating in bounded situations”.

2.4 Drug use in the school and youth population

Since submission of the 2008 United Kingdom Focal Point report, results have been published from *Smoking, Drinking and Drug Use amongst Young People in England 2008*, the *Scottish Schools Adolescent Lifestyle and Substance Use Survey* (SALSUS) for 2008, and a secondary analysis of the Northern Ireland *Young Persons' Behaviour and Attitudes Survey* (NISRA 2008; PHIRB 2009a).

2.4.1 Smoking, drinking and drug use among young people in England

The latest survey of smoking, drinking and drug use in England was undertaken in 2008 (Fuller 2009). Key findings are:

- 22.1% of 11 to 15 year olds reported lifetime use of any drug (Table 2.6);
- 15.0% reported recent use and 8.2% current use;
- cannabis was the most common drug across all recall periods; and
- girls were less likely to use drugs than boys.

Table 2.6: Percentage of pupils reporting lifetime, last year and last month use of individual drugs in England, 2008 by gender

| DRUG | LIFETIME USE | | | LAST YEAR USE | | | LAST MONTH USE | | |
|---------------------|--------------|--------|-------|---------------|--------|-------|----------------|--------|-------|
| | Male | Female | Total | Male | Female | Total | Male | Female | Total |
| Any drug | 22.8 | 21.3 | 22.1 | 15.9 | 14.1 | 15.0 | 9.2 | 7.2 | 8.2 |
| Amphetamines | 1.4 | 1.1 | 1.2 | 1.1 | 0.8 | 0.9 | 0.6 | 0.3 | 0.4 |
| Cannabis | 12.2 | 10.0 | 11.1 | 10.1 | 7.8 | 9.0 | 5.9 | 4.2 | 5.1 |
| Cocaine powder | 2.4 | 2.0 | 2.2 | 1.9 | 1.6 | 1.7 | 0.8 | 0.4 | 0.6 |
| Crack cocaine | 1.2 | 0.8 | 1.0 | 0.7 | 0.6 | 0.7 | 0.3 | 0.2 | 0.3 |
| Ecstasy | 1.8 | 1.3 | 1.6 | 1.5 | 1.0 | 1.3 | 0.8 | 0.3 | 0.6 |
| LSD | 1.1 | 0.7 | 0.9 | 0.8 | 0.6 | 0.7 | 0.4 | 0.2 | 0.3 |
| Magic mushrooms | 2.4 | 1.2 | 1.8 | 1.7 | 0.8 | 1.3 | 0.7 | 0.1 | 0.4 |
| Opiates | 1.2 | 0.8 | 1.0 | 0.8 | 0.6 | 0.7 | 0.5 | 0.2 | 0.3 |
| Volatile substances | 10.6 | 11.5 | 11.0 | 4.8 | 5.2 | 5.0 | 2.1 | 2.1 | 2.1 |
| Base | 3,943 | 3,811 | 7,754 | 3,943 | 3,811 | 7,754 | 3,943 | 3,811 | 7,754 |

Source: Fuller 2009

Age and gender

Drug use increases greatly between the ages of 12 and 13 years old and continues to rise with another large increase between ages 14 and 15. Gender differences are most pronounced amongst the youngest aged pupils (Table 2.7).

Table 2.7: Percentage of pupils reporting last year use of drugs in England, 2008 by age and gender

| | 11 YRS | 12 YRS | 13 YRS | 14 YRS | 15 YRS | TOTAL |
|---------------------|--------------|--------------|--------------|--------------|--------------|--------------|
| Boys | 5.4 | 5.6 | 14.2 | 18.8 | 29.7 | 15.9 |
| Girls | 2.2 | 4.9 | 12.7 | 18.4 | 27.8 | 14.1 |
| Total | 3.8 | 5.3 | 13.5 | 18.6 | 28.8 | 15.0 |
| Base (boys) | 639 | 805 | 788 | 775 | 936 | 3,943 |
| Base (girls) | 621 | 778 | 759 | 771 | 882 | 3,811 |
| Base (total) | 1,260 | 1,583 | 1,547 | 1,546 | 1,818 | 7,754 |

Source: Fuller 2009

Type of drug

For recent use, amongst pupils in the younger ages (aged 11 to 13), volatile substances were the most commonly reported drug. At age 14, pupils were more likely to report cannabis use with prevalence rates for 15 year olds higher for both cannabis and amyl nitrite. Sixty-three per cent of pupils who had taken a drug recently reported use of only one drug while 37% reported polydrug use, over half of whom had also used a Class A drug. Younger pupils were less likely to report polydrug use than older pupils (20% of 11 year old drug users compared to 42% of 15 year old drug users).

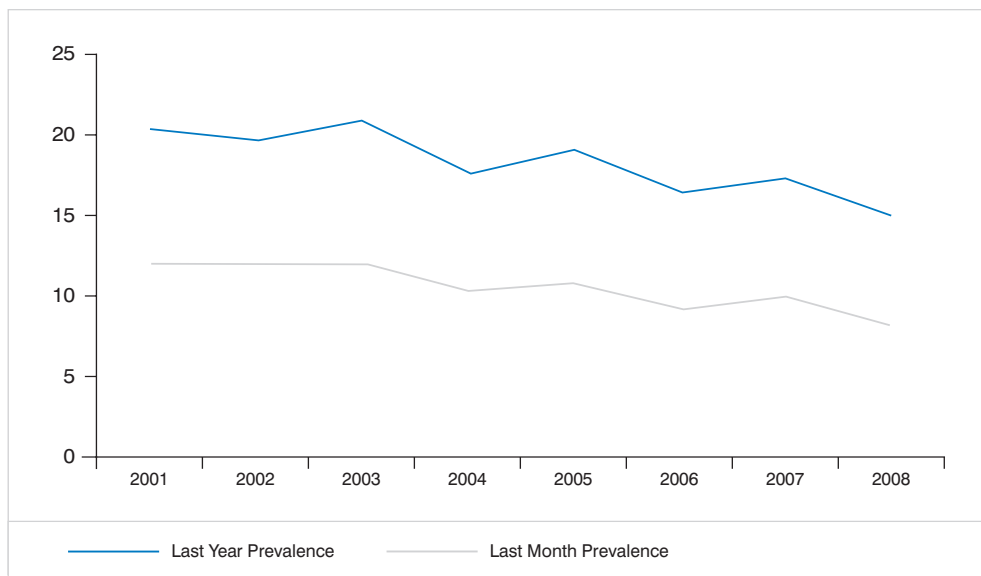
Frequency of use

Three per cent of all pupils reported monthly use of drugs, a fall from five per cent in 2007. This fall is due to a reduction in older pupils (ages 14 and 15) reporting use at least once a month. Of those reporting last year drug use, five per cent reported using drugs most days with just under a third (31%) reporting monthly use. Boys (33%) were more likely to report monthly use than girls (28%). Pupils who had used a Class A drug in the last year were more likely to report frequent use than other drug users; 12% reported daily use with over half (55%) reporting use at least once a month compared to five per cent and 31% of all pupils who had used drugs.

Trends in drug use

Recent drug use continues to fall amongst the school population from 20% in 2001 to 15% in 2008 (Figure 2.3). Current drug use has also fallen from 12% in 2001 to eight per cent in 2008. This is mainly due to a fall in cannabis use over the same period from 13.4% to 9.0%. There has also been a large decrease in the use of volatile substances (7.1% in 2001 to 5.0% in 2008) and magic mushrooms (2.1% to 1.3%). Cocaine powder use, as with the general population, increased over this time from 1.2% in 2001 to 1.7% in 2008 but has remained stable since 2007.

Figure 2.3: Drug use amongst school children in England, 2001 to 2008



Source: Fuller 2009

2.4.2 England: TellUs3 Survey

The **2008 TellUs3 Survey**⁴³ is the third in a series of annual surveys of children and young people⁴⁴ (DCSF 2009a). Results show that, in 2008, 11% of children in Year 8 (aged 12 and 13) and Year 10 (aged 14 and 15) reported lifetime use of any drug. Six per cent reported cannabis use in the past month with three per cent reporting use of cannabis on three or more occasions in the past month. Three per cent of pupils reported current use of other drugs.

⁴³ See: <http://www.ofsted.gov.uk/Ofsted-home/Publications-and-research/Browse-all-by/Documents-by-type/Statistics/TellUs3-National-Report>

⁴⁴ The TellUs3 Survey is a self completion survey conducted by the Department for Children, Schools and Families. It is designed to gather children and young people's views on their life, their school and local area. It includes questions used to measure, through National Indicators (NIs), the five Every Child Matters outcomes expected to be achieved as part of wider Government goals for children and young people as expressed through Public Service Agreements (PSAs) (see section 1.3). Children and young people in Years 6, 8 and 10 complete the survey online at school. The survey was carried out in the spring of 2008 with a sample of schools selected within each local authority area to represent different types of schools in the area. There were 148,988 responses from 145 local authority areas.

2.4.3 Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)

SALSUS was last carried out in 2008⁴⁵ and results were published in 2009 (NHS Scotland 2009). The key findings are that:

- a fifth of 15 year olds (20%) and five per cent of 13 year olds have used drugs in the last year;
- cannabis was the most commonly used drug for both ages; and
- boys were more likely than girls to take drugs at age 15 but there was no difference between genders at age 13.

Table 2.8: Percentage of 13 and 15 year olds reporting last year use of individual drugs in Scotland, 2008 by gender and age

| DRUG | 13 YEAR OLDS | | | 15 YEAR OLDS | | |
|----------------------|--------------|--------------|--------------|--------------|--------------|--------------|
| | Male | Female | Total | Male | Female | Total |
| Any drug | 5 | 5 | 5 | 22 | 19 | 20 |
| Amphetamines | 1 | 1 | 1 | 3 | 2 | 2 |
| Cannabis | 4 | 3 | 4 | 20 | 17 | 19 |
| Cocaine powder | 1 | 1 | 1 | 5 | 3 | 4 |
| Crack cocaine | 1 | 0 | 1 | 1 | 1 | 1 |
| Ecstasy | 1 | 1 | 1 | 5 | 4 | 4 |
| LSD | 1 | 0 | 1 | 2 | 1 | 2 |
| Magic mushrooms | 1 | 1 | 1 | 2 | 1 | 2 |
| Opiates | 1 | 1 | 1 | 2 | 1 | 1 |
| Volatile substances* | 2 | 2 | 2 | 3 | 2 | 3 |
| Base | 2,647 | 2,701 | 5,374 | 2,300 | 2,334 | 4,658 |

Source: NHS Scotland 2009

Amongst 13 year olds, volatile substances were the second most commonly used drug but, at age 15, recent use of ecstasy and cocaine powder was higher at four per cent. Almost half of pupils who had used drugs said they had used them outdoors (46% of 15 year olds and 47% of 13 year olds). The next most common place to take drugs was at someone else's home (36% of 15 year olds and 24% of 13 year olds). Girls were more likely than boys to report drinking alcohol the last time they used drugs (53% compared to 41%)

Frequency of use

One per cent of 15 year olds and less than one per cent of 13 year olds reported that they took drugs most days. Seven per cent of 15 year olds and one per cent of 13 year olds reported use at least once a month.

⁴⁵ Fieldwork was conducted between September 2008 and February 2009. 10,063 pupils completed the questionnaire and the overall response rate (both class and pupil response rate) was 59%.

Problematic use

Overall five per cent of boys and three per cent of girls felt they needed help because of their drug use. Only 12% of pupils who reported using drugs most days felt they needed help, 13% of drug using pupils reported being in trouble with the police because of drug use in the last year and five per cent reported being admitted to hospital overnight in the last year due to drug use.

Other factors related to drug use

Amongst 15 year olds, pupils from the most deprived areas were more likely to be current drug users than those from the least deprived areas, 17% compared to 11%. The survey included a behavioural screening questionnaire⁴⁶ and analysis showed that current drug users were significantly more likely to have an abnormal score for conduct, hyperactivity/inattention and pro-social behaviour than pupils who had never taken drugs. There was no statistically significant difference in emotion and peer relationship scores.

Fifteen year old current drug users were more likely to believe 'drug use is exciting' (65%) than recent (34%) or non-drug users (seven per cent). Only a quarter (26%) of current users felt that drug users needed help and advice compared to over three-quarters (80%) of those who had never taken drugs.

Trends

Recent drug use amongst 15 year olds fell from 23% in 2006 to 20% in 2008 and, amongst 13 year olds, from seven per cent to five per cent. However, current use remained relatively stable apart from a slight decrease amongst 13 year old boys from four per cent to three per cent. There was a large decrease in drug use between the 2004 and 2006 surveys but this may be due to a change in survey methodology⁴⁷. Therefore, it is difficult to interpret the long-term trend in drug use amongst Scottish school children.

2.4.4 Northern Ireland: Young Persons' Behaviour and Attitudes Survey 2007

Results from the *Northern Ireland Young Persons' Behaviour and Attitudes Survey (YPBAS)*⁴⁸ 2007 were reported in the 2008 United Kingdom Focal Point report (NISRA 2008). Recently published analysis examines changes⁴⁹ between the 2003 and 2007 surveys (PHIRB 2009a). It was found that:

- lifetime use of any drugs or solvents decreased from 23.0% to 18.9%;
- last year use decreased from 17.9% to 13.4%; and
- last month use decreased from 11.5% to 7.5%.

Lifetime use amongst boys decreased from 26.1% to 19.3%, with lifetime use of cannabis falling from 18.7% to 9.9%. However, there was only a small decrease in lifetime prevalence for girls (20.0% in 2003 to 18.8% in 2007) despite a fall in cannabis use from 14.0% to 8.5%.

⁴⁶ The survey incorporated a self-completion version of the Goodman Strengths and Difficulties questionnaire (<http://www.sdqinfo.com/>), which is used to identify behavioural problems in four to 17 year olds. The SDQ asks 25 attributes and pupils scores were grouped as 'normal', 'borderline' and 'abnormal'.

⁴⁷ In the 2006 and 2008 surveys, fieldwork was carried out earlier in the year making the age profile younger, which could have an effect on prevalence rates.

⁴⁸ The YPBAS is conducted among 11 to 16 year old post-primary pupils in Northern Ireland.

⁴⁹ All changes reported are statistically significant at the five per cent level.

2.4.5 ESPAD

The *2007 European School Survey Project for Alcohol and other Drugs (ESPAD)*, published in 2009 (Hibell et al. 2009), is a comparative study across a number of European and other countries, including the United Kingdom. The target population in the 2007 survey was young people born in 1991, with a mean age of 15.8. Almost a third (29%) of UK respondents had used drugs in the last year, but the use of drugs other than cannabis was less frequent (nine per cent). Nine per cent reported use of inhalants while two per cent reported the use of non-prescription tranquillisers or sedatives.

2.4.6 Other studies on drug use in the school and youth population

The Belfast Youth Development Study (BYDS)

Reporting on cocaine powder use patterns amongst young people aged 13 to 16 years, McCrystal and Percy (2009a)⁵⁰ show that use increased from 3.8% at age 13 to 14, to 4.8% at age 14 to 15, and to 7.5% at age 15 to 16. Users were more likely to be female; live in disrupted families; not attend grammar schools; live in the city of Belfast; use a range of substances; report higher levels of delinquency and formal contact with the criminal justice system than non-users; and report lower levels of commitment at school. Nevertheless, cocaine powder use was not a frequent activity amongst those using, with only one in ten reporting weekly use.

Further analysis of BYDS data has been undertaken looking at factors associated with teenage ecstasy use (McCrystal and Percy 2009b). Results show that lifetime ecstasy use more than doubled between the ages of 14 to 16 (from six per cent at age 14, to nine per cent at age 15 and 13% at age 16). Users were more likely to be female, regularly use alcohol, tobacco and cannabis, report higher levels of offending and anti-social behaviour, and report higher levels of truancy. Ecstasy users were much more likely to report cocaine powder use than non-ecstasy users (41% at age 16 compared to two per cent). Prevalence rates for ecstasy use were much higher than those reported in the *YPBAS* but the finding that girls are more likely to use ecstasy was similar. The authors suggest that the age of onset of ecstasy use may be falling and that there is a need for primary prevention programmes beginning in early adolescence.

Trends in young people's use of illegal and illicit drugs in Britain

Aldridge (2008) notes the steady rise in the prevalence of drug use amongst young people from the 1960s, with a sharper rise from 1990, culminating in a peak in the mid-1990s and a steady decline from 2000. Over this period, gender and socio-economic differences have remained stable. Nevertheless, it is suggested that there may now be changes in relation to ethnicity and these changes have implications for health educators.

⁵⁰ The Belfast Youth Development Study (BYDS) is a longitudinal study looking at the development of adolescent drug use. The current sample is of 13 to 16 year olds in schools participating in the BYDS, corresponding to the third, fourth and fifth years of the study.

Cannabis 'drugspeak' amongst young people

In a qualitative study involving young people from an educational project in Scotland, aimed at investigating how they describe and explain the onset and continued use of cannabis, it was found that initiation into use was between 11 and 15 years of age (modal age 13); such use being with friends or older siblings (Ross and Davies 2009)⁵¹. Not using was relatively rare within social networks, use being accepted as a part of growing up. Nevertheless, while use was often referred to in hedonistic terms, problems with continued heavy use were recognised. Of note, was that use often involved burning the drug in foil and inhaling it through improvised pipes or 'buckets', using language closely related to aspects of heroin use.

Cannabis use and 'safe' identities in an inner-city school

In research into social and institutional processes through which drug use may occur in the school environment, Fletcher et al. (2009) consider how school experiences may shape young people's drug-related attitudes and actions⁵². The authors suggest that cannabis use, and identities constructed in relation to it, play a key role in how students manage insecurity.

2.5 Drug use among specific groups in the adult population

2.5.1 Armed Forces

Compulsory drug testing in the Armed Forces was introduced by the *Armed Forces Act 1996*. Around 85% of servicemen and women are tested annually. The proportion of individuals testing positive for drugs has increased from 0.71% in 2000 to 0.90% in 2008, although positive rates have remained stable since 2005 (personal communication – Ministry of Defence).

2.5.2 Ethnic Minorities

Some data on drug use among ethnic minorities are included in general population survey data (see above). In the past year there have been no studies published specifically looking at drug use among these groups.

2.5.3 Drug use amongst gay men

Findings from the *National Gay Men's Sex Survey 2007*⁵³ showed relatively high use of illicit drugs with three quarters (76.1%) having ever used a drug on at least one occasion (Keogh et al. 2009). Since the previous survey (Hickson et al. 2007), use of all drugs except cannabis has increased although it is not reported whether these changes are statistically significant. As in the previous survey, amyl nitrite was the most commonly used drug followed by cannabis and ecstasy (Table 2.9). Recent cocaine powder use was high. Men who used drugs tended to use a variety of drugs. Use of most drugs peaks among men in their thirties.

⁵¹ Four focus groups were conducted at the initial stages of the study, with in-depth interviews with 11 young people using a broad interview schedule.

⁵² Case study qualitative data was collected through semi-structured interviews supplemented with observations. Fourteen students aged 14 to 15 were interviewed in autumn 2006 and in summer 2007. Five teachers were also interviewed.

⁵³ The Gay Men's Sex Survey is carried out by Sigma Research in partnership with 107 health promotion agencies across the United Kingdom. It uses a self-completion questionnaire distributed in booklet form by a range of Gay and HIV health promotion agencies. The survey is also available for completion online and heavily promoted by Gay commercial websites. In 2007 a final sample of 6,155 males aged 14 and over, living in the United Kingdom, who had sex with a man in the last year and/or identified as gay, bisexual or some other non-heterosexual identity.

Table 2.9: Last year use of individual drugs amongst gay men in the United Kingdom, 2005 and 2007

| DRUG | LAST YEAR USE (%) | |
|----------------------|-------------------|------|
| | 2005 | 2007 |
| Amphetamines | 7.2 | 9.5 |
| Amyl nitrite/poppers | 39.4 | 42.0 |
| Cannabis | 27.7 | 27.7 |
| Cocaine powder | 16.8 | 21.2 |
| Crack cocaine | 1.4 | 2.8 |
| Ecstasy | 18.5 | 20.7 |
| GHB | 3.6 | 7.0 |
| Heroin | 1.0 | 2.3 |
| Ketamine | 9.1 | 12.2 |
| LSD | 2.8 | 3.9 |
| Methylamphetamine | 2.8 | 4.7 |

Source: Hickson et al. (2007) and Keogh et al. (2009)

Results from the survey for specific areas of England, Wales, Scotland, Northern Ireland (and the Republic of Ireland), as well as Strategic Health Authority areas in England are also available⁵⁴.

⁵⁴ These are available at: <http://www.sigmaresearch.org.uk/go.php/local/gay/local07>

2.5.4 Drug use amongst people in nightlife settings

Measham and Moore (2009), present data on drug use amongst people attending bars and clubs in Manchester.⁵⁵ They found high levels of lifetime (97.5%), last month (79.3%) and on the day the fieldwork was carried out⁵⁶ (62.5%) drug use amongst club attendees. Although lower than club goers, drug use amongst those attending bars was also high compared to prevalence rates in the BCS (see 2.3.1) with 68.6% reporting lifetime use, 35.4% last month use and 19.9% use on fieldwork day (Table 2.10). The authors highlight the growing popularity of ketamine and MDMA powder suggesting that the former is part of a polydrug repertoire rather than a substance that is replacing the use of other drugs such as ecstasy.

Table 2.10: Percentage of respondents at club and bar venues reporting lifetime, last month and fieldwork day drug use in Manchester, England

| DRUG | LIFETIME | | LAST MONTH | | FIELDWORK DAY* | |
|-----------------|------------|------------|------------|------------|----------------|------------|
| | Club | Bar | Club | Bar | Club | Bar |
| Any drug | 97.5 | 68.6 | 79.3 | 35.4 | 62.5 | 19.9 |
| Amphetamine | 66.9 | 29.7 | 16.1 | 5.7 | 8.0 | 2.0 |
| Cannabis | 93.2 | 64.0 | 58.2 | 27.7 | 40.2 | 10.6 |
| Cocaine powder | 83.3 | 36.3 | 50.8 | 12.6 | 22.0 | 5.4 |
| Ecstasy | 84.8 | 36.3 | 53.9 | 11.1 | 41.5 | 5.7 |
| Ketamine | 44.0 | 7.1 | 18.0 | 2.9 | 10.8 | 0.9 |
| LSD | 43.7 | 17.1 | 3.4 | 0.3 | 0.3 | 0.3 |
| Magic mushrooms | 53.9 | 18.3 | 5.6 | 2.0 | 0.6 | 0.6 |
| MDMA powder | 39.6 | 0.3 | 14.6 | 0.3 | 6.5 | 0.0 |
| Base | 350 | 323 | 350 | 323 | 350 | 323 |

*Use on day of survey including intended use later that night

Source: Measham and Moore 2009

Within the different club genres, 'hard dance' club attendees were most likely to report last month drug use (83.7%) and more prolific drug use with prevalence for stimulants and ketamine highest amongst this group. Drum and bass club attendees were less likely than other club goers to report fieldwork night use of ecstasy, amphetamine and ketamine but more likely to report cannabis use. The authors conclude that differences in prevalence rates and patterns of polydrug use across nightlife settings support the notion that there are different 'socio-demographic groups operating within culturally, spatially and pharmacologically distinct local leisure scenes who are committed to their cultural groupings.' Attention is also drawn to what the authors term pre-loading, with 41.8% of club attendees having already taken drugs before being surveyed at the beginning of the club night.

⁵⁵ The study included sweep surveys of customers in Manchester city centre venues chosen for their contrasting genres of dance music. Surveys took place between November 2005 and March 2008. Drug use profiles were gathered from a total of 323 club goers. Data were compared to a previous survey of those attending bars in Manchester city centre in summer 2004. Drug use profiles were gathered from 350 bar attendees.

⁵⁶ Includes those who had already used drugs before being surveyed and those who stated they intended to use drugs later on in the night.

2.6 Drug use among specific groups in the school age population

2.6.1 Truants and excludees

Eleven per cent of pupils in England who had truanted or been excluded from school reported using drugs at least once a month compared to one per cent of pupils who had not. This proportion has fallen from 21% in 2003 (Fuller 2009).

Amongst 15 year olds in Scotland, current drug users were more likely to have truanted in the last year than those who had never used drugs; 61% compared to 20% (NHS Scotland 2009). Current drug users were also more likely to have truanted frequently; 28% of current drug users had truanted more than 10 times in the last year compared to five per cent of pupils who had never used drugs. Forty one per cent of current drug users had been excluded from school compared to eight per cent of pupils who had never used drugs.

2.6.2 Looked after children

In 2006, the Department for Children, Schools and Families (DCSF) started collecting information on the number of looked after children identified as having a substance misuse problem. Of the 43,700 children looked after for at least 12 months in the year ending 30th September 2008, 2,200 (4.9%) were identified as having a substance misuse problem, a decrease from 5.4% in the previous year (DCSF 2009b).

3. Prevention

3.1 Introduction

Prevention of young people's drug use is a key element of drug strategies in the United Kingdom. Family interventions, education, regeneration of communities and tackling social exclusion and poverty are the main aspects of prevention. Policies are embedded in, or complemented by, a much wider framework of social action to create the capacity of both individuals and communities to resist drugs, including policy for children and young people aimed at enabling them to reach their full potential. In England, the *Children's Plan* aims to facilitate this (DCSF 2007). The devolved administrations have similar documents, specifically *Getting it Right for Every Child and Delivering a Healthy Future: An Action Framework for Children in Scotland* (Scottish Executive 2006a; Scottish Executive 2007); and *Children and Young People: Rights to Action* (WAG 2004) in Wales. In Northern Ireland, *Our Children and Young People – Our Pledge: A 10 year strategy for children and young people in Northern Ireland, 2006-2016* (OFMDFMNI 2006) sets a framework for addressing the needs of young people. Improved education and early interventions for young people and families (especially those most at risk) and improved public information about drugs are priority areas.

Universal drug prevention initiatives are an important area of policy. Communication programmes, such as 'FRANK' in England and 'Know the Score' in Scotland, provide factual information and advice to young people and their families. In Northern Ireland, the Public Health Agency develops public information campaigns for various target groups and settings, and in Wales a bilingual (Welsh and English) helpline, 'Dan 24/7', is available. Throughout most of the United Kingdom, drug prevention is part of the national curriculum and the majority of schools have a drug education policy and guidelines around dealing with drug incidents. Guidance on drug education recommends an approach that incorporates all psychoactive substances, including alcohol and tobacco, and places drugs education within the wider health and social education agenda.

In England and Wales, all local areas are expected to produce Children's and Young People's Plans for all services for children and young people, including prevention and treatment. In Scotland, an Integrated Children's Services Planning Framework requires a single plan agreed with all relevant agencies to deliver integrated services for children and young people. Current policy acknowledges that some groups of young people are more vulnerable to substance misuse problems than their peers and suggests more needs to be done for these young people. The Early Years Framework has been developed in response to this.

Communities are provided with assistance to build the capacity to resist drugs, through a range of initiatives which are delivered by local partnerships. There are specific interventions targeting young people in deprived communities, for example, Positive Futures. In Scotland, a number of projects receive time limited funding from the Scottish Government in partnership with Lloyds TSB Partnership Drugs Initiative (PDI)⁵⁷, targeting children with, or at risk of, problem drug misuse as well as those affected by familial drug use.

Increasingly, family interventions are being set up, more specifically for problem drug users, to help support parenting, and therefore reduce the risk of drug use amongst their children but also with wider objectives.

3.2 Universal prevention

Universal prevention targets the entire population, regardless of individual levels of risk at national, local community, school, or neighbourhood level with programmes, initiatives and messages aimed at preventing or delaying the onset of illicit drug use.

⁵⁷ See: <http://www.ltsfoundationforscotland.org.uk/index.asp?tm=16&cookies=True>

3.2.1 School

Review of drugs education in England

In 2008 the Drug and Alcohol Advisory Group⁵⁸ published an evidence review of the effectiveness of drug and alcohol education (Advisory Group on Drug and Alcohol Education 2008). One of the key recommendations of the review was to make Personal, Social, Health and Economic (PSHE) education compulsory in schools. It also recommended that parents and carers should be supported in developing skills and knowledge about drug education and highlighted the importance of early intervention and support for vulnerable young people. The Department for Children, Schools and Families (DCSF) published the Government's response, which agreed with all of the recommendations made in the review and provided an outline of the actions that it will take (DCSF 2008).

In April 2009 an independent review into the proposal to make PSHE education a statutory requirement in all schools was published. Following on from this review a full public consultation was undertaken (DCSF 2009c). This public consultation was discussed in the first year progress review of 2008 UK drug strategy, where the Government re-emphasised its commitment to ensuring quality drug education for all young people (HM Government 2009a). *Revised Drug and Alcohol Guidance for Schools*, based on the findings from the review and wider evidence gathering will be published for consultation in November 2009.

Blueprint Drug Education Research Programme

A final evaluation report into the response of pupils and parents to the *Blueprint Drug Education Research Programme*⁵⁹ has been published (see last year's Focal Point report for implementation reports). The evaluation aimed to assess the following:

- how pupils and parents responded to the programme;
- pupils' awareness and knowledge of drug use;
- pupils' perception of drug use prevalence among same-age peers;
- perceived acceptability of drug use; and
- the quality and frequency of parent-child communication.

It was found that, in general, pupils were positive about the programme and were able to remember information about drugs and how to handle scenarios where they may be offered them. Parents also reported that they had gained skills from the programme which enabled them to talk to their children about drugs. However, the evaluation team were unable to assess the impact of the programme on pupils who had participated in it (by comparing them to pupils who had not received the programme) as the sample size was too small (Home Office 2009e).

⁵⁸ The Drug and Alcohol Advisory Group was established in response to the 2007 Children's Plan to examine the available evidence to make recommendations to the Government on how to improve drug and alcohol education delivered to young people. As part of that review the Drug Education Forum conducted a survey with over 350 drug education providers and commissioners. See also: <http://www.drugeducationforum.com/>

⁵⁹ Blueprint was a drugs education programme which was developed in reference to the evidence base and which ran in 23 pilot schools between 2004 and 2005. It provided drugs education lessons in addition to four other components which were: parents; media; health policy and community.

In 2008, the Department of Health commissioned research investigating the prioritisation of public health initiatives (Matrix Knowledge Group and Bazian 2008) with a focus on effectiveness and cost-effectiveness⁶⁰ (see section 5.3.2). One objective of the research focused on initiatives to prevent initiation and reduce continued use of drugs, and those which sought to reduce drug-related harms⁶¹. It was reported that the evidence suggested that school based drug prevention initiatives prevented uptake. In particular, a life skills programme which aimed to reduce cocaine powder consumption was highlighted as cost effective. However, a lack of data meant that conclusive support regarding the cost-effectiveness of other prevention initiatives could not be given.

Scotland: Health and Well-being Education

Scotland has recently reformed its school curriculum as part of the *Curriculum for Excellence*⁶² programme. Guidance on teaching and learning about substance misuse forms part of the Health and Well-being area of the curriculum. The aim is to ensure that young people are able to 'develop the knowledge and understanding, skills, capabilities and attributes which they need for mental, emotional, social and physical well-being now and in the future.'

Substance misuse education specifically focuses on the development of pupils' understanding of substance use (and misuse) across a variety of substances both legal and illegal; over the counter and prescribed medicines, alcohol, illegal drugs, tobacco and solvents. The impact on their future life choices of engaging in risky behaviours such as drug use is also explored as part of the lessons. The aim is to allow pupils to make an informed choice in the future and to promote the ethos of a healthy lifestyle (Scottish Government 2008c).

'Choices for Life'⁶³ concerts

In 2009, 13 pop concert style events, which were open to all Year 7⁶⁴ pupils, were held across seven venues in Scotland. They were delivered in partnership between the Scottish Crime and Drug Enforcement Agency (SCDEA)⁶⁵, the Scottish Police service, Learning and Teaching Scotland (LTS)⁶⁶, and the National Health Service (NHS) and funded by the Scottish Government. The purpose of the events was to provide young people with knowledge and information that will help them to make informed, healthy lifestyle choices in the future, delivered through video clips, quizzes and drama and designed to complement classroom work. Topics included education about the dangers of drugs, alcohol and smoking as well as the issues regarding negative peer pressure. The 2009 events were delivered to more than 80% of the country's Year 7 school pupils. Future planned developments include extending the messages into later school years, developing the understanding of parents and carers to emphasise the supportive role they can play, and to develop professional understanding in this area (Scottish Government 2009a).

⁶⁰ United Kingdom knowledge portals, guideline sites, health technology assessment and systematic review databases were searched for recommended interventions within the programme category. It is noted that the research was conducted in less than one month and whilst the results reported are robust, they do not provide sufficient input into decisions about how public health investments should be prioritised.

⁶¹ Eight objectives were outlined. Other objectives included: reduce smoking rates and prevent harm from smoking; prevent obesity, manage risk factors and address the complications of obesity; prevent dangerous drinking and minimise the harm from alcohol; reduce the incidence of sexually transmitted disease and reduce the rates of teenage pregnancy; promote breast feeding; promote healthy nutrition and dietary patterns which reduce the complications of illness; and promote health in the elderly and prevent diseases associated with age.

⁶² See: <http://www.ltscotland.org.uk/curriculumforexcellence/healthandwellbeing/index.asp>

⁶³ See: <http://www.choicesforlife.com/>

⁶⁴ Year 7 pupils are aged 11 and 12.

⁶⁵ See: <http://www.sdea.police.uk>

⁶⁶ LTS are responsible for the development of the school curriculum in Scotland.

Shared Responsibility Cocaine awareness project

The 'Shared Responsibility'⁶⁷ project, involving SCDEA in partnership with the Home Office, Scotland Yard, the Serious Organised Crime Agency (SOCA) and international partners such as the Colombian government, aims to utilise global collaboration to impact on the demand for and the production and supply of cocaine (see last year's Focal Point report for more details). A school project in Scotland linked to 'Shared Responsibility' which involved developing communication links between the SCDEA, the Colombian Government, and Colombian school children has won an award and received national media coverage after it was reported that the project used peer interaction between young people to share experiences of substance misuse from the viewpoints of both countries. It enabled young people to be exposed to a wide range of issues that demonstrate the impact of drugs on a local, national and global scale (personal communication - Scottish Government).

Wales: Substance Misuse Education Steering Group

In Wales a steering group has been set up to monitor progress of the aims of the **2008 Substance Misuse Strategy** (WAG 2008a) which relate to substance misuse education. The group is made up of officials from key areas of government and external stakeholders. The purpose of the group is to, over the next three years, advise the board responsible for the implementation of the drugs strategy on how best to provide consistent substance misuse education for young people who are under 25 years of age⁶⁸.

All Wales School Liaison Core Programme

The All Wales School Liaison Core Programme is delivered in partnership between specialist police liaison officers and teachers to mainstream school pupils. It has been running nationally since 2004. Details of the most recent evaluation of the programme, undertaken in 2007, were reported in last year's Focal Point report. It is anticipated that the next evaluation will be conducted in spring 2010. The 'disengaged' element of the programme (see 2008 Focal Point report) has been re-named as the 'inclusion' element. This aspect of the programme, specifically designed for pupils who have the potential for disengagement, was originally piloted in five areas and then extended to 14 areas. It does not, however, have national coverage as yet and therefore the focus of the 2010 evaluation will be on the impact of the 'core' elements of the programme (Substance Misuse Education Steering Group 2009).

Pupil attitudes towards drugs education

In 2008, similar to previous years, 60% of school pupils in England age 11 to 15 who were surveyed could recall having received drugs education in school in the previous year (Fuller 2009) (see section 2.4.1). Older pupils were more likely to remember these lessons than their younger counterparts (74% of Year 10 pupils compared to 44% of Year 7 pupils⁶⁹). Most pupils who remembered the lessons reported that they had helped them to: think about the risks associated with drugs (95%); find out more about drugs (91%); learn that drugs are illegal (85%); avoid drugs (81%); or think what to do if they were offered them (79%). Forty one per cent of pupils stated the lessons showed them that less young people than they thought took drugs.

Younger pupils were more likely than older pupils to say that the lessons helped them avoid drugs, think about what to do if offered drugs, realise that drugs are illegal, and see that not as many young people as they think take drugs compared to older pupils. Older pupils were slightly more likely to say that lessons helped them find out where to go for help or information about drugs. Pupils who had taken drugs in the last month and also recalled having drugs lessons were less likely than other pupils to say that the lessons had helped them think about the risks of taking drugs, what to do if they were offered them and to avoid taking drugs.

⁶⁷ See: <http://www.sharedresponsibility.gov.co/en/>

⁶⁸ See: <http://wales.gov.uk/topics/housingandcommunity/safety/substancemisuse/smeducation/?jsessionid=0lHDKWxQMTn0FQTMYrTm9GFDGp1kbXsmKz2Zry4J7ydnVwTTmqWL!-845036832?lang=en>

⁶⁹ Year 7 pupils are aged 11 and 12, Year 10 pupils are aged 14 and 15.

3.2.2 Community

Positive Futures

The *Positive Futures*⁷⁰ social inclusion programme, which has been running for more than nine years across England and Wales, now has 123 active projects which provide diversionary activities, such as sport, arts and leisure to young people in socially disadvantaged and high-crime areas. Prevention of substance misuse is one of the aims of the project. It is hoped that the opportunities provided by the projects will enable young people to develop skills which will enable them to make alternative choices in life such as education and employment. In 2007/08 around 60,000 young people took part in activities and the Government reported that in excess of 15,000 qualifications and other positive outcomes were achieved by participants (HM Government 2009a).

Cashback for Communities in Scotland

The Scottish Government, in partnership with Scottish sporting, arts and business associations, is funding a range of diversionary activities for young people as part of the 'CashBack for Communities' programme⁷¹. The projects are funded with money recovered through the *Proceeds of Crime Act 2002* and are targeted at young people from communities that are affected by deprivation. The aim is to increase the opportunities open to these young people and to help them develop new skills and interests. Around 280 youth organisations have received funding so far via a grant administered by Youth Link Scotland, and it is hoped that the initiatives will increase the chances of long-term positive outcomes for participants⁷². The Scottish Government has committed an investment of over €14.7 million (£13m) to a range of partners and it is reported that over 100,000 young people have taken part in activities so far (Scottish Government 2009a).

3.3 Selective prevention in at-risk groups and settings

Selective prevention initiatives target subsets of the total population that are deemed to be at greater risk for substance misuse such as truants or young offenders.

3.3.1 At-risk groups

FRANK advice for Foster Carers

The FRANK campaign in England has issued guidance aimed at foster carers which has been produced in partnership with the Fostering Network⁷³. Developed after consultation with young people in care, its aim is to give an introduction to the issues a young person in care may face in regards to drugs and alcohol. It also provides foster carers with relevant information and advice about drugs so that they can talk about them with the young people in their care or encourage them to use the information and resources available from FRANK. It has been produced in response to past research which has shown that young people in care are often more likely to be exposed to drugs and have less opportunity to talk to someone about them (Newburn et al. 2002; Ward et al. 2003). The intention of this guidance is to encourage foster carers to help this group of young people make informed choices about drugs and reduce the risks that they may face. It contains tips on how to start a dialogue about drugs; information around dealing with drug-related issues; and contact details on where to get further information. Since its launch in December 2008 over 9,000 information packs have been distributed (Home Office 2008a).

⁷⁰ See: <http://drugs.homeoffice.gov.uk/young-people/positive-futures/>

⁷¹ See: <http://www.cashbackscotland.com/>

⁷² See: <http://www.scotland.gov.uk/Topics/Justice/public-safety/17141/cashback>

⁷³ See: <http://www.fostering.net/>

Inspiring Scotland⁷⁴ provides funding, activities and services for vulnerable young people in Scotland. It is a partnership between Lloyds TSB Foundation for Scotland and a range of investors (government, trusts and foundations, private investors, businesses and charities). The aim is to support young people who potentially will not be working or in further education upon leaving school and help them to develop a purpose in their lives. It will focus on those who are not facing extreme difficulties at the moment, but who need extra support to prevent them from experiencing problems such as substance misuse and homelessness in the future.

3.3.2 At-risk families

England: Family Intervention Project pilots

The 2008 United Kingdom Drug Strategy proposed to take a whole family approach to drug prevention (HM Government 2008a) and work is taking place to ensure that there are better links between Family Intervention Projects (FIPs) and substance misuse providers and commissioners. FIPs are being set up in every local authority across England. The projects work with the most challenging families. Issues tackled include anti-social behaviour, youth crime, school absenteeism, drug and alcohol addiction, domestic violence, poor mental health and inter-generational social disadvantage. Projects deliver a multi-agency support package, including parenting skills, which address the needs of the whole family. A key worker works closely with the families co-ordinating services, providing practical support such as parenting and using a combination of support and sanctions to motivate the families to change. The Prime Minister announced in September 2009 that the programme will be expanded with up to 10,000 families per year benefiting from such interventions from 2012. Currently around 3,000 families are, or have, received support and this is estimated to increase to around 5,000 by March 2010. The Government has reported that results from the first 699 families to have formally completed interventions have been positive in terms of reduced risks to children, reported cases of anti-social behaviour, educational issues, youth crime, domestic violence, mental and physical health problems and reduced substance misuse issues. It is also reported that a national network of services that provide support and protection to children and families affected by substance misuse has been established to provide information and resources to such families. This work is being driven by a cross-government steering group as set out in the Drug Strategy, with a particular focus on strengthening links between all adult treatment services and Family Intervention Projects (HM Government 2009a) (see section 8.3.4).

Wales: The Strengthening Families Programme for 10 to 14 year olds

The *Strengthening Families Programme 10-14* has been operational in Cardiff since 2005. It aims to provide 'primary prevention' to at-risk children by building skills within their families, strengthening family bonds and reducing the risk factors that are associated with substance misuse in young people. The intervention consists of weekly sessions that typically last for a period of seven weeks. In the first hour of the session the young person and the family meet with their project worker separately and then for the second hour they meet their workers together as a family. The Welsh Assembly Government commissioned a qualitative evaluation into the project to assess whether it is appropriate to be rolled out on a national basis⁷⁵.

⁷⁴ See: <http://www.inspiringscotland.org.uk/>

⁷⁵ See: http://www.awardresearch.org.uk/documents/Assessing_the_potential.doc

The evaluation reported that the programme has long term potential as a drug prevention project by enabling young people to develop the skills which can be a protective factor against future substance misuse (such as resistance of peer pressure; dealing with stress; and goal setting). In addition to this it can also bring about favourable outcomes for participants in the shorter term by developing communication skills and understanding within the family unit, improving parenting skills and confidence building. The key achievements of the project were described as 'strengthening of families' and 'promoting multi agency collaboration'. The authors make several recommendations for how the project can be developed in the future and suggest that if it is adopted nationally, it should be accompanied by a long term evaluation of substance use prevention and the broader family outcomes (Segrott 2008).

3.3.3 Recreational settings

In Scotland over 200 pubs and clubs were involved in a 'Know the Score' anti-cocaine awareness weekend to inform 18 to 25 year olds of the health risks involved with cocaine powder use and to raise awareness of the 'Know the Score' drugs information campaign (see section 3.4). The promotional events aimed to engage with the target audience in a relaxed environment and focused on raising awareness of the 'Know the Score' campaign with pubs using branded materials throughout the weekend such as cocktail stirrers, beer mats, posters and t-shirts (Scottish Government 2009a).

3.4 National and local media campaigns

Talk to FRANK

The FRANK campaign has now been running for six years. During 2008/09 the Government spent €8.8 million (£6.97m) on FRANK and its main focus was two major campaigns about cannabis and cocaine powder. The €1.26 million (£1m) cocaine powder campaign⁷⁶ contained television and online adverts, targeted at 15 to 18 year olds, featuring a fictional dog, Pablo the drug mule, who had died whilst being used to smuggle cocaine powder. In the adverts Pablo wakes from the dead and uncovers the 'darker side' of cocaine powder. The key messages of the campaign were the possible risk of heart attack, nasal damage and other downsides of cocaine powder such as 'cocaine arrogance', addiction and its links with organised crime (Home Office 2008b). It is reported that this campaign received more than 700,000 hits on the YouTube⁷⁷ website (HM Government 2009a).

In response to the reclassification of cannabis from a Class C to a Class B drug in January 2009 (see section 1.2), FRANK also launched a series of adverts warning of the risks associated with cannabis use that were broadcast on television, radio and online. As before, the target audience was 15 to 18 year olds (HM Government 2009a).

The performance of the FRANK campaign in 2008/09 was evaluated⁷⁸ and it was found that:

- 90% of young people recognised FRANK advertising;
- 88% of young people recognised the recent 'Brain Crashers' cannabis television adverts;
- 74% of parents recognised at least one of the FRANK adverts;
- 87% of young people were aware of the helpline; and
- 66% of young people were aware of the website.

⁷⁶ See: http://www.dcsf.gov.uk/pns/DisplayPN.cgi?pn_id=2008_0273

⁷⁷ See: <http://www.youtube.com/>

⁷⁸ The evaluation involved interviews with just over 1000 young people and 500 parents.

The young people who were interviewed as part of the FRANK evaluation were asked who they would turn to if they needed information about drugs. Over half (59%) stated that they would go to FRANK; 44% said they would go to their mother and a fifth (20%) said that they would go to a doctor for information. Three quarters (75%) of young people interviewed said that they would be likely to visit the FRANK website (38% very likely; 37% quite likely) and just over three quarters (76%) would be likely to recommend it to others.

The FRANK helpline received 341,972 calls in 2008/09 (around 936 per day on average). Nearly a third of the calls were about cannabis and nearly a quarter were about cocaine powder. In 2008/09, the website⁷⁹ received 3.46 million visits and 31,052 email enquiries were replied to, with a fifth of emails relating to cannabis and cocaine powder. In 2007/08, the majority of callers were satisfied with the experience, with over half (53%) rating it as excellent and over a third (35%) as very good.

The FRANK website features the FRANK Bot⁸⁰ instant messaging service. It is offered to users as an alternative to sending an email or making a telephone call to FRANK and it can be downloaded from the website and added as a contact to the users' MSN instant messaging service. The service is automated and operates 24 hours a day, providing confidential drug information. In 2008/09 it was downloaded by 162,828 people, which incorporated 2.9 million conversations with users, with an average of nine sessions for each Bot user.

To enable professionals to support the campaign and reach young people with prevention messages, FRANK released a *Cocaine Action Update* in December 2008 and will release a cannabis information pack in autumn 2009 (personal communication - Home Office).

The Government has pledged its commitment to FRANK until at least March 2011 and will in future increase its focus on parents. FRANK has recently launched an SMS service where anyone can text their question to FRANK, and developed a cannabis self help package to support people to reduce or stop their cannabis use. There are also plans to extend FRANK to provide access to drugs interventions and support; make links into drug education in schools; provide increased support for local campaigns and improve the knowledge of helpline advisers of local services and interventions; review and update FRANK's leaflets and website information (Home Office 2008b).

The FRANK campaign also runs an annual awards ceremony⁸¹. It invites entries from local communication campaigns and community drug awareness projects. The winning campaign in 2009 came from Nottingham in the East Midlands of England and was entitled 'Heart and Soul of the Party' and consisted of a series of information materials regarding the dangers of mixing cocaine powder and alcohol.

The English School Survey

When asked about where helpful information about drugs could be found, English school pupils stated that television was the most likely source (65%). Magazines/newspapers and the internet were mentioned by just under half of pupils (49% and 46% respectively) with helplines the least likely source (16%). The FRANK campaign was mentioned by just under a third of all pupils (30%; boys 31%, girls 29%) with older pupils more likely to mention it than younger pupils (39% of 15 year olds compared to 16% of 11 year olds). Other key sources of information were teachers (64%); parents (61%) and the police (36%) (Fuller 2009).

⁷⁹ See: <http://www.talktofrank.com/>

⁸⁰ See: <http://www.talktofrank.com/article.aspx?id=1624>

⁸¹ See: <http://drugs.homeoffice.gov.uk/communications-and-campaigns/frank-campaign/awards/?version=1>

Scotland: Know the Score 'Informing Parents' campaign

In Scotland the 'Know the Score' communication campaign continues with support from the Scottish Government. In line with the drugs strategy (Scottish Government 2008d), one of its key focuses over the past twelve months has been the 'Informing Parents' campaign which aims to ensure that appropriate advice, information and resources are easily available to parents so that they are able to talk to their children about drugs. Resources available include the 'Know the Score' website⁸², a booklet entitled *Drugs: what every parent should know* (NHS Health Scotland 2008) the *Drug Recognition Guide* and ten pocket directories each focusing on a specific drug as well as posters and leaflets. A series of media adverts (online, television and radio) ran in Scotland between March and the end of April 2009 as part of a six weeks long 'Informing Parents' marketing campaign⁸³. The Scottish Government has reported that this has led to a substantial increase (41%) in the number of telephone calls received by the 'Know the Score' helpline and the number of visits made to its website (a six-fold increase) (Scottish Government 2009a).

Welsh Drug and Alcohol Helpline: DAN 24/7

In Wales, the Welsh Assembly Government continues to fund its own bilingual (Welsh and English) Drug and Alcohol Helpline, 'DAN 24/7', with a budget in place for at least the next two years. It provides a 24 hour service across the country which acts as a gateway service, designed to provide accurate information, guidance, advice and sign post callers to local relevant services. The call centre staff have all received drug and alcohol awareness training and are equipped with an electronic and manual database of services, literature and references designed to assist with a range of possible caller enquiries. Since October 2008 it has been managed by the North Wales NHS Trust and it is reported that call volumes have increased since then. On average, over 200 calls are received each month with the main focus being on advice about the harmful effects of (mainly class A) drugs. 'DAN 24/7' engages in marketing and promotion campaigns throughout the year, utilising poster campaigns and media events and targeting specific groups and times of the year such as University Fresher's week; Valentine's day; Christmas; the end of summer term and sixth form parties (personal communication – Welsh Assembly Government).

Northern Ireland: Public Health Agency

In Northern Ireland, the Health Promotion Agency⁸⁴ published an information leaflet regarding the associated health risks of using cocaine and wider social problems such as getting into trouble with the police and falling into debt⁸⁵. The Health Promotion Agency has now been superseded by the Public Health Agency⁸⁶.

⁸² See: <http://www.knowthescore.info/kts/451.html>

⁸³ See: http://www.sourceuk.net/article/13/13021/parents_should_know_the_score.html

⁸⁴ See: <http://www.healthpromotionagency.org.uk/work/Drugs/publications.htm>

⁸⁵ See: http://www.healthpromotionagency.org.uk/Resources/drugs/truth_about_cocaine_09.html

⁸⁶ See: <http://www.publichealth.hscni.net/> and <http://www.publichealth.hscni.net/publications/index.html>

4. Problem Drug Use

4.1 Introduction

Estimates of problem drug use in the United Kingdom are derived using two indirect measurement techniques: the capture-recapture (CRC) method; and the multiple indicator (MIM) method. Since 2006, all four UK administrations have published prevalence estimates to meet their policy requirements. The drugs and the data covered by these estimates differ across the United Kingdom.

Latest estimates for England are for 2006/07 for opiate and/or crack cocaine use with separate estimates for opiate use, crack cocaine use, and drug injecting by users of opiates or crack cocaine. In Scotland the latest estimates are for 2006, for opiates and/or benzodiazepine misuse and in Wales provisional estimates for 2006/07 for long duration or regular use of opiates and/or cocaine were published in 2009. Estimates for Northern Ireland for 2004 were published in 2006 and cover opiate and/or cocaine use. Based on these, it is estimated that there are a total of 404,884 problem drug users in the United Kingdom, and 147,855 injecting drug users (primarily of opiates or crack cocaine).

4.2 Indirect estimates of problem drug users

4.2.1 Prevalence estimates for England for 2006/07

New estimates of the prevalence of problem drug use in England for 2006/07, nationally and regionally, are from the third (and final) sweep of a three-year Home Office project (Hay et al. 2008). Estimates are for opiate and/or crack cocaine users (problem drug users) with separate estimates for opiate users, crack cocaine users, and injectors who use opiates and/or crack cocaine.

There were an estimated 328,767 problem drug users in England in 2006/07, a rate of 9.76 per thousand population aged 15 to 64; an estimated 273,123 opiate users, a rate of 8.11 per thousand population; an estimated 180,618 crack cocaine users, a rate of 5.36 per thousand population; and an estimated 116,809 injectors who use opiates and/or crack cocaine, a rate of 3.47 per thousand population (Table 4.1).

Table 4.1: Estimates of problem drug use and rates per 1,000 population aged 15 to 64 in England, 2006/07

| | ESTIMATE | 95% CONFIDENCE INTERVAL | RATE | 95% CONFIDENCE INTERVAL |
|-------------------------------------------|----------|-------------------------|------|-------------------------|
| Opiate and/or crack cocaine users | 328,767 | 322,128–340,196 | 9.76 | 9.57–10.10 |
| Opiate users | 273,123 | 268,530–283,560 | 8.11 | 7.98–8.42 |
| Crack cocaine users | 180,618 | 175,823–189,442 | 5.36 | 5.22–5.63 |
| Injectors of opiates and/or crack cocaine | 116,809 | 114,637–121,279 | 3.47 | 3.40–3.60 |

Source: Hay et al. 2008

In 2005/06 there were an estimated 332,090 problem drug users and 327,466 in 2004/05. Changes between the three sweeps of the study are not statistically significant and therefore rates nationally have remained stable across the three sweeps (Table 4.2). In addition, there was no significant change in estimates of opiate use throughout the three sweeps, and although there was a decrease in the estimated number of crack cocaine users between sweeps two and three, there was overall no significant change between sweep one and sweep three. There was, however, an overall decrease in injecting use between each sweep of the study i.e. between sweeps one and two (2004/05 and 2005/06) and between sweeps two and three (2005/06 and 2006/07) (Hay et al. 2008).

Table 4.2: Estimated number of problem drug users aged 15 to 64 in England, 2004/05, 2005/06 and 2006/07

| | 2004/05 | 2005/06 | 2006/07 |
|-------------------------------------------|---------|---------|---------|
| Opiate and/or crack cocaine users | 327,466 | 332,090 | 328,767 |
| Opiate users | 281,320 | 286,566 | 273,123 |
| Crack cocaine users | 192,999 | 197,568 | 180,618 |
| Injectors of opiates and/or crack cocaine | 137,141 | 129,977 | 116,809 |

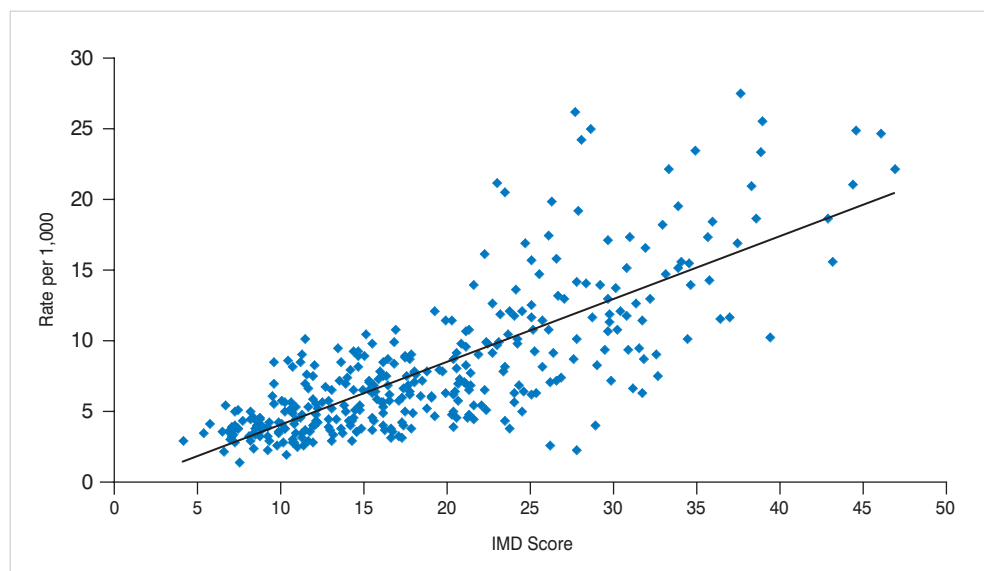
Source: Hay et al. 2008

Regional differences

As in the previous sweeps these latest estimates show marked variation in prevalence rates for opiate and/or crack cocaine users across Government Regions, although there were no significant changes between sweeps in rates for individual regions (Hay et al. 2008). London continues to have the highest rate of problem drug use per 1,000 population followed by the North West and Yorkshire and the Humber. The North West has the highest estimated rate per 1,000 population for opiate use, followed by Yorkshire and the Humber, then London. Yorkshire and the Humber has the highest estimated rates of injecting. The East of England has the lowest estimates for opiate use and injecting use and the South East has the lowest rate for crack cocaine use (Hay et al. 2008).

Further analysis of this dataset was undertaken by the North West Public Health Observatory. Using the rates of PDUs aged 15 to 64 years old per 1,000 population and the Index of Multiple Deprivation (IMD)⁸⁷ score (2007) for each local authority area, it was reported that local authority prevalence of problematic drug use was significantly and positively correlated to the Index of Multiple Deprivation (IMD) score ($p < 0.01$) (Figure 4.1).

Figure 4.1: Prevalence of problematic drug users (2006/07) (aged 15 to 64) by local authority of residence and Indices of Multiple Deprivation (2007)



Source: Shaw et al. 2009

⁸⁷ The Index of Multiple Deprivation (IMD) 2007 is derived from a range of economic, social and housing indicators which are combined into a single deprivation score for each small area in England. IMD scores can be calculated at a variety of geographical levels. See: <http://www.communities.gov.uk/communities/neighbourhoodrenewal/deprivation/deprivation07/>

Gender and age differences

In the latest sweep of estimates of problem drug use in England for 2006/07 (Hay et al. 2008) females continue to account for approximately one quarter of opiate and/or crack cocaine users (Table 4.3).

Table 4.3: Prevalence rate per 1,000 population of opiate and/or crack cocaine users by gender in England, 2006/07

| FEMALE | | | MALE | | |
|--------|--------|------|-------|--------|-------|
| Rate | 95% CI | | Rate | 95% CI | |
| 4.67 | 4.58 | 4.88 | 14.86 | 14.55 | 15.37 |

Source: Hay et al. 2008

Age

The highest prevalence of problem drug use continues to be amongst those in the 25 to 34 age group (Table 4.4).

Table 4.4: Prevalence rate per 1,000 population of opiate and/or crack cocaine users by age group in England, 2006/07

| 15 TO 24 YEARS | | | 25 TO 34 YEARS | | | 35 TO 64 YEARS | | |
|----------------|--------|------|----------------|--------|-------|----------------|--------|------|
| Rate | 95% CI | | Rate | 95% CI | | Rate | 95% CI | |
| 9.06 | 8.85 | 9.50 | 20.76 | 20.29 | 21.52 | 6.36 | 6.22 | 6.59 |

Source: Hay et al. 2008

4.2.2 Estimates of problem drug misuse in Scotland for 2006

More recent estimates of the prevalence of problem drug misuse in Scotland for 2006 were published by NHS ISD Scotland in October 2009 (Hay et al. 2009a). Estimates are for opiate and/or benzodiazepine users aged between 15 and 64 years and previous estimates have been published for 2000 and 2003.

The study found that there were an estimated 55,328 problem drug users aged between 15 and 64 in Scotland in 2006, an increase from 51,582 in 2003 (Hay et al. 2004). This equates to a rate of 16.16 per 1,000 population (Table 4.5). Seventy per cent were male, of whom 24% were aged between 15 and 24; 48% were between 25 and 34; and 28% were aged between 35 and 64.

The study also estimated that there were an estimated 23,933 people who were injecting opiates and/or benzodiazepines in Scotland in 2006 (a rate of 6.99 per 1,000 population). This estimate increased from the 18,737 injecting drug users calculated in 2003.⁸⁸

⁸⁸ The authors note that there have been some methodological changes between 2003 and 2006 and data issues which may suggest that it is inappropriate to regard the change in injecting prevalence in this time period as a true increase.

Table 4.5: Estimates of problem drug users and rates per 1,000 population aged 15 to 64 in Scotland, 2006

| | ESTIMATE | 95% CONFIDENCE INTERVAL | RATE | 95% CONFIDENCE INTERVAL |
|-----------------------------------------------|----------|-------------------------------|-------|-------------------------------|
| Opiate and/or benzodiazepine users | 55,328 | 54,451-57,234 | 16.16 | 15.91-16.72 |
| Injectors (of opiates and/or benzodiazepines) | 23,933 | 21,655-27,143 | 6.99 | 6.33-7.93 |

Source: Hay et al. 2009a

Regional differences in problem drug use prevalence rates were found in Scotland with comparatively low rates reported in island Council areas and the highest prevalence rate (32.7 per 1,000 population) reported in Glasgow City.

4.2.3 Provisional estimates of problem drug use in Wales

Provisional estimates of the prevalence of problem drug use in Wales for 2006/07 have been published (WAG 2009a). The definition of problem drug use is injecting drug use or long duration or regular use of heroin, other opioids, cocaine powder and crack cocaine. There were an estimated 19,394 problem drug users in 2006/07, a rate of 10.1 per 1,000 population aged 15 to 64 (range 15,085 – 31,780) (Table 4.6). Seventy-eight per cent were male of whom 53% were aged between 15 and 29; 47% were between 30 and 64.

Table 4.6: Provisional estimates of problem drug users and rates per 1,000 population aged 15 to 64 in Wales, 2006/07

| | ESTIMATE | RANGE | RATE |
|---------------|---------------|------------------------|-------------|
| Males 15-29 | 8,039 | 6,015–11,782 | 29.4 |
| Males 30-64 | 7,041 | 5,760–11,790 | 10.6 |
| Females 15-29 | 2,502 | 1,940–5,641 | 9.0 |
| Females 30-64 | 1,812 | 1,370–2,567 | 2.6 |
| Total | 19,394 | 15,085 – 31,780 | 10.1 |

Source: WAG 2009a

4.2.4 Estimates of problem drug use in the United Kingdom

Combining the new estimates for England, Scotland and Wales (Hay et al. 2008; Hay et al. 2009a; WAG 2009a) with the most recent estimate for Northern Ireland (The Centre for Drug Misuse Research 2006) it is possible to derive an estimate for the United Kingdom of 404,884, a rate of 10.1 per 1,000 population (Table 4.7). The estimate for the number of injecting PDUs is 147,900 (predominantly of opiates and crack cocaine), a rate of 3.7 per thousand population (Table 4.9).

Table 4.7: Estimates of problem drug use in the United Kingdom: number and rate⁸⁹ per 1,000 population aged 15 to 64

| COUNTRY | ESTIMATE | 95% CONFIDENCE INTERVAL | | RATE | 95% CONFIDENCE INTERVAL | |
|------------------|----------|-------------------------|---------|-------|-------------------------|-------|
| England | 328,767 | 322,128 | 340,196 | 9.76 | 9.57 | 10.10 |
| Northern Ireland | 1,395 | 1,316 | 1,910 | 1.28 | 1.21 | 1.75 |
| Scotland | 55,328 | 54,451 | 57,234 | 16.16 | 15.91 | 16.72 |
| Wales | 19,394 | 15,085 | 31,780 | 10.10 | 7.86 | 16.55 |
| United Kingdom* | 404,884 | 392,980 | 431,120 | 10.10 | 9.80 | 10.75 |

*Based on estimates of opiates and/or crack cocaine use in England for 2006/07; opiate use in Northern Ireland for 2004; opiate and/or benzodiazepine misuse in Scotland for 2006; long duration or regular use of opiates and/or cocaine in Wales for 2006/07.

Source: The Centre for Drug Misuse Research 2006; Hay et al. 2008; Hay et al. 2009a; WAG 2009a

Table 4.8: Estimates of injecting drug use in the United Kingdom: number and rate⁹⁰ per 1,000 population aged 15 to 64

| COUNTRY | ESTIMATE | 95% CONFIDENCE INTERVAL | | RATE | 95% CONFIDENCE INTERVAL | |
|------------------|----------|-------------------------|---------|------|-------------------------|------|
| England | 116,809 | 114,637 | 121,279 | 3.47 | 3.40 | 3.60 |
| Northern Ireland | 496 | 468 | 679 | 0.45 | 0.43 | 0.62 |
| Scotland | 23,933 | 21,655 | 27,143 | 6.99 | 6.33 | 7.93 |
| Wales | 6,662 | 6,538 | 6,917 | 3.47 | 3.40 | 3.60 |
| United Kingdom* | 147,900 | 143,298 | 156,017 | 3.69 | 3.57 | 3.89 |

*Based on estimates of injecting of opiates and/or crack cocaine in England for 2006/07, opiate and/or problem cocaine use in Northern Ireland for 2004 and injecting of opiates and/or benzodiazepines in Scotland, 2006. Estimates for Wales are extrapolated from England. Injecting estimates for Northern Ireland assume the same proportion of injecting as England.

Source: The Centre for Drug Misuse Research 2006; Hay et al. 2008; Hay et al. 2009a

⁸⁹ Calculated using the following population estimates for 15 to 64 year olds: England 33,670,500; Northern Ireland 1,090,990; Scotland 3,422,900; Wales 1,920,300; United Kingdom 40,104,690.

⁹⁰ See footnote 89.

Trends in prevalence of problem drug use and injecting drug use for the United Kingdom

Table 4.9 shows estimates provided over time by the United Kingdom Focal Point; the dates refer to the year the estimate was produced rather than the year the estimate refers to⁹¹. Table 4.11 shows estimates for injecting drug use; increases may reflect improved methodology rather than increased prevalence.

Table 4.9: Estimates of problem drug use: number and rate per 1,000 population, aged 15 to 64 in the United Kingdom

| YEAR OF ESTIMATE | ESTIMATE | 95% CONFIDENCE INTERVAL | | RATE | 95% CONFIDENCE INTERVAL | |
|--------------------|----------|-------------------------|-----------|-------|-------------------------|-------|
| 2004 ⁹² | 360,811 | Not known | Not known | 9.34 | 8.99 | 9.79 |
| 2006 ⁹³ | 357,160 | 344,263 | 375,615 | 9.26 | 8.92 | 9.73 |
| 2007 ⁹⁴ | 398,845 | 397,033 | 421,012 | 10.15 | 10.11 | 10.72 |
| 2008 ⁹⁵ | 403,547 | 395,378 | 423,907 | 10.19 | 9.98 | 10.70 |
| 2009 ⁹⁶ | 404,884 | 392,980 | 431,120 | 10.10 | 9.80 | 10.75 |

Source: Hay 2004; The Centre for Drug Misuse Research. 2006; Hay et al. 2006; Hay et al. 2007; Hay et al. 2008; Hay et al. 2009a; WAG 2009a

Table 4.10: Estimates of injecting drug use: number and rate per 1,000 population aged 15 to 64 in the United Kingdom

| YEAR OF ESTIMATE ⁹⁷ | ESTIMATE | 95% CONFIDENCE INTERVAL | | RATE | 95% CONFIDENCE INTERVAL | |
|--------------------------------|----------|-------------------------|-----------|------|-------------------------|------|
| 2004 | 123,498 | Not known | Not known | 3.20 | 3.07 | 3.34 |
| 2006 | 117,722 | 116,343 | 120,472 | 3.05 | 3.01 | 3.12 |
| 2007 | 164,036 | 158,881 | 178,614 | 4.18 | 4.04 | 4.55 |
| 2008 | 156,398 | 151,032 | 165,696 | 3.95 | 3.81 | 4.18 |
| 2009 | 147,900 | 143,298 | 156,017 | 3.69 | 3.57 | 3.89 |

Source: Hay 2004; National Centre for Drug Misuse Research 2006; Hay et al. 2006; Hay et al. 2007; Hay et al. 2008; Hay et al. 2009a

⁹¹ For more information on these estimates see previous United Kingdom Focal Point reports.

⁹² 2004 estimate is based on estimates of problem drug use by: Frischer et al. 2004 (England 2001); McElrath 2002 (Northern Ireland 2000); and Hay et al. 2001 (Scotland 2000). Estimates for Wales are extrapolated from England estimates.

⁹³ 2006 estimate is based on estimates as 2004 except for Hay et al. 2004 (Scotland 2003).

⁹⁴ 2007 estimate is based on estimates of opiates and/or crack cocaine use in England for 2004/05 (Hay et al. 2006), opiate and/or problem cocaine use in Northern Ireland for 2004 (The Centre for Drug Misuse Research 2006), and problem drug use in Scotland, 2003 (Hay et al. 2004). Estimates for Wales are extrapolated from England estimates.

⁹⁵ 2008 estimate is based on estimates as 2007 above except for England for 2005/06 (Hay et al. 2007).

⁹⁶ 2009 estimate is based on estimates of opiates and/or crack cocaine use in England for 2006/07 (Hay et al. 2008), opiate and/or problem cocaine use in Northern Ireland for 2004 (The Centre for Drug Misuse Research 2006), opiates and/or benzodiazepine use in Scotland, 2006 (Hay et al. 2009a) and for long duration or regular use of opiates and/or cocaine in Wales in 2006/07 (WAG 2009)

⁹⁷ For sources of estimates for each year see footnote for Table 4.9.

4.2.5 Reviews of PDU methodology

Estimating PDU prevalence using indirect methods

Hay et al. (2009b) discuss in more detail the findings of the 2005/06 sweep of the three year national PDU prevalence study in England. Outlining the methodology and data sources used to produce the estimates, the authors discuss the limitations of general household survey data when considering problem drug users and provide justification for the indirect estimation methods⁹⁸ which were employed in the research. It is reported that this study was one of the first to systematically employ these techniques to derive estimates of PDU prevalence and that the approach used has many strengths. However, the authors acknowledge that it is not possible to substantiate the results as there is a dearth of alternative methods of PDU estimation to compare them with.

Assessing the validity of recent estimates of problematic drug use in England

Frisher and Forsyth (2009) present a discussion regarding the validity of recent PDU estimates in England, published by the Home Office (Hay et al. 2006; Hay et al. 2007). They argue that whilst 2004/05 and 2005/06 PDU estimates for England show the highest recorded level of problematic drug use, other data sources, including the Home Office's *Drug Harm Index* (DHI), suggest that problematic drug use is on the decline.

The authors highlight some of the drawbacks associated with the indirect data collection methods which were used to produce the 2004/05 and 2005/06 estimates (capture-recapture and the multiple indicator method) and the difficulties faced in terms of validating those estimates. It is proposed that instead of utilising confidence intervals as a method of evaluating the robustness of the PDU estimates, the 'criterion validity' of the data could be examined instead. It is suggested that one way to do this would be to compare the current PDU estimates with trends in other PDU measures such as drug related deaths and hospital admissions alongside general prevalence survey data of last month class A drug use from the *British Crime Survey* (BCS).

4.3 Estimates of incidence of problem drug use

In an analysis of General Practice Research data (Frisher et al. 2009a) it was reported that incidence of drug use across all ages (16 to 59) either declined or stayed the same between 1998 and 2005, and this suggests an overall reduction in the number of new cases of drug misuse⁹⁹. The incidence of drug use in the 16 to 24 age group declined steadily from 1998 to 2005. This decline in incidence was statistically significant between 1998 and 2002 and between 2002 and 2005.

In the older age groups, there was no change for those aged 25 to 34 from 1998 to 2002; there was a significant increase for those aged 35 to 59 in the same time period. Between the years 2002 to 2005 there was no change in incidence for either group.

⁹⁸ Multi-sample capture-recapture and multiple indicator method for a description of methods see Hay et al. 2006; Hay et al. 2007; Hay et al. 2008a; and Hay et al. 2009.

⁹⁹ In this study 'drug misuse' was defined as either a GP recorded consultation or referral for one of 241 diagnostic codes for drug misuse disorders and/or having been prescribed treatment for illicit drug dependence.

4.4 Data on PDUs from non-treatment sources

Statistics from the Northern Ireland Addicts Index 2008

The Northern Ireland Addicts Index¹⁰⁰ provides information about individuals reported to be addicted to drugs classified under the *Misuse of Drugs Act 1971* (PHIRB 2009b). The index showed that at 31st December 2008:

- 281 individuals were registered on the Addicts Index, an increase of 24 from 257 in 2007;
- 83% of registered addicts were male in 2008 (81% in 2007);
- 25% of registered addicts were aged 29 years and under in 2008, compared to 29% in 2007;
- heroin was the most frequently used notifiable drug, reported by 77%;
- as in 2007, methadone (25%) and cocaine (six per cent) were the second and third most commonly reported drugs;
- in 2008, 51% of registered addicts whose injecting behaviour was known reported currently injecting: an increase from 44% in 2007;
- of the 281 addicts on the Index, 69 were registered within the last year; 139 have been registered between one and five years; the remaining 73 addicts have been registered between six and 19 years; and
- there were 212 re-notifications in 2008 (compared to 206 in 2007) and 69 new notifications.

Trends in drug misuse recorded in primary care in the UK from 1998 to 2005

Frisher et al. (2009a), in the study referred to earlier (section 4.3) discuss the difficulties in assessing the direction of change of PDU rates and assert that any increases suggested by analysis of treatment data may merely reflect a growth in treatment availability, rather than an upward trend in problem drug use. They report that there is conflicting evidence regarding problematic drug use with some studies such as the three year Home Office study (Hay et al. 2009) suggesting that it is increasing, whilst other information sources such as the *British Crime Survey* (BCS)¹⁰¹ and *Drug Harm Index*¹⁰² suggest that drug use may be stabilising or even falling. It is suggested that problem drug use may be declining and that government policies may be more effective than has been previously considered.

Estimating the prevalence of ex-injecting drug use in the population

Sweeting et al. (2008) describe a method of estimating the proportion of ex-injecting drug users in the population by using data from household surveys such as the *Offending Crime and Justice Survey* (OCJS)¹⁰³. The authors analysed responses to questions regarding when individuals began and stopped using heroin, with the assumption that heroin use has similar characteristics to injecting drug use in terms of initiation and length of time using. Although the authors concede that the data used in this analysis has limitations, they were able to demonstrate that unbiased estimates of injecting duration and historical patterns of initiation into injecting can be derived from a sample obtained from a population survey, and show how these can provide estimates of the proportion of this group in the population. They further showed how to obtain estimates of the prevalence of ex-injecting drug users by using additional information on the prevalence of current injecting drug users.

¹⁰⁰ People are registered on the Index if they are known to be, or a medical practitioner considers them to be, addicted to one or more of 14 controlled drugs.

¹⁰¹ See section 2.2.1 for the latest British Crime Survey (BCS) data.

¹⁰² See section 1.3.1 for the latest Drug Harm Index results.

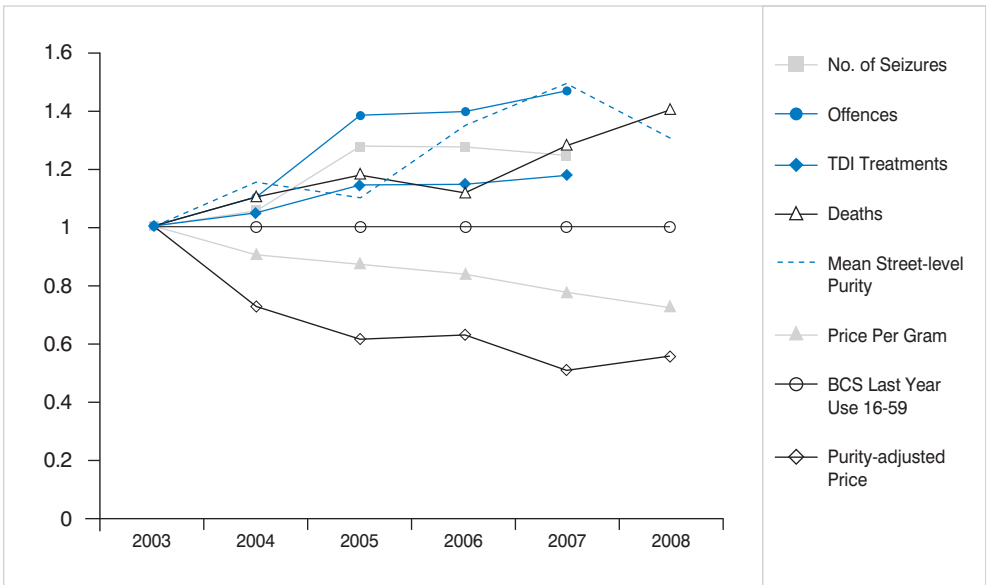
¹⁰³ The Offending, Crime and Justice Survey (OCJS) is a nationally representative, longitudinal, self-report survey which asks young people aged from 10 to 25 in England and Wales about their attitudes towards and experiences of offending. The survey was carried out in 2003, 2004, 2005 and 2006.

4.5 Relationship between indicators

The three-year sweep of PDU estimates in England suggests that problem drug use levels remained stable between 2004/05 and 2006/07 while the increase in estimated numbers between the 2003 and 2006 PDU estimates for Scotland may be the result of a change in methodology.

Figure 4.2 shows that, indexed to 2003¹⁰⁴ all other UK indicators for heroin apart from price increased. There is a strong positive correlation ($r = +0.998$) between offences and TDI treatments perhaps reflecting the growing role of the criminal justice system in referring offenders who are problem drug users into treatment. However, since 2005/06 the numbers presenting for primary opiate use has stabilised with a reduction in first time drug presentations.

Figure 4.2: Relationship between heroin indicators in the United Kingdom, 2003 to 2008: indexed to 2003



Source: Standard Tables 01; 06; 11; 13; 14; 16; and 34

It is suggested that the increase in drug-related deaths in the United Kingdom during 2008, particularly in Scotland, is a reflection of the ageing heroin using population and the growing number of older heroin users in treatment attests to this (see section 13.1.2). However, the increase in purity of heroin, decrease in price and levelling off in the number of seizures since 2005 (decrease in quantity of heroin seized) suggest better availability of heroin which could have an impact on the number of deaths. Indeed there is a strong negative correlation ($r = -0.917$) since 2003 between the price of heroin and deaths mentioning heroin/morphine.

During this time, there has been a large increase in cocaine powder presentations to treatment. There have also been increases in the number of hospital inpatient episodes¹⁰⁵ related to cocaine, the number of offences and in the number of deaths mentioning cocaine. The latest NTA Annual Report suggests that there is a "generational shift" in drug dependence¹⁰⁶. Data from the TDI show that clients presenting to treatment for cocaine powder use are younger than those presenting for heroin or crack cocaine use (see section 5.5.2).

¹⁰⁴ The first year of treatment data is 2003/04.

¹⁰⁵ See 2008 United Kingdom Focal Point report.

¹⁰⁶ See: http://www.nta.nhs.uk/media/media_releases/2009_media_releases/trends_in_drug_treatment_show_shift_away_from_trainspotting_generation_081009.aspx

5. Drug-related treatment: treatment demand and treatment availability

5.1 Introduction

United Kingdom drug strategies identify treatment as being effective in tackling problem drug use and therefore, seek to improve its quality and effectiveness. *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (DH and the devolved administrations 2007) and in England, *Models of care for treatment of adult drug misusers: update 2006* (NTA 2006) provide the basic framework for drug treatment, offering guidance on the structure and range of services to be commissioned in each area, as well as guidelines on clinical practice. The National Institute for Health and Clinical Excellence (NICE) also provides guidance in a number of areas. Treatment interventions in any given area are expected to include advice and information, care planning, psycho-social interventions, community prescribing, inpatient drug treatment and residential rehabilitation. In addition, drug misusers are to be offered relapse prevention and aftercare programmes; hepatitis B vaccinations; testing and counselling for hepatitis B and C and HIV; and needle exchange. Oral opiate substitution maintenance treatment with methadone is the most common pharmacological treatment used in treating heroin addiction; buprenorphine, injectable opiates such as injectable methadone and injectable diamorphine are also available.

Co-ordination and integration between a range of providers is seen as key in helping problem drug users reintegrate into society and all recent drug strategies in the United Kingdom focus on this area. While providing treatment remains a priority, housing, employment, education and training have also been identified as important, more particularly with new drug strategies having a much stronger focus on recovery and reintegration.

With access to effective treatment being a priority of the United Kingdom drug strategies, treatment capacity has increased substantially. This has been accompanied by significant financial investment. Some research initiatives are funded centrally to improve treatment engagement, and there are also a number of other initiatives to increase the capacity and improve effectiveness, for example nurse prescribing, guidance for pharmacists working with drug users, and continued encouragement to expand the role of general practitioners (GPs) in the treatment and care of drug misusers. Increased attention is being given to measuring the health and social outcomes associated with treatments.

Treatment demand indicator (TDI) data are from four separate systems: the National Drug Treatment Monitoring System (NDTMS) in England, the Scottish Drug Misuse Database, the Welsh National Database for Substance Misuse; and the Northern Ireland Drug Misuse Database. Data are combined for the United Kingdom. Continuous national data are only available from 2003/04. From 2003/04 to 2005/06, presentations to treatment increased substantially levelling off in 2006/07 before rising by three per cent in 2007/08. While the number of opiate presentations continues to increase, they account for a smaller proportion of all presentations than previously with cocaine powder and cannabis presentations rising.

5.2 Strategy and policy

England

NTA business plan 2009-10

The NTA business plan for 2009/10 (NTA 2009a) has been developed to continue delivery of effective and quality treatment commissioned locally and based on assessment of need and demand. There has been a marked change in focus from numbers in treatment to quality and 'effective' treatment in the UK Drug Strategy 2008 and this is reflected in the current NTA business plan. Specifically the business plan cites the NTA's priorities for the coming year as:

- shifting the focus of treatment to helping users achieve and maintain treatment outcomes and reintegrate into society;
- enhancing the NTA's ability to predict, monitor and disseminate positive treatment outcomes;
- strongly promoting the integration of drug treatment and other mainstream services (housing, employment, benefits) to provide a fuller support package;
- improving training and skills of drug treatment professionals to provide evidence-based, recovery-focused treatment programmes;
- ensuring treatment services are providing appropriate support and assistance to children of drug using parents; and
- positively promoting drug treatment in public.

New approaches to drug treatment and social reintegration: Drug System Change Pilots

One of the aims of the Drug Strategy, *Drugs: protecting families and communities* (HM Government 2008a) is to deliver new approaches to drug treatment and social reintegration in England. To achieve this aim, one of the key actions in the strategy is to develop pilot schemes to test new approaches that can provide better end-to-end management of drug users' needs through the treatment system, including more effective use of pooled funding and individual budgets, with a sharper focus on achieving positive outcomes for drug users, their families and their communities. These are referred to as Drug System Change Pilots; invitations to tender were issued in late 2008. The key principle underpinning them is that all partners should combine and integrate their efforts to maximise outcomes for drug users. Seven partnerships across England were awarded Drug Systems Change Pilot status¹⁰⁷, which commenced in April 2009 for two years¹⁰⁸. An independent evaluation process for the series of pilots as a whole is currently in the process of being developed¹⁰⁹.

Funding for residential services

The Department of Health has released the results of a national bidding process to allocate €68.4 million (£54.3m) aimed at developing the capacity and quality of the Tier 4 sector, as part of the Treatment Effectiveness Strategy¹¹⁰.

¹⁰⁷ The seven pilot sites are: Bradford (Yorkshire & Humber), Essex (East of England), Hampshire & Southampton (South East), Hertfordshire (East of England), Lambeth (London), Leicester (East Midlands) and Sefton (North West).

¹⁰⁸ See: http://www.nta.nhs.uk/about/board/board_meetings_and_papers/bd_2_2009/docs/BD2_2009_87_System_Change_Pilots.pdf

¹⁰⁹ See: http://www.nta.nhs.uk/news_events/newsarticle.aspx?NewsarticleID=150

¹¹⁰ See: http://www.nta.nhs.uk/news_events/newsarticle.aspx?NewsarticleID=113

Scotland

Waiting time targets in Scotland

In Scotland, targets are to be set for drug treatment waiting times for the first time. These are part of the latest NHS Scotland performance management (HEAT) targets (see section 1.3.1). At present waiting times in Scotland can be more than a year, although 90% of those offered an appointment for treatment are offered one within 14 days of the date on which their care plan was agreed¹¹¹.

5.3 Treatment systems

5.3.1 National Treatment Agency (NTA) guidance

Clinical governance in drug treatment

The NTA published a good practice guide on clinical governance aimed at providers and commissioners and users of drug treatment services (NTA 2009b). The purpose of the guidance was to provide the necessary information to improve clinical governance in drug treatment services across England. Specifically the guide provides information on the remit of clinical governance, components of clinical governance, individual roles, responsibilities and assurance procedures, the role of service users and carers, and implementation techniques.

Guidance on auditing drug misuse treatment

The NTA has published guidance to help drug partnerships and treatment providers who wish to audit their drug misuse treatment (NTA 2008a). It contains advice designed to support the use of audit in effective implementation of clinical guidance, focusing on suitable audit topics rather than how to conduct an audit. It is noted that the National Institute for Health and Clinical Excellence (NICE) publishes detailed audit criteria for its technology appraisals and clinical guidelines¹¹².

Tier 4 interventions practice guide

The NTA has published guidance on Tier 4 (inpatient) treatment services, aimed at treatment service managers, joint commissioners, providers and users of drug treatment services (Bradbury et al. 2008). Also published is a summary of good practice for residential drug treatment services (NTA 2009c). This highlights good practice in the commissioning of residential treatment services and best practice in delivering treatment in this environment. Good practice in commissioning recommends partnership working and clear strategies for treatment exit. Best practice in delivering treatment recommends established exit strategies, aftercare policies and staff management plans.

Towards successful treatment completion

The NTA produced a guide on good practice for successful treatment completion directed at providers, commissioners and service users (NTA 2009d). The guide aims to improve successful treatment exits and reduce the number of unplanned discharges from drug treatment. Guidance is provided on how to enhance retention of clients between initial assessment and first appointment, ensuring continued benefit for clients in treatment, appropriate treatment withdrawal and methods of combining planned treatment with social reintegration.

¹¹¹ See: <http://www.isdscotland.org/isd/5913.html>

¹¹² See: <http://www.nice.org.uk/>

Routes to Recovery

A series of documents and a summary publication have been published by the NTA (NTA 2009e) under the umbrella term of **Routes to Recovery**. This series is aimed at assisting clinicians and keyworkers in providing an effective service to support clients on their treatment journey to recovery. The series of documents include manuals and toolkits related to the ITEP (the International Treatment Effectiveness Project) and BTEI (the Birmingham Treatment Effectiveness Initiative)¹¹³ which both aim to improve treatment effectiveness, along with documents highlighting changes to the Treatment Outcomes Profile (TOP) and a number of good practice guides.

Psychosocial interventions in drug misuse: a framework and toolkit for implementing NICE-recommended treatment

A further toolkit from the NTA provides a practical framework for equipping drugs workers with the core skills to support users through treatment and towards recovery (NTA 2009f).

Guidance for the pharmacological management of substance misuse amongst young people

Guidance published in October 2009 sets out the responsibilities of medical and non-medical practitioners in the prescribing of medication to young people for substance misuse (DH 2009a). It describes pharmacological approaches to managing drug dependence in young people and sets out opioid prescribing protocols. Prescribing protocols for other non-opioid drugs and alcohol are also covered as well as a section on the management of co-morbid disorders. Further guidance on the pharmacological management of substance misuse amongst young people in secure environments was also published (DH 2009b).

Guidance on supporting users and carers

The NTA has published guidance for commissioners and service providers on supporting and involving carers (NTA 2008b).

Monitoring: Clarifying discharge codes for drug treatment services

In April 2009 a new business definition for the discharge code of 'drug free' was adopted after concerns about different interpretations of discharge codes used in the National Drug Treatment Monitoring System (NDTMS) in England. A more prescriptive definition of the 'drug free' discharge code was adopted for use when 'the client no longer requires structured drug treatment interventions and is judged by the clinician not to be using heroin (or any other opioids) or crack cocaine or any other illicit drug'¹¹⁴.

5.3.2 Treatment Reviews

Prioritising Investments in Public Health

In the Department of Health's *Prioritising investments in public health* report (Matrix Knowledge Group and Bazain 2008) (see section 3.2.1) it was found that opiate substitution programmes were effective at minimising drug-related harms. An example of a life skills programme which resulted in public expenditure savings higher than the programme cost through reductions in cocaine use was presented. The report was unable to provide any conclusive evidence regarding the cost-effectiveness of other treatment initiatives due to a lack of data.

¹¹³ See: http://www.nta.nhs.uk/areas/workforce/routes_to_recovery.aspx

¹¹⁴ See: http://www.nta.nhs.uk/areas/NDTMS/docs/core%20data%20set/adult_drug_treatment_business_definition_v6%201%201_030409.pdf

Drug and alcohol services in Scotland

Audit Scotland (2009) carried out a review of drug and alcohol services in Scotland (see section 1.4 for information related to expenditure on services). They found that there is variation across Scotland in the range and accessibility of drug and alcohol services. They recommend that the Scottish Government set clear national minimum standards for services including their range, quality and accessibility, and clarify accountability and governance arrangements for the delivery of these services. Further recommendations for public sector bodies include ensuring that all drug and alcohol services are based on an assessment of local need and are regularly evaluated; ensuring that service specifications setting out requirements relating to service activity and quality are in place; and setting clear criteria of effectiveness and expected outcomes for services and carrying out regular audits to ensure services adhere to expected standards.

Review of substitute prescribing services in Wales

The Healthcare Inspectorate Wales (HIW) conducted a review of substitute prescribing services in Wales (HIW 2009). The report was more critical of commissioning practices and procedures, and integration of services, than the actual delivery of individual services. There were concerns about throughcare and the use of integrated pathways for continuous care for individuals across services (for both adults and young people), and that delivery of services was a 'postcode lottery'. The report highlighted a lack of specialised inpatient services, with current provision mostly available within psychiatric care, and to varying degrees within primary care. Whilst the report recognised that there were many quality services, others were poorly managed, organised and located within sub-standard facilities or inappropriate locations. The report concluded that implementation of, and adherence to, the Welsh Substance Misuse Strategy varies across the country, particularly in relation to informed and organised commissioning and delivery of services. The report stated that there was evidence of excellent service provision, but, this was often as a result of the effort of individuals rather than quality local planning strategies, commissioning procedures and partnership working. The report includes 34 recommendations which address the issues highlighted by the report.

5.3.3 Treatment Outcomes

Effectiveness of community treatments for heroin and crack cocaine addiction in England

Marsden et al. (2009) used outcomes data from the NDTMS in England to assess the effectiveness of community treatments for heroin and crack cocaine addiction. They used change in the number of days of use of heroin, crack cocaine, or both between treatment start and review, to assess treatment effectiveness.¹¹⁵ At the study endpoint, 34% of clients were abstinent from both heroin and crack cocaine with 42% of heroin only users and 57% of crack cocaine only users abstinent. For clients using heroin, there was a significant reduction in days of heroin use from admission to review equivalent to 14.5 days. However, reduction in days of heroin use was smaller for clients using both heroin and crack cocaine at admission than for heroin only clients, with differences significant amongst the overall sample and those receiving pharmacological treatment but not for those receiving psychosocial treatment. For those using crack cocaine, the reduction in days of use was significant regardless of treatment type with an overall reduction of 7.7 days. The authors conclude that both treatment types are associated with a reduction in heroin and crack cocaine use, but the effectiveness of pharmacological treatment for clients using both heroin and crack cocaine is less pronounced than for users of heroin or crack cocaine only.

¹¹⁵ Data for 14,656 clients who started new treatment in England during Jan 1 – Nov 30 2008 were analysed, 74% of the cohort eligible for analysis at review with available data. All clients spent at least six months in treatment or were discharged before the study endpoint (May 31 2009). Clients were grouped according to type of treatment, pharmacological or psychosocial. Data were collected using the Treatment Outcomes Profile (TOP) See: (http://www.nta.nhs.uk/areas/outcomes_monitoring/default.aspx)

Key findings from the Scottish Drug Outcome Research cohort study

A summary of the main findings from Drug Outcome Research in Scotland (DORIS)¹¹⁶ (which took place between 2001 and 2004) was published in 2008 (McKeganey et al. 2008). The research conclusions with respect to treatment goals and treatment effectiveness were that:

- during the eight months post treatment initiation a decline in frequency and amount of drug use and dependence severity was found. Analysis of data at 16 and 33 months follow-up indicated that the majority of changes in drug using behaviour and dependence occurred during the initial eight months after treatment start. However, reductions in heroin use continued to be recorded after eight months;
- those who engaged in residential rehabilitation were twice as likely to be abstinent at 33 months post treatment initiation as those who engaged in other treatment initiatives (excluding prison based treatment);
- abstinence rates were associated with good mental health status at the beginning of treatment; and
- there were no differences in rates of abstinence between those on methadone maintenance and those in other types of treatment (apart from cannabis abstinence). However, the methadone users reported use of heroin less frequently.

The authors concluded that policy should take account of the requirement for a combined treatment approach for drug users and the effectiveness of different treatment approaches. Specifically methadone maintenance should be used to reduce the frequency of heroin use and to promote harm reduction, and residential rehabilitation to help achieve and maintain abstinence.

Severity of drug dependence and changes over time

Bloor et al. (2008a) investigated drug dependence as a predictor of drug consumption and non-drug related outcomes including involvement in crime and homelessness. Data from the DORIS study were analysed¹¹⁷. Drug dependence levels, as measured by the five-item Severity of Dependence Scale (SDS), fell significantly between the first two sweeps of DORIS which followed the cohort over 16 months. This decrease in dependence did not predict drug related and non-drug related outcomes including drug consumption and criminality. However, SDS scores at 16 months did predict the level of acquisitive crimes committed in the previous three months. The authors concluded that severity of dependence is not a suitable factor for predicting future drug use.

¹¹⁶ A cohort of over 1,000 drug users beginning a new episode of drug treatment in 2000 have been recruited onto the study from services located in rural, urban and inner city areas of Scotland and provided by specialist drug agencies, the Scottish Prison Service and the primary care sector. The 1,007 original DORIS participants (DORIS1) were re-interviewed eight months on (DORIS2), 16 months on (DORIS3) and 33 months on (DORIS4).

¹¹⁷ Data from interviews with 1,033 clients at 16 months on from sample recruitment were analysed using forward stepwise logistic regression models. See previous footnote.

5.3.4 User involvement

Service user involvement conferences

'Voices for Choices', the second national service user involvement conference, organised by the NTA in England, was held in January 2009, bringing together policymakers, Drug and Alcohol Team coordinators, treatment providers and drug and alcohol service users¹¹⁸.

The Welsh Assembly Government in association with the Wales Council for Voluntary Action held its first national service user conference in May 2009. The conference aimed to secure improved communication between service users, treatment providers, commissioners and the Welsh Assembly Government. Key outcomes of the conference were:

- the establishment of four regional service user groups;
- a national service user network; and
- agreement to hold an annual service user led conference.

User involvement in efforts to improve the quality of drug misuse services in England

A national survey of a representative sample of Drug Action Teams (DATs) in England (Patterson et al. 2009)¹¹⁹ found that the majority of DATs involved service users in service development or commissioning (84.7%), however, a lower proportion reported service user involvement directly with service commissioning processes (47.8%). Thirty-eight per cent of DATs reported that service user groups were in operation in their area and these had mostly been set up with the support and assistance of the DAT. Participants reported a change in the organisation and delivery of drug treatment services as a result of service user involvement, however, there was little data recorded on outcomes of this involvement, such as changes in retention or engagement. It was recognised that the success of service user involvement could be affected by the culture, organisational processes or individuals within the DAT. The authors concluded that service user involvement is welcomed by most DATs and has a role in service delivery. Methods to improve the impact of service user involvement included direct payment to service users, feedback dissemination and improved monitoring of outcomes.

Attitudes and knowledge of opiate-substitution therapy

Pinto et al. (2008) conducted research amongst service users into attitudes to, and knowledge, of two different opiate-substitution therapies¹²⁰, methadone-maintenance therapy (MMT) and buprenorphine-maintenance therapy (BMT). Participants presenting for treatment were presented with the choice of MMT or BMT. Twenty-two participants chose MMT and twenty chose BMT. Participants reported that their choice was based on previous experience or that of others. Those that chose MMT stated that their choice related to familiarity with the treatment, whereas those who chose BMT reported negative opinions of MMT and a belief that BMT would provide a more comfortable detoxification with less severe withdrawal and cravings. The authors concluded that previous experience or that of others is considered a more valuable source of information regarding these treatments than that provided by drug treatment agencies.

¹¹⁸ See: http://www.nta.nhs.uk/news_events/newsarticle.aspx?NewsarticleID=123

¹¹⁹ Fifty of the 149 DATs in England were selected to participate in the research. A cross-section survey was conducted with commissioners, providers and service user group members.

¹²⁰ Forty-two opiate dependent participants who were seeking drug treatment were recruited at the Bure Centre, Norwich.

What is most and least useful in residential rehabilitation?

The most and least useful aspects of residential rehabilitation were researched by Wilkinson et al. (2008)¹²¹. Participants had positive opinions and experiences of residential rehabilitation, and specific useful aspects cited included experienced and considered care from staff, feeling secure and in an environment with people with common difficulties, and receiving assistance to make change. The experiences that participants were most critical of related to their experiences before and after entering residential rehabilitation, specifically regarding preparation and aftercare. The authors concluded that residential rehabilitation services should provide holistic pre- and post-care packages, with aftercare focused on skills and social needs (employment, education, housing etc) in conjunction with other relevant agencies. Additionally, some participants indicated that they felt uncomfortable in therapy with people with different substance use issues (e.g. alcohol related). The authors suggest that therapeutic communities tailored to specific substance use issues may be beneficial.

5.3.5 Research and commentary on the drug treatment system

Counsellor attributes and client engagement

Simpson et al. (2009)¹²² conducted a study investigating the relationship between treatment engagement and client functioning, with a specific focus on how these factors related to the organisational environment of various treatment initiatives and the impact of staff at the services. The authors found that a client's psychosocial functioning and the attitude of staff were associated with treatment engagement. Clients with higher levels of self-efficacy, self-esteem and readiness for change along with low levels of anxiety, hostility and risk taking were more likely to fully engage with treatment initiatives indicating that these factors should be considered in the early stages of treatment programmes.

Maslow's Hierarchy of Needs and care planning in addiction services

An editorial by Best et al. (2008) discussed the relationship between care planning in drug treatment services and the Hierarchy of Needs as proposed by Maslow (1943)¹²³. Maslow's pyramid hierarchy theory is based on the requirement for satisfaction of an individual's needs at the bottom of the pyramid (i.e. physiological needs) prior to transition to the next pyramid section (i.e. safety needs). This continues until self-actualization at the top of the pyramid is reached. Best et al (2008) state that, in terms of drug treatment, the focus should be on the bottom of the pyramid, specifically that the initial physiological needs of a drug user may conceal other issues, and that, like the pyramid, 'lower-order' interventions should come prior to 'higher-order' interventions as 'higher-order needs' will not become apparent until 'lower-order needs' are responded to. Policy implications include reconsideration of initial comprehensive assessment in drug treatment, as it is designed to assess both higher and lower-order needs at this early stage of treatment. Additionally, a 'trans-disciplinary' approach including mental health professionals, GPs and housing advisors, is required to respond to the variety of needs of the drug user. Constant review of care planning is suggested as a more appropriate method of assessment as it will be sensitive enough to respond to changes in needs and desires during a treatment journey.

¹²¹ Qualitative interviews with individuals with experience of residential rehabilitation and relevant staff was undertaken in Wiltshire and Swindon, United Kingdom.

¹²² The study involved a diverse sample of drug treatment and outreach programmes in England where self-rating assessments were obtained from 1,539 clients and 439 counsellors representing 44 programmes. Results were interpreted using comparable data from studies of treatment programmes in the United States.

¹²³ Maslow, A. (1943). A theory of human motivation. *Psychological Review* 50 370-396.

General practitioners' management of psychostimulant drug misuse

In a study designed to establish baseline data regarding the attitudes of GPs to patients who use psychostimulant drugs¹²⁴ and their management of this issue, Alkhamis et al. (2009) surveyed GPs in north east Scotland¹²⁵. Analysis showed that the majority of GPs were unsurprised by the increase in use of these drugs in the area (86.1%) and felt that it was a clinical issue of importance (73%). However, there was a lack of certainty amongst GPs about their ability to recognise psychostimulant drug misuse (PSDM), with only 21% reporting feeling confident. Almost two-thirds of GPs (62%) were aware of patients within their practice misusing these drugs, although only 45% had at some point been involved in the care of a patient with PSDM issues. The opinion of the majority of GPs surveyed was that PSDM treatment was more suitable to specialist substance misuse services. The study highlighted the need for further education and training of GPs, guidance and a change in attitude in the area of PSDM to enhance recognition of the problem and encourage GP engagement in treatment.

The number, deployment, activities and attitudes of specialist consultant addiction psychiatrists in England

Durand et al. (2009) reported on a study undertaken in 2005 to identify the number of consultant addiction psychiatrists in the United Kingdom and investigate the deployment, tasks and views of this group¹²⁶. The research concluded that currently the role of consultant addiction psychiatrists is under-resourced, with approximately one-quarter of the recommended number in post¹²⁷. The authors concluded that whilst consultant addiction psychiatrists are fulfilling their clinical role, lack of resources negatively impacts upon teaching and training of recruits, research and service development.

Changing clinical practice in the United Kingdom – commentary

A commentary by Crome (2009) summarises clinical practice in addiction. The author discussed the need for further developments in education, training and research in order to attract medical students into the addictions medicine field. Whilst significant developments in recent years which have increased the number of consultant psychiatrists in this speciality are acknowledged, it is also argued that further developments are required including the development of specialist qualifications and further investment in addiction research funding. It is suggested that medical students who decide to pursue this speciality take 'a leap of faith' but the discussed developments and creation of a national research institute would enhance clinical research and attract more psychiatrists into this area.

Drug treatment at the crossroads. What it's for, where it's at and how to make it even better

DrugScope¹²⁸ reported on the outcomes of a number of events organised across the United Kingdom (in Edinburgh, Manchester and London) gathering together DrugScope members, other experts and stakeholders¹²⁹, representing a range of different views and treatment philosophies (Roberts 2009a). The objectives were to debate the results of and prospects for drug treatment, and to inform and shape the wider public and political debate, in response to criticism in the media, and amongst some politicians that drug treatment was failing. It is reported that there was a surprising degree of consensus, not least the

¹²⁴ Psychostimulants were defined as cocaine, crack cocaine, ecstasy, amphetamines and hallucinogens.

¹²⁵ After initial content setting meetings and a pilot survey, a structured cross-sectional postal survey was distributed to a sample of 250 GPs in north east Scotland. After two reminders a response rate was achieved of 52%.

¹²⁶ The research used a three-stage mixed methods design which included a mapping exercise, in-depth interviews and focus groups and a postal survey of consultant addiction psychiatrists (March 2005). A response rate of 67% was achieved for the postal survey.

¹²⁷ As recommended by the Royal College of Psychiatrists.

¹²⁸ DrugScope is an independent charity aiming providing expertise on drugs and is a national membership organisation for people working in the drug field. It aims to inform policy development and reduce drug-related harms to individuals, families and communities, providing information, promoting effective responses to drug taking, undertake research, advising on policy-making, and encouraging informed debate. See: <http://www.drugscope.org.uk/>

¹²⁹ Participants included service users, carers, drug treatment providers, managers, commissioners, GPs and other health service professionals, providers of related services, academics, policy makers and others. Many were members of DrugScope.

agreement that drug treatment deserves support and investment and is a sensible use of government money, so long as it benefits individuals, families and communities. There is strong support for the increased emphasis on 'recovery' and 'social (re)integration' noting that the emergence of recovery as a key concept for the drug sector provides an opportunity to address issues like housing and access to employment.

As a result of the debate, DrugScope made recommendations with regard to respecting evidence and expertise in the drugs debate, the rights of services users and how drug treatment and other support agencies should work in partnership to provide the best possible service for drug users. Specifically, DrugScope argued for: a Government funded communications strategy; services addressing diversity and the rights of their service users; facilitating involvement of users in treatment planning decisions; additional research into substitute prescribing and drug-related deaths; and partnerships across a range of support services with support available for families and carers.

Public attitudes to addiction and drug treatment

A DrugScope commissioned survey¹³⁰ found that 19% of those surveyed had a personal experience with drug addiction (either directly or indirectly amongst their family or friends), with 11% of respondents indicating that their experience was of a friend's drug addiction (Roberts 2009b). The majority of respondents felt that the aim of drug treatment should be to support the individual to overcome addiction (70%), with 44% stating that reduction in crime is important. Respondents also indicated a positive response to the use of government funds for drug treatment with large proportions agreeing that it was a sensible use of funds and a good investment.

The story of drug treatment

The NTA has produced *The Story Of Drug Treatment* which looks at developments the treatment system and the evidence base (NTA 2009g).

5.4. Availability and diversification of treatment

5.4.1 Inpatient and residential treatment

Review of diversity and the provision of inpatient and residential rehabilitation services

A review of the provision and commissioning of inpatient and residential rehabilitation services for drug users by local partnerships and how they meet the needs of a diverse range of clients (Commission for Health Audit and Inspection 2009) found that, overall, the majority were performing well (72%) with a further 15% seen as excellent and 13% as fair; none were seen as weak. However, the majority underperformed in some key areas.

While most needs assessments focused on diversity, it was not necessarily carried through adequately into strategic planning. Also, while there was evidence of good practice in commissioning inpatient and residential services, in a number of partnerships the commissioning of residential rehabilitation was not adequately integrated into other treatment commissioning mechanisms and there was a lack of integration of inpatient and residential services with community based services. Furthermore, policies on unplanned discharge of some inpatient and residential services were deficient in some areas. It was also noted that there was under-reporting to NDTMS by services, with 28% of inpatient and 41% of residential rehabilitation services either not reporting or reporting incomplete data.

Following the review, NTA is working with the weakest 10 to 15% of partnerships to develop plans to improve their performance.

¹³⁰ Questions relating to public opinion of addiction and drug treatment were included in an ICM Online Omnibus Poll (including non-drug related topics). A total of 1,039 responses were received from those aged over 18.

Tier 4 services in Wales

Following the review of Tier 4 services in Wales, the Welsh Assembly Government has issued guidance to improve and strengthen care pathways into and out of Tier 4 services. Additional funding of €1.26 million (£1m) of recurring funding has been made available since 2008/09 and a further €451,640 (£400,000) in 2009/10 to increase provision.

5.4.2 Alternative types of treatment

Randomised Injectable Opioid Treatment Trial (RIOTT): Evaluation of injectable methadone and heroin treatment in the UK

A multi-centre randomised controlled trial examining the effectiveness and cost-effectiveness of clinic-supervised treatment with injected opioids (methadone and heroin), for patients who are dependent on heroin but do not respond to conventional methadone substitution treatment¹³¹ is in its final stages. The study examines whether efforts should be made to optimise conventional treatment for such patients (e.g. regular attendance, supervised dosing, high oral methadone doses, access to psychosocial services) or whether such patients should be treated with injected methadone or heroin. Initial headline results released in September 2009¹³² indicate that the scheme reduced crime rates and prison sentences amongst the participants, and those prescribed heroin had better outcomes compared to those prescribed methadone.

The 1-2-1 Detox pilot

An independent evaluation of a pilot using a novel approach to opiate detoxification (Shaw, 2009) found that 65% successfully completed their detoxification¹³³, considerably higher than typical rates cited from community detoxification and equal to typical rates cited from inpatient detoxification. The pilot took place in a specialist aftercare service in Sefton, Merseyside which provided a safe, homely environment for detoxification, based on a model of community detoxification, and support was provided on a one-to-one basis. The ethos of the detoxification was to remove peer pressure and the influence of others also undertaking detoxification by ensuring each client had no contact with any other service users and high level of contact with professionals. The evaluation also found significant improvements in participants' drug consumption, and scores related to craving, withdrawal, anxiety, arousal and depression. The report concluded that the service should continue to operate beyond the pilot stage and also be trialled in other areas to assess effectiveness.

Commentary on pharmacological treatment for stimulant dependence

In a commentary in the journal *Addiction*, Marsden (2009) (who currently holds a research grant from the Medical Research Council to evaluate the feasibility of a multicentre controlled trial of modafinil for cocaine dependence), considers the trial of modafinil in Australia (Shearer et al. 2009). He suggests that, in part, this trial can be seen as a means of improving neurocognitive dysfunction and acceptance of clinical recovery programmes, considered to be important in the early stages of recovery. It is noted that modafinil has been shown to have the potential as an effective pharmacotherapy for dependence on cocaine or synthetic stimulants. Marsden praised the trials of modafinil in combination with psychosocial programmes, highlighting that this combined approach is advantageous in drug treatment.

¹³¹ The study is taking place in London (two sites), Brighton and Darlington. New supervised injecting clinics have been set up at each site. See: <http://www.iop.kcl.ac.uk/projects/?id=10114>

¹³² See: http://www.actiononaddiction.org.uk/news_and_campaigns/news/160_untreatable-or-just-hard-to-treat

¹³³ Seventeen clients completed 20 episodes of treatment between March 2008 and January 2009.

5.4.3 Treatment of specific groups

Specialist drug treatment services for young people: an evidence review

Briton (2009) produced an evidence review of the effectiveness of specialist young people's treatment services¹³⁴, targeted at professionals who work in these services (focused on services for under 18s)¹³⁵. A range of treatment interventions was considered: pharmacological; psychosocial including cognitive behavioural therapy, brief interventions, motivational interviewing, and multi-systemic therapy; family based; specialist harm reduction; and residential treatment. All were able to demonstrate effectiveness in reducing substance misuse, as well as having other positive outcomes such as reduced problem behaviour, increased involvement in positive activities, increased confidence and self-esteem, improved academic attainment, reduced criminal activity, improved mental health, improved family relationships and improved attendance at school. No intervention showed significantly better outcomes than any other.

RCT: Motivational Interviewing and drug information advice with young cannabis users

McCambridge et al. (2008) conducted a randomised controlled trial (RCT) with a sample of students from Further Education colleges in inner London who were regular users of cannabis (weekly or more frequent) but who had not sought help. It investigated if motivational interviewing (MI)¹³⁶ techniques were effective in bringing about a reduction in cannabis use when compared to a control intervention involving the provision of standardised 'drug information and advice giving' (DIA) consisting of a managed discussion with the participant and a series of harm reduction leaflets. Successful outcome was classified as a reduction in the frequency of consumption. At both three and six month intervals the study found that outcomes were no different between MI and DIA. It is reported however, that the outcomes varied substantially for both interventions depending on which practitioner had delivered it and that overall fidelity to the MI was not generally high, suggesting that this has reduced its effectiveness in this study. It is recommended that advice as a brief intervention and MI are further investigated, with attention given to practitioner effects and fidelity to MI, as both interventions are potentially effective.

The efficacy of primary care interventions for family members affected by the addiction problem of a close relative

Copello et al. (2009) conducted a randomised controlled trial investigating the efficacy of an intervention, designed for delivery by primary care health professionals, for close relatives of individuals with an alcohol or drug problem¹³⁷. Participants received one of two levels of the intervention i.e. brief or full intervention. Findings indicated that there were no significant differences between the brief and full intervention on participant's scores for symptoms of stress and behavioural coping, but an increase in scores was observed after the intervention. As there was no evidence to suggest that the interventions had a positive impact upon stress and coping, the authors concluded that a user friendly self-help manual could be as useful as a personal intervention.

¹³⁴ Young people's treatment is defined as "care planned medical, psychosocial or specialist harm reduction interventions aimed at alleviating current harm caused by a young person's substance misuse."

¹³⁵ Based on literature reviews and primary research published in peer review journals, which focus on substance misuse among this age range. Two scales were used, which ranged in points from zero to five, with five being the highest score. Only those achieving grade three or above are included in this report.

¹³⁶ The Motivational Interviewing (MI) involved the discussion with the participant whereby the interviewer listened 'empathically' to the participant and encouraged them to reflect upon their drug use in terms of its cost and benefits; their personal values and goals; risks and problems.

¹³⁷ A prospective cluster randomised comparative trial of the two interventions in 136 primary care practices in two areas of England. A total of 143 family members affected by the alcohol or drug problem of a relative were recruited into the study by primary health-care professionals. All recruited family members were seen on at least one occasion by the professional delivering the intervention and 129 (90%) were followed-up at 12 weeks. The method was to use two validated and standardised self-completion questionnaires measuring physical and psychological symptoms of stress (Symptom Rating Test) and behavioural coping (Coping Questionnaire) experienced by the family members.

Bonell et al. (2008) discuss the need for drug and alcohol treatment services to pay closer attention to the needs of gay men. They argue that drug strategy and policy does not take into account gay men's needs, and that drug treatment services are opiate-focussed and not 'gay-friendly', despite systematic review evidence suggesting that treatment interventions can be effective for other types of drug users and adapted to appeal to gay men. The authors suggest that more specific addressing of gay men's drug use could potentially have additional benefits for the health and incidence of infectious disease amongst this group.

Drug treatment for gay men

The report *Wasted Opportunities* (Keogh et al. 2009; see section 2.5.3) found that gay men felt that current drug treatment provision was unsuitable for their needs, with many participants reporting attempts at abstinence without support. It was found that their drug use was often connected to the club scene and therefore traditional treatment services were inappropriate. Participants also raised concerns about how gay-friendly treatment services were.

Mental Health factors as a risk factor for dropout from drug treatment

A systematic review of mental health issues¹³⁸ as a risk factor for treatment disengagement was conducted by Meier and Barrowclough (2009). The review concluded that past mental health problems were not a significant risk factor for treatment disengagement, however, there was no agreement in the literature with regard to individuals with co-existing current mental health and substance use problems. The research also investigated if drop-out risk was related to different types of mental health problems. No conclusions with regard to this issue could be made due to a lack of robust research in this area. However, there was some evidence to suggest that anti-social personality disorder may be associated with a greater risk of treatment disengagement. The authors tentatively concluded that overall those with Axis I disorders¹³⁹ were no more likely to disengage from treatment than those without, but those with anti-social personality disorder were potentially more vulnerable to unplanned treatment disengagement.

5.5 Characteristics of clients entering treatment

The treatment demand indicator (TDI) records the number of clients entering treatment in a particular year but cannot provide information on clients who are already in treatment within that year.¹⁴⁰ Data presented are from the National Drug Treatment Monitoring System (NDTMS) in England, the Scottish Drug Misuse Database, the Northern Ireland Drug Misuse Database and the Welsh National Database for Substance Misuse. Continuous national data are only available from 2003/04.

¹³⁸ Peer reviewed research published after 1 January 1990 was identified using the Medline and PsycInfo. Further papers were identified from the bibliographies of relevant publications. Fifty-eight studies, 84% from the USA, met the inclusion criteria for the review.

¹³⁹ Axis I includes all the mental health conditions except personality disorders and mental retardation.

¹⁴⁰ Treatment Demand Indicator. See: <http://www.emcdda.europa.eu/themes/key-indicators/tdi>

5.5.1 Treatment centres

Reports to the TDI are based on structured treatment only¹⁴¹. The majority of clients receive treatment through out-patient services (94%) (Table 5.1) although no information about treatment through GPs is available for Wales and Northern Ireland. In 2007/08 the number of inpatient treatments increased by 17% although this is in part due to Wales reporting inpatient data for the first time (excluding Wales, the increase elsewhere in the UK was 11%).

Table 5.1: Presentations by centre type in the United Kingdom, 2003/04 to 2007/08

| CENTRE TYPE | 2003/04 | | 2004/05 | | 2005/06 | | 2006/07 | | 2007/08 | |
|--------------|---------------|------------|----------------|------------|----------------|------------|----------------|------------|----------------|------------|
| | n | % | n | % | n | % | n | % | n | % |
| Outpatient | 91,659 | 91.9 | 111,434 | 94.6 | 121,202 | 94.4 | 120,226 | 93.8 | 123,850 | 93.8 |
| GP | 3,966 | 4.0 | 3,402 | 2.9 | 3,833 | 3.0 | 4,303 | 3.4 | 3,833 | 2.9 |
| Inpatient | 4,038 | 4.0 | 2,945 | 2.5 | 3,411 | 2.7 | 3,679 | 2.9 | 4,320 | 3.3 |
| Total | 99,663 | 100 | 117,781 | 100 | 128,446 | 100 | 128,208 | 100 | 132,003 | 100 |

Source: Standard Table 34

Only Northern Ireland provides treatment data from prisons although there are plans to collect data from prisons in England that will be available for reporting in 2011. Data from prisons in Northern Ireland are not included in this section but can be found in section 9.7.3. In 2007/08, data was provided from 1,607 outpatient treatment centres (98% coverage), 117 inpatient centres (80% coverage) and 217 GP centres (coverage unknown).

5.5.2 Characteristics of treated clients (TDI)

In 2007/08 there were 132,003 presentations to treatment services in the United Kingdom recorded through the Treatment Demand Indicator (TDI), an increase of three per cent on the previous year (128,208). Forty-two per cent were first treatment presentations. However, in Northern Ireland, first treatments accounted for a much greater proportion (77%) while first treatments in Wales accounted for only 26% of known cases (Table 5.2).

Table 5.2: Number and percentage of first treatments and previous treatments by individual country, 2007/08

| | FIRST TREATMENT | | PREVIOUS TREATMENT | |
|------------------|-----------------|------|--------------------|------|
| | n | % | n | % |
| England | 38,937 | 42.4 | 52,955 | 57.6 |
| Scotland | 4,621 | 40.8 | 6,697 | 59.2 |
| Wales | 1,628 | 25.9 | 4,667 | 74.1 |
| Northern Ireland | 1,415 | 77.1 | 420 | 22.9 |
| United Kingdom | 46,601 | 41.9 | 64,739 | 58.1 |

Source: Standard Table 34

¹⁴¹ Structured treatment follows assessment and is delivered according to a care plan.

Source of referral

Twenty-four per cent of first treatment presentations in 2007/08 were referred from the criminal justice system, the same proportion as in 2006/07. Those who had been previously treated were more likely than first treatment clients to have been referred from the criminal justice system (34%) and were more likely to be self-referred (39% compared to 35% of first treatments). GPs accounted for 11% of treatment referrals.

Drugs used

Opiates remain the most common primary drug accounting for 62% of all treatment presentations. Inpatient presentations were more likely to be due to opiate use; 78% in 2007/08. Cannabis was the next most common primary drug amongst treatment presentations; it accounted for 16% of all presentations in 2007/08 (Table 5.3).

Table 5.3: Primary drug by centre type in the United Kingdom, 2007/08

| DRUG | OUTPATIENTS | | INPATIENTS | | GP | | TOTAL | |
|-----------------|----------------|------|--------------|------|--------------|------|----------------|------|
| | n | % | n | % | n | % | n | % |
| Amphetamines | 4,274 | 3.6 | 77 | 1.8 | 65 | 1.8 | 4,416 | 3.5 |
| Benzodiazepines | 2,427 | 2.0 | 51 | 1.2 | 34 | 0.9 | 2,512 | 2.0 |
| Cannabis | 20,698 | 17.3 | 126 | 3.0 | 114 | 3.1 | 20,938 | 16.4 |
| Cocaine powder | 10,003 | 8.4 | 150 | 3.6 | 62 | 1.7 | 10,215 | 8.0 |
| Crack cocaine | 6,884 | 5.8 | 504 | 11.9 | 65 | 1.8 | 7,453 | 5.9 |
| Opiates | 72,188 | 60.4 | 3,278 | 77.7 | 3,337 | 90.5 | 78,803 | 61.9 |
| Other | 2,966 | 2.5 | 33 | 0.8 | 12 | 0.3 | 3,011 | 2.4 |
| Sub Total | 119,440 | 100 | 4,219 | 100 | 3,689 | 100 | 127,348 | 100 |
| Not Known | 4,410 | | 101 | | 144 | | 4,655 | |
| Total | 123,850 | | 4,320 | | 3,833 | | 132,003 | |

Source: Standard Table 34

However, amongst first treatment presentations, opiates accounted for only 42% of presentations with cannabis accounting for over a quarter (27.2%) and cocaine powder for 13% (Table 5.4). The picture differs across the United Kingdom, however, with opiates the primary drug for only six per cent of first presentations in Northern Ireland and benzodiazepines (40.1%) and cannabis (37.6%) accounting for the majority. Outside of England, presentations for crack cocaine are low at under one per cent of first presentations compared to seven per cent in England.

Table 5.4: Number and percentage of first drug treatment demands by primary drug of use in the United Kingdom, 2007/08

| DRUG | ENGLAND | | NORTHERN IRELAND | | SCOTLAND | | WALES | | UK | |
|-----------------|---------|------|------------------|------|----------|------|-------|------|--------|------|
| | n | % | n | % | n | % | n | % | n | % |
| Amphetamines | 1,718 | 4.5 | 11 | 0.8 | 122 | 3.3 | 125 | 8.5 | 1,976 | 4.4 |
| Benzodiazepines | 523 | 1.4 | 567 | 40.1 | 162 | 4.4 | 33 | 2.2 | 1,285 | 2.9 |
| Cannabis | 10,618 | 27.6 | 459 | 32.4 | 798 | 21.5 | 376 | 25.6 | 12,251 | 27.2 |
| Cocaine powder | 5,350 | 13.9 | 130 | 9.2 | 394 | 10.6 | 106 | 7.2 | 5,980 | 13.3 |
| Crack cocaine | 2,781 | 7.2 | 0 | 0.0 | 28 | 0.8 | 13 | 0.9 | 2,822 | 6.3 |
| Opiates | 16,247 | 42.3 | 82 | 5.8 | 2,046 | 55.1 | 751 | 51.2 | 19,126 | 42.5 |
| Other | 1,180 | 3.1 | 166 | 11.7 | 163 | 4.4 | 64 | 4.4 | 1,573 | 3.5 |
| Sub Total | 38,417 | 100 | 1,415 | 100 | 3,713 | 100 | 1,468 | 100 | 45,013 | 100 |
| Not Known | 520 | | 0 | | 908 | | 160 | | 1,588 | |
| Total | 38,937 | | 1,415 | | 4,621 | | 1,628 | | 46,601 | |

Source: Standard Table 34

Age

Forty per cent of those presenting for treatment in 2007/08 were aged between 25 to 34, and 28% were under the age of 25. These proportions are similar to previous years although the proportion aged over 34 years old increased from 29% in 2005/06 to 32% in 2007/08. Amongst first treatments, 40% were under the age of 25 (Table 5.5).

Table 5.5: Age of drug users identified through TDI in the United Kingdom, 2007/08

| | <25 | | 25 TO 34 | | 34> | | MISSING | ALL |
|------------------|--------|----|----------|----|--------|----|---------|---------|
| | n | % | n | % | n | % | n | n |
| All treatments | 36,934 | 28 | 53,136 | 40 | 41,922 | 32 | 11 | 132,003 |
| First treatments | 18,428 | 40 | 15,651 | 34 | 12,512 | 27 | 10 | 46,601 |

Source: Standard Table 34

Cocaine powder presentations had a lower age profile, with 37.8% aged 15 to 24 and over three-quarters (76.8%) aged 15 to 34. People presenting for treatment for primary cannabis use were younger still; 57.2% were aged 15 to 24 with a further 11.9% under the age of 15. Table 5.6 shows that the age profile of primary cannabis presentations continues to get lower.

Table 5.6: Age of individuals reporting cannabis as primary drug in the United Kingdom, 2003/04 to 2007/08 as a percentage of all presentations

| YEAR | AGE | | | | | | |
|---------|------|----------|------|----------|----------|----------|----------|
| | <15 | 15 to 19 | <20 | 15 to 24 | 25 to 29 | 30 to 34 | 15 to 34 |
| 2003/04 | 11.1 | 32.9 | 44.0 | 50.5 | 12.9 | 10.5 | 73.9 |
| 2004/05 | 11.5 | 36.9 | 48.4 | 52.7 | 11.3 | 9.8 | 73.7 |
| 2005/06 | 11.3 | 40.2 | 51.5 | 55.1 | 11.0 | 8.9 | 75.0 |
| 2006/07 | 11.0 | 42.4 | 53.4 | 56.3 | 10.1 | 8.1 | 74.5 |
| 2007/08 | 11.9 | 43.5 | 55.4 | 57.2 | 9.9 | 7.6 | 74.7 |

Source: Standard Table 34

There is a large difference in the age profiles of users of different stimulants with around two-thirds (65.1%) of primary MDMA/ecstasy clients aged 15 to 24 compared to only a quarter (24.2%) of primary amphetamines clients. Over half (54.2%) of primary MDMA/ecstasy users were under 20 years of age with five per cent over the age of 40 compared to 20% of amphetamines users aged 40 or older.

Presentations for primary crack cocaine had a similar age profile to amphetamines presentations with 23.2% over the age of 40 and 58.8% aged 15 to 34. There was a gender difference in age between primary crack cocaine users with 20.4% of females aged 15 to 24 compared to 16.7% of males. A quarter (24.9%) of male primary crack cocaine users were aged over 40 compared to 19.0% of females. The ageing profile of heroin users entering treatment is discussed in section 13.1.2.

Gender

73% of presentations were male. Proportions were the same amongst first treatments and in the previous year.

Injecting status

Just under half of those presenting for treatment were current (last four weeks) or former injecting drug users with 22% reporting current injecting (Table 5.7). Females were slightly more likely than males to have never injected, 54% compared to 51%.

Table 5.7: Injecting status amongst all clients entering treatment in the United Kingdom, 2007/08 by gender

| INJECTING STATUS | MALE | | FEMALE | | TOTAL | |
|-------------------------------------|---------------|-------------|---------------|-------------|----------------|------------|
| | n | % | n | % | n | % |
| Ever injected, but not currently | 21,721 | 26.8 | 8,175 | 27.2 | 29,896 | 26.9 |
| Currently injecting (in last month) | 18,202 | 22.4 | 5,753 | 19.1 | 23,955 | 21.5 |
| Never injected | 41,229 | 50.8 | 16,117 | 53.6 | 57,346 | 51.6 |
| Sub Total | 81,152 | 100 | 30,045 | 100 | 111,197 | 100 |
| Not known/missing | 14,917 | | 5,889 | | 20,816 | |
| Total | 96,069 | 72.8 | 35,934 | 27.2 | 132,003 | 100 |

Source: Standard Table 34

Over a third of primary opiate presentations (34.7%) reported injecting as their main route of administration, although this falls to 29.4% of all first treatments. The proportion is higher in Northern Ireland (41.2%) and Scotland (39.1%) than in England (35.4%).

Almost a quarter (23.2%) of primary amphetamines presentations reported injecting as main route of administration with men (28.7%) more likely to do so than women (11.6%).

Labour status

TDI data on labour status is only available from Scotland and Northern Ireland. Data from prisons in Northern Ireland have been excluded. Of those with known labour status entering treatment in Scotland during 2007/08, 71% were unemployed and a further nine per cent were economically inactive. Only 15% were in regular employment. Those entering outpatient treatment were less likely to be unemployed (70%) than those entering GP (88%) or inpatient (78%) treatment. In Northern Ireland, 44% were unemployed and a further 25% were economically inactive, 17% were in regular employment.

Living status

In Scotland during 2007/08, 83% of clients entering treatment were in stable accommodation and 16% were in unstable accommodation. Just over a quarter (27%) lived alone, a similar proportion (26%) lived with parents and 18% lived with just a partner. Three per cent lived alone with a child and a further 10% lived with a partner and child.

5.5.3 TDI trends

Presentations for treatment increased substantially between 2003/04 and 2005/06 from 99,663 to 128,446, an increase of 29% (Table 5.8). However, presentations remained stable in 2006/07 before rising slightly by three per cent to 132,003 in 2007/08. The proportion of presentations for opiates continues to fall although numbers remain relatively stable while cannabis and cocaine powder presentations have increased, the latter by 22% since 2006/07.

Table 5.8: Number and percentage of all drug treatment presentations by primary drug in the United Kingdom, 2003/04 to 2007/08

| DRUG | 2003/04 | | 2004/05 | | 2005/06 | | 2006/07 | | 2007/08 | |
|-----------------|---------------|------|----------------|------|----------------|------|----------------|------|----------------|------|
| | n | % | n | % | n | % | n | % | n | % |
| Amphetamines | 3,474 | 3.7 | 3,731 | 3.6 | 4,134 | 3.5 | 4,622 | 3.8 | 4,416 | 3.5 |
| Benzodiazepines | 1,929 | 2.1 | 2,503 | 2.4 | 2,297 | 1.9 | 2,226 | 1.8 | 2,512 | 2.0 |
| Cannabis | 9,849 | 10.7 | 14,801 | 14.1 | 18,793 | 15.8 | 19,108 | 15.6 | 20,938 | 16.4 |
| Cocaine powder | 3,739 | 4.0 | 5,093 | 4.9 | 6,890 | 5.8 | 8,372 | 6.9 | 10,215 | 8.0 |
| Crack cocaine | 4,980 | 5.4 | 5,842 | 5.6 | 6,857 | 5.8 | 7,096 | 5.8 | 7,453 | 5.9 |
| Opiates | 66,012 | 71.4 | 70,179 | 67.0 | 77,580 | 65.1 | 77,849 | 63.7 | 78,803 | 61.9 |
| Other | 2,494 | 2.7 | 2,662 | 2.5 | 2,540 | 2.1 | 2,890 | 2.4 | 3,011 | 2.4 |
| Sub Total | 92,477 | 100 | 104,811 | 100 | 119,091 | 100 | 122,163 | 100 | 127,348 | 100 |
| Not Known | 7,186 | | 12,970 | | 9,355 | | 6,045 | | 4,655 | |
| Total | 99,663 | | 117,781 | | 128,446 | | 128,208 | | 132,003 | |

Source: Standard Table 34

Amongst first treatments, the number of primary opiate users has fallen for the past two years and is now 17% lower than in 2005/06 (Table 5.9). Presentations for primary cannabis use have more than doubled since 2003/04 and increased by eight per cent between 2006/07 and 2007/08. Cocaine powder presentations have increased from 1,683 in 2003/04 to 5,980 in 2007/08 and now account for 13% of first treatment presentations compared to six per cent in 2003/04. In the last year cocaine powder presentations increased by 21% amongst first treatment presentations.

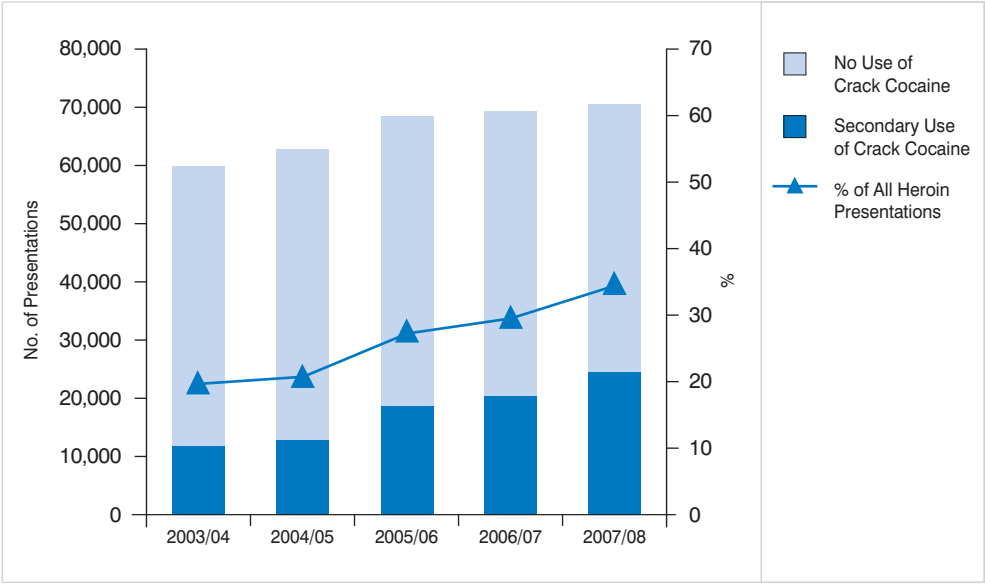
Table 5.9: Number and percentage of first drug treatment presentations by primary drug in the United Kingdom, 2003/04 to 2007/08

| DRUG | 2003/04 | | 2004/05 | | 2005/06 | | 2006/07 | | 2007/08 | |
|-----------------|---------------|------|---------------|------|---------------|------|---------------|------|---------------|------|
| | n | % | n | % | n | % | n | % | n | % |
| Amphetamines | 1,455 | 5.1 | 1,619 | 4.1 | 1,812 | 3.9 | 2,045 | 4.3 | 1,976 | 4.4 |
| Benzodiazepines | 675 | 2.3 | 1,226 | 3.1 | 1,153 | 2.5 | 916 | 1.9 | 1,285 | 2.9 |
| Cannabis | 5,289 | 18.6 | 8,653 | 22.1 | 11,506 | 24.8 | 11,325 | 24.0 | 12,251 | 27.2 |
| Cocaine powder | 1,683 | 5.8 | 3,016 | 7.7 | 4,197 | 9.1 | 4,951 | 10.5 | 5,980 | 13.3 |
| Crack cocaine | 1,722 | 6.0 | 2,589 | 6.6 | 3,116 | 6.7 | 2,900 | 6.1 | 2,822 | 6.3 |
| Opiates | 16,656 | 57.8 | 20,464 | 52.3 | 23,021 | 50.0 | 21,561 | 45.7 | 19,126 | 42.5 |
| Other | 1,329 | 4.6 | 1,525 | 3.9 | 1,528 | 3.3 | 1,468 | 3.1 | 1,573 | 3.5 |
| Sub Total | 28,809 | 100 | 39,092 | 100 | 46,333 | 100 | 45,166 | 100 | 45,013 | 100 |
| Not Known | 1,056 | | 3,405 | | 3,292 | | 1,999 | | 1,588 | |
| Total | 29,865 | | 42,497 | | 49,625 | | 47,165 | | 46,601 | |

Source: Standard Table 34

The proportion of presentations reporting any use of crack cocaine or cocaine powder (primary and/or secondary) remained stable in 2007/08 after increases in previous years. 23% of all presentations reported crack cocaine use (n = 29,401) and 14% reported cocaine powder use (n = 17,606) in 2007/08 compared to 24% and 13% respectively in 2006/07. However, the proportion of heroin presentations reporting secondary use of crack cocaine continued to increase from 20% in 2003/04 to 35% in 2007/08 (Figure 5.1).

Figure 5.1: Number and percentage of primary heroin presentations reporting secondary use of crack cocaine in the United Kingdom, 2007/08



Source: Standard Table 34

5.6 Trends of clients in treatment

5.6.1 Clients in treatment

Data on clients in treatment are currently only available from England and Wales. Scotland started collecting data on individuals in treatment in April 2009.

Information from the NDTMS for England shows that in 2008/09, 207,580 individuals aged 18 and over were in contact with structured drug treatment services, a three per cent increase since the previous year (200,805)¹⁴² (NTA 2009h). Of all clients in treatment, 83% were problem drug users¹⁴³ (172,624). 49% of all clients (100,085) were opiates only users with only four per cent crack cocaine only users (8,296). However, a further 31% of all clients (64,243) reported both opiate and crack cocaine use. Over half of clients in treatment in London (52%) reported crack cocaine use alone or with opiates; 12% reported use of crack cocaine only and 40% reported use of opiates and crack cocaine.

In Wales during 2008/09 there were 19,126 clients in treatment¹⁴⁴, an increase of 50% (12,772) since the previous year.

¹⁴² Data for 2007/08 are different from data reported in the 2008 UK Focal Point Report. This is due to a change in methodology (see NTA 2009i). Previous data cannot be compared.

¹⁴³ Defined as those using opiates and/or crack cocaine

¹⁴⁴ Individuals may be counted more than once in a year

The changing profile of substance users engaged in treatment

A recent report into non-opiate substance use in the North West of England indicated that use of alcohol, amphetamines, cannabis, cocaine powder and ecstasy (AACCE) is more prevalent amongst younger individuals in structured treatment (aged under 30 years) than those aged over 30, and that patterns of drug use are changing with a decrease in problematic opiate use amongst the under 30s (Hurst et al. 2009). Cannabis was stated as the most common primary problematic substance amongst under 18 year olds in contact with structured drug treatment, with cocaine powder use steadily rising amongst 18-29 year olds. In Liverpool, problematic cocaine powder use (61.8%) was more frequently reported by AACCE clients (of all ages) than problematic cannabis use (51.1%).

Indications of Public Health in English Regions: Drug Use

The Indications report included analysis of individuals in structured drug treatment by region (Shaw et al. 2009). Findings showed that over 70% of young people (under the age of 18) reported their main problematic substance as cannabis and over one-quarter of problematic drug users aged between 15 and 24 years were in contact with structured drug treatment in 2006/07 (28.4%, n=17,238). In 2006/07 the rate of individuals in contact with structured drug treatment varied from 3.44 per 1,000 population in the East of England to 7.99 per 1,000 population in the North West. A relatively low percentage of those in contact with structured drug treatment in London reported heroin as their main problematic substance (44.0%) and a high percentage reported crack cocaine (15.5%) and cocaine powder (8.8%). There was a significant positive correlation between Index of Multiple Deprivation (IMD) score and the number of individuals in contact with structured drug treatment services by local authority.

5.6.2 Treatment engagement

The TDI cannot be used to consider treatment engagement rates as data do not take account of those individuals already in treatment prior to, and during, the reporting period. However NDTMS data for England can be used to estimate engagement as they count individuals in contact with treatment services in a given year.

NDTMS data show that of those in treatment in 2006/07, 148,866 were problem opiate and/or crack cocaine users (either using these as primary drug or as a secondary or tertiary drug) (Table 5.10), that is 45% of the estimated number of problem drug users. This compares with 42% (136,228) in 2005/06. The in treatment figure for opiate users was 140,357, constituting 51% (46% in 2005/06, n = 128,630) of the PDU estimate of opiate users, while the in treatment figure for crack cocaine users was 46,415 constituting 26% of problem crack cocaine users (21% in 2005/06, n = 39,832), indicating increased engagement.

Table 5.10: Problem drug users in drug treatment in England 2005/06 and 2006/07

| | PDU ESTIMATES (2005/06) | NDTMS (2005/06) | | PDU ESTIMATES (2006/07) | NDTMS (2006/07) | |
|-----------------------------------|-------------------------------|--------------------|------|-------------------------------|--------------------|------|
| | n | n | % | n | n | % |
| Opiate and/or crack cocaine users | 332,090 | 136,228 | 41.0 | 328,767 | 148,866 | 45.3 |
| Opiate users | 286,566 | 128,630 | 44.9 | 273,123 | 140,357 | 51.4 |
| Crack cocaine users | 197,568 | 39,832 | 20.2 | 180,618 | 46,415 | 25.7 |

Source: Standard Table 07; NTA 2009h

Using NDTMS data for 2008/09 (172,624 PDUs in treatment) and PDU estimates for 2006/07, treatment engagement rises to 52.3% of problem drug users (NTA 2009h).

5.6.3 Substitution treatment

Statistics from the Northern Ireland substitute prescribing database

In 2007/08 there were a total of 507 individuals in contact with substitute prescribing treatment services in Northern Ireland, an increase of 10% from 2006/07 (n = 463) (PHIRB 2008a). Over this period, 86 individuals discontinued from the scheme with the main reason given as 'managed discontinuation of substitute prescribing'. On March 31st there were 367 clients receiving substitution medication, 89% (n = 328) of whom were stabilised. Of these, 49% were prescribed buprenorphine and 47% were prescribed methadone.

The mean age of clients, on 31st March 2008 was 34 years old with 44% aged between 26 and 34 years old and 10% aged 18 to 25 year old. The majority (74%) were male. Fifty-six per cent of clients reported that their main route of administration was injecting.

Data from the National Drug Treatment Monitoring Service (NDTMS) in England

Data from NDTMS show that in 2007/08, 131,468 individuals were receiving treatment in specialist drug treatment prescribing services¹⁴⁵, an 11% increase from 2006/07 (n = 118,107) and a 49% increase since NDTMS started collecting the data in 2004/05 (n = 88,196)¹⁴⁶. Data for 2008/09 show that 147,504 clients received a prescribing intervention (NTA 2009h).

Data from the Welsh National Database for Substance Misuse

Data show that in 2008/09 there were 2,617 referrals to agencies that provide substitute prescribing or prescribing services, a decrease from 3,000 in 2007/08. In 2006/07 there were 1,837 referrals.¹⁴⁷ (personal communication – Welsh Assembly Government).

¹⁴⁵ Data on the drug prescribed is not collected centrally. While the majority will be receiving methadone or buprenorphine, other drugs may also be prescribed.

¹⁴⁶ See: House of Commons Written Answers, 26th November 2008, column 2076W: <http://www.publications.parliament.uk/pa/cm200708/cmhansrd/cm081126/text/81126w0132.htm#08120135004620>

¹⁴⁷ Data completeness and quality is lower for 2006/07 than for later years.

6. Health correlates and consequences

6.1 Introduction

Data on drug-related deaths (DRD) submitted to the EMCDDA by the United Kingdom are based on three different definitions. The EMCDDA definition refers to deaths caused directly by the consumption of at least one illegal drug¹⁴⁸. The definition used to measure deaths for the United Kingdom Drug Strategy, is where the underlying cause is drug abuse, drug dependence, or poisonings where any of the substances scheduled under the *Misuse of Drugs Act 1971* are involved. The definition used by the Office for National Statistics (ONS) is much wider and includes legal drugs¹⁴⁹. The Drug Strategy definition has been adopted by the General Mortality Registers (GMRs) across the United Kingdom and is a subset of the ONS definition. Information on deaths is also available from a Special Mortality Register (SMR)¹⁵⁰. In the United Kingdom, based on the EMCDDA definition, DRDs rose steadily from 1996, when 1,152 deaths were registered, until 2000, fell until 2003, and have risen since.

HIV prevalence among injecting drug users (IDUs) in the United Kingdom was 1.5% in 2008, similar to that seen in recent years, and higher than in the late 1990s. In London prevalence has been higher at, or near, four per cent. Prevalence of hepatitis C (HVC) is much higher at around 40%.

Prevalence and attribution of dual diagnosis remain difficult to estimate. Depression, anxiety disorders, personality and psychotic disorders are commonly reported amongst drug users, although prevalence varies with setting and specific sub-populations. It has been suggested that from 1993 to 1998 there were at least 195,000 co-morbid patients and 3.5 million general practitioner (GP) consultations involving such patients in England and Wales.

The impact of maternal drug use on unborn children is well known as is the fact that babies are affected by withdrawal from maternal drug use. In the United Kingdom, there is little evidence of HIV transmission to babies through maternal infection specifically associated with drugs. However, there is a risk of hepatitis transmission, particularly HCV, where the risk of transmission amongst babies whose mothers test positive is six per cent.

¹⁴⁸ These deaths are known as 'overdoses', 'poisonings' or 'drug-induced deaths'. See: <http://www.emcdda.europa.eu/themes/key-indicators/drd>

¹⁴⁹ See Wells (2009): http://www.statistics.gov.uk/downloads/theme_health/HSQ43.pdf

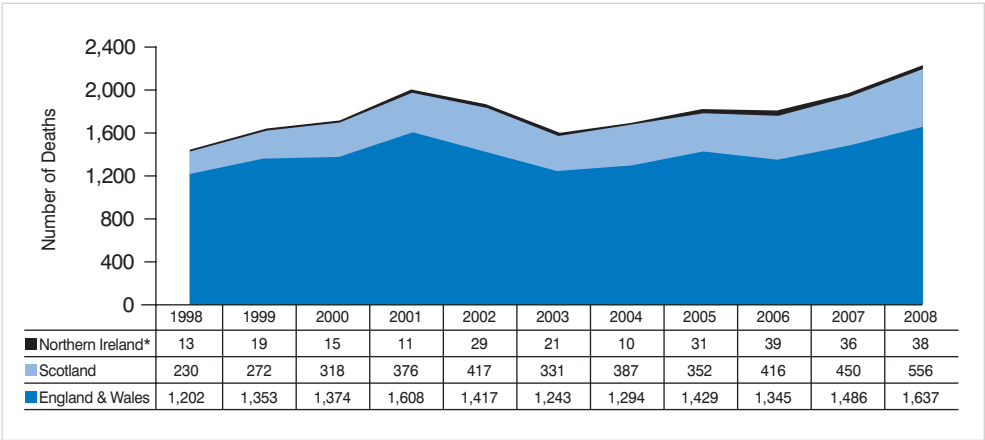
¹⁵⁰ The National Programme on Substance Misuse Deaths (np-SAD) uses data from inquests into drug-related deaths reported by Coroners in England, Wales, Northern Ireland, Guernsey, Jersey and the Isle of Man; Procurators Fiscal in Scotland and the Scottish Crime and Drug Enforcement Agency.

6.2 Drug-related deaths and mortality of drug users

6.2.1 Direct overdoses and indirect drug-related deaths

Using the EMCDDA definition of drug-related death, the latest information across the United Kingdom is for 2008. There were 2,231 deaths in 2008, an increase of 13.1% since 2007 (1,972) (Figure 6.1). The total now exceeds the previous peak in deaths reached in 2001.

Figure 6.1: Drug-related deaths in the United Kingdom, 1998 to 2008: EMCDDA definition



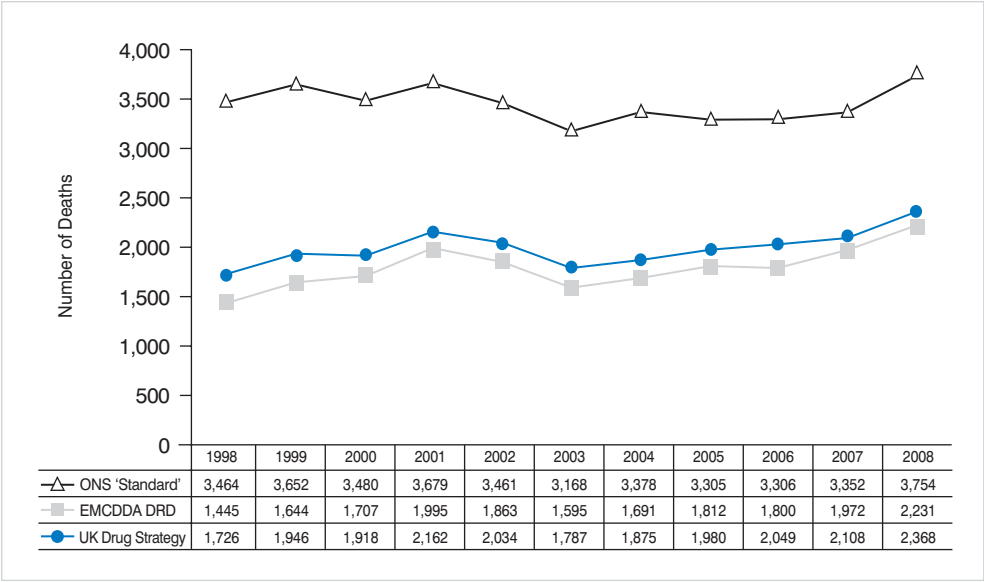
*Data are now based on year of registration not year of death and historical data have been updated accordingly

Source: Standard Table 06

The number of deaths per 100,000 population (all ages) shows that differences exist between the different countries within the UK. Thus, in 2008 the rate using the EMCDDA Standard was 10.8 in Scotland compared to 3.0 in England & Wales and 2.1 in Northern Ireland. The UK average was 3.6.

The slightly different Drug Strategy definition, which measures the impact of the United Kingdom Drug Strategy¹⁵¹ shows the number of deaths in 2008 was 2,368, an increase of 12% since 2007 (2,108) (Figure 6.2). While drug-related deaths increased in 2008 in Scotland (26.2%), Northern Ireland (14.3%) and England (9.3%), in Wales drug-related deaths decreased by 12.7%. Using the much wider ONS definition, the total number of deaths in 2008 was 3,754, an increase of 12% from the previous year (3,352). While deaths have risen since 2004 using the EMCDDA and Drug Strategy definitions, deaths remained relatively stable until 2008 using the ONS definition.

Figure 6.2: Comparison of total number of deaths using three definitions in the United Kingdom, 1998 to 2007



Source: Standard Table 06

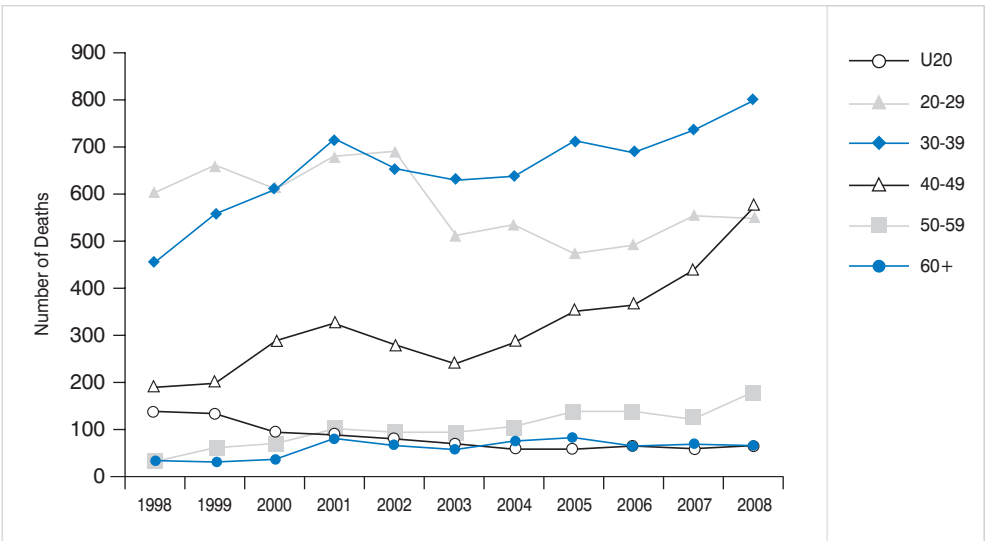
¹⁵¹ The definition is mainly relevant to England but for the purpose of this report, it is used to compile data on DRDs across the United Kingdom.

Age and Gender

Using the EMCDDA definition, in 2008, 1,796 deaths (80.5%) were of males and 430 (19.5%) were of females. Deaths amongst females increased by 35.9% between 2007 and 2008 and they now account for a higher proportion of all drug-related deaths than in previous years. The average age of death was 37.3 years with males (36.7 years) tending to be around three years younger than females (39.8 years)¹⁵². There was little variation in these figures across the constituent countries of the United Kingdom. Average age of death has increased from 31.7 in 1996 to 37.3 in 2007.

The increase in deaths up to 2001 was largely due to the doubling of deaths amongst those in their thirties (351 in 1997 to 717 in 2001), and those in their forties (148 to 326). Between 2001 and 2003, deaths fell in all age groups, with the largest decrease amongst those in their twenties. Since 2003, the largest increase has been amongst people in their forties with deaths more than doubling from 239 to 572. In 2008 there was a large rise in deaths amongst people in their fifties from 121 in 2007 to 183 in 2008, giving an increase of 95% since 2003. This compares to a 27% rise amongst those in their thirties and seven per cent rise amongst those in their twenties (Figure 6.3). Since the peak in 2001, deaths have decreased for those in every age group under 35 years of age (ST06).

Figure 6.3: Number of deaths by age group in the United Kingdom, 1998 to 2008; EMCDDA definition



Source: Standard Table 06

¹⁵² Average age is calculated from grouped data.

Drugs mentioned on death certificates in the United Kingdom

Most deaths continue to be linked with the use of opiates, primarily heroin/morphine and, to a lesser extent, methadone (Table 6.1). Heroin/morphine mentions increased by 10% in 2008 while mentions of methadone increased by 26%. However, cocaine mentions rose even further, by 32%, and are now double the number of mentions in 2003. The rise in diazepam mentions can be explained by a change in reporting methodology in Scotland¹⁵³. Ecstasy mentions fell by 14% in 2008 and by 30% since 2002.

Table 6.1: Drug mentions on death certificates in the United Kingdom, 2002 to 2008

| DRUG | YEAR | | | | | | |
|-----------------|-------|------|------|-------|------|-------|-------|
| | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
| Heroin/Morphine | 1,118 | 883 | 977 | 1,043 | 985 | 1,130 | 1,243 |
| Methadone | 300 | 292 | 300 | 292 | 339 | 441 | 556 |
| Cocaine | 161 | 161 | 192 | 221 | 224 | 246 | 325 |
| Ecstasy | 79 | 66 | 61 | 73 | 62 | 64 | 55 |
| Diazepam | 356 | 282 | 217 | 205 | 186 | 223 | 489 |
| Temazepam | 89 | 114 | 87 | 55 | 55 | 56 | 55 |

Source: Wells 2009; GROS 2009 NISRA 2008

6.2.2 Special Mortality Register: The National Programme on Substance Abuse Deaths (np-SAD)

The np-SAD Annual Report for 2009 (Ghodse et al. 2009), which contains data from the SMR shows:

- the total number of DRDs reported in 2008 was 1,490, a decrease of 3.2% over the number reported (1,539) in the previous Annual Report. It is not yet clear why this fall contrasts with the trend shown by the General Mortality Registers;
- the demographic profile of fatalities reported by coroners to the np-SAD remains consistent with previous reports. The majority of cases were males (74%), under the age of 45 years (71%), and of a White Ethnic group (95%);
- the principal underlying causes of death were: accidental poisoning (64%); intentional self-poisoning (13%); and poisoning of undetermined intent (12%);
- opiates/opioids (i.e. heroin/morphine, methadone, other opiates/opioid analgesics) alone or in combination with other drugs, accounted for the majority (69%) of all np-SAD cases;
- heroin/morphine alone or in combination with other drugs, accounted for the highest proportion (45%) of fatalities;
- the principal drugs implicated in deaths of 16 to 24 year olds were heroin/morphine (38%), alcohol-in-combination (32%), and methadone (27%). Stimulants also accounted for a large proportion of cases: cocaine (16%), ecstasy-type drugs (eight per cent) and amphetamine (seven per cent);

¹⁵³ Figures for 2008 in Scotland are not directly comparable with those from earlier years due to the revision of the questionnaire which collected information about the drugs found in the body. It is believed that this accounted for the majority of the rise in benzodiazepine mentions in 2008.

- over the past decade, alcohol has contributed on average to one-third (32%) of all drug-related deaths notified to the np-SAD that meet the Programme's case criteria; and
- the presence of piperazines in post mortem toxicology analysis was detected in 13 cases in 2008, a rise from three cases in 2006 and nine in 2007. They are usually found in combination with other stimulants and alcohol.

6.2.3 National Monitoring Group into drug-related deaths in Wales

The Welsh Assembly Government chairs a National Monitoring Group into drug-related deaths which oversees the work of four Regional Confidential Review Panels. These Panels periodically analyse a sample of deaths where illicit and prescribed drugs were involved to ensure that lessons learned are translated into changes at service planning and delivery levels.

Some of the key findings from the deaths reviewed in Wales in 2008 include:

- 81% of cases involved males and most fatalities occurred between the ages of 20 and 40 years of age;
- 86% of deaths occurred at the deceased's own home or friend's home;
- heroin/morphine (alone or in combination) was recorded as the medical cause of death in 49% of cases; and
- polydrug use was a feature of toxicology results including in the main heroin/morphine, alcohol, benzodiazepines and antidepressants.

6.2.4 Deaths associated with Volatile Substance Abuse

There were 58 deaths associated with Volatile Substance Abuse (VSA) in 2007 (51 in 2006 and 46 in 2005). This is the fifth lowest figure since 1981 and compares with the all-time peak of 152 in 1990 (Field-Smith et al. 2009). Gas fuels, including 27 lighter fuel deaths, accounted for 42 cases; aerosols for six; nitrous oxide for three; 'poppers' for two; and other substances accounted for nine cases. In addition to these deaths, there were seven deaths resulting from the inhalation of helium. Seven of the deaths occurred in the under-18 age-group, 11 were aged 18 to 24 years, and 15 were aged 25 to 34 years. The median age was 31 years (range 16 to 79 years).

6.2.5 AIDS

Deaths of IDUs with AIDS accounted for 7.8% of the total number of AIDS deaths in England & Wales up to the end of December 2008 (1,326 out of 17,004 since recording began). In Northern Ireland the proportion was 6.0% (five out of 83), but in Scotland it was 50% (737 out of 1,473). The levelling off in the annual number of deaths of IDUs with AIDS seen in recent years has given way to a slight increase. However, the UK figure of 58 for 2007 (55 in 2006) is about 27% of the peak level in 1995 (212). By the end of December 2008, 24 deaths had been reported for that year; the number is likely to increase (personal communication - Health Protection Agency).

6.2.6 Research on drug-related deaths

Recording of clinical information in drug-related deaths in Scotland

Baldacchino et al. (2009a)¹⁵⁴ examined the completeness of data available from case files of 237 deceased individuals in contact with services six months prior to drug deaths in Scotland during 2003. They observed that socio-demographic details such as ethnicity (49%), living accommodation (66%), education and income (52%) and dependent children (73%) were reported much more frequently than medical problems. Medical and psychiatric history was recorded in only 12%, blood-borne viral status in 17% and life events in 26%. The authors concluded that relevant data were missing in the case files reviewed, and suggested that additional training is needed to improve accuracy and completeness of datasets.

The role of hair analysis for investigating drug-related deaths

In a study by Paterson et al. (2009) looking at the role of hair analysis in establishing chronic drug use, it was found that reliable information concerning long-term drug use was important in a wide range of cases including: demonstrating a history of drug use or lack of it, indicating tolerance or intolerance, compliance with medication, death due to long-term cocaine use and its role in depression/suicide, sudden unexplained death, and excited delirium. The authors conclude that such evidence can be invaluable to the pathologist, coroner, and the family of the deceased in understanding both the medical cause of death and the circumstances surrounding the death.

The role of substance misuse in deaths amongst adolescents

In a review of suicide risk among young people, Webb (2009) observed significant gender differences in comorbidities associated with suicide among substance misusers, with a greater prevalence of depressive symptoms and psychological distress among female substance misusers.

In a study by Valle et al. (2008) examining cases of unnatural death (poisoning, violence, unintentional injury) in young people aged eight to 18¹⁵⁵ it was found that, of the 77 cases identified, 16 (21%) died from alcohol/drug misuse, 20 (26%) by suicide or probable suicide and 41 (53%) by other injuries and poisoning. Qualitative analysis highlighted: bullying, teenage sexualisation and pregnancy, alcohol and substance misuse, reconstituted family difficulties, and out of control behaviour as being significant factors on the causal pathway.

Mortality rates of individuals with hepatitis C

A study of IDUs in Bristol found that more than half who were HCV positive were undiagnosed with the infection (Hickman et al. 2009). The all-cause and overdose mortality rates for IDU were 0.75% and 0.4% respectively; and the standardised mortality ratio was 7.8 (95% CI: 5.4-10.8).

McDonald et al. (2009) examined all-cause, liver-related and drug-related mortality and excess risk of death from these causes in a large cohort of HCV-mono-infected and HIV-co-infected persons in Scotland¹⁵⁶. A total of 1,715 HCV mono-infected and 305 HIV co-infected persons died of any cause during the follow-up period (mean of 5.4 and 6.4 years, respectively). Significant excess mortality was observed in both HCV mono-infected and HIV co-infected populations from liver-related underlying causes (SMRs of 25, 95% CI = 23-27; and 37, 95% CI = 26-52 for the two groups, respectively) and drug-related causes (25, 95% CI = 23-27; 39, 95% CI = 28-53).

¹⁵⁴ Between 2004 and 2006 from the cases reported to the coroner for East London, hair was submitted for analysis in addition to the routine specimens for 286 selected cases where drug use was thought to be involved in the death.

¹⁵⁵ Cases from between 1996 and 2002 were identified from Oxfordshire death registers, and data from coroners' inquests were analysed to determine cause of death and involvement of professional agencies.

¹⁵⁶ Cohort consisted of 20,163 cases confirmed to be infected with hepatitis C between 1991 and 2005.

Using Bayesian capture-recapture methods, King et al. (2009) estimated the number of current injectors in Scotland in 2003 at 24,700 (95% highest probability density interval: 20,700 - 32,100). Expert information was used to construct upper and lower bounds on the number of drug-related deaths pertaining to injectors, which were then used to provide bounds on injectors' drug-related death rates. The researchers conclude that failure to incorporate expert information could result in over-estimation of drug-related death rates for subclasses of injectors in 2003-05.

Mortality amongst homeless adults

Morrison (2009) undertook a retrospective five-year study of two fixed cohorts, homeless adults and an age and sex-matched random sample of the local non-homeless population in Greater Glasgow National Health Service Board area for comparison. Over five years of observation, 1.7% (209 out of 12,451) of the general population and 7.2% (457 out of 6,323) of the homeless cohort died. Among patients who had been hospitalised for drug-related conditions, the homeless cohort experienced a seven-fold increase in risk of death from drugs compared with the general population.

Deaths attributed to ecstasy use

Mortality was examined as part of a systematic review of observational evidence on the harmful effects of ecstasy (Rogers et al. 2009) (see section 6.4.2). In the 10 years to 2006, the GMR and the np-SAD recorded an average of around 50 drug-related deaths per year involving ecstasy; it was the sole drug implicated in around 10 cases per year. Retrospective case series, based on hospital emergency department records, reported a death rate of zero to two per cent from emergency admissions related to ecstasy. Two syndromes most commonly reported as the immediate cause of death are hyperthermia and hyponatraemia. The authors conclude that ecstasy is associated with a range of acute harms but appears to be a rare cause of death in isolation.

Patterns of mortality amongst drug users in treatment

Hurst et al. (2009) examined the pattern of mortality in treated drug users reported to the National Drug Treatment Monitoring System (NDTMS) in North West England between 2003 and 2008. They observed a significant difference in age of death between drug-related death cases and other death cases, with DRD cases dying approximately five years earlier on average. Furthermore, injecting drug use was observed to be associated with deaths from heart conditions.

Drug related deaths in Fife

Baldacchino et al. (2009b) investigated drug related deaths in Fife, Scotland. They reported that over half of individuals who died of a drug related cause had been imprisoned in their lifetime (52%). And half of those who had been imprisoned died in the six months post-prison release.

Mortality rates amongst clients prescribed methadone

A Scottish study examined mortality rates in a 10-year retrospective cohort of patients prescribed methadone. The crude mortality rate in the cohort was eight per cent. Overuse of methadone, history of psychiatric admission, and increasing co-morbidity were all associated with an increase in all cause mortality. History of psychiatric admission and history of prescription of benzodiazepines were significantly associated with mortality in this group (McCowan et al. 2009).

6.3 Drug-related infectious diseases

Information on infectious disease is based on that presented in Shooting Up: Infections among injecting drug users in the United Kingdom 2008 (HPA et al. 2009).

6.3.1 HIV

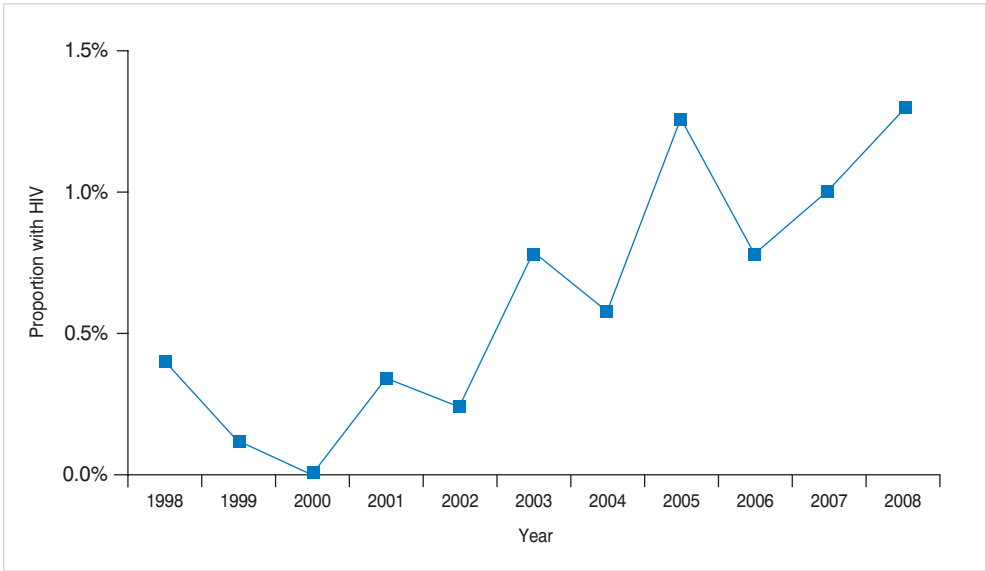
The overall prevalence of HIV seen among IDUs in 2008 was similar to that in recent years, and remains higher than in the late 1990s. The Unlinked Anonymous Prevalence Monitoring Programme (UAPMP) survey of current and former IDUs in England and Wales indicates an overall HIV prevalence of 1.5% in 2008, this is higher than the prevalence of 0.8% found in 1999. In 2008 the prevalence was 1.7% among men and 1.3% among women, with prevalence increasing with age from 1.0% among those aged under 25 years to 1.9% among those aged 35 years and over (ST 09).

In London, the prevalence was 3.8%, whilst elsewhere in England it was 1.0% (HPA et al. 2009). Combining data for 2007 and 2008 the prevalence of HIV infection among IDUs in the UAPMP agency survey in Northern Ireland was 2.2% and in Wales was 0.8% (HPA et al. 2009).

The HIV prevalence among those who reported injecting in the four weeks prior to taking part in the UAPMP survey (current IDUs) has increased in recent years. In 2008 the overall prevalence amongst current IDUs in England and Wales was 1.6% (HPA et al. 2009). In London, the HIV prevalence amongst current IDUs has changed little in recent years and was 5.0% in 2008 (HPA et al. 2009). However, outside of London, the HIV prevalence among current IDUs in England and Wales has increased; it was 0.25% in 2003 and had changed little since the mid-1990s, it then increased to 0.66% in 2004. Prevalence amongst this group has remained elevated since then; 1.6% in 2005, 0.7% in 2006, 0.6% in 2007 and 1.1% in 2008 (HPA et al. 2009).

There is also evidence that ongoing HIV transmission among IDUs within the United Kingdom has increased in recent years. In particular, the HIV prevalence amongst recent initiates in England, Wales and Northern Ireland (those injecting for less than three years) has been elevated since 2003. The prevalence among the recent initiates participating in the UAPMP survey has remained higher than it was prior to 2003, with the prevalence being 1.3% in 2008 compared with 0.25% in 2002 (HPA et al. 2009, Figure 6.4).

Figure 6.4: Trends in the prevalence of HIV infection among recently* initiated injecting drug users in England, Wales & Northern Ireland**, 1998 to 2008



* Those who started injecting drugs during the three years prior to participating in the survey.

** Includes Northern Ireland from 2002.

Source: Data from Unlinked Anonymous Prevalence Monitoring Programme survey of injectors in contact with drug agencies.

In Scotland, the prevalence of HIV among IDUs is monitored through the surveillance of people undergoing voluntary confidential HIV testing. This found a HIV prevalence of 0.5% among IDUs undergoing testing during 2008 compared with prevalences of 1.4% to 3.2% in the early to mid-1990s and 0.3% to 0.9% during the period 1998 to 2006 (HPA et al. 2009, ST09).

The annual number of HIV diagnoses among IDUs in recent years has been low and relatively stable, at an annual average of 151 reports during the period 1998 to 2007 (HPA et al. 2009). By the end of June 2009, 152 HIV diagnoses had been reported in the United Kingdom for 2008 (48 in London, 15 in Scotland, and 89 elsewhere) where infection was thought to have been acquired through injecting drug use. This figure is likely to rise further as additional reports are received for 2008. Whilst the annual number of reports of newly diagnosed HIV infections associated with injecting drug use has not changed greatly over recent years, the proportion of the reports from outside London and Scotland has increased from 38% during the period 1994-1998 to 51% during 2004-2008 (HPA et al. 2009).

6.3.2 Viral hepatitis

Hepatitis C

The prevalence of hepatitis C infection among IDUs remains high overall (HPA et al. 2008). Of the (current and former) IDUs participating in the UAPMP survey in 2008, in England and Wales two-fifths (40%) had antibodies to hepatitis C¹⁵⁷, is the same as in 2007 and similar to that seen in recent years. However, this is higher than the level seen in 1999 when prevalence was 35%. The prevalence was similar among men and women, and increased with age from 19% among those aged under 25 years to 55% among those aged 35 years and over (ST09).

In England, the overall hepatitis C prevalence among the IDUs participating in the UAPMP survey was 41%. However, there were marked regional variations from 21% in the North East to 56% in London and 58% in the North West (data from 2007 and 2008 combined). The prevalence in Wales and Northern Ireland was lower than in many of the English regions: combining data from 2007 and 2008, hepatitis C prevalence in Wales was 24%, and in Northern Ireland it was 31% (HPA et al. 2009).

Amongst current IDUs participating in the UAPMP survey in England, Wales and Northern Ireland, the prevalence of hepatitis C has increased since the beginning of the decade, from 33% in 2000 to 40% in 2008. Testing for hepatitis C was added to the UAPMP in 1998. Retrospective testing of the stored samples from those participating in 1992, 1994 and 1996 found HCV prevalences¹⁵⁸ that were higher among current and former IDUs than those in more recent years (HPA et al. 2009). A recently published trend analysis examining the survey data from 1992 to 2006 found that after adjusting for test sensitivity, the overall HCV prevalence among current IDUs decreased markedly between 1992 and 1998 before rising again (Sweeting et al. 2009).

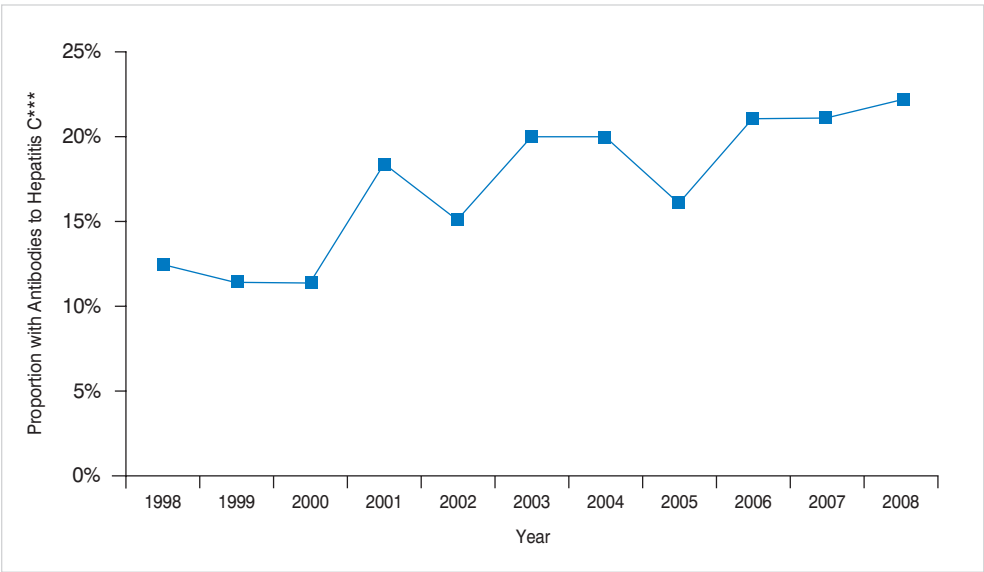
There were higher prevalences of hepatitis C infection among several sub-groups of current IDUs. In 2008, those who reported injecting crack cocaine in the past four weeks were more likely to have hepatitis C (54% compared to 33% of those who had not) as were those who reported injecting cocaine (48% compared with 39% of those who had not). Higher hepatitis C prevalence was also associated with having injected into the groin (48% compared with 36% of those who had not) or legs (46% compared with 39% of those who had not) during the past four weeks. Those who had ever been homeless were more likely to have antibodies to hepatitis C (42%) than those who had not (34%) (HPA et al. 2009).

¹⁵⁷ The sensitivity of the oral fluid test used in the UAPMP agency survey is approximately 92%.

¹⁵⁸ Samples prior to 1998 were collected with a different oral fluid collection device. Hepatitis C test on samples collected using this older device has sensitivity of approximately 74%, results presented here are adjusted so as to be comparable with those from samples collected with current oral fluid collection device.

In 2008, among recent initiates to injecting participating in the UAPMP agency survey in England, Wales and Northern Ireland, the prevalence of HCV was 22%, similar to that between 2001 and 2007. However, the prevalence among this group remains higher than it was in 2000 and earlier years (Figure 6.5).

Figure 6.5 Trends in past hepatitis C infection among recently initiated* injecting drug users in England, Wales & Northern Ireland**, 1998 to 2008



* Those who started injecting drugs during the three years prior to participating in the survey.

** Includes Northern Ireland from 2002.

*** The sensitivity of the test used for antibodies to hepatitis C is approximately 92%.

Source: Unlinked Anonymous Prevalence Monitoring Programme survey of injectors in contact with drug agencies.

Amongst 358 IDUs surveyed at needle exchanges in Glasgow in 2007, the estimated sero-prevalence of hepatitis C was 74% (Health Protection Scotland 2008), similar to the estimated sero-prevalence of 71% found among 435 Glasgow IDUs recruited from needle exchanges in 2005. Among 57 current IDUs surveyed in Glasgow in 2007 who had commenced injecting in the previous five years, the sero-prevalence of hepatitis C was 57%; this compares to a sero-prevalence of 50% among 81 equivalent IDUs surveyed in 2005 (HPA et al. 2009).

Data on diagnosed infection in the United Kingdom are monitored through laboratory reports rather than through the use of statutory notifications. Whilst data from both of these types of systems have limitations, laboratory reports are regarded as being more useful. However, risk factor information is often missing or incomplete. There have been marked increases in the annual number of new diagnoses throughout the UK - reflecting increased availability and easier access to voluntary confidential testing (see section 7.3.2). In England a total of 69,864 diagnoses of hepatitis C infection had been reported up to the end of 2008. The total number of laboratory reports each year has increased from under 1,000 per annum prior to 1995 to over 6,000 per annum since 2004, with 8,190 reported in 2008. Laboratories in Wales have reported a total of 4,047 diagnoses of hepatitis C infection; including 266 diagnoses in 2008. In Northern Ireland a total of 1,291 diagnoses have been reported, with 132 of these reported in 2008. A total of 25,355 persons had been diagnosed hepatitis C positive in Scotland with 1,720 reported in 2008. The majority of these infections are likely to have been acquired through injecting drug use as over 90% of diagnoses with risk factor information reported this as the route of infection (HPA et al. 2009, ST9).

Hepatitis B

In 2008, 13% of the current and former IDUs who took part in the UAPMP survey in England, Wales and Northern Ireland had antibodies to hepatitis B core antigen (anti-HBc, a marker of previous or current hepatitis B infection)¹⁵⁹; this compares with 20% in 1999 (HPA et al. 2009).

Data on diagnosed infection in the United Kingdom are monitored through laboratory reports rather than through the use of statutory notifications. In England and Wales there was a substantial deterioration in the quality of hepatitis B reporting resulting in the data for 2004 to 2007 being unavailable¹⁶⁰. Following implementation of national standards for the surveillance of hepatitis B and C in England, cases of acute hepatitis B are now being reported again nationally. In 2008, a total of 620¹⁶¹ cases were reported, of these 242 (39%) had associated exposure information and only 25 (10%) of these were injecting drug users (HPA et al. 2009).

In Scotland and Northern Ireland, reported hepatitis B diagnoses encompass both acute and chronic infections. In Scotland, there were a total of 615 reports in 2008; this is higher than in recent years and probably reflects a rise in clinical recognition of chronic cases. The proportion of these with injecting drug use given as the main risk has declined from 30% in 1999 to less than one per cent in 2008; however, risk factor information is rarely provided (HPA et al. 2009). In Northern Ireland, prior to 2002 the total number of reports of hepatitis B infection fluctuated at around 30 each year. Since then, the number of reports has risen with 101 in 2008. Some of these infections will have been related to injecting drug use (HPA et al. 2009).

6.3.3 Other infectious morbidity

Cases of wound botulism continue to occur among IDUs in the United Kingdom though at a lower level than previously. In 2008, four suspected cases were reported. In previous years, three, 22, 28 and 41 suspected cases were reported in 2007, 2006, 2005, and 2004 respectively (HPA et al. 2009).

There were no cases of tetanus reported among IDUs in 2008. Cases of tetanus have been occurring among IDUs in recent years, albeit in lower numbers than earlier this decade. In the three year period 2005 to 2007, seven of the fourteen cases of tetanus reported in the UK were in IDUs (four in 2005, one in 2006, and two in 2007) indicating tetanus continues to affect IDUs (HPA et al. 2009).

Health Protection Scotland reported a cluster of cases of necrotising fasciitis among IDUs in the West of Scotland during December 2008, two of whom had died¹⁶².

Cases of severe infection related to both meticillin resistant *Staphylococcus aureus* and Group A streptococci continue to occur among IDUs (HPA et al. 2009). For example, data from the mandatory enhanced surveillance of MRSA bacteraemia in England from 2006 and 2008 indicate that among those reports with risk factor information (optional and provided in 31% of all reports) three per cent reported injecting drug use as a risk factor (HPA et al. 2009).

¹⁵⁹ The sensitivity of the oral fluid test used in the UAPMP agency survey up to 2006 was approximately 75%. Due to changes in available laboratory consumables a revised test was introduced in 2007 the sensitivity of which is still being confirmed.

¹⁶⁰ Publication of hepatitis B surveillance data was stopped while problems with the routine laboratory surveillance system were addressed.

¹⁶¹ Those cases classified as either acute or probable acute infections by local Health Protection Units, or as acute by laboratories.

¹⁶² See: <http://www.hps.scot.nhs.uk/ewr/article.aspx>

Lamagni et al. (2008) carried out further analyses on data from the European enhanced surveillance (Strep-EURO) programme¹⁶³ to try to understand the reasons behind increased cases of *Streptococcus pyogenes* in IDUs. Among the 2,298 cases with known risk information, 20% were recorded as being IDUs, with proportions higher in England (21%) and Scotland (16%) than in Wales (four per cent) and Northern Ireland (three per cent). IDUs, however, accounted for 52% of those aged 15 to 44. Just under a third of IDU cases were potentially linked to another case and clustered IDUs were more likely to be admitted from an institution for the homeless. The authors suggest that there was an epidemic of infections amongst IDUs peaking in 2003 and that one explanation could be the increase in cocaine injecting.

Symptoms of a possible injecting site infection appear to be common among IDUs, with 31% of IDUs participating in the UAPMP survey in 2008 reporting they had experienced an abscess, sore or open wound, possible symptoms of an injecting site infection, during the previous year. The reporting of such a symptom was associated with having been homeless in the last year, with 34% of those homeless during the last year reporting a symptom compared with 29% of those not homeless during the last year (HPA et al. 2009).

These symptoms of possible injecting site infections were found to be associated with a number of factors among current IDUs. Overall, 35% of the current IDUs participating in the UAPMP survey in 2008 reported these symptoms during the last year. Current IDUs who injected into their hands, legs or feet during the last four weeks reported higher levels of symptoms. Higher levels of symptoms were also found among those who in the last four weeks had injected cocaine (HPA et al. 2009).

Simple conservative estimates of associated healthcare costs range from €19.5 million (£15.5m) per year to as high as €37.8 million (£30m); though if less conservative unit costs assumptions are made the total may be much higher (€59.2 million (£47m)). The vast majority of these costs are due to hospital admissions and the uncertainty is due to little data on length of hospital stays (Hope et al. 2008).

¹⁶³ See: <http://www.hpa.org.uk/HPA/AboutTheHPA/WhatWeDo/InternationalWork/1216711958782/>

6.4 Other drug-related health correlates and consequences

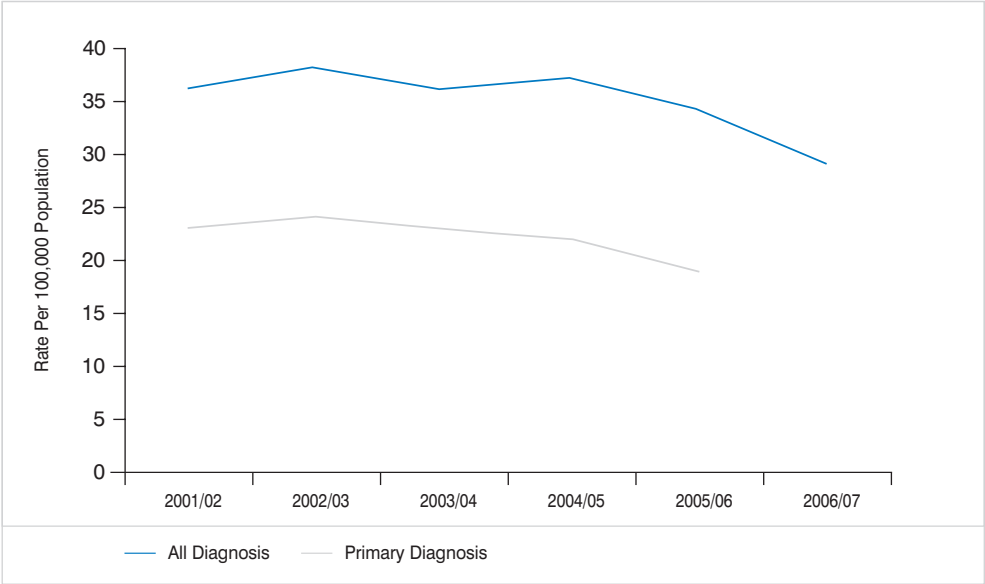
6.4.1 Psychiatric co-morbidity

Prevalence

Scotland

Inpatient hospital data from Scotland show that in 2006/07, 5.5% of psychiatric inpatient discharges had a diagnosis of drug misuse (as either a main or supplementary diagnosis), a rate of 29 discharges per 100,000 population (ISD Scotland 2008). The rate per 100,000 population was stable between 2001/02 and 2004/05 with a decrease in 2005/06 and again in 2006/07 (Figure 6.6).

Figure 6.6: Psychiatric inpatient discharges with a diagnosis of drug misuse in Scotland, 2001/02 to 2006/07; rate per 100,000 population



Source: ISD Scotland 2008

In 2006/07, 61% of psychiatric inpatient discharges with a discharge diagnosis of drug misuse recorded use of multiple drugs or other psychoactive substances, an increase from 53% in 2005/06. Opioids were the most commonly recorded drug reported in 24% of cases. Cannabinoids were the second most commonly recorded drug (eight per cent), a fall from 16% the previous year.

England

A household survey of adult psychiatric morbidity in England in 2007 (see section 2.2.4) found the prevalence of drug dependence amongst respondents to be 3.4% with most dependent on cannabis only (2.5%) (Fuller et al. 2009). 14% of adults who were dependent on cannabis only and 36% of those dependent on other drugs were receiving treatment for a mental or emotional problem.

Impact of cocaine use on people with severe mental health problems

Clutterbuck et al. (2008), in an exploratory study on the extent and impact of cocaine/crack cocaine use in individuals with severe mental health problems¹⁶⁴ found that in 2006, 11.5% (n=64) of the mental health teams' clients were identified by their care-coordinator as having a severe mental health problem and using cocaine/crack in the past 12 months. Staff reported increased aggression, an exacerbation of psychosis and deterioration of physical health amongst cocaine/crack users. Comparing findings with a similar study carried out in 1998, the authors found that there had been a significant increase in the proportion of the total caseload of mental health teams reported as being cocaine users (5.6% in 1998). Users in 2006 were significantly older than those in 1998 and more likely to use with impairment and dependence but less likely to be classified as 'dependence with institutionalisation'. The authors conclude that the latter reduction may be due to increased knowledge amongst staff about how to deal with clients with co-morbid cocaine use.

Impact of substance misuse on outcomes in first-episode psychosis

A study carried out by Turkington et al. (2009) in Northern Ireland¹⁶⁵ looked at one year outcomes amongst patients with first-episode psychosis. At baseline, a third of patients misused substances (including alcohol) with cannabis (20.7%) the most misused substance after alcohol (33.0%). At presentation, male gender and cannabis use were associated with an earlier age of onset. Individuals who continued to misuse substances at one year had more severe depressive symptoms at baseline than those who stopped using substances. and outcomes for depression were significantly worse at follow-up. Using the Global Assessment of Functioning tool, at follow-up the persistent group of substance misusers did significantly worse than the stopped group or never used group. Relapse rates were also worse amongst persistent users but there was no significant difference between those who had stopped and those in the never used group. The authors conclude that persistent substance misuse is associated with poorer one year outcomes but the similarities in outcomes between the never used and stopped group shows that substance misuse at presentation is not associated with poorer one year outcomes. They say that this demonstrates the need to address substance misuse issues early with people with first-episode psychosis.

¹⁶⁴ The study was carried out in 2005-06 within adult community-based mental health services in a mental health trust in Birmingham, England. Five outreach teams, one early intervention service and the homeless mental health team participated in the study. The same teams took part in a study by Graham et al. (2001), enabling comparison over time. All care co-ordinators in the teams were asked to complete a prevalence survey questionnaire about clients in their caseload known to be using cocaine/crack, which included severity ratings. Furthermore semi-structured interviews were carried out with 12 opportunistically sampled care co-ordinators to explore staff perceptions of cocaine/crack use amongst clients with severe mental health problems.

¹⁶⁵ 272 individuals aged 18 to 64 were recruited from general psychiatric services between 1st January 2004 and 31st December 2004. Of these, 188 were eligible and contacted at follow-up. Face-to-face assessments were performed at presentation and at one year. A number of standardised assessment tools were used which are explained in the original article and substance misuse was assessed using these. Patients were divided into three groups for analysis: people who had no substance misuse at baseline or one year, 'never'; people with substance misuse at baseline but not at one

Self-reported reasons for substance misuse amongst dual diagnosis clients

Two studies have been published looking at self-reported reasons for substance misuse amongst dual diagnosis clients. Healey et al. (2009)¹⁶⁶ found that patterns of, and reasons for, substance use amongst patients with a dual diagnosis of bipolar disorder and substance misuse were often based on past personal experiences and were idiosyncratic. Despite this, five main themes emerged: experimenting in the early illness; living with a serious mental illness; enjoying the effects of substances; feeling normal; and managing stress. The authors note that results from the study need to be complemented by quantitative data before being extrapolated to the wider population of dual diagnosis patients with bipolar disorder.

Another study carried out by Gregg et al. (2009) used Q methodology to examine reasons for substance use amongst dual diagnosis patients with schizophrenia¹⁶⁷. Analysis found three distinct groups of substance users: those who predominantly use for social and enhancement purposes (40% of participants); those who use to regulate negative affect and alleviate positive symptoms (29%); and those who use substances to augment themselves and intensify their experiences (20%). Five participants (11%) did not fit exclusively in any of these groups. The only significant difference between the groups was that those in the group who used to regulate negative affect were more likely to be female than the other two groups (54% compared to 17% for the first group and 22% for the third). Overall the most frequently endorsed reasons for use were 'to chill out or relax' (91%) and to have a good time with friends (84%). The authors suggest that the identification of subgroups of users has clear implications for therapeutic interventions targeting substance use in this population.

6.4.2 Health correlates and consequences related to ecstasy use

Health Technology Assessment systematic review on harmful health effects of recreational ecstasy

Rogers et al. (2009) carried out a systematic review of observational evidence on the harmful health effects of recreational ecstasy for the Health Technology Assessment (HTA) programme¹⁶⁸. They found that evidence provides a fairly consistent picture of deficits in neurocognitive function for ecstasy users compared to ecstasy naïve controls. However, although the effects were consistent and strong for some measures, particularly verbal and working memory, the effect size generally appeared to be small. The authors contend that there are substantial shortcomings in the methodological quality of analysed studies including measurement, publication and selection bias. Furthermore no studies assessed quality of life of participants and the suggestion is that deficits do not significantly impair the average ecstasy user's everyday functioning. The authors conclude that despite ecstasy being associated with a wide range of acute harms, it remains a rare cause of death when reported as a sole drug. However, due to the poor quality of available evidence it is not possible to quantify the risk of acute harms in any meaningful way.

¹⁶⁶ Participants were recruited from out-patients, community mental health teams or specialist drug or alcohol services in two mental health trusts in north-west England. Inclusion criteria were a SCID-DSM-IV diagnosis of bipolar disorder and a SCID-DSM-IV diagnosis of a substance use disorder, and that the participant was over the age of 18 and willing to give written informed consent. Participants were recruited until all clinical and socio-demographic features were represented and thematic saturation was achieved. The study took a grounded theory approach with a multi-disciplinary research team analysing transcripts for themes.

¹⁶⁷ Forty-five participants were recruited from community mental health teams, assertive outreach teams and inpatient psychiatric wards in three mental health trusts in Greater Manchester, England. Inclusion criteria were a diagnosis of schizophrenia, schizoaffective disorder or schizophreniform disorder combined with substance or alcohol abuse or disorder (SCID IV criteria). The sample consisted of 34 males and 11 females. Q methodology was used consisting of a set of 58 statements derived from existing literature, tape recorded therapy sessions and interviews with 10 schizophrenic people with co-morbid substance use problems. Participants were asked to sort responses into a Q Sort response matrix and data analysis was carried out using a dedicated software package (PQ method).

¹⁶⁸ The HTA programme is part of the National Institute of Health Research. MEDLINE, EMBASE, PsycINFO and Web of Knowledge were searched. Additional information on deaths was collected from the General Mortality Register and np-SAD. Studies were categorised according to design with systematic research syntheses the most valid (Level I), controlled observational studies the next (Level II) and uncontrolled case series or reports (Level III) used where neither Level I or Level II evidence was available. Of the 4394 papers identified, 795 were reviewed in full and 422 met inclusion criteria.

ACMD review of harms related to ecstasy use

In 2008, the ACMD reviewed the harms related to the use of ecstasy (ACMD 2009a). It found that evidence on extensive chronic use and mental health harms is currently equivocal and that, unlike amphetamines and cocaine, MDMA is rarely implicated in significant episodes of paranoia. While MDMA is undoubtedly harmful and high doses may lead to death, fatalities are relatively low given its widespread use and risks can be minimised by following advice. They also conclude that there is low risk of developing dependence and that the physical harms are more closely linked with amphetamines rather than heroin or cocaine.

Sleep differences in current and abstinent ecstasy users

A web-based questionnaire study using subjective estimates of sleep quality¹⁶⁹ found that current ecstasy-only users reported significantly worse sleep quality and a greater total sleep time than controls (Carhart-Harris et al. 2009). However, despite poorer sleep, the median sleep quality rating of current ecstasy users was 'moderately satisfactory' so effects were not severe. 55% of current ecstasy users reported differences in sleep compared to before they took ecstasy, most believing it was more disturbed. Abstinent ecstasy users reported significantly greater night-time awakenings than controls and 21% reported their sleep had changed since taking ecstasy. The authors conclude that the findings provide some subjective support that lasting sleep disturbances are a possible consequence of ecstasy use.

Brain serotonin transporter binding in former users of ecstasy

Selvaraj et al. (2009) found that there was no significant difference in neuronal serotonin transporter (SERT) binding between former MDMA users, drug naïve individuals and polydrug controls who had never used MDMA¹⁷⁰. They conclude that, as previous studies have consistently shown neurotoxic effects of current MDMA use on brain serotonin transporters, the results indicate a possible recovery of 5-HT function after cessation of MDMA use.

Disrupted 'reflection' impulsivity

In a study measuring reflection impulsivity in ecstasy users¹⁷¹, Clark et al. (2009) found that current and previous ecstasy users did not differ from drug naïve controls. The authors hypothesised that serotonin involvement in impulsivity would mean that impulsivity would be exacerbated in the ecstasy groups. However, the only group to show significant differences to the drug naïve group were regular cannabis users. The results support the authors' previous findings with chronic amphetamine and opiate users, that regular drug use can affect reflection impulsivity. However, they conclude that "the results appear to challenge a simplistic pathway from ecstasy consumption to elevated impulsivity via serotonin neurotoxicity."

¹⁶⁹ A web-based questionnaire was hosted on the University of Bristol Psychiatry Department's website. Sixty-two questions were asked including demographic questions, questions on ecstasy use, other drug use and self-constructed sleep questions. A total of 1035 participants submitted acceptable forms, 857 of whom had taken ecstasy. Of these 89 were predominantly ecstasy only users, 31 current (used in the last 28 days) and 58 former/abstinent users.

¹⁷⁰ Three groups of male volunteers were recruited via newspaper/magazine adverts and word of mouth. The groups consisted of 12 former regular MDMA users (use on more than 25 occasions and non-use for one year), nine polydrug users who reported never using MDMA and 19 drug-naïve controls. A semi-structured drug-use history interview was completed with participants. A radiotracer was injected and PET scans performed on a high-sensitivity CTI scanner. All volunteers also had an MRI scan performed.

¹⁷¹ 46 current ecstasy users, 14 former users, 15 current cannabis users and 19 drug-naïve controls were recruited from newspaper/magazine adverts in Cambridge, England. Current users were abstinent for three weeks. An information sampling task was designed which consisted of a fixed reward and reward conflict condition.

Updating function in ecstasy users

A study looking at updating function of executive processes in ecstasy users¹⁷² found that ecstasy users were impaired in four out of six of sub-groups (Montgomery and Fisk 2008). The tests measured the ability to delete information from the memory that is no longer relevant and replace it with more recent salient information. The study also found a negative correlation between total lifetime use and weekly use of ecstasy and letter and spatial updating performance. However, the authors note the higher levels of cannabis and other drug use amongst the ecstasy group, labelling the group ecstasy/polydrug users.

6.4.3 Health correlates and consequences related to cannabis use

Ammonia release from heated 'street' cannabis

Bloor et al. (2008b) found that the use of heating devices such as vapourisers to minimise the toxic effects of high molecular weight compounds (including tar) in cannabis smoke may increase the exposure to low molecular weight toxic compounds such as ammonia¹⁷³. Ammonia levels in smoking apparatus were 50-170 p.p.m. compared to levels of 10 p.p.m. in the mainstream smoke of cannabis cigarettes. Levels of up to 250 p.p.m. were recorded in the sidestream smoke of cannabis cigarettes suggesting that ammonia is released into the atmosphere. Effects of increased exposure to ammonia may include asthma provocation, bronchial hyperreactivity and neurobehavioural impairment.

Neural basis of THC and CBD: Effects during response inhibition

A study looking at how THC and CBD (two main psychoactive ingredients in cannabis) affect response inhibition¹⁷⁴ found that THC had an effect on the area of the brain that mediates response inhibition but CBD did not (Borgwardt et al. 2008).

The impact of cannabis use on trends in diagnosed schizophrenia

Frisher et al. (2009b) tested the hypothesis that, due to an increase in cannabis use over the past 30 years, there would be a corresponding increase in schizophrenia/psychosis diagnoses¹⁷⁵. Looking at the annual incidence and prevalence of diagnoses of schizophrenia and psychoses in general practice, the authors found a decrease in diagnoses in the United Kingdom between 1995 and 2005. This supports evidence from inpatient hospital statistics and household surveys. The authors conclude that the study provides no evidence for a causal link between cannabis and schizophrenia/psychoses.

¹⁷² Seventy-three ecstasy users and 45 non-ecstasy users completed updating tasks using letter and spatial updating to assess updating function (ability to replace old information with more pertinent new information) of executive processes (a concept used by psychologists relating to cognition and brain processes) in working memory. Participants were recruited by approaching university students and through the snowballing technique. A background questionnaire was used to look at patterns of drug use. The participants were analysed by splitting into six groups based on span length (longest sequence successfully recalled) for both spatial and letter span.

¹⁷³ 'Street' cannabis was supplied from Home Office samples of cannabis seized by local police forces. Material was heated in two commercially available devices and the air was sampled into a SIFT-MS (Selected Ion Flow Tube Mass-Spectrometry) instrument for analysis. Smoke from three per cent National Institute on Drug Abuse cannabis cigarettes was also analysed.

¹⁷⁴ Functional magnetic resonance imaging was recorded while 15 participants performed a Go/No-Go task following an oral dose of either THC, CBD or a placebo in a double-blind, placebo-controlled, repeated measure within-subject design.

¹⁷⁵ The study used the General Practice Research Database (GPRD) to determine the annual rate of new and existing diagnosed cases of schizophrenia/psychosis over the period 1996 to 2005 in the United Kingdom. The cohort was all patients aged 16 to 44 in 183 practices reporting to the GPRD. Analysis was carried out based on patient years of exposure (PYE).

Effects of cannabis use on outcomes of psychotic disorders

Zammit et al. (2009) carried out a systematic review examining the effects of cannabis use on outcomes for people with psychosis¹⁷⁶. Use of cannabis was associated with increased risk of relapse or re-hospitalisation across the studies as well as reduced treatment adherence. Associations between cannabis use and psychotic symptoms were more inconsistent as were associations with other measures of treatment response. However, the authors found that most of the studies did not adjust for baseline illness severity or other important confounders such as alcohol or other drug use. The importance of establishing the effects of cannabis on outcomes for people with psychotic disorders is stressed.

6.4.4 Health correlates and consequences related to ketamine use

Ketamine use and urinary tract problems

There have been increasing reports of a link between ketamine use and urinary tract problems. Staff at Bristol Urological Institute in England report an 'alarming increase in people presenting to urological services in South West England with bladder problems associated with chronic ketamine use' (Cottrell et al. 2008a). Patients present with symptoms of severe urinary frequency, urgency, haematuria and suprapubic pain. A case report of ketamine associated cystitis was published in 2009 (Hoskins 2009) and Cottrell and Gillatt (2008) highlight the importance of medical staff being aware of possible links between urinary tract problems and ketamine use. Data from the Bristol Drugs Project, which has worked closely with hospital staff, suggest that urinary tract symptoms get progressively more prevalent amongst more heavy users¹⁷⁷. While symptoms may ease with cessation of ketamine use, there are reports of long-term effects and intractable problems such as requiring bladder removal.¹⁷⁸

Ketamine use, cognition and psychological well-being

Morgan et al. (2009a) compared frequent, infrequent and ex-ketamine users with polydrug and non-drug using controls to see if there were differences in cognitive functions and psycho-pathological symptoms¹⁷⁹. They found that frequent ketamine users had greater impairment in working memory, episodic memory and aspects of executive function as well as reduced psychological well-being. Infrequent users did not show distinct cognitive impairments but did display increased levels of delusional and dissociative symptoms. Ex-ketamine users showed evidence of elevated delusions but no cognitive impairment. The study concludes that cognitive impairments following ketamine use are confined to heavy users and that this group exhibits higher levels of psychopathology including schizophrenia-like symptoms.

¹⁷⁶ Inclusion criteria for the study were that they were longitudinal studies of people with psychosis, or case-control studies nested within longitudinal designs. Outcomes were specified a priori. Thirteen studies met inclusion criteria.

¹⁷⁷ See presentation given at 2008 National Conference on Injecting Drug Use: http://www.exchangesupplies.org/conferences/NCIDU/2008_NCIDU/presentations/rachel_ayres.html

¹⁷⁸ See: <http://news.bbc.co.uk/1/hi/england/bristol/7867449.stm>

¹⁷⁹ The study recruited 150 participants (30 in each category) via an existing database and snowball sampling. Frequent ketamine users were defined as those using the drug more than four times a week, infrequent users those who used less than four times a week but at least once a month and ex-users were defined as those who had been abstinent for a minimum of one month. Polydrug users were matched with current ketamine users for use of other drugs. All participants abstained from drugs for 24 hours prior to the test. A number of neurocognitive assessments were used in addition to a number of tests of psychological well-being.

Morgan et al. (2009b) examined whether persistent ketamine use is associated with oculomotor¹⁸⁰ and cognitive deficits typical of schizophrenia¹⁸¹. Compared with matched groups of polydrug users who did not take ketamine and non-drug using controls, ketamine users made significantly more antisaccade¹⁸² errors but were no different on other oculomotor tests. Compared with schizophrenia patients, ketamine users were no different on antisaccade errors but performed better on other oculomotor tests. Ketamine users performed better than schizophrenia patients and no different from controls in memory tests. The study concludes that chronic ketamine use is not a good model of oculomotor and cognitive deficits in schizophrenia.

6.4.5 Non-fatal drug emergencies and hospital admissions

As in earlier UK Focal Point Reports, data on drug overdoses are provided using hospital inpatient data and ICD-10 codes¹⁸³ T40 and T43.6. Previously data have been provided for individual countries within the United Kingdom. However, data presented here are for the United Kingdom based on inpatient discharges in any position. Data are likely to be an underestimation of the true impact as evidence from the poisons unit at Guy's and St. Thomas' hospitals suggest that over half of recreational drug toxicity patients are not admitted to hospital. Furthermore, an analysis of one month's data from the poisons unit found that only 24% of patients presenting with recreational drug-related toxicology were given an ICD-10 code, none of which allowed identification of the individual drug involved.

Data for 2007/08 show that of the 32,511 inpatient discharges recording poisoning by drugs¹⁸⁴, half (51%) were due to 'other opioids' (including morphine and codeine). These are likely to be linked to intentional self-poisoning. 99% of all drug poisonings were emergencies. There were 3,071 heroin poisonings, almost all of which were emergencies (99%). The next most common individual drug was cocaine (2,477 discharges) followed by methadone (1,365 discharges).

There were 21,115 inpatient discharges related to mental and behavioural disorders due to drugs¹⁸⁵. This excludes those related to 'dependence syndrome' since these are likely to be planned inpatient treatment patients. The drugs most commonly involved were opioids (5,570), cannabinoids (4,993), and cocaine (4,223). However, cases involving cocaine were more likely to be emergencies (90%) compared to those involving opioids (86%) and cannabinoids (78%).

Hospital admissions attributed to psychoactive substance use

The rate of hospital admissions attributed to psychoactive substance use¹⁸⁶ has been steadily increasing in England since 2001/02 (Shaw et al. 2009). In 2006/07 the rates of hospital admissions attributed to psychoactive substance use varied from 69.5 per 100,000 population in the East of England to 206.4 per 100,000 population in the North West. The largest number of admissions in 2006/07 for this reason was amongst the 25-39 age group (n=20,291). Hospital admission attributed to psychoactive substance use was significantly positively correlated to deprivation. Analysis by geo-demographic classification¹⁸⁷ showed that those in the most deprived category were 17 times more likely to be admitted to hospital for an episode attributed to psychoactive substance use than those in the most affluent category.

¹⁸⁰ Third cranial nerve that supplies all the extrinsic muscles of the eye.

¹⁸¹ Twenty ketamine users who had used for at least one year twice a month or more were recruited from a database and snowball sampling and 17 polydrug users who were matched with the ketamine group but did not use ketamine were also recruited. Twenty patients with schizophrenia and 20 healthy controls were selected, based on age and National Adult Reading Test IQ from a prospective longitudinal study of first-episode psychosis in London. A number of oculomotor tasks and tests of neuropsychology were carried out.

¹⁸² Rapid eye movement directed towards a stimulus.

¹⁸³ See: <http://www.who.int/classifications/icd/en/>

¹⁸⁴ Using ICD-10 diagnosis codes T40 and T43.6.

¹⁸⁵ Using ICD-10 diagnosis codes F11 to F19 excluding F17. Codes ending .2 were also excluded.

¹⁸⁶ Not including alcohol.

¹⁸⁷ See: <http://www.beacon-dodsworth.co.uk/products/people-classification/>

Health benefits of reduction of individual's use of illegal drugs

In an analysis of data collected as part of the Drug Outcome Research in Scotland (DORIS) study, which took place between 2001 and 2004 (see section 5.3.3) it was found that significant physical and psychological health benefits in participants were associated with a reduction in the use of or dependence on illegal drugs. Both were also associated with a decrease in the amount of visits to accident and emergency (A&E) departments (McIntosh et al. 2008).

6.4.6 Pregnancies and children born to drug users

Inpatient hospital data on effects of maternal use of drugs

In the United Kingdom during 2007/08 there were 382 inpatient discharges with an ICD-10 code P04.4 related to fetus and newborn affected by maternal use of drugs of addiction and 1,615 discharges with an ICD-10 code P96.1 related to neonatal withdrawal symptoms from maternal use of drugs of addiction.

Scotland

Data from Scotland show that in 2006/07 there were 566 maternities for which drug misuse was recorded, a rate of 10.4 per 1,000 maternities. This is an increase from 339 in 2002/03 (6.7 per 1,000) and from 486 in 2005/06 (9.3 per 1,000). 71% (405) of these births were recorded as full-term normal birth-weight compared to 90% of all births and 19% were pre-term compared to eight per cent of all births (ISD 2008).

Analysis of inpatient data in Scotland shows that between 2003 and 2006, there were 1,477 babies discharged from hospital with a diagnosis related to maternal drug use (ICD-10 codes P04.4 and P96.1). Of these, 59% were classed as coming from the most deprived areas, with a further 22% from the next most deprived. Only three per cent were from the least deprived areas¹⁸⁸.

Changing patterns of heroin use and its effect on babies

Best et al. (2009) studied the impact of pregnancy on heroin and crack cocaine use patterns amongst mothers in contact with specialist addiction treatment services in a city in England¹⁸⁹. The study showed no significant reduction in the frequency of heroin use between the first and second trimester but the reduction in frequency from the second to third trimester and the three months after birth was significant. Crack cocaine use reduced significantly from the first to second trimester and from the third trimester to three months after birth.

The average birth weight of the babies was 5.3lbs (range = 2.5-7.6lbs) and they were born after an average of 34.4 weeks of gestation (range = 24-37 weeks). There were significant positive correlations between quantity of heroin used during the first, second, third, and ninth month of pregnancy and the baby's birth weight and in all nine months the correlation was positive. In nine cases the mother reported that the child was treated for withdrawal symptoms after birth (45% of those who answered the question). These babies did not have a lower birth weight but the gestation period was longer. There were no differences in the amount of heroin used in any of the three trimesters between those who reported their baby had been treated for withdrawal symptoms and those who did not. The findings suggest that the pattern of change of heroin use in pregnancy does not impact on the extent of prematurity or low birth-weight.

¹⁸⁸ Using Scottish index of Multiple Deprivation (SIMD). Scottish Parliament Written Answers 19/08/09.

¹⁸⁹ The study recruited 24 women from a specialist mother and baby treatment team in Birmingham, England out of 36 eligible to take part (66.7%). Subjects were recruited on a voluntary basis to take part in a one-off interview about their heroin use during pregnancy and after childbirth. The researchers used the Lifetime Drug Use History instrument and additional questions to assess each participant.

Strabismus in children of misusing mothers

Ghetau et al. (2009), in a review of the literature on the occurrence of strabismus¹⁹⁰ in children of parents misusing substances, found that there are very few studies on the topic but those that do exist, suggest that prevalence of strabismus is much higher in infants exposed prenatally to substance misuse than in the general population. Despite this evidence, they found researching the topic to be difficult with recruitment of study participants and attendance at eye examinations poor. They conclude that there is a need for increasing awareness amongst professionals of the relationship between strabismus and substance misuse in pregnancy.

Maternal methadone use in pregnancy

Dryden et al. (2009), in a retrospective cohort study looking at factors associated with the development of neonatal abstinence syndrome (NAS) amongst babies born to mothers prescribed methadone¹⁹¹, found that 46% of babies received pharmacological treatment for NAS. Prescribed methadone dose was independently associated with the likelihood of an infant receiving treatment for NAS. Infants whose mothers were prescribed methadone were more likely than those in the general hospital population to be born prematurely (20% compared to nine per cent) and 23% weighed less than the ninth centile. The stillbirth rate of 1.3% was almost double that of the hospital as a whole. Despite accounting for only three per cent of hospital births, babies born to drug misusing mothers occupied 18% of bed days for the neonatal unit over the study period.

6.4.7 Drug driving

Statistics from the Department for Transport, published in the *Road Safety Compliance Consultation* (Department for Transport 2008) (see section 9.5) show that in 2007, there were 71 fatal casualties in accidents where impairment due to illicit or medicinal drugs was a contributory factor; 261 serious injuries and 790 slight injuries.

Prevalence of drugs and alcohol in victims of road traffic fatalities

Elliott et al. (2009) studied the prevalence of drugs and alcohol found in 1,047 road traffic fatalities in England and Wales between 2000 and 2006 where further details had been requested by HM Coroner or police¹⁹². They found that 54% of all victims were positive for drugs and/or alcohol with the highest proportion amongst pedestrians (63%, n=79). For drivers (n=603), 32% (n=105) of those positive for drugs and/or alcohol involved drugs only and 26% (n=87) involved drugs and alcohol. Of these, 35% tested positive for cannabinoids, 15% for cocaine and nine per cent each for opiates, benzodiazepines and amphetamines. For motorcyclists, 48% were positive for drugs and/or alcohol. Of these, 44% were positive for drugs alone with 22% positive for drugs and alcohol. Cannabinoids were the most frequently identified drug in this group (53%) followed by opiates (20%). Of the three categories of victims in control of a vehicle (including cyclists), 53% tested positive for drugs and/or alcohol compared to 58% of those not in control of a vehicle (passengers and pedestrians).

¹⁹⁰ Strabismus is a disorder in which the eyes do not line up in the same direction when focusing.

¹⁹¹ A retrospective cohort study of infants born to women prescribed methadone and delivered in a single hospital in Glasgow during the period 1st January 2004 to 31st December 2006. 450 infants were delivered to drug misusing mothers, six were stillborn.

¹⁹² The presence of drugs or alcohol was determined as part of routine casework at the request of HM Coroner and the police from various areas in England and Wales. Analysis was performed using a number of techniques allowing identification of over 700 drugs and drug metabolites. Many different drugs including over-the-counter and prescription drugs were included.

6.4.8 Other drug-related health consequences

Devlin and Henry, (2008) in a clinical review of the major consequences of illicit drug consumption, provide a summary of the major complications associated with different types of substance use. Respiratory complications are most closely related to cocaine use, with specific symptoms associated with the inhalation of crack cocaine but there can also be a consequence of cannabis use. Cocaine use can also cause cardiovascular problems and hyperthermia. MDMA use can cause hyperthermia and is associated with liver problems. The authors suggest that due to the prevalence of drug use in the general population, every medical practitioner should have a working understanding of the basic pharmacology and acute implications of illicit drugs.

Methaemoglobinaemia in cocaine users in Scotland

In February 2009, NHS Greater Glasgow and Clyde reported two cases of methaemoglobinaemia in Scottish cocaine users¹⁹³. It is not known what causes it but it creates a lack of oxygen in the blood. Symptoms include blue lips, headache, abnormal heart rate, breathlessness, fatigue, dizziness, loss of consciousness, seizures and in severe cases, coma and death.

Risk environments: Injecting drug use and unstable housing

Research conducted with IDUs¹⁹⁴ to establish the health risks associated with 'speedball'¹⁹⁵ injecting, asked participants about their experiences of living in unstable housing, including temporary accommodation in hostels, bed and breakfast accommodation, supported housing or living on the streets (Briggs et al. 2009). The results of the study highlighted that both injecting in public and whilst in hostels had implications for health risks and compromised hygiene. In terms of public injecting, fears raised by participants included being interrupted leading to rushed injecting, lack of hygiene and reduction in safe practices and even 'missed hits'. The poor physical features of the environment such as lack of privacy and light were also raised as concerns in terms of increasing the risk of missing a vein.

It was found that whilst hostels were often described as more 'stable' accommodation and sometimes viewed as a 'safe haven' from the health impacts that injecting in public places can bring, there could also be downsides to living in them, with some participants describing the 'risk environment' associated with them. Included were descriptions of pressure from other users to share drugs, equipment and/or borrow money; creation of new associations with other IDUs and formation of drug-injecting arrangements leading to sharing of drugs and increased usage (for fear of 'missing out') and sharing of equipment.

The authors conclude that whilst some of the risks associated with public injecting may be negated by living in a hostel, other risk factors associated with that particular environment may then come into play. Whilst it does have the potential for bringing about harm reduction there are also risk factors associated with IDUs living in a hostel. It is recommended that further research is undertaken to explore this further, as these results are limited due to the nature of qualitative data such as that captured by this study.

Public injecting and symbolic violence

Parkin and Coomber (2009) discussed the relationship between public injecting and what they call symbolic violence. Symbolic violence refers to *'non-violent coercion by means of social and cultural control that is premised upon domination, complicity and misrecognition'*. The research found that injecting drug users who used public places were often displaced as a result of policies, practices (specifically harm reduction policies and practices) and staff attitudes which were considered to be symbolically violent. The impact of this displacement potentially put the injecting drug users at greater health risks (including death) through moving to injecting in more inappropriate and disparate environments.

¹⁹³ See: http://news.bbc.co.uk/1/hi/scotland/glasgow_and_west/7876387.stm

¹⁹⁴ Qualitative, in-depth interviews were undertaken with 45 IDUs in the Bristol and London areas of England, most of whom had recently been homeless and a thematic analysis was conducted on the interviews.

¹⁹⁵ In this case speedball is defined as combining crack and heroin in a single injection.

7. Responses to health correlates and consequences

7.1 Introduction

In 2001 an action plan to reduce drug-related deaths (DRDs) was introduced in England and Wales (DH 2001). This was updated as part of *Reducing Drug-related Harm: An Action Plan* with a focus on three key areas: campaigns, improving delivery and surveillance (DH and NTA 2007). In Scotland a strategy and action plan to reduce DRDs was published in 2005 (SACDM 2005). In relation to the prevention of drug-related infectious diseases, a public health approach aimed at containing HIV transmission began in the 1980s. The subsequent action, involving harm reduction measures, is regarded as having been successful in helping to contain HIV amongst injecting drug users (IDUs), measures include: the provision of free needles and syringes; promoting the safe disposal of used equipment; information campaigns on safer sex and safer injecting; and HIV/AIDS counselling, support and testing. Treatment for infectious diseases is provided as part of the National Health Service (NHS), including the provision of anti-retroviral treatment for HIV and HCV.

A Hepatitis C Action Plan for England was published in 2004 (DH 2004), prioritising prevention of infection and disease progression. *A Hepatitis C Action Plan for Scotland* was launched in 2006 (Scottish Executive 2006b) and a second phase of the plan, supported by €63 million (£43m) over three years, was launched in May 2008. *An Action Plan for the Prevention, Management and Control of Hepatitis C* was launched in Northern Ireland in 2007 (DHSSPSNI 2007). The National Institute for Health and Clinical Excellence (NICE) in England has published clinical guidelines that recommend the use of contingency management in order to encourage testing for and vaccination against infectious diseases (NICE 2007a).

Standards of care for problem drug users with mental health problems were agreed in 2001 (HAS 2001). Guidance on good practice (DH 2002a) and the provision of services were developed in England. The Department of Health highlighted the need for generic health services to work in partnership with other agencies, such as drug services (DH 2002b).

Treatment for wound infections is available through primary care, accident and emergency (A&E) departments, and in some areas, through needle exchange schemes and specialist drug services. Those in prison have access to HIV and hepatitis testing, and vaccination against HBV.

Increasingly there is recognition of the needs of pregnant drug users, with systems in place to ensure that they are identified and that their needs, and those of their babies, are met.

7.2 Prevention of drug related emergencies and reduction of drug-related deaths

Database on drug-related deaths in Scotland

The Scottish Government, in partnership with local Alcohol & Drug Partnerships (ADPs) and the NHS Scotland Information Services Division (ISD) has developed a national database of drug-related deaths. The database gathers personal details about the drug user including information on their drug taking history; where they were living and with whom (including children); whether they were known to services or were on waiting lists; what drugs were found at the scene of their death and in their toxicology report; whether they were on methadone or other drugs and whether the drugs were prescribed to them or not. Full data collection started on 1 January 2009. The national database is hosted by ISD with ADPs responsible for collecting the data at a local level (Scottish Government 2008e).

Reducing drug users' risk of overdose

The Scottish Government has published a research report which considers a range of interventions that may be employed by health professionals, drug users and their family and friends in order to prevent drug related deaths and overdose. It aimed to investigate ways to achieve an increase in the number of overdose witnesses who call the emergency services and also researched techniques that could be used to prevent deaths while they were waiting for help to arrive. It made a series of recommendations including: improving the quality of the way emergencies are responded to; improving needs assessments for drug users who may be at risk from overdose; extended care provision such as take home naloxone, user education, syringe exchange and prevention strategies; overdose information and training for emergency service staff, drug workers, police and clinical staff; and training and information for drug users and their family and friends (Rome et al. 2008).

Bereavement booklet – help for family and friends following an overdose

A booklet entitled '*Overdose: Bereavement – What Happens Now?*' has been produced by service users within the National Forum on Drug-related Deaths in Scotland. It contains guidance and advice for the family and friends of individuals who have died of a suspected overdose. It explains what procedures take place after an overdose and where to go for help and advice on coping with grief. It will be distributed in General Practitioner (GP) surgeries, drug treatment centres, libraries and community centres (Scottish Government 2008e).

Response to 2008 Scottish drug related death statistics

Following the release of the 2008 drug related death statistics for Scotland, the Scottish Drugs Forum (SDF)¹⁹⁶ re-emphasised the need to focus on prevention and treatment of drug problems in line with the aims of the drugs strategy. The SDF has organised a public conference focussing on older drug users in response to the increasing proportion of drug related deaths in this group and is working in partnership with European collaborators to identify the key issues which need to be addressed. Deaths among older drug users were also raised as a key concern in the second *National Forum on Drug-related Deaths in Scotland report* (Scottish Government 2009d). In the same report it was observed that several factors in combination are often associated with drug related deaths and this necessitates a range of actions to tackle the issue. Recommendations include:

- the expansion of overdose awareness training to key workers in services, including homelessness services;
- improved police training in the reasons why some people are reluctant to call the emergency services and first aid;
- recording and monitoring of non-fatal overdoses so that lessons can be learned as to what actions save lives; and
- improved treatment options for individuals with dual diagnosis; and identification of substance misuse issues by all types of services so that clients can then be referred to specialists when appropriate.

The report goes on to say that an instructional leaflet for the ambulance service regarding what to do if an individual refuses treatment is required and that the dangers associated with polydrug use, particularly combining alcohol with injecting drugs and alcohol and cocaine, must continue to be emphasised. A report into the number of drug deaths in the Fife area of Scotland (Baldacchino et al. 2009b) also included recommendations about education and training for polydrug users and suggested that individuals on methadone maintenance programmes should be screened more often to establish if they are at increased risk of overdose. It also recommends more outreach services for vulnerable groups who have trouble attending services.

¹⁹⁶ See: <http://www.sdf.org.uk/sdf/3149.html> and <http://www.sdf.org.uk/sdf/3089.html> and <http://www.scotland.gov.uk/News/Releases/2009/08/12105412>

Pilot study into the provision of overdose training and naloxone for use by family members in England

Reducing Drug-related Harm: An Action Plan (DH and NTA 2007) recommended that family members are one of the groups that should be targeted to reduce the risks of overdose. In response to this, a pilot project is to be undertaken in England which will involve overdose training and the provision of naloxone for families of drug users. The NTA asked for expressions of interest from organisations to run this scheme in early 2009 and have since identified 16 areas where the pilot schemes will run. The aim of the pilot is to identify areas of good practice and learning about how families can best prepare themselves to respond to an overdose with naloxone, it will involve around 950 family members and carers¹⁹⁷.

Take home naloxone and overdose training with opiate users in treatment

Training in how to deal with an overdose and the administration of naloxone was provided to a group of opiate users in treatment (Strang et al. 2008). The participants completed a questionnaire pre and post training to establish if it had changed their knowledge about overdose and how to manage an emergency situation. They were given a supply of take home naloxone after the post training assessment and were then followed up three months later to investigate how much of the training they could recall. It was reported that the knowledge of participants had significantly improved regarding the risks of an overdose; the signs of an overdose; what action to take if it happens; and confidence around naloxone administration. In the three months after the initial training sessions, 18 actual overdoses occurred (where the participants were either directly involved or had witnessed it) and naloxone was used to reverse the overdose on 12 occasions (all of which were successful) and of them, ten involved the clients' own supply of naloxone being administered. One death was reported in one of the six cases where naloxone was not used. The authors suggest that wider implementation of training and supply of naloxone could help to reduce deaths related to opiate overdose.

Naloxone and overdose training in Scotland

A similar pilot study to the one above was also carried out amongst a sample of Scottish drug users and their family and friends (McAuley et al. 2009). Twenty three drug users and their 'buddies' (family members, friends or other users) were trained in the practical use of naloxone and how to recognise and manage an overdose situation. The study had three aims: to assess whether training in naloxone administration and overdose management could be delivered to clients effectively; monitor how responsibly clients would manage their supply of naloxone and how effectively they used it when in an overdose situation; and to further enhance the range of initiatives aimed at reducing drug related deaths to users, families and service providers. The results of this study found that participants were responsive to training in naloxone administration and were also able to look after their supply for a prolonged period of time, as the majority of those who were followed up at two and six month intervals were still in possession of the take-home naloxone that they had been given once they had satisfactorily completed the training period. It was reported that during the study period three overdoses were witnessed by participants and, of them, two overdoses were reversed as a result of the participants administering naloxone. The authors recommend that the model used in this study should be continued and replicated on a wider scale.

Prison-based naloxone-on-release RCT in England and Scotland

A pilot randomised controlled trial (RCT) of take home naloxone, given to prisoners on their release from jail, is to be undertaken in a sample of prisons in England and Scotland. The N-ALIVE (NALoxone InVEstigation) project is funded by the Medical Research Council (MRC)¹⁹⁸ and aims to reduce drug related deaths amongst injecting heroin users, who are at particular risk of overdose in the first weeks after release from prison¹⁹⁹.

¹⁹⁷ See: http://www.nta.nhs.uk/news_events/newsarticle.aspx?NewsarticleID=126 and http://www.nta.nhs.uk/media/media_releases/2009_media_releases/life_saving_kits_to_be_given_to_families_of_injecting_drug_users.aspx

¹⁹⁸ See: <http://www.mrc.ac.uk/ResearchPortfolio/Grant/Record.htm?GrantRef=G0800012&CaselId=10956>

¹⁹⁹ See: <http://www.publications.parliament.uk/pa/ld200708/ldhansrd/text/81016w0002.htm>

International directory of naloxone programmes

The coverage of naloxone distribution programmes globally is currently sporadic. In response to this, Glasgow Addiction Services²⁰⁰ in Scotland are conducting an international mapping exercise in order to establish where this intervention is currently used and to compile a directory of such programmes²⁰¹.

Naloxone website

A website designed to increase knowledge of the potential life saving effects of naloxone and to inform a wider audience of its uses has been designed by a team of health practitioners and academics.²⁰² The site contains information regarding the legal aspects of take home naloxone; details of participating pharmacies and latest research. It is aimed at healthcare professionals and substance use workers in addition to substance users and their carers (Scottish Government 2009e).

Take home naloxone demonstration sites in Wales

In May 2009 the Welsh Assembly Government introduced demonstration sites for the issue of take home naloxone to opiate users, their families, carers or friends. The demonstration sites cover Welsh prisons, Cardiff, Newport, Swansea and North Wales and include training in the use of naloxone, resuscitation and overdose prevention advice.

Welsh guidance and training protocol for take home naloxone

The Welsh Assembly Government (WAG) has produced a training guide and set of protocols, for use by Community Safety Partnerships and service providers, as part of the introduction of take home naloxone schemes which are currently running in nine areas of Wales (WAG 2009b). It states that there are three fundamentals to the introduction of these schemes which should be followed: suitable training will be required for those who will be administering naloxone; local protocols should be agreed regarding supply and administration of it; and there should be an effective and sufficient data collection system in place at all service providers so that the use of naloxone can be evaluated.

Reducing avoidable deaths related to substance misuse

A study commissioned by the Welsh Assembly Government aimed to inform the process of developing partnerships within emergency care settings to develop, test or introduce interventions to reduce drug overdoses (AWARD 2009). The study had two parts: one provided a national snapshot of the incidence and patterns of non-fatal overdoses between 1st December 2007 and 29th February 2008 and provided in-depth case studies of drug poisoning patients who attended A&E at a single hospital; the other provided a systematic overview of interventions and a systematic review of the effectiveness of interventions. Identification of non-fatal poisonings from the Welsh Ambulance Service NHS Trust and A&E information systems proved difficult as command and control data were inaccurate and other information was not stored electronically. Nevertheless, 1,827 cases were identified, of which 10% had a history of substance misuse and/or overdose. The largest group amongst the 47 case studies had taken benzodiazepines.

The systematic review found that there was little evidence of effectiveness of interventions to prevent poisonings and that most evidence that did exist relates to take home naloxone rather than interventions through other settings such as emergency departments. The study concludes that the high level of repeat presentations to emergency services provides an opportunity to target interventions at high-risk individuals and that information systems should be developed and linked in order to identify patients and patterns of presentations.

²⁰⁰ See: http://www.glasgow.gov.uk/en/Residents/Care_Support/Drugs_Alcohol/

²⁰¹ See: <http://www.ihra.net/March2009#DevelopinganInternationalDirectoryofNaloxoneProgrammes>

²⁰² See: www.take-homenaloxone.com

In October 2008 a best professional practice seminar in pathology and toxicology investigations of drug-related deaths in Wales was held. The seminar was attended by over 50 experts working in pathology and toxicology services in Wales. Best practice advice has been issued to all pathologists and toxicologists working in Wales and a follow up seminar is planned for late 2010.

7.3 Prevention and treatment of drug-related infectious diseases

Implementation of Reducing Drug-related Harm: An Action Plan

The National Treatment Agency (NTA) has begun the implementation of a programme of initiatives aimed at reducing drug related harm. They are focused under three main headings of information campaigns, improving service delivery of harm reduction services and improved surveillance of service provision. These were previously outlined as key recommendations in *Reducing Drug-related Harm: An Action Plan* (DH and NTA 2007) which were discussed in last year's Focal Point report. The 'Harm Reduction Works' information campaign provides targeted harm reduction resources and advice to drug users and service providers. It includes a raft of information materials such as posters and DVDs, covering a range of topics such as safer injecting; hepatitis C testing and how to avoid infection; hepatitis B and vaccination; HIV; overdose awareness; injecting crack cocaine and groin or femoral injecting. There is a dedicated website²⁰³ from which service providers can order these information resources. With the aim of improving service delivery of harm reduction services, the NTA has published *Good Practice in Harm Reduction* (NTA 2008c). This has been developed using interview data from service providers who gained high scores in the Healthcare Commission and NTA joint improvement review (Healthcare Commission and NTA 2008) (see last year's Focal Point report for details). It aims to provide examples of what works well in service provision and to highlight how drug partnerships could improve in terms of planning and delivery of services.

Shooting up: Infections among injecting drug users in the United Kingdom 2008

In the 2008 *Shooting Up* report, the Health Protection Agency (HPA et al. 2009) conclude that there is a continued need to provide harm reduction and support services for injecting drug users and to develop them further in accordance with published guidelines. In particular there is a need to ensure the continued development of high-quality, accessible needle-exchange services which provide sufficient injecting equipment to prevent the sharing of needles and syringes, and an appropriate range of injecting-related equipment, other than needles and syringes. It also stresses the importance of providing:

- a range of easily-accessible drug treatment and support services that encourage drug users to reduce and cease injecting, and reduce or stop their drug use;
- information and practical advice on safer injecting practices, avoiding injecting site infections, prevention of blood-borne virus transmission and the safe disposal of used equipment;
- hepatitis B vaccination services, with follow-up strategies for those who have started the vaccination course;
- tetanus vaccine and boosters to those IDUs who may need them and hepatitis A vaccination, where appropriate;
- diagnostic tests for hepatitis C and HIV, and referral pathways for those infected to specialist assessment and treatment;
- health checks and treatment for injection site infections; and
- interventions to encourage safer injection practice and to decrease or stop injecting.

²⁰³ See: <http://www.harmreductionworks.org.uk/>

7.3.1 Needle exchanges and sharing of equipment

Infections among IDUs are typically due to poor injection related hygiene and, in particular, the sharing of injecting equipment has been associated with transmission of HIV and hepatitis C. A range of preventative interventions have been adopted in the UK that are designed to reduce the harm associated with drug use. Key among these is the widespread provision of needle and syringe exchanges. In 2008, almost all the current and former IDUs participating in the UAPMP²⁰⁴ survey in England reported that they had accessed a needle exchange service (91%). High levels were also found in Wales (94%) and in Northern Ireland (94%) (2007 and 2008 data combined) (HPA et al. 2009).

The sharing of needles and syringes (direct sharing) is a key route by which infections may be transmitted among IDUs: 19% of the current IDUs participating in the UAPMP survey reported direct sharing in the four weeks before taking part in the survey in 2008. This is the lowest level of direct sharing reported in this survey for over a decade. In 1997, direct sharing was reported by 17%. It then rose to 34% in 2002, before falling to 23% in 2007. In England, direct sharing was reported by 19% in 2008 and, when combining data for 2007 and 2008, 19% reported this in Northern Ireland and 20% in Wales (HPA et al. 2009).

Direct sharing in the last four weeks was more common among those current IDUs who reported injecting crack cocaine, cocaine powder, and an amphetamine. Those who had been homeless in the last year were also more likely to report sharing (HPA et al. 2009).

The sharing of filters, mixing containers and flushing water can also pass on infections and participants in the UAPMP survey continued to report sharing of these items. In England, 37% of current injectors reported sharing these items in 2008, compared with 54% in 2002. Substantial levels of sharing were also reported in Wales (38%) and in Northern Ireland (25%) (2007 and 2008 data combined). The most commonly shared items in England, Wales and Northern Ireland were mixing containers such as spoons (31%) (HPA et al. 2009).

In the financial year 2007/08²⁰⁵, drug treatment agency reports to the Scottish Drug Misuse Database (SDMD) indicated that 27% of current IDUs had shared a needle and syringe in the previous month; this compares with 29% in 2006/07 (HPA et al. 2009).

NICE Guidance on Needle Exchange Services

The National Institute for Health and Clinical Excellence (NICE) has published guidance on the optimum provision of needle exchange services (NICE 2009). The guidance is targeted mainly at health professionals and drug workers who are involved in the provision of needle and syringe programmes, although it noted that it may also be of interest for the wider public and injecting drug users. It aims to help individuals who inject illicit drugs and/or non-prescribed substances such as anabolic steroids. It is recommended that local data regarding the number of injectors, type of drugs used and demographics of injectors, alongside prevalence data regarding infections and other problems caused by injecting, is collected and analysed to ensure that services are meeting local need. The local community and drug users should also be engaged with in order to develop services in the future. There are further recommendations regarding how best to meet local need; the different types of services that should be offered; how and what equipment should be dispensed; what safer injecting advice should be given; and appropriate training for staff who work in the services.

The final guidance was preceded by a consultation process involving a wide range of stakeholders and the development of a series of fieldwork reports and consultation documents. Published outputs from the fieldwork include:

- a review of the effectiveness and cost-effectiveness of needle and syringe programmes for injecting drug users (Jones et al. 2008);
- needle and syringe programmes: providing injecting equipment to people who inject drugs: fieldwork report (Sumnall et al. 2008);

²⁰⁴ See section 6.3 for more information.

²⁰⁵ Provisional data.

- assessing the cost-effectiveness of interventions linked to needle and syringe programmes for injecting drug users: an economic modelling report (Vickerman et al. 2008); and
- injecting equipment schemes for injecting drug users: qualitative evidence review (Cattan et al. 2008).

The review into the effectiveness and cost-effectiveness of needle and syringe programmes, produced by the Centre for Public Health at John Moores University, was unable to draw any firm conclusions as to what works best due to a scarce evidence base. However, it did recommend that services providing a wide range of harm reduction resources are preferable to those that provide sterile needles and syringes only and that further research into this area was needed as a matter of urgency (Jones et al. 2008).

Northern Ireland Needle and Syringe Exchange Scheme

Northern Ireland has operated a Needle and Syringe Exchange Scheme since 2001, and activity monitoring information is collected from ten pharmacies that offer the service (PHIRB 2009c).

Table 7.1 shows that in 2008/09:

- there were 13,389 visits to participating pharmacies by users of the scheme, an increase of 18% from 2007/08;
- 135,700 syringes were issued in 2008/09, an increase of 16% from 2007/08;
- 53% of cin bins issued to users of the scheme were returned; and
- 86% of visits were made by male clients.

The Needle and Syringe Exchange Scheme is currently being expanded to cover 14 sites across Northern Ireland, and will incorporate relevant outreach services.

Table 7.1: Syringe provision: number of visits, syringes issued and proportion involving return of used equipment in Northern Ireland, 2001/02 to 2008/09

| YEAR | NUMBER OF VISITS | NUMBER OF SYRINGES ISSUED | % RETURN RATE ²⁰⁶ |
|---------|------------------|---------------------------|------------------------------|
| 2001/02 | 5,213 | 67,989 | 67 |
| 2002/03 | 6,043 | 67,516 | 61 |
| 2003/04 | 7,508 | 82,731 | 59 |
| 2004/05 | 7,440 | 86,056 | 54 |
| 2005/06 | 8,797 | 85,801 | 44 |
| 2006/07 | 9,997 | 97,684 | 40 |
| 2007/08 | 11,387 | 116,935 | 54 |
| 2008/09 | 13,389 | 135,700 | 53 |

Source: DAIRU 2003; DAIRU 2004; DAIRU 2005; DAIRU 2006; DAIRU 2007; PHIRB 2008b; PHIRB 2009c

²⁰⁶ Since April 1st 2007 the method of calculation of the return rate of used equipment has changed from the proportion of visits involving the return of used equipment to the number of cin bins returned as a percentage of the number issued at every visit, hence the 2006/07 figure is different from that reported in last year's Focal Point report.

Welsh pilot needle exchange data collection project

In January and February 2008 a needle exchange monitoring system was piloted in six areas of Wales for a period of four weeks (Smith 2008). The needle exchange services collected data from clients each time they visited and recorded the amount of equipment that was issued alongside demographic and drug use information. The data were collected on a paper form which included a unique bar code identifier and was returned to an external company for optical scanning.

A review of the pilot scheme by the All Wales Needle Exchange forum²⁰⁷ concluded that it is feasible to develop a useful monitoring system with the minimum use of resources and effort from service providers. Further research is being conducted on the best way to move this monitoring system forward in the future including consideration of the proposed English and Scottish monitoring systems and an evaluation of the different available options will be undertaken.

In the four week period of the pilot:

- a total of 1,772 transactions took place;
- 1,067 unique service users attended the needle exchanges;
- the majority (89%) were White Welsh or White British (76% and 13% respectively);
- 81% of clients were male; 16% female and three per cent unknown; and
- the majority (89%) of clients were aged between 20 and 44 (Table 7.2).

Table 7.2: Number and percentage of individuals visiting participating needle exchange services in Wales by age and sex in January and February 2008

| AGE OF INDIVIDUALS | MALE | FEMALE | TOTAL | % |
|--------------------|------------|------------|-------------|--------------|
| Under 20 | 24 | 10 | 34 | 3.2 |
| 20-24 | 159 | 40 | 199 | 18.8 |
| 25-29 | 218 | 47 | 265 | 25.1 |
| 30-34 | 177 | 31 | 208 | 19.7 |
| 35-39 | 148 | 17 | 165 | 15.6 |
| 40-44 | 90 | 11 | 101 | 9.6 |
| 45-49 | 25 | 5 | 30 | 2.8 |
| Over 50 | 12 | 7 | 19 | 1.8 |
| Not recorded | 34 | 2 | 36 | 3.4 |
| Total | 887 | 170 | 1057 | 100.0 |

Source: Smith 2008

²⁰⁷ See: <http://www.wnef.org.uk/>

The most common primary drug was heroin (73%) followed by steroids (12%) and amphetamine (eight per cent). The most common secondary drug was crack cocaine (23%) followed by amphetamine (22%), benzodiazepines (17%) and cocaine powder (15%) (Table 7.3).

Table 7.3: Number and percentage of individuals visiting participating needle exchange services in Wales by primary, secondary and tertiary drug in January and February 2008

| | PRIMARY DRUG | | SECONDARY DRUG | | TERTIARY DRUG | |
|----------------------|--------------|--------------|----------------|--------------|---------------|--------------|
| | n | % | n | % | n | % |
| Heroin | 770 | 72.9 | 23 | 10.9 | 3 | 2.9 |
| Cocaine powder | 8 | 0.8 | 31 | 14.7 | 15 | 14.6 |
| Crack cocaine | 15 | 1.4 | 49 | 23.2 | 21 | 20.4 |
| Amphetamine | 85 | 8.0 | 46 | 21.8 | 21 | 20.4 |
| Benzodiazepine | 15 | 1.4 | 35 | 16.6 | 14 | 13.6 |
| Methylamphetamine | 0 | 0.0 | 1 | 0.5 | 9 | 8.7 |
| Human Growth Hormone | 18 | 1.7 | 14 | 6.6 | 6 | 5.8 |
| Steroids | 130 | 12.3 | 12 | 5.7 | 7 | 6.8 |
| Insulin | 1 | 0.1 | 0 | 0.0 | 7 | 6.8 |
| Unspecified | 14 | 1.3 | 0 | 0.0 | 0 | 0.0 |
| Total | 1,056 | 100.0 | 211 | 100.0 | 103 | 100.0 |

Source: Smith 2008

Needle exchange monitoring systems

A new national web based system²⁰⁸ to collect information from local needle exchange services in England was introduced by the NTA in April 2008 in order to improve the quality and consistency of data collection (NTA 2008d). At the time of writing there have been no published outputs from the system.

Needle exchange in Scottish prisons

In both phase one and two of the *Hepatitis C Action Plan for Scotland* (Scottish Government 2008b; 2009f) the implementation of needle exchange facilities within prisons has been stated as an aim. However, this has stalled pending agreement between the Scottish Prison Service, Scottish Government and the Prison Officers Association.

ACMD review of foil as a harm reduction intervention

In its annual report the ACMD states that it is in the process of considering the evidence regarding the use of foil as a harm reduction measure with respect to smoking (chasing) heroin as an alternative to injecting. The findings of the review are due to be reported to Government by the end of 2009 (ACMD 2009e).

²⁰⁸ See: http://www.nta.nhs.uk/areas/drug_related_deaths/needle_exchange_monitoring_system/default.aspx

7.3.2 Viral hepatitis prevention and treatment

Hepatitis C

Health Protection Agency annual report: hepatitis C in the UK

Whilst it is noted that the situation in the UK has improved, the Health Protection Agency suggest that there still needs to be more effort in increasing the number of IDUs who engage with drugs services and these services need to ensure that effective harm reduction interventions are delivered in order to prevent infection. It also calls for prisons to work harder at ensuring drug users have access to treatment. The importance of improving the quality of needle exchange services and providing appropriate training and education on hepatitis C for staff and clients of such services is also emphasised in the report (HPA 2009).

ACMD Prevention Working Group on hepatitis C prevention

The Prevention Working Group on hepatitis C prevention (consisting of ACMD members, HPA staff and co-opted experts) has published a report entitled *The Primary Prevention Of Hepatitis C among Injecting Drug Users* (ACMD 2009f). The report makes a series of recommendations and suggests the need for a synergistic approach to hepatitis C prevention and interventions provided in drug services such as: offering sterile injecting equipment in services that provide methadone; needle and syringe providers offering service users a route into drug treatment; increased hepatitis C testing of service users by all services that have regular contact with injectors; and further research evaluating the impact of hepatitis C interventions in order to strengthen the evidence base.

Increasing the numbers of IDUs tested for hepatitis C

In England, increasing the proportion of IDUs who are aware of their infection status through improved uptake of voluntary confidential testing is one of the aims of the *Hepatitis C Action Plan for England* (DH 2004). Of those IDUs taking part in the 2008 UAPMP survey²⁰⁹, 77% reported having undertaken a voluntary confidential test, compared to 49% in 2000. Forty nine per cent of those infected with hepatitis C were aware of their status, compared to 40% in 2000 (HPA et al. 2009). Of UAPMP participants from Wales, 35% reported never having a voluntary confidential test for hepatitis C in 2007/08, with almost two-thirds of those with hepatitis C unaware of their infection. Less than one in ten (7.6%) of the participants from Northern Ireland in 2007/08 reported not having been tested for hepatitis C, and almost a third of the participating IDUs with hepatitis C in the province were unaware of their hepatitis C infection (HPA et al. 2009). Among IDUs surveyed at needle exchanges in three Scottish Health Boards during 2007, as part of the Needle Exchange Surveillance Initiative (NESI), a large proportion (56%) of respondents who were hepatitis C antibody-positive in saliva had not been previously diagnosed (that is, they had either never been tested, had not received their test result, or reported their status as hepatitis C- negative) (HPA et al. 2009).

²⁰⁹ Drug users in contact with specialist drug services.

Hepatitis C Action Plan for Scotland: Phase two – Year one progress

The Scottish Government has reported that the key target in the *Hepatitis C Action Plan in Scotland* (Scottish Government 2008b) for 2008/09 has been met, with the expectation that 560 people who are infected with hepatitis C will have commenced antiviral treatment in 2008, against a target of a minimum of 500. Progress has been made in establishing a new infrastructure to enable the NHS to better identify, diagnose, treat and support those with hepatitis C; identification of the training and development needs of staff in hepatitis C related posts has commenced; and national guidelines for injecting equipment provision and strategies to effectively communicate and raise awareness of hepatitis C issues amongst the public and professionals are in development. These activities are underpinned by a national and local programme management infrastructure which aims to ensure actions are delivered and investment is used in the most efficient and effective way (personal communication - Scottish Government). An event for stakeholders was held in May 2009 to discuss progress on the action plan²¹⁰ and a first year progress report has also been published (Scottish Government 2009f).

Scottish Drugs Forum HCV project

The Scottish Drugs Forum (SDF) has set up a project aimed at reducing hepatitis C among young drug users. The project will be funded for a two year period with money from the *Hepatitis C Action Plan* and will include training for youth workers who deal with vulnerable young people²¹¹.

Consultation on blood borne viral hepatitis action plan for Wales 2009-2014²¹²

In Wales a four month consultation took place between April and July 2009 on a proposed action plan on blood borne viral hepatitis. It is concerned with the planning and provision of services in Wales to reduce the spread of blood borne viral hepatitis and to increase diagnosis levels in the number of individuals who are currently infected but undiagnosed. The action plan aims to improve treatment and support and enable treatment and prevention programmes to be monitored and evaluated (WAG 2009c).

Randomised controlled trial in primary prevention of hepatitis C amongst IDUs

An RCT was conducted amongst two groups of IDUs who were not currently infected with hepatitis C, in order to compare the effectiveness of two interventions designed to prevent future infection (Abou-Saleh et al. 2008). The first intervention, Simple Educational Counselling (SEC) consisted of a single ten minute intervention involving the giving of preventative information and advice on risk factors associated with hepatitis C to the first group of IDUs. The other intervention, Enhanced Prevention Counselling (EPC) consisted of a series of four sessions lasting between 40 and 60 minutes. The sessions were based on psychological theories of behavioural change and motivation and were delivered by trained drugs workers and guided by a manual. The authors were unable to establish any significant differences in efficacy between the two interventions due to low sample sizes and retention levels.

²¹⁰ See: <http://www.hepcscotland.co.uk/action-plan.html>

²¹¹ See: <http://www.sdf.org.uk/sdf/596.html>

²¹² See: <http://www.adjudicationpanelwales.org.uk/consultations/healthsocialcare/blood/?jsessionid=pNISKtbBk8kHzyKVDzLXn5H1pMPLXHvqZX0FyHv1gRdHRKGJLN43!2055306406?cr=4&lang=en&ts=3>

Hepatitis B

Hepatitis B can be prevented by a safe and effective vaccine. The UK has a selective vaccination programme. The proportion of IDUs in the UAPMP survey who have taken up an offer of the hepatitis B vaccination has increased markedly over time, rising from 25% in 1998 to 72% in 2008 (based on self-reported data²¹³). Self-reported vaccination uptake varied by region and country (combining 2007 and 2008 data), and in Wales was 60% and in Northern Ireland 79% (HPA et al. 2009). Community-wide surveys of IDUs in Glasgow found a significant increase in hepatitis B vaccine uptake among those who had injected for five years or less in 2001/02 (52% compared with 16% in 1993, 1994 and January-March 1999). Further increases in vaccine uptake were seen among IDUs, surveyed in Glasgow during 2004, who had injected for five years or less (65%); 2005 (60%); and 2007 (60%) (HPA et al. 2009).

7.3.3 HIV prevention and treatment

In 2008, 28% of IDUs who took part in the UAPMP agency survey reported never having had a voluntary confidential test for HIV; this is the lowest level ever recorded in the survey. This reflects an increase in the uptake of testing in recent years as, before 2003, uptake had changed little since the survey started in 1990, with 42% reporting never having had a test in 2002. Of those who had antibodies to HIV, 64% were aware of their infection in 2008, similar to the level seen in the previous two years, but higher than in 2005 (47%) (HPA et al. 2009).

In 2008, 1,112 HIV-infected IDUs were seen for HIV-related treatment or care in England, Wales and Northern Ireland, a 23% increase since 2000, when 903 IDUs were seen for care. While 24% of IDUs were not receiving antiretroviral therapy in 2008, the majority were, with 56% on a combination of three drugs and 17% receiving four or more drugs. In Scotland, 362 HIV-infected IDUs were seen for HIV-related treatment or care in 2008, a 13% decrease since 2000 when 418 IDUs were seen for care. While 8.3% of IDUs were not receiving antiretroviral therapy in 2008, the majority were; with 54% on a combination of three drugs and 37% receiving four or more drugs (HPA et al. 2009).

Proposed HIV Action Plan in Scotland

The Scottish government has published a draft action plan to reduce transmission rates and levels of undiagnosed HIV. It is believed that there may be a population of injecting drug users who are not displaying outward symptoms of HIV and therefore, may have gone undiagnosed for a number of years. It is proposed that in order to prevent transmission of HIV from this group, future prevention efforts should be continued and aligned more closely with those for hepatitis C (which presents a higher risk to this group). The Scottish Government is planning to set up a HIV Action Plan group to oversee the implementation of the action plan when the final version is published (Scottish Government 2009g).

Information campaigns

Advice to injecting drug users was issued in Scotland, where there were several reported cases of necrotising fasciitis²¹⁴ among injecting drug users in January 2009.

²¹³ Vaccination uptake data should be interpreted with caution as they are based on self-reports.

²¹⁴ See: <http://www.hps.scot.nhs.uk/ewr/article.aspx>

7.4 Responses to other health correlates among drug users

7.4.1 Mental Health

Cannabis and mental health: FRANK media campaign

The FRANK media campaign launched a series of television adverts aimed at 11 to 18 year olds warning teenagers of possible links between cannabis use and mental health problems (see section 3.4).

Department of Health consultation on mental health services

DH is currently undergoing a consultation process on its *New Horizons: towards a shared vision for mental health*²¹⁵ document which sets out cross-governmental proposals to develop and improve the delivery of mental health services, including those for dual diagnosis. The proposals focus on prevention of mental illness; early identification and intervention; and local support that is tailored to the individual. The consultation closes in autumn 2009 with implementation due to begin in 2010 (DH 2009c).

NICE guidance: Psychosis with Problematic Substance Misuse

NICE has commissioned the National Collaborating Centre for Mental Health to develop clinical guidelines for the assessment and management of psychosis in conjunction with problematic substance misuse. A scope has been published which defines what the guidance will cover and who it will be applicable to. The guideline's expected publication date is March 2011²¹⁶.

Mutual aid groups in substance misuse practice

In a literature review incorporating published material and grey literature, Baldacchino et al. (2008) discussed the benefits and drawbacks of mutual aid²¹⁷ or 'self help groups' in terms of its usefulness in mental health and substance misuse practice. They reported that there is currently a dearth of UK based evidence around this area (most of what is available is from the United States). From what was available they generally found that studies were typically poor in terms of methodology and had small sample sizes so it was difficult to make generalisations. However it was reported that groups were often associated with a range of subjective benefits for participants which tended to be particular to each group (they were unable to generalise because of 'heterogeneity in the outcomes'). They suggest that more research is needed in this area and a heightened awareness of this approach could be beneficial to practice.

²¹⁵ See: http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_103144

²¹⁶ See: http://www.nccmh.org.uk/guidelines_smipsm.html and <http://www.nice.org.uk/Guidance/CG/Wave15/8#projectTeam>

²¹⁷ Although there is no official definition of 'mutual aid groups' this study reported a consensus amongst researchers of the following three features: 'they are run for and by people who share the same health or social issue; their primary source of knowledge is based on sharing direct experience; they occur as voluntary collectives predominately in the third sector of society as opposed to the statutory or private sectors'.

Acceptability and applicability of Cue Exposure Therapy as a relapse prevention intervention for individuals who have substance misuse and mental health problems

In a qualitative study²¹⁸ mental health professionals who work with dual diagnosis clients were trained in the principles of Cue Exposure Therapy (CET)²¹⁹ and then assessed the effectiveness of the training sessions and considered how the skills learnt in them could be adapted and applied with their clients (Manley 2008). Many participants stated that they had used some of the techniques in practice since the training and were more likely to have discussions around cravings with their clients in the future. Although the confidence of all participants had increased significantly post training, they all thought that they needed more training. Participants who had specific training in substance misuse (diploma level or above) were more likely than others to feel that CET could be of use with their clients.

7.4.2 Parental substance misuse

Babies affected by parental substance use

The City of Edinburgh Council²²⁰ reported that there has been an increase in the past year in the number of vulnerable babies in Edinburgh, Scotland who have been referred to foster carers. In most cases this is due to parental substance misuse and/or maternal addiction to drugs or alcohol. In response to this the council has appealed for more potential foster carers to come forward and has launched a training DVD to help those caring for vulnerable babies, focusing on the specific needs of babies born with Neonatal Abstinence Syndrome (NAS). National guidance developed by the Getting it Right for Every Child in Kinship and Foster Care²²¹ group entitled *Moving Forward in Kinship and Foster Care* has been published (Scottish Government 2009h). It highlights examples of good practice and includes recommendations regarding improving recruitment and retention of foster carers.

Changing profile of pregnant women engaging with specialist outreach addictions service

In a comparison of women accessing a perinatal outreach service for pregnant substance users the authors found that the profile of clients had changed over time (using data from 1989 to 1991 and 2002 to 2005) (Mayet et al. 2008a). In the later data clients were significantly older, more likely to be from BME groups and to use cocaine or be polydrug users.

The service provided joint addictions and maternity care to clients and it is proposed that this may be a preferable approach to pregnant substance users rather than two separate services which is more usual. It worked closely with local maternity services in order to increase referral rates and was able to attract a high proportion of woman who were not already in treatment for their substance use and who lived in unstable accommodation due at least in part to its 'assertive outreach' approach to recruitment and retention of clients. It is concluded that integrated services such as this one should be further developed and improved to recruit women at an earlier stage of pregnancy.

²¹⁸ Thirty eight mental health practitioners from a variety of settings were given a half day training session about CET including behavioural theory of craving; self-efficacy in coping with craving; and coping techniques for clients to respond to situations where drug-related triggers occur.

²¹⁹ CET is a technique whereby clients are asked to think about the particular things that bring about cravings so that they can in future recognise the cues and triggers that can lead them to relapse with the overall aim of being able to control and reduce those cravings.

²²⁰ See: http://www.edinburgh.gov.uk/CEC/Corporate_Services/Corporate_Communications/Press_Releases/NewsRelease.jsp?ID=4214 and <http://news.scotsman.com/education/Five-babies-a-month-in.5110901.jp>

²²¹ See: <http://www.scotland.gov.uk/Publications/2009/02/27085637/0>

In a follow up to the above article, a comparison of the outcomes of clients attending a perinatal outreach service for substance using pregnant women were investigated, comparing client data from 1989 to 1991 against data from 2002 to 2005, in order to identify if outcomes had changed over that timescale (Mayet et al. 2008b). The client outcomes from 2002 to 2005 were also compared against those of non-substance using women from the local maternity hospital from corresponding years. It was found that outcomes were generally good for the substance using mothers and the rate of neonatal deaths were similar to that for the local hospital data. However, high rates of low birth weight; premature births and admissions to special baby units were reported amongst the substance using mothers and there had been few changes in outcomes over the timescale of the comparisons apart from lower rates of treatment for Neonatal Abstinence Syndrome (NAS).

8. Social correlates and social reintegration

8.1 Introduction

There is a large volume of evidence from the United Kingdom showing the association between problem drug use and social exclusion. A high proportion of problem drug users have been socially excluded as children and young people; many are poorly educated; a high proportion live in inappropriate housing; and research in 2008 suggested that just over 80% (266,798) of problem drug users in England were in receipt of state benefit, representing seven per cent of all those receiving such benefits (Hay and Bauld 2008). There are also further concerns about the effect of parental drug use on children, leading to problems of social deprivation for them.

Social reintegration is a key element within recent drug strategies in England, Scotland and Wales. The strategy for Northern Ireland also recognises the need to provide support with housing and employment and wider support with social reintegration. There are various programmes to help drug users. The Supporting People Programme, introduced in 2003, provides housing related support to vulnerable groups generally, including people with drug problems. Progress2work (p2w), initiated in 2002, supports recovering drug users who are drug free or stabilised in gaining employment. The Building Safer Communities Fund aims to develop communities that are resistant to drugs. Social inclusion programmes such as Positive Futures can bridge the gap between universal and targeted services (see 3.2.2). Attention is also focused on the impact of parental drug use on children. In addition, there is a growing number of responses to neighbourhood problems associated with problem drug use, including drug dealing. For example, the *Anti-Social Behaviour Act 2003* seeks to stop the use of premises for drug dealing. Also, there is guidance to tackle the inappropriate disposal of drug paraphernalia.

8.2 Social exclusion and drug use

8.2.1 Housing

Data from the National Drug Treatment Monitoring System (NDTMS) in England show that, in 2008/09 10% of clients presenting for treatment reported an urgent housing problem (no fixed abode) with a further 16% reporting a housing problem such as staying with friends or family short-term or residing in a short-term hostel (NTA 2009h). Problem drug users were more likely to report housing problems than other clients.

Data from the Scottish Drug Misuse Database show that 16% of clients entering treatment in Scotland in 2007/08 were homeless (ISD 2008).

Findings from the Drug Outcome Research in Scotland study (DORIS), which took place between 2001 and 2004 (McKeganey et al. 2008) (see section 5.3.3) identified socioeconomic status as a risk factor for homelessness amongst drug users. Specifically there were significant differences between those who had never been homeless and the three homeless groups (homeless entrants, continuing homeless and homeless leavers) with respect to financial gain from criminal/illegal activity in the previous six months, with the 'continuing homeless' group the most likely to report this activity. This study also found an association between employment or participation in education/training and reported accommodation stability.

Illegal drug and alcohol-related litter in Scottish social housing schemes

Research conducted in social housing 'schemes' in Scotland examined the type and extent of drug-related litter in these areas (Forsyth and Davidson 2009)²²². Examination of photographs of litter in the social housing communities showed limited evidence of drug-related litter (such as needles/syringes) in comparison to alcohol-related litter (such as bottles and broken glass).

8.2.2 Employment and education

Sixteen per cent of clients entering treatment in Scotland in 2007/08 were employed, 70% were unemployed, and 13% were either in school, excluded from school, long term sick/disabled, or in prison (ISD 2008). A similar proportion of clients entering treatment in Northern Ireland were employed (17%) although a smaller proportion were unemployed (44%).

From 2006/07 to 2007/08 the total number of permanent exclusions (all reasons) from schools in Wales decreased by 20%. However, within this, the proportion permanently excluded due to substance misuse (including alcohol) increased from 7.6% in 2006/07 to 10.4% in 2007/08 (personal communication – Welsh Assembly Government).

8.2.3 Families

Thirty three per cent of new clients entering treatment in Scotland in 2007/08, reported having dependent children under 16 years of age (ISD 2008).

McKeganey et al. (2008), reporting on the DORIS cohort of drug users in Scotland (see section 5.3.3), found that 20% had at least one child living with them after eight months in treatment. Women receiving methadone treatment at baseline were four and a half times more likely to retain custody of their children compared to women receiving other forms of treatment. House ownership/tenancy was also linked to retention of children for both male and female parents, however, single parent status was linked with non-retention of children. Retention of children was not related to consumption and severity of drug dependence, unlike many other non-drug outcomes such as health, crime and employment.

The impact on the children of drug using parents

Forrester and Harwin (2008) examined the effect of parental substance use (alcohol or drugs) on welfare outcomes for children²²³. The authors investigated the outcomes for children two years after referral, specifically focusing on living arrangements, education, emotional/behavioural outcomes and impact on health. The findings showed that at the two year follow-up 46% of children remained in their previous living arrangement, 26% were residing with other family members (other than parents) and 27% had been taken into formal care arrangements. Those taken into formal care were less likely to have a non-substance using parent and more likely to have been a baby identified at risk. Analysis of the other outcomes indicated that two years after referral 47% of children had no problems in these areas. However, one-third (31%) had continuing problems and 22% had more problems than at referral. The authors concluded that professionals involved in support and care of children of substance using parents should pay greater attention to developing positive educational, emotional/behavioural and health outcomes in addition to living arrangements.

²²² The survey piloted the use of interpretive photography to assess the threat that these pose in the community (n = 1,239 pictures of such items).

²²³ All files being allocated for long term social work in four London boroughs over an average of one year were examined (290 families). Of the 290, 100 families with 186 children involved concerns about parental substance misuse.

Maternal drug use and child protection outcomes

A prospective cohort study of children in Bristol, England born to drug using mothers (self declared) compared the outcomes of those children at the age of five years old ('case' children) with children in a control group that were born in the same hospital and within the same time frame (1997 to 1998) to mothers who did not self-report drug use (Street et al. 2008). The children in both groups were matched according to social class and gestational age. The authors searched the local authority child protection registers at age 18 months and again at five years to establish if there were differences in the outcomes between the two groups. It found a significant difference between groups in that 47.3% of the children born to maternal drug users had been subject to child protection procedures during the first five years of life, compared to 18.8% of the control children. Additionally, six 'case' children had been taken into care (four temporarily and two permanently) compared to one 'control' child taken into temporary care. However, there were no indications of the current drug using status of the mothers for either group at this point in the child's life. The findings are limited as the child protection outcomes in this study are 'proxy markers' for the potential abuse experienced by the children and do not reflect the complexity of what is happening in each individual case.

Estimating the numbers of children of problematic drug users in the North West of England

In the Cheshire and Merseyside areas of the North West of England, a review of data collected via NDTMS and Drug Interventions Programme (DIP) drug monitoring systems was conducted to provide an estimate of the number of children of PDUs²²⁴ (Duffy et al. 2009). The DIP data was also used to examine residential status²²⁵. There were differences in the residential status of children of male and female PDUs, with the majority of males (57%) stating that their child(ren) were living with a partner. Female PDUs provided a wider range of answers with around a third stating that their child(ren) (32%) lived with them and around a third (34%) said they were living with a family member.

Estimates of the number of children of drug using parents produced from these datasets ranged from 14,517 using NDTMS data (three per cent of children under 16 years old in the area) to 24,552 using DIP data (five per cent of children under 16 years old in the area). From amalgamated data it was estimated that there were 19,029 children of drug using parents (four per cent of children under 16 years old in the area). The difference in the estimates can be attributed, at least in part, to the way that parental status is recorded within each system, and the report discusses the benefits and limitations of each dataset.

It is reported that the number of children of drug using parents potentially poses a significant burden to both support services and the families of PDUs who often provide 'kinship care' to these children. The importance of producing reliable estimates of children of PDUs is highlighted in terms of the need for service providers to be able to make the necessary investment and resources available for the appropriate level of support services this group requires.

²²⁴ Data relating to parental status and number of children from the National Drug Treatment Monitoring System (NDTMS) and the Drug Interventions Programme (DIP) was extracted and analysed independently, and as an amalgamated dataset.

²²⁵ Due to the different methods of data recording the DIP data provided the fullest picture of residential status and therefore was the only dataset this data was reported from.

The nature and extent of parental substance use

The extent of parental problematic substance use (drugs and alcohol) was examined as a sub-theme of the Belfast Youth Development Study (BYDS)²²⁶ (Percy, Thornton and McCrystal 2008). The authors examined the extent and nature of drug and alcohol use amongst families of the BYDS cohort; this included parental and dependent children substance use. Findings showed that there was a high level of disapproval of drug use amongst parents (over 90%). However, one per cent of parents reported problem drug use. When drug and alcohol use were considered together the proportion of the BYDS cohort living in a household with problem substance use increased considerably (15% exposed to hazardous drinking, 12% of households had two or more problem drinkers and 38% had a cannabis using sibling). The authors conclude that consideration of the harm for children and young people of parental substance use is essential within support and treatment services.

The impact of drug use on adult family members

The UK Drug Policy Commission (UKDPC) has commissioned research to consider the impact on adults who have a family member who uses drugs. The aim is to estimate the number of adults affected and to place a financial value on the support and care they provide, as well as the cost to society of the harm experienced by them. The review also seeks to identify effective practice, in terms of both how family members can be involved in the process of treatment and recovery, and how their own support needs can be met.

8.2.4 Barriers accessing health and social care

In a qualitative study with IDUs²²⁷ exploring their experiences of accessing generic health care services (as opposed to specific addiction services), it was found that participants had faced a range of barriers which were often specific to them as an individual (Neale et al. 2008). Negative attitudes towards IDUs from service providers (both actual and also anticipated by IDUs due to embarrassment about their own behaviour) was a commonly discussed barrier and there was often difficulty in physically getting to services either because of distance or due to opening hours that did not fit in with their lifestyle. Due to the limitations of the qualitative data, it was difficult for the authors to generalise the findings, however there were some other frequently mentioned barriers, across a range of services, namely: inability to access services; 'burden of appointments'; poor health; finance; and fear of being told bad news by doctors. The paper goes on to discuss why some clients are treated differently to others by practitioners using social exclusion theory and the theoretical concept of knowledge and power.

Asian and African-Caribbean communities

Research undertaken with Asian and African-Caribbean communities²²⁸, by the University of Central Lancashire (UCLAN)²²⁹, found that drug use was varied and complex. Participants indicated that they had concerns about confidentiality in drug treatment, with only seven per cent reporting that they would seek treatment from a specialist drug treatment service. The research concluded that stigma attached to drug use is a barrier to treatment engagement and drug treatment services need to be proactive in engaging drug users from these communities.

²²⁶ The Belfast Youth Development Study (BYDS) is a longitudinal community based survey.

²²⁷ Seventy five current injectors were recruited from three needle exchanges in different parts of West Yorkshire, England. They were interviewed using a semi-structured format about their experiences of accessing generic health services.

²²⁸ Questionnaires, interviews and focus groups were undertaken with a total of 265 participants from three areas (Aylesbury, Chesham and Wycombe).

²²⁹ See: <http://drugs.homeoffice.gov.uk/publication-search/dip/community-engagement-project?view=Standard&pubID=645240>

8.2.5 Sex workers

In a qualitative study of female sex workers²³⁰ in London it was found that most participants worked to pay for crack cocaine and found themselves in a 'vicious circle' of using drugs and working more to fund that drug use. They were often subjected to violence in the course of their working lives in addition to experiences of violence and abuse in their early family life. Most of the women had children and the authors suggest that services could be more flexible in terms of providing child care. Unstable accommodation was also a key feature of most women's lives. All participants had experience of treatment services and whilst the general view was positive, it was suggested that there were not enough services and the support was not provided for long enough. The authors conclude that flexibility of approach and an appreciation by staff of the needs of this particular group are key factors in service delivery (Mosedale et al. 2009).

8.2.6 Perceptions of anti-social behaviour

Analysis of the 2008/09 *British Crime Survey* (BCS), focused on the seven strands that comprise the overall summary measure of perceptions of anti-social behaviour (ASB).²³¹ These were teenagers hanging around on the streets; vandalism, graffiti and other deliberate damage to property or vehicles; people using or dealing drugs; people being drunk or rowdy in public places; rubbish or litter lying around; noisy neighbours or loud parties; and abandoned or burnt-out cars. The analysis found that the proportion of adults who perceived a high level of ASB fell from 19% in 2001/02 (the first year in which this measure could be calculated) to 17% in 2008/09 (Walker et al. 2009).

Perceptions of problems with people using or dealing drugs decreased from 31% in 2001/02 to 28% in 2008/09 although there was a statistically significant increase from 26% in 2007/08.

The 2008 Place Survey²³² collects information on 18 national indicators (NI) (see section 1.3.1), one of which is NI 42: perceptions of drug use or drug dealing as a problem (CLG 2009b). Thirty one per cent of respondents reported that drug use or drug dealing was a problem in their local area. While national figures are provided it is noted that this survey is primarily for use at the local level and that the British Crime Survey, where an identical question is asked, should be used at the national and regional level

8.3 Social reintegration

8.3.1 Housing

The Drug Interventions Programme

A factsheet on housing from DIP (see section 9.3.1) states that stable accommodation is an essential element in an individual's rehabilitation and crucial in preventing relapse and reoffending²³³. Partnership working between departments and agencies responsible for housing, drug treatment, crime reduction and health is required to provide a better approach to solving the housing issues of drug users, specifically the most vulnerable i.e. those exiting treatment or prison without stable accommodation.

²³⁰ A series of unstructured interviews were conducted with 12 women who were (or had been) sex workers and drug users lasting between 30 minutes to an hour. The key themes emerging from the interviews were then picked out during the analysis of results.

²³¹ The overall measure forms one of the indicators for a Government Public Service Agreement (PSA) on 'Making Communities Safer' (PSA 23). In addition, two of the strands (perceiving problems with people being drunk or rowdy and perceiving problems with people using or dealing drugs) are performance indicators for PSA 25 'Reduce the harm caused by alcohol and drugs'. The set of PSA targets for the spending review period 2005/06 to 2007/08 concluded at the end of March 2008.

²³² Each local authority was responsible for running its own survey, a manual was provided to provide information on standards required in conducting the survey.

²³³ See: <http://drugs.homeoffice.gov.uk/publication-search/dip/dip-housing-december-08>

Improving Practice in Housing for Drug Users

A paper focusing on housing and related support for drug users, *Improving Practice in Housing for Drug Users - A Partnership Project* (Home Office 2008c), was produced by a partnership group of government departments and agencies²³⁴. The paper is aimed at accommodation providers and drug support services in order to promote the role of housing in drug users' recovery. It includes case studies providing examples of problems, issues, practices and solutions for drug users seeking a variety of types of housing. The paper recognises how partnerships between housing providers and drug support agencies can assist in improved outcomes for the individual, not only in relation to housing and drug use but also to engagement with other support services and a reduction in criminal activity and anti-social behaviour. The paper promotes flexibility, service user involvement and consistency in local approaches to housing for drug users (a factor it indicates as vital to drug treatment success and reintegration).

Joint projects between treatment and homeless services

There are now a number of joint projects at the local level between drug treatment services and homeless projects. Examples of such projects are: a methadone programme within a homeless hostel, helping with multiple needs issues; a new project using contingency management to increase the uptake of hepatitis B vaccination; testing and treatment of HCV and HIV amongst homeless injectors living in a hostel; and detoxification and support being provided within some homeless units with support from specialist drug treatment services (personal communication - National Treatment Agency).

Supporting People housing support

Between 2006/07 and 2008/09 there has been a year-on-year increase in the number of people with a drug problem who have received housing support from Supporting People²³⁵, from 4,589 in 2006/07 to 5,435 in 2008/09²³⁶.

8.3.2 Education and training

Progress2work

Progress2work supports individuals recovering from drug misuse to find and gain employment, access training and to deal with housing or debt problems²³⁷. Between September 2004 and January 2009 12,203 individuals accessed support from Progress2work and entered education or training; 7,602 accessed specialist training with 4,966 completing this training.

8.3.3 Employment

Welfare Reform Bill

The Welfare Reform Bill is currently passing through Parliament. The Bill contains proposals to pilot a new benefits and sanctions system for heroin or crack cocaine users whose addiction is preventing them from finding work. The objectives are two-fold, to test:

- ways of identifying people on benefits with problematic drug use;
- a new mandatory integrated approach to treatment and employment support

²³⁴ The partnership included The Home Office Drug Interventions Programme (DIP), Communities and Local Government (CLG), the Ministry of Justice National Offender Management Service (NOMS), the Housing Corporation, the Department of Health's (DH) Care Services Improvement Partnership (CSIP) and the National Treatment Agency (NTA) for Substance Misuse.

²³⁵ Supporting People is a national scheme which promotes independent living in a supported environment for vulnerable people. See: <http://www.spkweb.org.uk/>

²³⁶ See: <http://www.theyworkforyou.com/wrans/?id=2009-07-21c.288485.h&s=supporting+people+drug#g288485.r0>

²³⁷ See: http://www.direct.gov.uk/en/Employment/Jobseekers/programmesandservices/DG_173698

The Bill also introduces a new Treatment Allowance that drug users who are part of the pilot will receive during the period that they are on the new drug and employment programme. The benefit will be paid at the same rate as the underlying benefit (either Jobseekers Allowance or Employment and Support Allowance) but the conditions of entitlement will be varied and replaced with more appropriate conditions for supporting recovering drug users.

The new regime will be piloted from October 2010 in five Jobcentre Plus districts²³⁸ where identified problem drug users (users of heroin or crack cocaine) receiving Jobseekers Allowance (JSA) or Employment Support Allowance (ESA) will be referred for an assessment. If appropriate, they will be referred onto a new contracted employment and support programme. When they join the programme they will be required to agree a rehabilitation plan with the programme provider. This will bring together agreed actions required to stabilise their drug use and to address any other barriers to employment that they might face. Those who agree and take the actions in the plan will receive a treatment allowance for the duration of the programme. Those who refuse to attend an assessment may be subject to a financial benefit sanction and referred to undertake a series of mandatory drug tests

Jobcentre Plus Drugs Co-ordinators across England

From late April 2009 problem drug users in England claiming either Jobseekers Allowance or Employment and Support Allowance and not already in drug treatment are being encouraged to attend a drug treatment agency for an initial meeting about accessing treatment. This initiative is being supported by a network of Jobcentre Plus Drugs Co-ordinators, who are being funded by the Department of Health (DH), which has committed €10.2 million (£9m) over three years. The co-ordinators provide a link between Jobcentre Plus and drug treatment services, across England²³⁹.

Progress2work

Progress2work is a voluntary employment programme that offers additional employment support to recovering drug users, over and above that already received through mainstream employment support. In 2007/08, 21% of those in contact with Progress2work gained employment (2,700 of 12,850 individuals)²⁴⁰. After 13 weeks 1,450 remained in work.

Findings from DORIS

Analysis of the DORIS data in Scotland (McKeganey et al., 2008) showed an association between gaining paid employment and a number of variables for drug users in treatment. Paid employment was positively associated with assistance to obtain employment from drug treatment agencies; younger age; less participation in criminal activity; and lower levels of drug dependence. However, aspects of the lifestyle of an individual in drug treatment were found to act as obstacles to gaining employment, for example chaotic lifestyle, lack of previous experience of employment. As the strongest association was assistance from treatment agencies the authors concluded that this is a key factor in employment for those in drug treatment and should be a consideration of drug treatment agencies in partnership with employment agencies. Furthermore, the authors suggest that programmes which assist individuals in preparation for finding work by investing time in improving self-confidence, motivation and chaotic lifestyles, such as Progress2work in England and Wales and the New Futures Fund in Scotland, are more appropriate as an employment-based stepping stone for those in drug treatment, prior to joining mainstream programmes such as New Deal.

²³⁸ The five districts are Merseyside, Lancashire and Cumbria, West Yorkshire, Birmingham and Solihull and Central London.

²³⁹ See: http://www.nta.nhs.uk/news_events/newsarticle.aspx?NewsarticleID=146

²⁴⁰ See: <http://www.theyworkforyou.com/wrans/?id=2009-03-31b.261076.h>

Getting problem drug users (back) into employment

The UKDPC commissioned research regarding access to employment for recovering drug users. As part of this the University of Manchester conducted a two part project. The first part of the research investigated drug use and benefits entitlement and receipt, with a particular focus on problem drug use (Harris 2008). It also examined the potential impact on problem drug users (PDUs) of proposed reform to policy.

It was reported that within the UK benefits system PDUs had previously had 'low visibility', however, more recently there has been a new focus on initiatives and policies for PDUs. Specifically these have been designed to reduce benefit dependence and enhance PDUs ability to gain paid employment.

It is however suggested that while drug misuse is often the cause of other problems related to mental and/or physical health, it is the latter that trigger entitlement to benefits. The underlying cause, which may be drug misuse, may be of no concern to the benefit authorities (nor the social security legislation itself) and the drug problem may remain hidden and therefore will not be reflected in the official statistics. Furthermore, the author believes there should be concerns about implementing tougher procedures for PDUs to access benefits when there are gaps in current knowledge of how PDUs are treated within the benefits system.

The second part of the research investigated barriers and issues faced by PDUs gaining paid employment and examined the most effective models and initiatives to enhance (re-)entry into the labour market (Spencer et al. 2008)²⁴¹.

The authors concluded that:

- employment is an integral part of a problem drug user's recovery, and can make positive changes to the individual's self-esteem and confidence;
- volunteering is an important element in preparing problem drug users for work;
- employers lack accurate knowledge about problem drug use and perceive employment of PDUs as high-risk, but this is in contrast to the actual experiences of employers who had done so, and therefore easily accessible information and support should be available for employers;
- PDUs generally demonstrate a high level of commitment to their work and are employable across a range of sectors;
- accommodation that is appropriate to a PDU's stage of treatment is critical; and
- there is a need for incentives to encourage employers to employ PDUs.

Following on from these reviews, the UKDPC concluded in a further report (UKDPC 2008) that there is currently much heterogeneity in the way PDUs are dealt with within the benefits system and many of them are 'invisible'. However, there are examples of good practice and these need to be promoted. Also support and information for employers and more active engagement with them is essential if programmes to encourage reintegration and recovery for problem drug users are to be successful. The report goes on to make 34 recommendations to help improve access to employment for drug users.

²⁴¹ Employer perspectives were gathered through a United Kingdom-wide national web survey (135 respondents) and 52 telephone interviews. Service provider perspectives were gathered through 30 face-to-face and telephone interviews. Problem drug user perspectives were explored through 26 face-to-face interviews.

8.3.4 Families

Drug strategies across the United Kingdom are concerned with the impact of drug use on family members, particularly the children of drug using parents. See section 3.3.2 for interventions for at-risk children.

Interventions for children and families where there is parental drug misuse

As part of the Department of Health Policy Research Programme, Drugs Misuse Research Initiative (DMRI) phase II²⁴², Kroll and Taylor (2009) looked at interventions for children and families where there is parental drug misuse²⁴³. The report concluded that, unless there is evidence presented to the contrary, all children residing with drug using parent(s) should be considered 'children in need'. It was suggested that there is a need for preventative, family focused approaches, a new package for families, and that it is important to take into account the views of both parents and their children.

Parental substance misuse: An Islington perspective

Nagle and Watson (2008) published a discussion on the impact of parental substance misuse on children, with a particular focus on the authors' experience of responding to this issue in Islington, London. After recognition of problems within Islington regarding delivery of services to parents with substance use issues, two specialist roles to respond to both substance misuse and childcare were commissioned. The aim of these posts was to improve treatment engagement and retention, and respond to child welfare issues. The authors concluded that the commissioning of the two posts led to a change in culture of attitude and stereotypes across treatment and social work services, bridging the gap between services and enhancing partnership working. It was recommended that this new working strategy could foster improved outcomes for both children and parents, however, there is a continued need for clear guidance on working with substance using parents and their children.

Addressing substance misuse amongst parents of children at risk of neglect

A multi-agency approach to address substance misuse amongst parents whose children are at risk of neglect was implemented in Brighton and Hove, England (Welsh et al. 2008). The paper discusses the partnership between Brighton Oasis Project, a women-only agency which provides psychosocial drug treatment and support to children, and Parents of Children at Risk, a service established to address the needs of substance misusing parents whose children have been identified as at risk. The joint working of these agencies has improved outcomes for substance users and their children. Specifically, the partnership has meant more families have remained together and there has been improved communication between children's and adult's services in the area with a 'family approach' to problems rather than dealing with individual's needs in isolation.

²⁴² Ten projects focusing on areas related to drug treatment and aims to deliver research-based evidence to underpin the development and delivery of effective services and interventions in the field of drug misuse were funded. The value of the programme was around £1.4 million from 2005 to 2008.

²⁴³ The research was conducted from March 2006 to March 2008, in a largely rural, predominantly White area of England, with four sets of interrelated data: case record analysis of the files of 28 children from 14 families on the area child protection register where parental drug misuse was an issue (and a family member had given consent); interviews with 42 children and young people between four and 20 years (average age: 12.6 years) with drug misusing parents; interviews with 40 drug misusing parents and seven grandparents, together with a focus group of parents; and interviews with 60 health and social care professionals from voluntary and statutory sector drug services, statutory child care and primary health care, together with a series of multi-professional focus groups.

Families First

The final evaluation report into the Families First project in Middlesbrough has been published (Woolfall et al. 2008). The project provides intensive support to families and their children (typically under the age of five, including newborns and pregnant mothers) who have been (or are at risk of) being placed on the child protection register and being taken into care. It aims to enable the families to change their lives such that the child(ren) can remain safely in the family home. The evaluation found that children of problem drug/ alcohol users who were on the verge of being taken into care were, in the majority of cases, able to stay with their families after the intensive support of the project was given to their parents. The availability of kinship care, usually provided by grandparents, was an important factor in preventing children being taken into care in the short term for many families. The average cost of the intensive family support provided by the project was much lower than the typical cost of placing a child into care. It was also noted that, in many cases, drug using parents displayed a reduction or cessation of drug use or maintenance of methadone in the twelve month follow up, although causality could not be determined.

Service provision for children of drug using parents engaged with DIP in Wales

A mapping exercise undertaken to map service provision for children whose parents were in contact with the Drug Interventions Programme (DIP) in Wales was undertaken by Barnardos Cymru (Jones 2009). The report highlighted gaps in knowledge about service provision for children of drug using parents, pathways for referral for children in need and their role in the safeguarding of children. Whilst it was recognised that information about DIP clients' children is recorded there were inconsistencies in how these data were gathered and recorded and the procedures to be followed when the client does not wish to disclose information about their children's well-being. Staff training needs and the need for future research investigating methods for positive engagement responses amongst DIP clients who are parents were also discussed.

Regional Hidden Harm Action Plan in Northern Ireland

Following a commitment in the *New Strategic Direction for Alcohol and Drugs* (DHSSPSNI 2006), in October 2008 a **Regional Action Plan** to address 'hidden harm' amongst children of substance misusing parents²⁴⁴ was published in Northern Ireland (DHSSPSNI 2008). The principles underlying the Action Plan and the regional action that the Department for Health, Social Services and Public Safety is committed to undertake in the first year of the three-year plan are set out. Initial action focuses on the development of relationships, structures and processes to promote effective joint working between services. The plan provides guidance to assist in the development of integrated local Hidden Harm Action Plans by March 2009.

ACMD 'Pathways to Problems' Implementation Group

In their annual report, the ACMD (ACMD 2009e) state that the findings from the implementation group set up to monitor progress against the recommendations made in their 2006 *Pathways to Problems* report (ACMD 2006) are due for release in 2009. Key aims of the 24 recommendations in the original report included improving outcomes for children and young people through better services and a reduction in the attractiveness of drugs and alcohol.

The role of family in recovery

A seminar paper published by DrugScope and Adfam (2009) discussed the effect of drug use on the family, and how the family can play an important role in recovery from drug dependency. The family is promoted as having a positive impact on treatment engagement, retention and recovery, and the need for support service provision for families is highlighted. The report recommends further investigation into the role and contribution of families, including an economic analysis.

²⁴⁴ See: <http://drugs.homeoffice.gov.uk/publication-search/acmd/hidden-harm>

Scotland: Early Years Framework

The Scottish Government and COSLA²⁴⁵ jointly published an early years framework in December 2008 (Scottish Government 2008f). It contains a set of guidelines that aim to provide children with the best possible start in life and the steps the Scottish Government, local partners and practitioners in early years services need to take in order to achieve those aims. The framework sets out a vision for childrens' early years. Key themes of the framework are supporting parents; focusing on the importance of zero to three year olds in order to improve outcomes; improving play opportunities and access to play; and early intervention to support children and families.

8.3.5 Sex workers

The Tyneside Cyrenians GAP Project aimed to address issues with women involved in sex work/sexual exploitation and provide a holistic approach to their needs²⁴⁶. They recognised drug and alcohol misuse as a factor associated with sex work. Drop-in services, assertive outreach and an individual and tailored service were recommended as methods to overcome barriers to engagement. Therapeutic activity and partnership working were highlighted as methods to improve service provision.

8.3.6 Other social reintegration initiatives

Drug System Change Programme Pilots

One of the key actions of the 2008 UK Drug Strategy is to test innovative projects offering to manage drug users throughout the treatment system in partnership with a range of support services in the local area (see section 5.2).²⁴⁷

Second Chance Programme

Sport Universities North East England (SUNEE) delivered the Second Chance programme²⁴⁸, involving sports-based activities for hard to reach groups, including drug users, with the aim of engagement, participation, development of athleticism and healthy campus initiatives. Drug Interventions Programme (DIP) clients received football coaching sessions based in university grounds, with later expansion to include anyone in contact with drug or alcohol treatment services. SUNEE also included other sports and physical training based activities targeted at improving the outcomes for problematic drug users, offering diversionary activities and experiences outside of drug use. Evaluation findings showed that the programmes had positive physical benefits, improved treatment retention, and provided an opportunity for positive achievements.

²⁴⁵ COSLA (Convention of Scottish Local Authorities) represents Scottish local government (councils and local authorities).

²⁴⁶ See: <http://drugs.homeoffice.gov.uk/publication-search/dip/engaging-women-sexwork?view=Binary>

²⁴⁷ See: http://www.nta.nhs.uk/about/board/board_meetings_and_papers/bd_2_2009/docs/BD2_2009_87_System_Change_Pilots.pdf

²⁴⁸ See: <http://drugs.homeoffice.gov.uk/publication-search/dip/students-coaching-clients> and <http://www.sunee.org.uk/home/>

9. Drug-related crime, prevention of drug related crime and prison

9.1 Introduction

Drug use is not a crime in the United Kingdom, but possession, dealing and trafficking are specific offences under the *Misuse of Drugs Act 1971*. While within the United Kingdom recorded crime is falling overall, recorded drug crimes continue to rise. In addition, the number of persons dealt with by the courts for drug offences, cautioned or issued formal cannabis warnings, has also risen, mainly for cannabis related offences. A prison sentence is the most common outcome when found guilty of import/export and trafficking offences but a fine or community order, which can include a drug rehabilitation requirement (DRR), are the most common disposals for possession offences.

Police records on general criminal offences do not contain information on the offenders' drug habits, neither do records of specific drug law offences. It is therefore not possible to provide an accurate estimate of the number of offences that are drug-related, but there is substantial research evidence of the link between drug use, particularly use of heroin and crack cocaine, and acquisitive crime. Around three-quarters of the users of these drugs admit to committing crime to support their habit. Over two-thirds of those in custody are reported to be problematic drug users. However, acquisitive crime, to which drug-related crime makes a substantial contribution, has continued to fall in recent years.

The Drug Interventions Programme is a key part of the Government's strategy for tackling drugs and reducing crime in England and Wales. Introduced in 2003, the programme aims to get drug-misusing offenders out of crime and into treatment and other support. More intensive elements operate in those areas with the highest acquisitive crime.

In Scotland, Drug Treatment and Testing Orders (DTTOs) provide offenders with access to treatment services as a requirement of the order, whilst piloting has taken place of drug testing of arrestees to enable individuals to engage on a voluntary basis with treatment services.

There is a range of measures to prevent drugs entering prison including clearly-defined searching procedures covering all possible routes; passive and active drug dogs, with passive dogs available to all prisons; CCTV surveillance of all social visit areas and low-level fixed furniture; and comprehensive measures to tackle visitors attempting to smuggle drugs, including closed visits, visit bans and police arrest. Recently introduced initiatives include mobile phone blocking to prevent contact with dealers and the introduction of body orifice searches. Since April 2006 in England and Wales, responsibility for prison health services has been fully devolved to the National Health Service (NHS), and an Integrated Drug Treatment System (IDTS) has been developed to improve the availability and quality of drug treatment in prison, bringing it in line with treatment in the community. In Scotland, responsibility for health care in prisons is to be transferred to the National Health Service. For the first time in the United Kingdom an injecting equipment exchange programme will be piloted in a Scottish prison as part of the *Hepatitis C Action Plan for Scotland* (phases 1 and 2) (Scottish Government 2006b; 2008b).

9.2 Drug-related crime

National Indicator for England: Drug-related (Class A) Offending

As part of the performance measurement system to identify progress against the implementation of the 2008 drug strategy action plan (HM Government 2008b), a new National Indicator (NI) has been published, following a period of consultation (see section 1.3). *NI 38: Drug-related (Class A) offending* sets out a formula to calculate the 'volume of proven offending in a follow-up 12 month period by (Class A) drug misusers identified in the course of contact with the criminal justice system' and provides details of data collection sources and frequency (CLG 2009).

9.2.1 Drug law offences

Recorded crime

Data show that in the United Kingdom during 2008/09, there was a six per cent increase in police recorded drug offences, a smaller increase than in previous years (Table 9.1). Previous increases were, in part, due to the introduction of the cannabis warning in England and Wales in 2004 and greater use of this power by police. The use of cannabis warnings now seems to have levelled off although they accounted for two-thirds of police recorded drug offences in England and Wales in 2008/09. There was a large increase in 'other' drug offences in England and Wales in 2008/09 (36%) although these only account for a small proportion of total recorded drug offences.

Table 9.1: Recorded crime: Drug offences in the United Kingdom by offence type and country, 2002/03 to 2008/09

| | YEAR | | | | | | |
|--------------------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|
| | 2002/03 | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 | 2008/09 |
| ENGLAND AND WALES | | | | | | | |
| Trafficking* | 22,435 | 24,628 | 24,190 | 25,276 | 26,550 | 28,130 | 29,644 |
| Possession | 119,896 | 118,006 | 120,866 | 152,602 | 167,003 | 200,019 | 212,150 |
| Other drug offences** | 989 | 877 | 781 | 601 | 680 | 809 | 1,113 |
| Total offences | 143,320 | 143,511 | 145,837 | 178,479 | 194,233 | 228,958 | 242,907 |
| NORTHERN IRELAND | | | | | | | |
| Trafficking | 291 | 405 | 375 | 349 | 473 | 529 | 607 |
| Possession | 1,633 | 2,184 | 2,247 | 2,595 | 1,938 | 2,191 | 2,367 |
| Total offences | 1,924 | 2,589 | 2,622 | 2,944 | 2,411 | 2,720 | 2,974 |
| SCOTLAND | | | | | | | |
| Trafficking | 10,148 | 9,537 | 9,333 | 9,613 | 10,890 | 9,827 | 10,315 |
| Possession | 30,510 | 32,463 | 32,268 | 34,440 | 31,329 | 30,559 | 31,805 |
| Other drug offences*** | 280 | 275 | 222 | 194 | 203 | 360 | 389 |
| Total offences | 40,938 | 42,275 | 41,823 | 44,247 | 42,422 | 40,746 | 42,509 |
| UNITED KINGDOM | | | | | | | |
| Trafficking | 32,874 | 34,570 | 33,898 | 35,238 | 37,913 | 38,486 | 40,566 |
| Possession | 152,039 | 152,653 | 155,381 | 189,637 | 200,270 | 232,769 | 246,322 |
| Other drug offences | 1,269 | 1,152 | 1,003 | 795 | 883 | 1,169 | 1,502 |
| Total offences | 186,182 | 188,375 | 190,282 | 225,670 | 239,066 | 272,424 | 288,390 |

* Trafficking usually includes production, supply, possession with intent to supply, possession on a ship, carrying on ship and unlawful import and export.

** For England and Wales 'other drug offences' mainly concerns permitting premises to be used for the production, supply and use of drugs.

*** For Scotland 'other drug offences' includes production and manufacture of drugs (not illegal cultivation), money laundering related offences and other drugs offences not designated as trafficking or possession.

Source : Walker et al. 2009; Kershaw et al. 2008; PSNI 2006a; PSNI 2008a; PSNI 2009a; Scottish Government 2009i

Arrests for drug offences

Having fallen after the introduction of the cannabis warning, arrests for drug offences in England and Wales increased by 17% between 2006/07 and 2007/08 (Table 9.2). A similar increase is seen in recorded drug offences over this period. Arrests data do not enable identification of the individual drug involved so it is not possible to surmise what the cause of this large increase is. However, recorded crime data do show that possession of other drugs apart from cannabis increased by 15% between 2006/07 and 2007/08 (Kershaw et al. 2008).

Table 9.2: Number of persons arrested for drug offences in England and Wales, and Northern Ireland, 2002/03 to 2008/09

| | YEAR | | | | | | |
|-------------------|----------------|----------------|---------------|---------------|---------------|----------------|---------|
| | 2002/03 | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 | 2008/09 |
| England and Wales | 131,100 | 113,100 | 84,800 | 88,600 | 89,393 | 104,532 | |
| Northern Ireland | 1,295 | 1,754 | 1,356 | 1,440 | 1,726 | 1,896 | 2,014 |
| Total | 132,395 | 114,854 | 86,156 | 90,040 | 90,926 | 106,428 | |

Source: Povey et al. 2009; PSNI 2004; 2006b; 2008b; 2009b

Convictions for drug offences

In the United Kingdom during 2007, there were 134,920 drug offences where the offender was found guilty or issued with a caution.²⁴⁹ This is an increase of nine per cent from 2006 when there were 124,344 drug offences. There was again a large increase in the number of cocaine powder offences, up 24% on the previous year. Large increases were also seen in ecstasy offences (15%), crack cocaine offences (13%) and to a lesser extent, heroin offences (five per cent). In England and Wales during 2007, 104,207 formal warnings for cannabis possession were given, an increase of 28% on the previous year (81,311) (MOJ 2008a).

Table 9.3: Drug offences where the offender was found guilty or issued a caution in the United Kingdom, 2000 to 2007 by individual drug

| | YEAR | | | | | | | |
|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|
| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005* | 2006* | 2007* |
| Amphetamines | 6,637 | 4,950 | 5,820 | 6,163 | 6,249 | 6,864 | 7,422 | 7,478 |
| Cannabis | 75,989 | 72,691 | 83,152 | 85,768 | 82,845 | 54,813 | 55,984 | 55,563 |
| Cocaine powder | 5,451 | 3,090 | 6,990 | 7,905 | 9,382 | 12,028 | 15,470 | 19,216 |
| Crack cocaine | 1,216 | 1,460 | 1,830 | 2,270 | 2,450 | 3,734 | 4,076 | 4,613 |
| Ecstasy | 6,630 | 7,880 | 6,590 | 5,940 | 6,209 | 6,337 | 6,233 | 7,189 |
| Heroin | 12,297 | 12,380 | 11,860 | 11,277 | 12,412 | 15,629 | 15,741 | 16,557 |
| LSD | 260 | 150 | 90 | 150 | 90 | 183 | 172 | 165 |
| Total | 105,039 | 103,080 | 113,465 | 117,532 | 122,459 | 118,706 | 124,344 | 134,920 |

* Data since 2005 are on an all offence basis; data for 2000 to 2004 are based on principal drug offence.

Source: Standard Table 11

²⁴⁹ Data includes cautions in Northern Ireland but data on convictions were not available at the time of writing. The figure for 2006 has been used for Northern Ireland convictions which amount to under one per cent of the total UK offences.

9.2.2 Other drug related crime

Drug-related crime: key findings from the Scottish cohort study

A report from the Drugs Outcome Research in Scotland (DORIS) study, which took place between 2001 and 2004 (McKeganey et al. 2008) (see section 5.3.3) provided further evidence for a link between drug consumption and acquisitive crime. Specifically, the report found that those in treatment had reduced drug consumption and therefore had a lesser need for acquisitive crime to fund their drug use. This finding was consistent with that of other research suggesting that drug consumption is a better predictor of levels of crime than treatment engagement and the authors suggested that further research investigating the relationship between reduced drug consumption, cessation and crime is required.

Drug use and violence amongst young offenders

In a survey on alcohol and violence among young male offenders in Scotland, McKinlay et al. (2009)²⁵⁰ found that a high proportion had used drugs in their lifetime (Table 9. 4). Comparisons were made with a survey undertaken in 1996, showing significant increases in the use of ecstasy, cocaine powder, crack cocaine, LSD and solvents. However, there was a non significant fall in the use of heroin.

In considering the relationship between drug use and offending, it was found that a majority reported that they used legal means to obtain money for drugs, particularly from their own wages (the proportion increasing from one-in-ten to one-in-four between surveys) with the numbers who obtained money for drugs through acquisitive crime falling from 44.6% to 25.8%.

Table 9.4: Number and percentage of young offenders reporting using drugs in Scotland, 1996 and 2007

| EVER USED | LIFETIME USE 1996 | | LIFETIME USE 2007 | | LAST MONTH USE 2007 | |
|--------------------------|-------------------|------|-------------------|-------|---------------------|------|
| | n | % | n | % | n | % |
| Alcohol With Other Drugs | 92 | 64.8 | 119 | 78.8* | - | - |
| Solvents | 19 | 13.5 | 40 | 28.0* | - | - |
| Cannabis | 109 | 77.3 | 134 | 85.4 | 97 | 66.4 |
| Heroin | 38 | 27.0 | 29 | 19.7 | 23 | 15.9 |
| Methadone | - | - | 22 | 14.8 | 13 | 8.7 |
| Benzodiazepines | 75 | 53.2 | 97 | 61.8 | 61 | 43.6 |
| Ecstasy | 78 | 55.3 | 105 | 68.2* | 65 | 45.8 |
| Amphetamines | 72 | 51.4 | 83 | 54.2 | 35 | 24.3 |
| Cocaine powder | 35 | 24.8 | 110 | 70.1* | 63 | 45.7 |
| Crack cocaine | 8 | 5.6 | 32 | 21.2* | 15 | 10.0 |
| LSD | 72 | 51.1 | 51 | 33.6* | 13 | 8.8 |
| Magic Mushrooms | - | - | 50 | 32.5 | 9 | 6.0 |
| Ketamine | - | - | 22 | 14.7 | 8 | 5.4 |
| Injected Drugs | - | - | 14 | 9.1 | 10 | 6.5 |

*statistically significant change **Source:** McKinley et al. 2009

²⁵⁰ The sample size was 172 young offenders in one institution in Scotland. It was a convenience (quasi-random) sample of offenders recruited at admission to the Young Offender Institution, using qualitative interviews.

There was an association between alcohol and violent crime but the numbers reporting that their offending was related to drug use was small. The exception was with the use of diazepam which, when mixed with alcohol, reportedly resulted in greater levels of drunkenness and more uncontrolled (and serious) violence. The authors suggest that the role of diazepam in facilitating violence needs investigating further.

Violent crime amongst drug users entering treatment

The DORIS study also focused on assaults committed by participants and results showed that 21.1% of male and 12.0% of participants reported recently committing assault (McKeganey et al. 2008). Assault committed by both males and females was associated with ever being physically abused. Male perpetrated assault was also associated with sale or supply of drugs and committing theft in the previous 90 days. Female perpetrated assault was also associated with homelessness or residence in a hostel/shelter. The authors recommended that drug treatment agencies should give consideration to the potentially violent tendencies of their clients and should offer support to respond to these issues.

Criminal thinking and self-control among drug users in court mandated treatment

Packer et al. (2009) researched the links between self-control and criminal thinking amongst drug using offenders attending a mandatory drug treatment programme²⁵¹, with a focus on how these factors related to drug use and offending. Findings showed links between the factors and drug use and offending, with low self-control strongly positively associated with high criminal thinking. Age and type of substance used also impacted upon criminal activity. The authors concluded that whilst the results showed that there were associations between the factors, the relationship between drug use and crime is more complicated than a model simply consisting of self-control and criminal thinking can explain.

Causal connection between drug misuse and crime

Bennett and Holloway (2009) investigated the causal link between drug use and crime based on Goldstein's (1985) tripartite conceptual framework²⁵² through interviews with drug-using prisoners in England and Wales prisons²⁵³. Bennett and Holloway found that two of the three strands of the framework (economic-compulsive and psychopharmacological) did explain the connection between drug use and crime, however, the influence of the systemic strand was not well supported by their research. The authors found that the relationship between drug use and crime was influenced by social and cultural settings, and crime was not just committed to obtain drugs or money for drugs, but drugs were also used to celebrate successful criminal activity.

²⁵¹ Fifty drug using offenders attending a Drug Interventions Programme clinic in Birmingham, England, under the terms of a Drug Rehabilitation Requirement (DRR) completed standardised measures of self-control and criminal thinking.

²⁵² Goldstein proposed that explanations of the link between drug use and crime can be divided into: economic-compulsive, psychopharmacological and systemic. Goldstein, P. (1985). The drugs/violence nexus: A tripartite conceptual framework. *Journal of Drug Issues* 15 493-506.

²⁵³ Participants were asked to identify if any of their crime were related to drugs, and if they responded positively were asked to provide a narrative about the offence. Forty-one male participants were interviewed from two English prisons and one Welsh prison.

Drug use amongst those in contact with the Drug Interventions Programme

Data on the use of drugs in the previous month amongst those in contact with the Drug Interventions Programme (DIP) were included in the *Indications of Public Health in the English Regions* drug use report (Shaw et al. 2009). The rate per 1,000 population of individuals assessed by DIP (aged 18-64) varied from 1.72 in the East of England to 4.12 in London. Findings showed that reports of monthly use of drugs by those assessed by DIP were particularly high for heroin (reported by 59% of females and 42% of males) and crack cocaine use (reported by 47% females and 31% of males). Comparing between the genders, reports of amphetamines, cannabis, cocaine powder and ecstasy use in the previous month were higher for men than for women, while reports of last month use of benzodiazepines, crack cocaine, heroin and illicit methadone use were higher amongst women than men.

Patterns of crime amongst those in contact with the Drug Interventions Programme

The *Indications* report (Shaw et al. 2009) included analysis of the types of crime committed by problematic drug users (PDU) and non-PDUs²⁵⁴ in contact with the Drug Interventions Programme (DIP). The report indicated that PDUs were more likely to commit burglary and shoplifting offences and non-PDUs were more likely to commit *Misuse of Drugs Act 1971* offences and violent crimes. Approximately one-fifth of all crimes committed by non-PDUs in the East of England, South East and South West were violent crimes.

9.3 Prevention of drug-related crime

In the United Kingdom, the prime focus in terms of preventing or reducing drug-related crime continues to be through identifying drug misusing offenders as early as possible in the criminal justice process and engaging them in appropriate treatment and support.

In England, a National Indicator related to drug-related (Class A) offending was published in 2009 (see section 1.3.1).

9.3.1 Drug Interventions Programme (DIP) in England and Wales

Expansion of the Drug Interventions Programme

From April 2009 there has been a further expansion of DIP 'intensive' activity (testing on arrest) in Wales, Bedfordshire and Blackpool, where only testing on charge has mostly been operating until now. This has brought in Required Assessment²⁵⁵ to cover most of England and Wales. There has also been an expansion of Restriction on Bail which means that people who test positive for Class A drugs and who appear before any England or Wales court, can have the restriction applied to their bail (that is, they must agree to an assessment of their drug problem if bail is to be applied).

²⁵⁴ Problematic drug users were defined as those who indicated that they had used opiate or crack cocaine in the previous month. All other individuals in contact with DIP were categorised as non-PDU.

²⁵⁵ Required Assessment (for treatment needs) is a mandatory drugs assessment for anyone testing positive for Class A drugs.

DIP review

A review of DIP in England and Wales conducted by management consultants (Ville and Company 2009²⁵⁶) found that DIP has made considerable improvements in the identification and outcomes for drug users in contact with the criminal justice system and positively impacted upon the services provided for this group. The report identified a number of areas for improvement within DIP, and recommended that:

- offender interventions should be accompanied by best practice guidance; an annual user satisfaction survey, and partnership working across various government departments to enhance life skills and access to accommodation and employment;
- the delivery chain for DIP should be amended to include new funding practices based on national need, clear criteria for intensive and non-intensive funding and reviews of how DIP grants are applied for and commissioned;
- guidance documents for local delivery practices should be developed in collaboration with commissioners and providers to ensure best practice and clear information streams; and
- future delivery of DIP should take place within the framework of the Integrated Offender Management (IOM) system as both programmes focus on reducing reoffending.

Before the expansion in April 2009, more than 240,000 tests for Class A substances have been conducted every year and approximately 37% of tests are positive. More than 200,000 drug using offenders have entered treatment through DIP since the programme began in 2003.²⁵⁷

Drug Interventions Programme: Wales Annual Report.

The annual report for the Drug Interventions Programme (DIP) in Wales 2007/08 (Hardy and Williams 2009) outlined DIP progress in each of the Welsh police force areas (North Wales, Dyfed Powys, Gwent and South Wales). The report highlighted improvements in service delivery, but recognised the continued need for DIP and drug treatment as drug use continues to rise in Wales. Key issues and required actions included re-commissioning of services, service user involvement, appointment to currently vacant key posts and performance monitoring against key performance indicators. Specific key issues and actions are discussed for each area.

Updated introductory leaflet about the Drug Interventions Programme

The Home Office released an updated leaflet detailing the role, procedures and process of the Drug Interventions Programme (DIP). The document outlined the variety of treatment programmes available under DIP within the different criminal justice settings (police custody, court, prison and community) and the overall benefits of DIP to the individual and communities²⁵⁸.

²⁵⁶ The methodology was as follows: semi-structured interviews with 46 people working at local level and 20 at national level. A National survey of DIP leads covering 67% of DATs (55 from intensive and 45 from non-intensive schemes). Seven workshops with 68 practitioners across the country. Four workshops with 19 people on the DIP programme. A review of nationally available data on need, funding and performance and over 70 relevant documents.

²⁵⁷ See: <http://drugs.homeoffice.gov.uk/news-events/newsletter/dip-ebulletins/drugs-e-bulletin-september-2009>

²⁵⁸ See: <http://drugs.homeoffice.gov.uk/publication-search/dip/dip-generic-leaflet>

9.3.2 Reducing re-offending

Re-offending of drug offenders

In 2007, of those sentenced at court for cannabis possession offences (n = 14,913), 57% were repeat offenders with 17% having three or more previous convictions or cautions for the same offence (MOJ 2008a).

Amongst adults being released from prison or commencing a court order²⁵⁹ for drug possession or small-scale supply in the first quarter of 2007 (n = 2,449), 34% re-offended within a year (not necessarily another drug offence). Of the 2,673 offences committed by the cohort, 604 (23%) were for the same offence, 407 (15%) were for theft, 389 (15%) for motoring offences, 307 (11%) for non-serious violence, and 277 (10%) for absconding or bail offences. A further three per cent were for drug trafficking (MOJ 2009a).

Of those whose original offence was drug trafficking (excluding small-scale supply) (n = 941), 21% re-offended within a year. Of the 484 offences committed, only 17 (four per cent) were for the same offence with 93 (19%) for theft, and 71 (15%) for drug possession.

Changes in offending following prescribing treatment for drug misuse

Millar et al. (2008) investigated the link between treatment engagement and numbers of offences committed amongst problematic drug users (opiate and/or crack cocaine users)²⁶⁰. They found that, post-engagement with treatment, the number of offences committed by this group fell by approximately half (from 4,381 to 2,348) and 50% of the sample did not commit any crimes after contact with treatment, with the biggest decrease in acquisitive crime (from 1,234 to 635). Further analysis concluded that those who did continue to commit crime after treatment engagement were serial offenders. The authors concluded that this study provides some evidence for the links between treatment and crime. However, they recognised that other factors may also have been involved in the decreases in offences and that further research is warranted.

The effectiveness of interventions for drug-using offenders in the courts, secure establishments and the community: a systematic review

Perry et al. (2009) conducted a systematic review of 24 randomized control trials, conducted between 1980 and 2004, investigating the effectiveness of drug treatment initiatives for drug users identified through the criminal justice system. The findings indicated that traditional parole and probation was more effective compared to community release accompanied by drug testing and intensive supervision before trial. Risk of re-offending was more greatly reduced by therapeutic community initiatives than individual treatment. The review did not provide enough information on cost and cost-effectiveness to draw any conclusions.

Youth Crime Action Plan

The **Youth Crime Action Plan**, released in 2008 (see UK Focal Point on Drugs report 2008), detailed actions required across various government departments to tackle and reduce youth crime (HM Government 2008c). A progress report one-year on from the launch of the plan (HM Government 2009b) reported reduced drug consumption amongst young people, increased support provision and that a greater number of young people were involved in positive activities.

²⁵⁹ Sentences under probation supervision excluding fines.

²⁶⁰ Anonymised data from the Police National Computer was matched to information in the National Drug Treatment Monitoring System database.

9.4 Interventions in the criminal justice system

9.4.1 Sentencing for drug offenders

Cannabis possession offences

A circular from the Ministry of Justice provides guidance on the use of a penalty notice for disorder (PND) for personal possession offences²⁶¹. The Association for Chief Police Officers (ACPO) published revised guidance on policing the possession of cannabis using a three-stage escalation policy (ACPO 2009). The guidance states that an offender should usually be given a cannabis warning for a first-time possession offence unless there are aggravating circumstances. If the offender is caught in possession of cannabis for a second time, a PND should be issued, which would be recorded on the Police National Computer. Anyone found in possession of cannabis who already has a PND should be dealt with by arrest. A national system, PentiP is being developed to replace the two systems used at present to record PNDs. This should be operational in all areas in England and Wales by the end of 2011 and will include verbal warnings such as cannabis warnings, PNDs and a number of vehicle offences.²⁶²

Drug Rehabilitation Requirements

The Drug Rehabilitation Requirement (DRR), available as part of a community sentence or suspended sentence order, is now the primary means for offenders to address identified drug misuse needs in the community. In 2008/09 the National Offender Management Service delivered 17,642 DRR commencements and 7,380 completions. The completion rate for DRRs rose to 47% (from 43% in the previous year).

Consultation on sentencing of drug dealers

A consultation paper published by the Sentencing Advisory Panel recommended a two year cut in custodial sentences imposed upon 'drug barons' (decreasing the sentence range to between 10 and 14 years) as the current long sentences are an ineffective deterrent. The report suggests that the seizure of assets and use of serious crime prevention orders may be a more effective deterrent for those at the top of the drugs supply chain²⁶³. The consultation closed on 15th July 2009.

Sentencing statistics

In 2007, 48,923 persons were proceeded against in court for drug offences in England and Wales, 91% of whom (n = 44,565) were found guilty (MOJ 2008b). However, the proportion found guilty differed with offence type; only 81% of those accused of drug trafficking and 82% of those accused of other drug offences were found guilty compared to 96% of those accused of import/export offences and the same proportion accused of possession offences.

Of the 44,500²⁶⁴ sentenced for drug offences during 2007, 18% were given immediate custody. Ninety per cent of those found guilty of import/export offences were sentenced to immediate custody (Table 9.5). Possession offences were most likely to be dealt with by a fine (43%) with a quarter (25%) given a community sentence, which could include a drug rehabilitation requirement.²⁶⁵ Only four per cent of possession offences received a sentence of immediate custody with the average sentence length ranging from 2.7 months for Class C drug offences and 4.1 months for Class A drug offences.

²⁶¹ See: <http://www.justice.gov.uk/publications/docs/circular-05-2009-pnds-cannabis-possession.pdf>

²⁶² See: <http://www.npia.police.uk/en/11260.htm>

²⁶³ See: www.sentencing-guidelines.gov.uk/docs/drug_offences.pdf

²⁶⁴ This is different from those found guilty as it is possible to be found guilty in one year but sentenced in another.

²⁶⁵ For more detailed information on disposals available to the courts see the 2008 United Kingdom Focal Point Report.

Table 9.5: Number and percentage of offenders receiving each disposal for drug offence type in England and Wales, 2007

| | IMMEDIATE CUSTODY | | SUSPENDED SENTENCE | | COMMUNITY SENTENCES | | FINE | | OTHER | | TOTAL NUMBER OF OFFENCES | |
|---------------|-------------------|-------------|--------------------|------------|---------------------|-------------|---------------|-------------|--------------|-------------|--------------------------|------------|
| | n | % | n | % | n | % | n | % | n | % | n | % |
| Import/export | 782 | 89.5 | 31 | 3.5 | 23 | 2.6 | 22 | 2.5 | 16 | 1.8 | 874 | 2.0 |
| Trafficking* | 6,084 | 52.7 | 2,003 | 17.3 | 2,278 | 19.7 | 593 | 5.1 | 597 | 5.2 | 11,555 | 26.0 |
| Possession | 1,232 | 3.9 | 592 | 1.9 | 7,871 | 25.0 | 13,413 | 42.6 | 8,398 | 26.7 | 31,506 | 70.8 |
| Other | 88 | 15.6 | 52 | 9.2 | 124 | 21.9 | 162 | 28.7 | 139 | 24.6 | 565 | 1.3 |
| Total | 8,186 | 18.4 | 2,678 | 6.0 | 10,296 | 23.1 | 14,190 | 31.9 | 9,150 | 20.6 | 44,500 | 100 |

*includes production, supply and possession with intent to supply

Source: MOJ 2008b

Just over half (53%) of those found guilty of trafficking offences were sentenced to immediate custody, although this proportion increased amongst Class A drug offenders (70% were given immediate custody). Similarly, for import offences, immediate custody was more likely for Class A offenders (95%) than for Class C offenders (88%).

In Scotland during 2007/08, 8,477 offenders were found guilty of a drug offence at court. Of these, 60% (n = 5,085) were issued a fine, 14% (n = 1,218) were sentenced to prison, and 12% (n = 975) were given a caution or admonition (Scottish Government 2009).

9.4.2 Alternatives to prison

With a continuing increase in the prison population, it has been argued in a review of prisons that changes are required in existing sentencing legislation including modification of the use of custody for specific groups of low risk offenders and types of offences, reserving prison space for more serious and dangerous offenders and offences (Lord Carter 2007). Following this review, it has been suggested by the Ministry of Justice that community sentences, including drug rehabilitation programmes, can be a more effective punishment than short prison sentences, and there are currently pilots on Intensive Alternatives to Custody (IAC) for all offenders, not just drug users.

Intensive Alternative to Custody (IAC) pilots began in March 2008 in Derbyshire probation area, with additional pilots commencing in other probation areas in September 2008 (South Wales and West Yorkshire) and April 2009 (Merseyside, Humberside and Manchester). The aim of IAC is to provide a valid alternative to short custodial sentences (under 12 months). The programme aims to provide rehabilitation to these offenders, considering that individuals given custodial sentences shorter than 12 month typically re-offend and derive least benefit from probation-based initiatives. The role of the pilot programmes is to identify and trial a variety of alternatives reporting on their effectiveness, ability to reduce offending and compliance. The aim of the programme is to prevent offending whilst on probation and assist in cessation of offending in the long-term.

The Ministry of Justice has called for Expressions of Interest to conduct: a process evaluation of IAC pilots in South Wales, Dyfed Powys, Merseyside, Humberside and West Yorkshire; a break-even analysis of all IAC pilots; a feasibility study for an outcome evaluation of all IAC pilots; and, potentially an outcome evaluation on the basis of the feasibility study²⁶⁶.

²⁶⁶ See: www.homeoffice.gov.uk/rds/pdfs09/eoi-alter-custody.pdf

9.4.3 Drug Courts

Dedicated drug courts

In 2008 a process evaluation report on a pilot dedicated drugs court indicated that this system can have positive benefits for offending drug users (Matrix Knowledge Group 2008). In 2009 the model of dedicated drugs courts was extended to four further pilot sites: Cardiff, Barnsley, Salford, and Bristol Magistrates' Courts.

Therapeutic jurisprudence and procedural justice in Scottish Drug Courts

McIvor (2009) conducted research into the role of Scottish drug courts as part of an ongoing review of outcomes for those in contact with drugs courts and their value for money^{267, 268}. Specifically, the article aimed to investigate the role of the court Sheriffs, individuals in charge of supervising the progress of those subject to drug court orders. The research found that participants largely praised the court Sheriffs who were found to be motivating and encouraging, and enhanced participant's outcomes. However, there was some variance in the service provided by the Sherriffs dependent on attitude and approaches. The report concluded that drugs courts are beneficial to those who come into contact with them and when services are provided in partnership with social workers, health professionals, treatment agencies and the criminal justice system they are most effective for re-integration.

9.4.4 Interventions for offenders with mental health problems

Community orders and mental health

The Community Order in England and Wales was discussed in last year's Focal Point report. A choice of 12 different requirements can be attached to an order, including drug and alcohol treatments and a Mental Health Treatment Requirement (MHTR). It was reported last year that the MHTR was rarely used in practice and in response to this, research was carried out to investigate the reasons behind this. It found that there was confusion amongst practitioners in the legal and health professions about who the sentence can be applied to. In addition, offenders with a dual diagnosis of mental health and substance misuse were more likely to receive a Drug Rehabilitation Requirement (DRR) than a MHTR. The report went on to recommend that clearer guidance should be developed by the Government on the use of the MHTR²⁶⁹ (Khanom et al. 2009).

Review of people with mental health problems or learning disabilities in the criminal justice system

In a report by Lord Bradley (DH 2009d) it is recommended that, as dual diagnosis is highly prevalent amongst offenders, addressing both mental health and drug misuse issues must be carefully considered in terms of how these offenders are currently dealt with in court and in specialist mental health and drug courts. It goes on to say that all types of court should have liaison and diversion services available. It states that mental health and substance use services do not currently work well together and that separate policies in the areas of mental health and substance use mean that services are not synergised. It calls for the urgent development of services for dual diagnosis offenders with the sharing of information between agencies and joint care planning.

²⁶⁷ Pilot Drug Courts were established in Scotland in 2001 and 2002. These courts were aimed at drug dependent repeat offenders.

²⁶⁸ The research draws upon interviews with Sheriffs, other professionals (social workers, drugs workers, nurse and medical officers, the Drug Court Co-ordinator and Procurator Fiscal) and participants.

²⁶⁹ See also: http://www.scmh.org.uk/news/2009_community_sentences_with_MHTR.aspx and <http://www.publications.parliament.uk/pa/ld200809/ldhansrd/text/90721w0003.htm#09072149001392>

In response to this the Government has accepted, in principle, the need for a review of how offenders are currently dealt with by drug and other courts and the National Programme Board²⁷⁰ will consider the resource implications of developing a more appropriate model if it is deemed necessary. The board will also consider the resource implications of improving services for prisoners with a dual diagnosis. A national plan will be developed by the Board by October 2009 (MOJ 2009b).

9.4.5 Interventions for young offenders

Youth Rehabilitation Order

The Government is to introduce a Youth Rehabilitation Order in England and Wales in November 2009, with a drug treatment/support requirement. The order will aim to provide a treatment package tailored to the young person's needs with a focus on addressing their offending and responding to the victim's needs.

Youth justice schemes

In January 2009 a pilot Youth Justice Liaison and Diversion scheme was implemented in several sites across England^{271, 272}. The aim of these schemes is to provide support to young people with other issues (such as mental health, unstable housing, substance misuse) when they initially come into contact with the police. Scheme staff will work in partnership with the police and Crown Prosecution Service to identify young people who require additional support and where these needs are identified, specialist assessments are conducted. It is anticipated that the scheme will reduce youth offending and provide direct access to support for those with additional needs. The pilots will run for two years and will be independently evaluated.

Young people in 'coerced' drug treatment

Research conducted by Greaves et al. (2009) investigated the effectiveness of the Drug Interventions Programme (DIP) for young offenders²⁷³. The research found that opiate dependence was linked to a desire to engage in treatment and frequency of acquisitive crimes. However, crack cocaine users were less likely to indicate a desire to enter drug treatment programmes. There was high praise for drug treatment workers but less desire from the sample to receive specialist prescribing initiatives. The authors concluded that drug treatment is effective for some drug users, however, it is a more acceptable route for opiate users in contact with the criminal justice system than stimulant users.

²⁷⁰ This will be made up of representatives from the Department of Health, Home Office, Ministry of Justice and DCSF.

²⁷¹ The pilot site areas are Halton and Warrington, Cheshire; Kensington and Chelsea, west London; Lewisham, south London; Peterborough; South Tees and Wolverhampton.

²⁷² See: http://www.scmh.org.uk/news/2009_youth_justice_schemes.aspx

²⁷³ Structured interviews were conducted with a sample of 36 drug users accessing treatment in Birmingham through DIP.

9.4.6 Other interventions in the criminal justice system

Process evaluation on Mandatory Drug Testing of Arrestees pilots in Scotland

A process evaluation of mandatory drug testing of arrestees pilots implemented in three police stations in Scotland (in Edinburgh, Aberdeen and Glasgow)²⁷⁴,²⁷⁵ reported that the pilot schemes all appear to have been implemented with relatively few problems at the early stages (Skellington Orr et al. 2009). The biggest challenge faced by the pilots has been a lower than expected throughput of referrals into the scheme. It was anticipated that up to 5,000 people a year would be tested, with approximately 50% testing positive. Over the four month evaluation period 3,308 tests were carried out, resulting in 1,106 positive tests (33%), and 223 individuals engaged in treatment. This lower than expected number had an impact on almost every aspect of delivery for the schemes. Specifically, there was a staffing impact with a lighter workload for staff resulting in re-evaluation of job roles and more dedicated time for care management. The report concluded that whilst the programme is targeting the most vulnerable, the numbers of referrals and individuals accessing treatment were not as large as expected.

Value for money analysis showed that on measures of numbers engaging with treatment services (including assessments), the MDTA pilots were less cost-effective than the Arrest Referral schemes, already established in Scotland.

Specimen for verifying drug status

Paterson (2008) undertook a literature review investigating the use of different specimens to establish a person's drug use (urine, oral fluid and hair) and the advantages and disadvantages of each. The author highlights the established methods for collecting and analysing urine samples, but recognises the problem with observing urine collection and substitution/adulteration of urine samples. More recent methods including oral fluid and hair samples have disadvantages relating to analysis techniques. Specifically, there is a lack of information about drug concentration in oral fluid which is known to be considerably lower than that of urine and has a smaller window of detection, while hair samples require laboratory analysis.

Drug Testing Kits

It is reported that Suffolk Police are now using drugs testing kits to test a very small amount of the drugs seized in order to get an immediate result to provide evidence in a possession case at a magistrate's court²⁷⁶.

²⁷⁴ The aim of the pilots is to encourage problem drug users who come into contact with the criminal justice system to engage with treatment services as a means of addressing the individual's drug misuse problem and associated offending behaviour. Under the scheme, anyone arrested for defined 'trigger' offences (acquisitive crime and drug offences) are subject to mandatory oral fluid testing for heroin and/or cocaine. Those testing positive are required to undergo an assessment with a drugs assessor with a view to determine any dependency on drugs. Upon completion of the initial assessment, individuals who would benefit from treatment are introduced to drug treatment providers, although any subsequent uptake of treatment services is voluntary.

²⁷⁵ The pilots were due to run for two years until June 2009 and the evaluation ran for a five month period between October 2008 and February 2009, and involved an analysis of statistical data collected by the schemes, as well as qualitative data. Interviews with the main service providers (the police, drugs assessors and treatment providers and Crown Office and Procurator Fiscal Service representatives) were carried out and a small sample of arrestees (nine) took part in the research to provide feedback on the way that it had been received.

²⁷⁶ See: http://www.policeoracle.com/news/New-Drug-Testing-Kits-Launched_19489.htm

The Home Office has commissioned work to create a drug data warehouse. This will map and assess offending behaviour in relation to a range of criminal justice and health interventions using existing administrative data sources including, but not limited to, the Police National Computer (PNC)²⁷⁷, the National Drug Treatment Monitoring System (NDTMS) and DIP data²⁷⁸.

9.5 Drug driving

Prevalence of drug driving

A survey of motorists²⁷⁹ by the motoring organisation RAC found that nine per cent of 17 to 24 year olds and 13% cent of 25 to 34 year olds had driven under the influence of drugs (RAC 2009). A quarter of 17 to 24 year olds reported being in a car when they believed the driver was under the influence of drugs.

In McKeganey et al.'s (2008) report from the DORIS study, the infrequency of arrests for drug driving in Scotland was highlighted as those who reported drug driving stated that they had done so on numerous occasions (a fifth of those who reported drug driving had been arrested, on average once, for the offence). The majority of those who reported drug driving (16.3% of study sample) were males (86.3%) and the average age was 28.3 years. The authors concluded that there was inconsistency in current detection of drug driving and more efficient methods are required.

Consultation on road safety compliance

A consultation document on road safety compliance, including consideration of drug driving, was published by the Department for Transport (DfT) at the beginning of 2009 (Department for Transport 2008). The document highlighted the difficulty in obtaining evidence that a driver is impaired by drugs, and the resulting lack of convictions for this crime. It called for views on ways of enforcing current drug driving laws, which is currently a complex procedure, and also asked stakeholders to consider whether a new offence needs to be created.

In addition to a publicity campaign highlighting the dangers and implications of drug driving²⁸⁰ the DfT sought to find ways of enforcing the existing law. Proposals included:

- supporting current research to develop drug screening devices for use by the police;
- training police officers to conduct field impairment testing;
- revising procedures for testing of those suspected of drug driving to acquire samples more easily;
- work in partnership with drug treatment agencies to ensure drug driving is part of prevention sessions;
- use of roadside surveys to investigate the prevalence of drug driving; and
- conducting discussions with the Coroners' Association to establish the scope for drug analysis of road fatalities.

²⁷⁷ PNC holds details of people, vehicles, crimes and property that can be electronically accessed by the police and other criminal justice agencies. It is a national information system maintained and delivered by the National Police Improvement Agency.

²⁷⁸ See: <http://www.homeoffice.gov.uk/rds/whatsnew1.html>

²⁷⁹ 1,109 British motorists were surveyed via the internet in April 2009. The sample was nationally representative.

²⁸⁰ A new THINK! campaign on drug driving for 2009/10 with a budget of £2,000,000 was launched in August 2009. See: <http://www.dft.gov.uk/think/drugdrive/>

In addition, the DfT investigated the potential of creating a new offence of drug driving in order to allow a more effective police response to offenders. The DfT suggested that it may be possible to create a law which would apply if any of the drugs controlled under the *Misuse of Drugs Act 1971*, and known to impair driving skills, were found to be present in the body.

A chart review of assessment of driving and related issues in drug misusers

Thangavelu and Rhinds (2009) investigated the frequency of discussions about drug driving between clients and staff during drug treatment sessions²⁸¹, and how this fitted with guidelines. The study found drug driving was explicitly discussed in only 28% of cases and in more than half of cases the driving status of the client was not recorded (i.e. whether or not they currently drove a vehicle). The authors concluded that assessments were not following the guidelines and procedures set by the drug treatment service with regard to drug driving, and additionally the lack of reporting of current drug drivers to the DVLA suggested an ethical dilemma amongst practitioners and policy makers.

9.6 Drug use and problem drug use in prisons

9.6.1 Prevalence, patterns of use and risk behaviours

Mandatory Drug Testing in prisons in England and Wales

Data from mandatory drug testing in prisons²⁸² in England and Wales show that 7.7% of prisoners tested positive for an illicit drug in 2008/09, a decrease from the previous year (9.2%). This compares with a positive rate of 24.4% in 1996/97. Cannabis was the most common drug with 3.7% testing positive followed by opiates (3.4%) and benzodiazepines (0.9%).

From April 2008 buprenorphine was added to the panel of drugs tested for under mandatory drug testing. 2.1% of tests were positive for buprenorphine, although to allow comparison with 2007/08 these positives were not included in the overall positive rate of 7.7%. Had they been included the overall positive rate would have been 9.2%. From 2009/10 positives for buprenorphine will be included in the overall positive rate.

The Scottish Prison Survey 2008

A standard table based on this survey was provided to the EMCDDA in 2008, but was not published in time to report in the 2008 United Kingdom report (ST12). The survey (SPS 2008) found that:

- use of illegal drugs in the 12 months prior to entering prison was reported by seven out of 10 prisoners (69%), with cannabis and cocaine powder the most commonly used drugs;
- a fifth of prisoners (22%) stated that they had committed the offence for which they had been incarcerated in order to fund a drug habit;
- a fifth of prisoners (21%) had been in treatment prior to entering prison and half (52%) had received a drug assessment upon initial contact with the prison. A similar proportion (47%) stated that, if they were offered help for drug misuse, they would take it;
- a quarter of prisoners (26%) reported use of illegal drugs in the month prior to survey whilst resident in prison, a decrease from 30% in 2007. Of these, heroin (69%), cannabis (66%) and benzodiazepines (45%) were the most commonly used drugs; and
- three per cent of prisoners reported injecting drugs in the month prior to survey and whilst incarcerated with 80% of these reporting having shared a needle.

²⁸¹ A chart review of healthcare professionals in drug treatment services, 100 case records were analysed for evidence of documentation with respect to this.

²⁸² Random testing in approximately 140 prisons in England and Wales. In 2008/09 59,555 tests were carried out.

Addiction Prevalence Testing

In 2007 Addiction Prevalence Testing (APT) was introduced to Scottish prisons to assess progress against the 'Offender Outcome' of 'reduced or stabilised substance misuse'. Over two months of each year five per cent of all individuals entering prison are tested for illegal drugs²⁸³ and five per cent of prisoners exiting prison are tested to assess the effectiveness of drug treatment initiatives. Findings for 2007/08 found that almost two-thirds of prisoners (64%) tested positive for illegal drugs upon entrance to Scottish prisons and one-quarter (26%) tested positive at exit. Table 9.6 shows the proportion testing positive on reception and those testing positive prior to release in 2007 for particular drugs (ISD 2008).

Table 9.6: Results of drug testing on reception and prior to release in Scottish prisons, 2007

| DRUG | % POSITIVE TESTS ON RECEPTION | % POSITIVE TESTS PRIOR TO RELEASE |
|-----------------|-------------------------------|-----------------------------------|
| Amphetamines | 3 | 1 |
| Barbiturates | 1 | 0 |
| Benzodiazepines | 39 | 14 |
| Buprenorphine | 1 | 0 |
| Cannabis | 44 | 6 |
| Cocaine | 8 | 1 |
| Methadone | 2 | 2 |
| Opiates | 34 | 13 |

Source: ISD 2008

Drug use amongst prisoners in Northern Ireland

The Northern Ireland Prison Service provides drug reports each quarter²⁸⁴; reports covering the year 1st December 2007 to 30th November 2008 suggest that during this period 1,688 prisoners were dependent on drugs, although only 82 were heroin users; with over 43% (732) reporting cannabis as main drug of dependence. Voluntary drug testing was undertaken on 4,803 occasions, with 3,468 (71.2%) tests proving negative. Drug finds during the period included: 49 grammes of amphetamines, 1.1kg of cannabis and 100 ecstasy tablets.

²⁸³ Twenty per cent of the total entries into prisons (24,480) were tested in 2007/08 (n=4,828). Testing was only undertaken on individuals with a sentence of 31 days or more.

²⁸⁴ See: <http://www.niprisonservice.gov.uk/module.cfm/opt/14/area/Drug%20Report/page/drugseizures/>

Drug use and perceived treatment needs among newly sentenced prisoners

Stewart (2009) investigated levels of drug use amongst individuals entering prison (i.e. pre-custody) and how this related to their self-assessment of treatment requirements²⁸⁵. Findings showed that approximately four-fifths (79%) of participants reported lifetime use of illegal drugs and over two-thirds (69%) reported use in the previous year. Around a third of participants (31%) reported heroin or crack cocaine use in the previous year. Almost half of participants who reported recent use of any drug reported that they required drug treatment. Factors associated with self-assessment of treatment need included use of heroin/crack cocaine, previous drug treatment, unstable accommodation, lack of employment and poor mental health. The author concluded that drug assessments upon entrance to prison are important, and drug interventions should begin immediately after the initial assessment and be multidisciplinary in approach.

Changes in illegal drug use in women following imprisonment

Plugge et al. (2009) examined changes in illicit drug use amongst women post-imprisonment²⁸⁶. The study found a reduction in the proportion of women who reported daily illicit drug use prior to imprisonment from 53% to 14% one month post-imprisonment. Thirty eight per cent of participants reported lifetime injecting of drugs prior to imprisonment, whilst only two per cent reported injecting whilst imprisoned. Analysis of the types of drugs taken pre- and post-imprisonment indicated a change from predominantly heroin and crack cocaine use before imprisonment to benzodiazepine and opiate substitute use afterwards. The authors concluded that there is a need to decrease the availability of illicit drugs in prisons (with an emphasis on illicit prescribed drugs) and to provide improved prison drug treatment services for women.

9.7 Responses to drug-related health issues in prisons and other custodial settings

9.7.1 Strategy and policy

NOMS Drug Strategy

The National Offender Management Service (NOMS) has published *The National Offender Management Service Drug Strategy 2008-2011* (NOMS 2009a). The strategy seeks to provide early interventions for young people and to manage offenders with drug misuse problems. It is intended to deliver a number of overarching aims of government as set out in Public Service Agreements (PSAs), including: PSA 25, to reduce the harm caused by drugs and alcohol; PSA 23, to make communities safer by reducing drug-related re-offending; and PSA 14, to increase the number of children and young people on the path to success.

The strategy has two main strands:

- to build on and develop existing services in order to deliver improved outcomes consistent with the aims and actions of the Government's Drug Strategy; and
- to take stock and set the groundwork for a range of initiatives that will introduce more profound changes to drug services delivered in the community and in prisons.

²⁸⁵ A sample of 1,457 prisoners was recruited to a general purpose longitudinal survey of convicted prisoners starting a new sentence. Data were collected by structured interviews on reception to prison.

²⁸⁶ Recruitment took place in two prisons in England and follow-up in 13 prisons. 505 women prisoners participated, a response rate of 82%. Questions about drug use were contained within a questionnaire which examined broad aspects of health. On entry into prison, women answered questions about daily drug use and injecting drug use prior to imprisonment. One month later the questionnaires examined drug use during this period of imprisonment.

Objectives are to:

- increase the access to and quality of drug interventions, matched to individual needs;
- target drug-misusing offenders to receive community sentences, where appropriate;
- reduce the supply of drugs into prison;
- strengthen the continuity of case management between community and custody;
- continuously improve value for money; and
- expand the evidence base.

The NOMS Drug Strategy Action Plan sets out the actions that will be taken by NOMS and partner agencies to deliver the strategy (NOMS 2009b). *Getting the Message Across, Communicating and Promoting the NOMS Drug Strategy*, provides detail regarding the organisation and processes for delivery and key messages about drug programmes, initiatives and services to stakeholders (NOMS 2009c).

In August 2009 the NTA confirmed an additional €3.3 million (£2.9m) funding for drug treatment in 25 English prisons for 2009/10²⁸⁷. This funding has been specifically provided for improving treatment facilities and providing better access to reintegration and recovery services (such as education and family support) whilst in prison rather than post-release.

Scotland

In Scotland, responsibility for health care in prisons is to be transferred to the National Health Service (Scottish Government 2009a).

In the last year, the Scottish Government has piloted a new model of care in Her Majesty's Prison (HMP) Edinburgh, to support prisoners in their recovery from problem drug use, which, following an evaluation, is to be introduced in all prisons throughout Scotland as part of the new Scottish Prisons Service (SPS) substance misuse strategy to be launched later this year (Scottish Government 2009a).

²⁸⁷ See: http://www.nta.nhs.uk/media/media_releases/2009_media_releases/drug_treatment_for_prisons_to_get_funding_boost.aspx

9.7.2 Drug treatment system

Integrated drug treatment system in prisons (IDTS)

In March 2009 the NTA published details of the €44 million (£39m) funding package made available for the Integrated Drug Treatment System (IDTS)²⁸⁸, a prison based drug treatment system which aims to provide enhanced drug treatment within prisons and ensure continuity of care between prison and the community for those exiting prison. From 1st April 2009 IDTS funding was available to all adult prisons in England and the roll-out is expected to be completed in 2011.

In August 2009 the NTA published *Breaking the Link*, a report detailing the progress of IDTS. The report details the impact of drug treatment in prison on reducing crime and reoffending, and the costs to communities and society. Whilst the data collection systems for IDTS are still in the bedding-in stage, the early figures suggest that the system is increasing the number of problem drug users accessing drug treatment in prisons and is becoming more effective. The report also highlights areas for continued improvement and monitoring in the IDTS including the transition between care in prison and in the community (NTA 2009i).

The National Offender Management Service (NOMS) published guidance on the delivery of psychosocial support intervention sessions for the first 28 days of an individual's contact with IDTS (NOMS 2009d)²⁸⁹. The aim of these sessions is to support clinical interventions, take into consideration previous drug treatment and provide a starting point for further prison or community-based treatment. The sessions seek to make the individual aware of the effects of their drug use; the harm it causes to themselves and others; make plans for change; identify drug related triggers and situations and create strategies for coping; improve well-being and improve treatment retention. The guidance sets out the requirements for delivery of the sessions, content of sessions, learning outcomes, notes for keyworkers and useful session resources.

Prison Drug Treatment Strategy Review Group

Following recommendations from a Pricewaterhouse Coopers (2008) review of existing prison drug treatment resources effectiveness (see United Kingdom Focal Point Report 2008), the Prison Drug Treatment Strategy Review Group (PDTSRG) was established and met for the first time in February 2009²⁹⁰. The remit of the group is to supervise the implementation of the recommendations and the development of prison based drug treatment programmes.

Drug misuse treatment in offender populations: Evidence review

The Drugs Misuse Treatment in Offender Populations *Annual Evidence Update* (AEU) 2009 compiled by NHS Evidence,²⁹¹ is the first AEU on this topic and includes expert advice based on literature (systematic reviews and meta-analyses) from January 2005 to March 2009. The aim of the AEU is to provide a synopsis of evidence related to effectiveness of interventions with offending drug users. The expert panel concluded that interventions for offending drug users continue to be developed with criminal justice settings providing the best opportunity for engagement of this group. Continued research into effectiveness of treatment interventions with offending drug users is required.

²⁸⁸ The objective of IDTS is to increase the range of treatment options available to those in prison. Specifically, substitute prescribing, integration of prison clinical and psychological treatments into one system, with a single care plan, working to the standards set out in Models of Care and the Treatment Effectiveness Strategy, and integration of prison and community treatment.

²⁸⁹ See: http://www.nta.nhs.uk/areas/criminal_justice/idts_the_first_28_days_psychosocial_support_interventions_resource_pack.aspx

²⁹⁰ See: <http://www.pdtsrg.co.uk/>

²⁹¹ See: <http://www.library.nhs.uk/PUBLICHEALTH/ViewResource.aspx?resID=314438&pgID=1>

Dual diagnosis in prison

Dual diagnosis (i.e. a co-existing mental health and substance use problem) is more prevalent amongst those in prison than the general population. In a review of unmet needs for prisoners with mental health problems, Edgar and Rickford (2009) found that provision for prisoners with dual diagnosis varied depending on the prison. Whilst some prisons reported good levels of provision for this group, others had fragmented services and prisoners were required to deal with one or other problem first rather than both simultaneously and others did not provide any dual diagnosis services. The authors highlighted a lack of integration between drug treatment and mental health services in prisons.

Randomised controlled trial comparing dihydrocodeine and buprenorphine for opiate detoxification in prison

Sheard et al. (2009) conducted a randomised control trial comparing the use of buprenorphine and dihydrocodeine for opiate detoxification within prison²⁹². Higher rates of opiate-free urine samples five days post-detoxification were found amongst the buprenorphine group (57% vs 35%). Follow-up rates of participants after exit from prison were low in both groups. The authors concluded that dihydrocodeine was unsuitable for prison detoxification and the high relapse rate for both drugs indicates that maintenance programmes should also be promoted.

Key findings from the Scottish cohort study

Drug treatment in prison and in the community was compared as part of the 2001 to 2004 DORIS cohort study (McKeganey et al. 2008). Findings showed that both populations (prison and community) benefited from drug treatment, however, those receiving drug treatment in the community had improved drug and non-drug outcomes. Those receiving treatment in the community had access to a more varied range of treatment programmes and had more positive opinions of support received. The authors concluded that these findings may impact upon the extent of improvements seen in the prison population, and whilst recognising the difficulties associated with delivering drug treatment in prisons, recommended that Scottish prisons should consider offering a wider range of treatment and further investigate the negativity felt amongst prisoners regarding prison-based support.

9.7.3 Drug treatment amongst offenders

Prison drug treatment – England and Wales

In 2008/09 Counselling, Assessment, Referral, Advice and Throughcare (CARAT) services delivered 66,133 substance misuse triage assessments to prisoners in England and Wales. In the same period there were 10,881 prison-based accredited drug treatment programme starts and 8,054 completions.

In 2008/09 a total of 19,550 extended substitution treatments were reported by prisons in England and Wales.

NDTMS in prisons

In line with national performance indicators²⁹³ and proposals set out in the 2008 drug strategy (HM Government 2008a), development of the National Drug Treatment Monitoring System (NDTMS) for use in prisons is currently being undertaken (MOJ and NTA 2009).

²⁹² Open labelled, pragmatic randomised controlled trial. Ninety adult male prisoners requesting opiate detoxification were randomised to receive either daily sublingual buprenorphine or daily oral dihydrocodeine.

²⁹³ Public Service Agreement (PSA) 25 in England states that: 'publication of regular treatment performance information by the National Drug Treatment Monitoring System (NDTMS) is a key delivery lever to improve provision of drug treatment.'

Drug treatment in Scottish prisons

Since August 2005 enhanced addiction services have been provided within Scottish Prison Service (SPS) establishments. A range of non-pharmacological interventions are available, based on assessed need, to provide the complex individual paths to recovery from substance misuse.

Data on the number of prisoners being prescribed methadone on a given day (one day in December) are available for the years 2004 to 2007 (ISD 2008) (Table 9.7). There was a year-on-year increase in the proportion of prisoners in Scotland receiving prescribed methadone from 14% in 2004 to 19% in 2007. Currently, as of August 2009, 20% of the Scottish prison population are receiving opiate substitute treatment (OST), this represents nearly double the number of prisoners receiving OST when compared to 2005. SPS are currently undergoing further integration of addiction services and clinical services to provide a complete package of care for all prisoners receiving OST.

Table 9.7: Number and percentage of prisoners being prescribed methadone in Scotland on a given day, 2004 to 2007

| | 17 DEC 2004 | 30 DEC 2005 | 8 DEC 2006 | 14 DEC 2007 |
|------------------------|-------------|-------------|------------|-------------|
| Number | 845 | 984 | 1,228 | 1,354 |
| % of prison population | 14 | 16 | 17.1 | 18.7 |

Source: ISD 2008

Treatment demand indicator (TDI) data from prisons in Northern Ireland

TDI data (see section 5.5) from Northern Ireland show that in 2007/08 there were 148 presentations to treatment in prisons, almost two-thirds of which (64.2%) were for primary cannabis use.

9.8 Reintegration of drug users after release from prison

See section 8.3.1 for further information about housing for individuals leaving prison.

Continuity-of-care for drug users in prison

A guidance document produced by the Home Office, Ministry of Justice and National Treatment Agency (2009) detailed the treatment journey for a drug-using individual prior to entering prison, upon entry into prison, whilst in prison, and after release from prison, with the aim of providing continuity-of-care. The guidance includes a 'journey map' which outlines the different roles and responsibilities of individuals and agencies involved in the care of this group. Guidance about appropriate actions for different scenarios for exit from prison is also included.

10. Drug markets

10.1 Introduction

The *United Kingdom Threat Assessment of Serious Organised Crime 2009/10* (SOCA 2009a) suggests that, "the United Kingdom illegal drugs market remains extremely attractive to organised criminals." Class A (heroin, cocaine and ecstasy) and other drugs are widely available throughout England, Scotland and Wales while in Northern Ireland the heroin and crack cocaine markets are much smaller.

Most of the identified drug supply chains to the United Kingdom follow well-established trafficking routes. While cannabis is still imported in large quantities to the United Kingdom from Europe, there has been a large increase in domestic cannabis cultivation over the past few years. Large commercial cannabis cultivation operations have been discovered and there is evidence of involvement by South East Asian criminal gangs.

The overall picture of United Kingdom drugs distribution appears increasingly complex and diverse. Many traffickers in the United Kingdom, particularly White British criminals import and distribute more than one type of drug. London, Birmingham and Liverpool continue to be important centres for drugs distribution but other smaller cities and towns are also involved. In Scotland, the main source of heroin is from Liverpool via the Glasgow area.

In general the quantity of seizures has been rising in the United Kingdom, cannabis being the most seized drug. The number of herbal cannabis seizures has increased since the introduction of cannabis warnings and there have been increasing seizures of cannabis plants. However, seizures mainly of Class A drugs have achieved short-term disruptions rather than a sustained reduction in the size of the United Kingdom drugs market. The Serious Organised Crime Agency (SOCA) suggests that drug seizures are more likely to impact on purity of drugs at street level than price.

Purity of cocaine powder has fallen substantially at street level since 2003, while the average purity of seizures by HM Revenue and Customs (HMRC) also fell in 2008 suggesting increasing adulteration both within the United Kingdom and upstream.

The price of cocaine powder, heroin and ecstasy has decreased since 2003 while the price of other drugs has remained stable. When adjusting for purity, however, cocaine powder prices have risen since 2003.

The most recent estimate of the size of the illicit drug market in the United Kingdom is €7.7 billion (£5.3bn) in 2003/04, with a wide margin of error of €5.8 billion (£4bn) to €9.5 billion (£6.6bn)²⁹⁴. In Scotland the size of the illicit drug market has been estimated at €2.1 billion (£1.4bn) for 2006.

²⁹⁴ The study used a survey-based demand side approach to estimate market size. Data from the Schools Survey 2003, the Offending Crime and Justice Survey 2003 and the Arrestees Survey 2003/04 were analysed to estimate the prevalence of drug use, frequency of use quantity used and expenditure on drugs by juveniles, the general adult population and adult arrestees. Estimates of price and quantities were compiled from a number of sources including NICS price data and FSS purity data. The estimate was based on data sources for England and Wales and extrapolated to the United Kingdom as a whole.

10.2 Availability and supply

10.2.1 Availability in the general population

The Serious Organised Crime Agency's (SOCA) 2008/09 Annual Report (SOCA 2009b) states that reports of the ready availability of cocaine powder in the United Kingdom are mistaken. The report points to large reductions in the purity of what is sold as cocaine powder (see section 10.4.2) and intelligence of domestic shortages during the 2008 Christmas period as evidence of reduced availability.

Retail-level drug distribution

A review of the literature describing different patterns of drug distribution at retail-level (Potter 2009) has been published. It suggests that concepts such as social supply are not clearly defined and that the relationship between user and dealer should be examined further to better understand conceptual issues.

10.2.2 Availability amongst school children and young people

Data on availability of drugs amongst school children is from the *Scottish Schools Adolescent Lifestyle and Substance Use Survey* (SALSUS) 2008 (NHS Scotland 2009) and the survey on *Smoking, Drinking and Drug Use among young people in England in 2008* (Fuller 2009).

Scotland

In 2008 17% of 13 year olds and 45% of 15 year olds reported that it was either fairly easy or very easy to obtain illegal drugs. Boys were slightly more likely than girls to report so; 33% compared to 29%. Fifty one per cent of 15 year olds and 22% of 13 year olds reported ever being offered drugs with cannabis the drug most likely to be offered (12% of 13 year olds and 40% of 15 year olds reported ever being offered cannabis). The next most common drugs were ecstasy (17%), cocaine powder (13%) and poppers (12%). Four per cent of 15 year olds reported being offered crack cocaine and heroin.

England

In 2008 33% of pupils aged 11 to 15 years old reported ever being offered drugs. Older pupils were more likely to have been offered drugs; 11% of 11 year olds, 29% of 13 year olds, and 57% of 15 year olds reported being offered drugs. This is higher than in Scotland reflecting the higher proportion who reported drug use in England (see section 2.4.1). Pupils were most likely to report being offered cannabis (22%) followed by volatile substances (13%), poppers (10%) and cocaine powder (nine per cent). Seven per cent of pupils reported being offered crack cocaine and five per cent heroin. There was little difference between genders apart from at the lower ages (11 and 12 years old), where boys were more likely to have been offered drugs.

Trends

Scotland

The proportion of school children perceiving drugs to be easy²⁹⁵ to obtain has decreased since 2004 as has the proportion reporting ever being offered drugs (Table 10.1). The latter is mainly due to a fall in the proportion having been offered cannabis: from 57% of 15 year olds and 26% of 13 year olds in 2004 to 40% and 12% respectively in 2008. The only drug that 15 year olds were more likely to report being offered in 2008 was cocaine powder, which rose from 10% in 2004 to 13%. However, there was no increase between the 2006 and 2008 surveys and a slight reduction amongst 13 year olds from five per cent to four per cent.

²⁹⁵ Those reporting it as either 'very easy' or 'fairly easy'.

Table 10.1: Proportion of school children reporting that drugs are easy to obtain and ever being offered drugs in Scotland, 2004 to 2006 by age

| DRUG | 13 YEAR OLDS | | | 15 YEAR OLDS | | |
|-------------------------|--------------|------|------|--------------|------|------|
| | 2004 | 2006 | 2008 | 2004 | 2006 | 2008 |
| Drugs easy to obtain | 31 | 21 | 17 | 58 | 48 | 45 |
| Ever been offered drugs | 33 | 23 | 22 | 63 | 53 | 51 |

Source: NHS Scotland 2009

England

The proportion of pupils who reported having been offered drugs fell from 42% in 2003 to 33% in 2008 with a decrease from 36% in the previous year. There have been decreases in almost all individual drugs including the most commonly reported drugs: cannabis (27% in 2003 to 22% in 2008), volatile substances (19% in 2003 to 13% in 2008), and poppers (12% in 2003 to 10% in 2008). The proportion being offered cocaine powder has remained stable at nine per cent.

Sources of supply amongst school children

Data on sources of supply are available from Scotland only (NHS Scotland 2009). In 2008, of those who had ever taken drugs, 72% of 13 year olds and 81% of 15 year olds said that they got drugs from a friend, mostly the same age or older. Nine per cent of 13 year old drug users and four per cent of 15 year old drug users reported getting drugs from a stranger, with girls less likely to report a stranger as the source of drugs than boys (two per cent compared to seven per cent). Thirteen year olds were more likely to report getting drugs from a sibling (seven per cent) or parent (four per cent) than 15 year olds (three per cent and one per cent respectively).

10.2.3 Production, sources of supply and trafficking patterns within the country and from and towards other countries

Production, sources of supply and trafficking patterns to the United Kingdom

Information on the supply of drugs is provided by the Serious Organised Crime Agency (SOCA) through their annual Threat Assessment publication. The latest assessment (SOCA 2009a) includes the following:

Heroin

Most identified supply chains to the United Kingdom follow well-established trafficking routes. The primary trafficking route is overland from Afghanistan to Europe, transiting through Iran, Pakistan, Turkey and the Balkans. Most of the heroin moved along these routes ends up in the Netherlands before entering the United Kingdom. In addition, a significant amount of Afghan heroin arrives directly by air routes from Pakistan via couriers and parcels and is aided by the existence of large and established Pakistani communities in the United Kingdom.

Cocaine

An estimated 65 to 70% of the United Kingdom's identified cocaine supply is believed to be produced in Colombia. Peru and Bolivia account for the vast majority of the remaining 30 to 35%. The Iberian Peninsula, predominantly Spain and to a lesser extent Portugal, continue to be the main entry points into Europe for shipments of cocaine from South America (primarily Venezuela) destined for the United Kingdom. The Netherlands is the most important secondary distribution point for the importation of cocaine into the United Kingdom entering via ports in the south east of England. West Africa is used as a consolidation point and a centre for logistics, command and control. Since mid June 2008, the airbridge has been disrupted possibly as a reaction to law enforcement interdictions in West Africa. SOCA's Annual Report 2008/09 uses the example of a joint operation with the Sierra Leone authorities to demonstrate how new routes through West Africa are being disrupted (SOCA 2009b). Some British organised crime groups are able to source cocaine directly from contacts in South America or West Africa.

Synthetic drugs

Almost all of the ecstasy consumed in the United Kingdom is manufactured in the Netherlands or Belgium, and commonly enters by sea through Dover, Felixstowe and Harwich. Synthetic drug production in the Netherlands and Belgium relies heavily upon precursor chemicals made in China, obtained through criminal networks from Chinese companies. BMK (benzyl-methyl-ketone), used in the production of amphetamines has been legally produced in Russia since 2004 resulting in an increase in BMK being sourced from Russia. Some amphetamines are manufactured within the United Kingdom, although this appears to be on a relatively small scale.

Cannabis

Cannabis is imported into the United Kingdom from Europe in bulk by organised criminals, sometimes in mixed loads alongside Class A drugs, and in smaller amounts for sale, and for personal use. In addition, there has been an increase in cannabis cultivation within the United Kingdom using residential and industrial premises and intensive cultivation methods capable of producing multiple crops a year. There is strong evidence of the involvement of South East Asian criminal gangs in large growing operations (see section 11.2.2).

Importation into the UK

The Channel Tunnel and ports in the South-East of England are the most widely used entry points for Class A drugs with traffickers making significant use of Heavy Goods Vehicles (HGVs) concealing loads. Some British criminals import drugs in private and hire cars and small vans while a proportion of the drugs are also brought in by couriers. Low-level couriers and drivers are often used to transport drugs into the United Kingdom using a 'little and often' method.

Data from Her Majesty's Revenue and Customs (HMRC) and the UK Border Agency show that 69% of seized heroin and 53% of seized cocaine were transported in freight. Forty three per cent of seized cocaine was carried by passenger traffic compared to 20% of seized heroin. Post, as a mode of transport, accounted for only a small proportion of seized drugs; four per cent for heroin and two per cent for cocaine (House of Commons 1497W²⁹⁶).

²⁹⁶ See: <http://www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090205/text/90205w0025.htm>

The illegal drug trade in the United Kingdom

SOCA reports that a large number of foreign nationals are involved in the illegal drug trade in the United Kingdom (SOCA 2009a). Turkish and Kurdish criminals based in London control much of the heroin trade with criminals from Pakistan and other south Asian countries exploiting family connections to supply and distribute heroin, particularly in the north of England and the Midlands. While there is strong evidence of South East Asian involvement in large-scale domestic cannabis cultivation, little is known about distribution.

Tackling organised crime

In August 2008, the Organised Crime Partnership Board was established bringing together SOCA, The Police Service, UKBA and HMRC. In July 2009 a strategy on tackling organised crime, ***Extending our reach: A comprehensive approach to tackling serious organised crime*** was published (Cabinet Office and Home Office 2009). One of the aims is for an integrated approach to tackling organised crime which uses a common model to assess harm and places harm reduction at the centre rather than, for example, quantities of drugs seized or criminals incarcerated. SOCA's harm framework was published in its 2008/09 Annual Report (SOCA 2009b). Other actions involve structural changes, changes to working practices, managing serious organised criminals more intensively in prisons, and increasing the use of tax investigation.

Inquiry into the cocaine trade

The Home Affairs Committee has launched an investigation of the cocaine trade²⁹⁷. The inquiry is focusing on:

- whether cocaine powder is now a street drug rather than just one used recreationally by the relatively well-to-do;
- the influence of 'celebrity cocaine culture' as criticised in the UNODC's report on the UK last year;
- the effectiveness of advertising campaigns in deterring use;
- trends in the use of crack cocaine;
- international collaboration: the responses of the producer countries;
- international collaboration: the EU's external borders;
- international collaboration: effects on the transit countries;
- SOCA's role;
- HMRC's role; and
- the police response: possession and dealing.

²⁹⁷ See: http://www.parliament.uk/parliamentary_committees/home_affairs_committee.cfm

Drug transaction cycles

An economic analysis of drug transaction 'cycles' was carried out by Caulkins et al. (2009), based on interviews of prisoners incarcerated for drug trafficking offences²⁹⁸. By re-analysing interviews they conclude that drug dealing cycles are short with drugs often being bought and sold in less than a week. However, cycle frequency differs in relation to both drug and transaction size with smaller transactions and heroin and crack cocaine purchases more frequent. They argue that this demonstrates that not much inventory is held within the UK. In price markups they found stability over drugs and time, although no account is taken of purity. This, they contend, warrants further analysis and explanation. By computing markup coefficients and applying them to price markups from importation to first domestic sale, they found that only 42% of an importer's revenues were attributable to importation and the remainder was due to domestic distribution by breaking it down into smaller sizes.

10.3 Seizures

Previous data have been provided for the United Kingdom. However, new data from Scotland were not available at the time of writing. Instead data are presented for England and Wales from 2003 to 2007/08 and for Northern Ireland from 2003 to 2008/09.

England and Wales

The number of seizures increased by 17% in 2007/08 continuing the upward trend since 2004 (Table 10.2). This is largely due to the introduction of the cannabis warning, which has meant that the number of cannabis seizures has more than doubled over this period. However, the proportion of all seizures which involve cannabis has remained stable at around 75%. The largest increase in number of seizures involves cannabis plants (32%) (see section 11.3). However, seizures of cocaine powder have also increased sharply with a change of 26% on the previous year and almost double the number of seizures from 2005. There have been decreases over the past year in the number of ecstasy and LSD seizures.

Table 10.2: Number of seizures of drugs by law enforcement agencies in England and Wales, 2003 to 2007/08

| DRUG | 2003 | 2004 | 2005 | 2006/07* | 2007/08 | % CHANGE FROM 2006/07 |
|-------------------------|----------------|----------------|----------------|----------------|----------------|-----------------------|
| Amphetamines | 5,862 | 6,174 | 7,425 | 8,030 | 8,412 | + 4.8 |
| Cannabis – herbal | 29,517 | 40,985 | 72,252 | 104,007 | 130,635 | + 25.6 |
| Cannabis – resin | 41,771 | 33,449 | 39,295 | 30,902 | 29,325 | - 5.1 |
| Cannabis plants | 2,680 | 2,780 | 4,098 | 5,497 | 8,102 | + 32.2 |
| Cocaine powder | 6,907 | 7,912 | 11,912 | 16,079 | 20,318 | + 26.4 |
| Crack cocaine | 4,755 | 4,900 | 6,350 | 6,586 | 7,191 | + 9.2 |
| Ecstasy type substances | 6,114 | 5,938 | 6,336 | 7,752 | 6,807 | - 12.2 |
| Heroin | 10,569 | 11,074 | 13,331 | 13,205 | 13,463 | + 2.0 |
| LSD | 124 | 137 | 194 | 160 | 138 | - 13.8 |
| Total | 109,146 | 107,359 | 161,113 | 186,028 | 216,792 | + 16.5 |

*In 2006/07 seizures data moved to a financial year basis

Source: Smith and Dodd 2009a

²⁹⁸ The report is based on 65 interviews from the study carried out by Matrix Knowledge Group (2007) looking at aspects of the drug market in the UK and reported in the UK Focal Point's Annual Report 2008.

Police seizures accounted for 97% of all seizures in 2007/08. London police forces made a third of all police seizures (33%) with the South East region the next highest (11%). While police seizures accounted for the vast majority of seizures, Her Majesty's Revenue and Customs (HMRC) accounted for most of the quantity of seized drugs. The quantity of heroin seized fell between 2003 and 2006/07 but remained at the same level in 2007/08 (Table 10.3). The amount of cocaine powder seized has been stable since 2005. In 2007/08, the quantity of ecstasy seized fell by 86% while the quantity of amphetamines increased by 30%. The quantity of cannabis resin fell again continuing the trend since 2005 while the quantity of herbal cannabis also fell in 2007/08. However, the number of cannabis plants seized increased by 48% to over half a million plants.

Table 10.3: Quantity of seizures of drugs by law enforcement agencies in England and Wales, 2003 to 2007/08

| DRUG | UNIT | 2003 | 2004 | 2005 | 2006/07* | 2007/08 | % CHANGE FROM 2006/07 |
|-------------------|---------------|--------|--------|---------|----------|---------|-----------------------|
| Amphetamines | Kg | 1,530 | 1,207 | 2,038 | 1,359 | 1,765 | +29.9 |
| Cannabis – herbal | Kg | 29,517 | 21,384 | 20,420 | 25,679 | 19,927 | - 22.4 |
| Cannabis – resin | Kg | 69,029 | 62,062 | 49,190 | 19,721 | 16,568 | - 16.0 |
| Cannabis plants | Plant | 80,498 | 88,674 | 208,357 | 344,360 | 508,460 | + 47.7 |
| Cocaine powder | Kg | 6,813 | 4,571 | 3,765 | 3,191 | 3,433 | +7.6 |
| Crack cocaine | Kg | 251 | 133 | 49 | 58 | 35 | - 39.7 |
| Ecstasy | Tablet (000s) | 6,730 | 4,649 | 2,946 | 6,584 | 947 | -85.6 |
| Heroin | Kg | 2,657 | 2,109 | 1,864 | 1,033 | 1,041 | +0.8 |
| LSD | Dose (000s) | 2 | 36 | 1,077 | 6 | 2 | - 66.7 |

*In 2006/07 seizures data moved to a financial year basis

Source: Smith and Dodd 2009a

Northern Ireland

In 2008/09 the number of seizures increased to over three thousand, an increase of eight per cent on the previous year. The number of herbal cannabis seizures has increased greatly in the past few years from 180 in 2005/06 to 897 in 2008/09. Over the same period the number of cannabis plant seizures increased from 45 to 173. However, unlike in England and Wales, the number of cannabis resin seizures remained relatively stable over this period. The number of ecstasy seizures has remained stable while cocaine powder seizures have increased by almost 300% since 2004/05. There was a fall in the number of amphetamines seizures in 2008/09.

Table 10.4: Number of seizures of drugs by police in Northern Ireland, 2003/04 to 2008/09

| DRUG | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 | 2008/09 |
|-------------------|--------------|--------------|--------------|--------------|--------------|--------------|
| Amphetamines | 130 | 147 | 138 | 188 | 132 | 95 |
| Cannabis – herbal | 109 | 131 | 180 | 486 | 811 | 897 |
| Cannabis – resin | 1,819 | 1,841 | 2,086 | 1,438 | 1,480 | 1,630 |
| Cannabis plants | 59 | 43 | 45 | 105 | 115 | 173 |
| Cocaine powder | 77 | 87 | 168 | 278 | 405 | 345 |
| Crack cocaine | 3 | 0 | 0 | 0 | 0 | 1 |
| Ecstasy | 342 | 317 | 256 | 411 | 436 | 353 |
| Opiates (powder) | 14 | 14 | 30 | 43 | 38 | 46 |
| LSD | 1 | 9 | 15 | 7 | 6 | 10 |
| Total | 2,347 | 2,402 | 2,767 | 2,590 | 2,968 | 3,198 |

Source: PSNI 2006b; PSNI 2009b

Due to relatively small quantities of some drugs, large seizures can have a disproportionate effect on overall quantities and changes should be interpreted with care. In 2008/09 the quantity of ecstasy fell substantially while the amount of cocaine powder increased on the previous year but was lower than the amount seized in 2005/06 and 2006/07 (Table 10.5). The amount of herbal cannabis seized increased substantially in 2008/09 while the number of cannabis plants increased sevenfold.

Table 10.5: Quantity of seizures of drugs by police in Northern Ireland, 2003/04 to 2008/09

| DRUG | UNIT | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 | 2008/09 |
|-------------------|---------------|---------|---------|---------|---------|---------|---------|
| Amphetamines | Kg | 17 | 79 | 74 | 18 | 13 | 6 |
| Cannabis – herbal | Kg | 33 | 20 | 69 | 27 | 70 | 249 |
| Cannabis – resin | Kg | 2,204 | 933 | 426 | 3684 | 78 | 743 |
| Cannabis plants | Plant | 1,173 | 574 | 1,504 | 1,448 | 4,006 | 30,904 |
| Cocaine powder | g | 11,471 | 21,332 | 27,124 | 36,140 | 17,883 | 24,152 |
| Crack cocaine | g | 9 | 0 | 0 | 0 | 0 | 7 |
| Ecstasy | Tablet (000s) | 223 | 351 | 92 | 119 | 245 | 34 |
| Opiates (powder) | g | 189.9 | 5.1 | 321.8 | 592.4 | 106.5 | 130.7 |
| LSD | Dose | 6 | 8,146 | 308 | 127 | 186 | 169 |

Source: PSNI 2006b; PSNI 2009b

Seizures by the Serious Organised Crime Agency

SOCA works jointly with United Kingdom police forces, HMRC and the UK Border Agency. Often, to protect sensitive intelligence sources, seizures are attributed to local police forces. Outside of the United Kingdom, SOCA has no power to seize drugs so the actual physical act of seizing drugs is left to the relevant overseas law enforcement bodies. Despite this, data show that in 2007/08 there were 178 United Kingdom seizures in SOCA operations and 360 overseas²⁹⁹. These cannot be added to other seizures as this may introduce double-counting.

Other seizures

Heroin hydrochloride, also known as 'crystal heroin', has been seized by UK law enforcement in varying amounts from street size deals to multi-kilo amounts (SOCA 2009a).

²⁹⁹ See Written Answers 19/01/09: <http://www.theyworkforyou.com/wrans/?id=2009-01-19b.245949.h&s=seizures+soca#g245949.r0>

10.4 Price/purity

The price of drugs in the United Kingdom appears to be influenced by the purity or potency of the substance involved. The price of the weaker cannabis resin is lower than the stronger herbal cannabis, which in turn is cheaper than more potent strains of sinsemilla. A 'two-tier' market exists for cocaine powder, with a more adulterated product selling for less than higher quality cocaine powder.

Project Endorse

In October 2008, a SOCA initiative known as Project Endorse began. All seizures of heroin, cocaine and amphetamines above 25g were subject to full forensic examination. The physical appearance, chemical profiles and chemical composition of the drug are examined and recorded on a searchable database. This not only provides richer purity data but also allows law enforcement seizures to be linked and is therefore of direct operational value. Since the pilot scheme ended, SOCA has been running the project at a reduced level.

10.4.1 Price of drugs at street level

Law enforcement agencies³⁰⁰ collect national data on drug prices while DrugScope conducts a random snapshot of drug prices in different areas of the United Kingdom³⁰¹.

Mean price of illicit drugs in the United Kingdom

Data from law enforcement agencies suggest that the price of heroin and cocaine powder has again fallen while the price of other drugs has remained stable (Table 10.6). However, when adjusting for purity, cocaine powder prices increased until 2005 and have remained stable since (see section 10.4.2). There are considerable regional variations in the price of drugs across the United Kingdom. Street prices of brown heroin vary widely depending on where it is purchased with prices of €33.4 (£30) per gram in London and Manchester and €112.9 (£100) in Belfast (SOCA 2009a).

Prices in Euros for 2008 may be misleading due to a large change in the exchange rate.

³⁰⁰ Figures provided are derived from returns by police forces in the United Kingdom. The information is obtained from a number of sources including: prisoner interviews, informants, test purchases, recording procedures and intelligence. The figures shown in this chapter are the averages of the police force data returns, rather than the most representative price, and therefore may differ from figures quoted elsewhere from the same source (See Standard Table 16 for fuller details of methodology).

³⁰¹ Information collected by journalists from Druglink, the organisation's magazine, who call 100 drug services, DATs, police forces and service user advocates in 20 areas of the United Kingdom.

Table 10.6: Law enforcement agencies: Mean price of illegal drugs in the United Kingdom, 2003 to 2008

| DRUG | PRICE PER GRAM EXCEPT WHERE OTHERWISE STATED | | | | | |
|--------------------------|----------------------------------------------|---------------------------|---------------------------|--------------------------|---------------------------|---------------------------|
| | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
| | EXCH. RATE: £1=€1.4456 | EXCH. RATE: £1=€1.4739 | EXCH. RATE: £1=€1.4629 | EXCH. RATE: £1=€1.467 | EXCH. RATE: £1=€1.4619 | EXCH. RATE: £1=€1.2588 |
| Amphetamines | £9.00 | £8.00 | £10.00 | £9.00 | £9.00 | £10.00 |
| | €13.01 | €11.79 | €14.63 | €13.20 | €13.16 | €12.59 |
| Cannabis herb* | £2.54 | £2.54 | £2.64 | £2.68 | £3.95 | £2.85 |
| | €3.67 | €3.74 | €3.86 | €3.93 | €5.77 | €3.59 |
| Cannabis resin* | £2.32 | £2.00 | £1.94 | £2.12 | £2.82 | £2.85 |
| | €3.35 | €2.95 | €2.84 | €3.11 | €4.12 | €3.59 |
| Cannabis (sinsemilla) | | | | | £6.21 | £5.63 |
| | | | | | €9.08 | €7.09 |
| Cocaine powder | £55.00 | £51.00 | £49.00 | £49.00 | £46.00 | £40.00 |
| | €79.51 | €75.17 | €71.68 | €71.88 | €67.24 | €50.35 |
| Crack cocaine** | £19.00 | £18.00 | £19.00 | £18.00 | £65.00 | £65.00 |
| | €27.47 | €26.53 | €27.80 | €26.41 | €95.02 | €81.82 |
| Ecstasy (per tablet) | £5.00 | £4.00 | £4.00 | £3.00 | £3.00 | £3.00 |
| | €7.23 | €5.90 | €5.85 | €4.40 | €4.39 | €3.78 |
| Heroin | £62.00 | £55.00 | £54.00 | £52.00 | £48.00 | £45.00 |
| | €89.63 | €81.06 | €79.00 | €76.28 | €70.17 | €56.65 |
| LSD (per dose) | £3.00 | £3.00 | £3.00 | £3.00 | £3.50 | £3.00 |
| | €4.34 | €4.32 | €4.39 | €4.40 | €5.12 | €3.78 |

Note : The source data were provided rounded, usually to the nearest pound.

*Before 2007 the cannabis values were based on the price for an ounce. In 2007 this changed to being based on a usual street deal of 1/8oz. The price has been converted to gram equivalent.

**Crack cocaine prices before 2007 were provided per rock (0.2g) not per gram. Prices after 2007 cannot be compared to earlier prices.

Source: Standard Table 16

Results from the DrugScope survey of street drug prices show that cocaine powder prices have again fallen to an average of €44 (£39) per gram. The price of MDMA powder has also fallen while all other drug prices have remained stable. Cannabis prices cannot be compared to previous years due to a change in methodology (Table 10.7).

Table 10.7: DrugScope: Mean price of drugs at street level in the United Kingdom, 2006 to 2009

| DRUG | PRICE PER GRAM EXCEPT WHERE OTHERWISE STATED | | | |
|-----------------------------------|----------------------------------------------|---------------------------|---------------------------|---------------------------|
| | 2006 | 2007 | 2008 | 2009 |
| | EXCH. RATE: £1=€ 1.470 | EXCH. RATE: £1=€1.4619 | EXCH. RATE: £1=€1.2588 | EXCH. RATE: £1=€1.1291 |
| Amphetamines | £9.70 | £9.80 | £9.00 | £9.00 |
| | €14.23 | €14.33 | €11.33 | €10.16 |
| Cannabis herb* (standard quality) | £2.47 | £3.07 | £3.14 | £4.43 |
| | €3.62 | €4.49 | €3.95 | €5.00 |
| Cannabis resin* | £1.91 | £1.94 | £1.80 | £3.00 |
| | €2.80 | €2.84 | €2.27 | €3.39 |
| Cannabis (high quality)* | £4.27 | £4.73 | £4.63 | £5.71 |
| | €6.26 | €6.91 | €5.83 | €6.45 |
| Cocaine powder | £43.00 | £43.00 | £42.00 | £39.00 |
| | €63.08 | €62.86 | €52.87 | €44.03 |
| Ketamine | £28.00 | £25.00 | £20.00 | £22.00 |
| | €41.08 | €36.55 | €25.18 | €24.84 |
| Ecstasy (per tablet) | £3.00 | £2.40 | £2.30 | £2.00 |
| | €4.40 | €3.51 | €2.90 | €2.26 |
| Heroin | £46.00 | £43.00 | £49.00 | - |
| | €67.48 | €62.86 | €61.68 | - |
| MDMA powder | £40.00 | £38.00 | £39.00 | £36.00 |
| | €58.68 | €55.55 | €49.09 | €40.68 |

*Until 2008, cannabis prices were converted from ounce prices but in 2009 they were converted from quarter ounce prices.

Source: DrugScope

10.4.2 Purity of drugs at street level and composition of drugs/tablets

Caution must be taken interpreting change over the last year since data provided in 2008 are from both the Forensic Science Service (FSS)³⁰² and LGC Forensics while previous data were from FSS only. Table 10.8 shows the mean percentage purity for drugs seized by police in England and Wales³⁰³. The purity of heroin has fallen slightly but is still higher than in 2003 and 2004. The purity of amphetamines also fell in 2008 and SOCA report that most of the street-level amphetamine seized through Project Endorse is under five per cent purity, sometimes as low as one per cent (SOCA 2009b). Standard table 14 provided to the United Kingdom Focal Point shows that the range of purities across all drugs is large.

Table 10.8: Mean percentage purity of certain drugs seized by police in England and Wales, 2003 to 2008

| DRUG | 2003 | 2004 | 2005 | 2006 | 2007 | 2008* |
|----------------|------|------|------|------|------|-------|
| Amphetamines | 10.8 | 9.0 | 10.1 | 10.6 | 10.9 | 7.8 |
| Cocaine powder | 51.2 | 42.4 | 42.7 | 34.5 | 33.2 | 28.8 |
| Crack cocaine | 69.6 | 63.7 | 64.8 | 49.5 | 52.3 | 43.1 |
| Ecstasy** | 64.5 | 66.7 | 66.3 | 48 | 51.8 | 33.1 |
| Heroin (brown) | 32.7 | 39.9 | 46.5 | 43.5 | 49.8 | 42.7 |

*From 2008 data have been provided from FSS and LGC Forensics. Previous data were from FSS only.

**mg of MDMA base per tablet.

Source: Standard Table 14

Cocaine purity

The average purity of cocaine powder at importation fell to 63% in 2008, with the remaining content being cutting agents added upstream. During 2008 the United Kingdom wholesale price of cocaine powder rose from an average of €43,857 (£30,000) per kilo in 2007 to €44,058 (£35,000) in 2008 (personal communication – SOCA) and SOCA reports that in March 2009 it had risen to €50,810 (£45,000) (SOCA 2009a)³⁰⁴. The mean purity of cocaine powder available at street level has dropped to less than one third demonstrating that cocaine powder is being extensively cut to maintain profit margins. Data in Table 10.8 show that the mean purity of cocaine powder has fallen from 51% in 2003 to 29% in 2008. This downwards trend is continuing; analysis of cocaine powder seizures between October and December 2008 weighing 25 to 50 grams shows mean purity to be 23%. Furthermore, reports suggest that a third of all cocaine powder seizures are under nine per cent purity³⁰⁵.

The fall in average purity is aligned to a steady decrease in the price of what is sold as cocaine powder at street level although, indexed with average price, purity appears to have fallen greatest (Figure 10.1). Indeed when adjusting prices for purity, prices have effectively risen since 2005³⁰⁶ (Table 10.9). A 'two-tier' market has developed for street-level cocaine powder, with lower purity cocaine powder available at a lower price, and higher purity, higher-priced cocaine powder available to those who can afford it³⁰⁷.

³⁰² There are other forensic agencies providing services to police forces in England and Wales but FSS and LGC Forensics cover around 90% of all police forces.

³⁰³ Police seizures are used as a proxy for purity of street-level drugs although there will also be some large seizures.

³⁰⁴ While some of this price rise is due to a change in the exchange rate between Sterling and the Euro, there are also reports of price rises in the Euro zone.

³⁰⁵ See: <http://news.bbc.co.uk/1/hi/uk/8044275.stm>

³⁰⁶ Prices have not been adjusted for inflation.

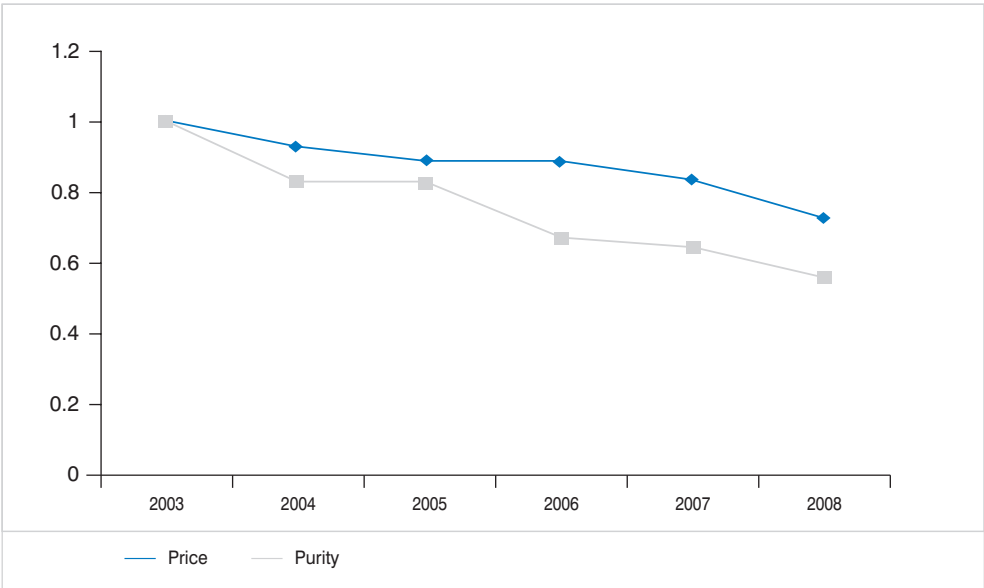
³⁰⁷ See Martin Barnes from DrugScope's oral evidence given to the Home Affairs Select Committee on the cocaine trade.

Table 10.9: Purity-adjusted price of cocaine powder per gram in the United Kingdom, 2003 to 2008: indexed to 2003

| DRUG | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
|----------------|---------------|---------------|---------------|----------------|----------------|---------------|
| Cocaine powder | £55 | £61.58 | £58.75 | £72.70 | £70.94 | £71.11 |
| | €79.51 | €90.76 | €85.95 | €106.63 | €103.71 | €89.51 |

Source: Standard Tables 14 and 16

Figure 10.1: Price and purity of cocaine powder in England and Wales, 2003 to 2008: indexed to 2003



Source: Standard Tables 14 and 16

Crack cocaine purity has also fallen substantially at street level since 2005 and is linked to the fall in cocaine powder purity.

Ecstasy purity

The MDMA content of ecstasy tablets continues to fall. In 2008 the average content (mean mg) of MDMA per tablet was 33 mg compared to 52 mg in 2007. However, the majority of ecstasy tablets analysed by FSS and LGC Forensics in 2008 contained MDMA as the main drug with adulterants such as caffeine and BZP also detected. Last year there were reports of users switching to the more expensive MDMA powder, which is a higher purity product. The mean purity of MDMA powder at street level in 2008 was 62% and 79% at wholesale level.

The proportion of illicit drug tablets analysed by FSS in 2008 that contained MDMA only was 51%. This is a fall from 73% in 2007 and 99.5% in 2005. This is mainly due to a large increase in seizures of tablets containing piperazines and this increase is expected to continue (personal communication – FSS).

The UK Focal Point is not able to provide data on cannabis potency due to methodological problems. Data from forensic services are not representative of the cannabis on the street for a number of reasons. The majority of cannabis seizures are not analysed due to the fact these data are not needed for evidential purposes, especially in the case of small possession amounts dealt with by a cannabis warning. Furthermore, herbal cannabis is not broken down by type and the proportion that is skunk (not traditional herbal) cannabis can affect the data. Police forces and forensic services also have varying sampling methods, and analytical methods and the quality of these standards varies.

As a result of these difficulties, the Home Office carried out a potency study in 2008 based on street seizures and using the same standards across forensic laboratories. These data were reported in the UK Focal Point's 2008 Report and will form the benchmark for future potency studies. One of the ACMD's recommendations regarding the re-classification of cannabis was that this study be repeated in the future, and the Government accepted this recommendation.

10.5 Estimating the size of the illicit drug market

Casey et al. (2009) estimated the size and value of the illicit drug market in Scotland in 2006.³⁰⁸ The combined value of the recreational and problem drug use (PDU) markets was estimated to be €2.1 billion (1.4bn) in 2006. The study found that:

- the problem drug use market accounted for just under two-thirds of the value (63%) of the total illicit drugs market;
- heroin accounted for the largest expenditure share (39%); and
- cannabis (19% of total market value) and cocaine powder (17% of total market value) were the next biggest markets.

The report states that the biggest difficulty in compiling these estimates concerned the amount of drugs used by recreational users. The authors suggest that further work is required on drug consumption levels in order to refine the estimates.

³⁰⁸ The study used prevalence data from the Scottish Crime and Victimization Survey; estimates of problem drug use in Scotland for 2006; information on drug consumption from the Drug Outcomes Research in Scotland (DORIS) study, Scottish Drug Misuse Database and the Independent Drug Monitoring Unit (IDMU); and price data from the Scottish Crime and Drug Enforcement Agency (SCDEA).

Part B:
Selected Issues



11. Cannabis markets and production

11.1 Legislation on cannabis production, trafficking and use

The *Misuse of Drugs Act 1971* is the primary legislation relating to offences involving possession, supply and production of controlled drugs. Under the Act, drugs are divided into three classes, A, B and C, which determine the maximum penalties for offences. Originally Class B, cannabis was downgraded in 2004 to Class C, although the maximum penalties for supply and production remained the same. The downgrading of cannabis saw the introduction of the cannabis warning, an administrative sanction for offences involving the possession of small amounts of cannabis for personal use. In 2008 the decision was made to reclassify cannabis back to Class B and it came into effect in January 2009. The penalties for supply and production remained the same and the cannabis warning still exists although there is a policy of escalation for repeat offenders.

The *Criminal Law Act 1977* defined the interpretation of cannabis for the purposes of the *Misuse of Drugs Act 1971* as plant material only, not seeds (Figure 11.1).

Figure 11.1: Definition of cannabis in the Criminal Law Act 1977

"Cannabis" (except in the expression "cannabis resin") means any plant of the genus *Cannabis* or any part of any such plant (by whatever name designated) except that it does not include cannabis resin or any of the following products after separation from the rest of the plant, namely:

- (a) mature stalk of any such plant,
- (b) fibre produced from mature stalk of any such plant, and
- (c) seed of any such plant.

Source: Criminal Law Act 1977

11.2 Markets

11.2.1 The size of the United Kingdom cannabis market

There have been a number of attempts to estimate the size of the cannabis market in the United Kingdom. Pudney et al. (2006) estimate that the quantity of cannabis used in the UK during 2003/04 was 412 tonnes (+ or – 155 tonnes), equating to expenditure of €1.5 billion (£1.03bn) (with a wide margin of error of + or - €625.9 million (£433 million)). A recent study funded by the European Commission, based on consumption rates in the United States, estimated cannabis demand in the UK during 2005 to be 450.4 tonnes (low estimate, 201.3; high estimate, 937.1) with a Euro value of €1.515 billion (low estimate, €677.0; high estimate, €3.152 billion) (Kilmer and Pacula 2009). Preliminary results from a French study on cannabis markets in Europe suggest that cannabis demand in the UK was 290.1 tonnes in 2006³⁰⁹. Expenditure estimates have not been published yet.

Estimates of spending on cannabis have also been carried out by the Independent Drug Monitoring Unit (IDMU) based on results of their annual survey of festival goers (IDMU 2004). Using different estimates of regular use derived from a number of sources, they estimate that the annual spend on cannabis in 2003 was between €1.41 billion (£0.978bn) and €5.56 billion (£3.844bn).

³⁰⁹ See: http://www.emcdda.europa.eu/attachements.cfm/att_78751_EN_1_Costes.pdf

Analysis carried out by law enforcement agencies in 2008 suggests that the annual demand for skunk³¹⁰ cannabis in the United Kingdom is around 92.3 tonnes equating to a street value of €0.98 billion (£0.78bn)³¹¹. This, it is acknowledged, is a conservative estimate based on the presumption that skunk cannabis accounts for 38% of the domestic market, which is a much lower proportion than found in other studies (see section 11.2.4 for estimates of market shares) [personal communication – law enforcement agencies].

A study carried out in London estimated use of cannabis amongst 'socially integrated' users (Moskalewicz et al. 2009). Subjects were all weekly cannabis users derived from an opportunistic sample³¹². The researchers found a mean daily consumption of 1.5g of herbal cannabis (median = 0.9g) and 1.3g of cannabis resin (median = 1.0g) per user, similar to the amount reported by Pudney et al. (2006) and Atha (2005).

Despite each of these estimates being carried out for different years, the results are broadly similar as they are mostly based on a demand side approach which uses household surveys of drug use, small-scale surveys of drug consumption patterns and one price data point to estimate market size.

11.2.2 History of cannabis domestic production

Traditionally the cannabis market in the United Kingdom has been dominated by imported cannabis. In the 1970s there were very few reported incidents of cannabis production while during the 1980s cases were likely to be amateur cultivators growing on windowsills, greenhouses or gardens (Potter 2008). These often used the seeds collected from imported herbal cannabis and cuttings from friends. Since the early 1990s, however, domestic cultivation has grown with the use of hydroponics and other cannabis technology. The availability of 'grow-your-own' guides, growing equipment, and a wide range of cannabis seeds has expedited this, as did the increase in internet use. This precipitated an increase in more commercially focused growing operations (Hough et al. 2003). From a law enforcement perspective, two policy options traditionally existed: treat small-scale cultivation as a possession offence; or, where there is evidence of commercial gain, treat it as an offence of possession with intent to supply.

However, since 2004 there has been a considerable increase in large-scale commercial cultivation of cannabis, so called cannabis farms or factories. The definition of a cannabis farm used by police is:

"Any premises, whether commercial or residential, shall be deemed a cannabis farm if the premises, or part therein, has been adapted to such an extent that normal usage would be inhibited and usually present within the premises, or part therein, are items solely concerned for the production of cannabis." (NPIA 2009)

Factories are often run by South East Asian criminal groups and located in residential properties, commercial premises and industrial units. There are reports of illegal immigrants working as 'gardeners' in these factories to pay off debts to smugglers (SOCA 2008). There have also been reports of trafficked children being used in cannabis farms (Daly 2007).

The emergence of cannabis farms has altered the landscape of domestic production in the United Kingdom and the involvement of organised crime in such enterprises causes great concern for law enforcement agencies. This was a motivating factor in the Association of Chief Police Officers' (ACPO) decision to support the reclassification of cannabis from Class C back to Class B in 2008. While this type of cultivation is the focus of the law enforcement community's effort, there nevertheless remains a significant amount of cannabis being grown for personal, social and small-scale commercial reasons.

³¹⁰ Sinsemilla is known as 'skunk' in the United Kingdom. This term is used throughout the chapter.

³¹¹ Using a high estimate that the cost of 1/8 ounce is £30.

³¹² One hundred 'socially integrated' users were accessed through semi-snowballing and network techniques mainly through opportunistic sampling methods. Participants were asked how much they used in a typical using day, how much they spent per day and how many days they used a month.

Grow shops

The publication of home cultivation guides and the selling of growing equipment and seeds are all legal, providing there is no criminal intent. *The Serious Crime Act 2007* came into effect on 1st October 2008 and replaced the common law offence of incitement, with a statutory offence of encouraging or assisting a crime. The provisions of encouraging and assisting an offender are wider than the common law offence of incitement and could include a grow/head shop owner providing advice about growing cannabis.

Potter (2008) found that demand for grow-light equipment has increased substantially since the mid-1990s with one manager of a grow-light manufacturing company reporting growth of 25 to 50% per annum and stating that, since 1990, the number of specialist grow shops increased from three to around 80. Indeed one cannabis growing website lists 51 websites in the UK, with equipment also available from international sellers³¹³.

The Home Secretary has stressed the need for local solutions to the problem of grow shops and 'headshops'. In one local authority in the North of England, police are working with the local council to investigate whether a byelaw could be created to regulate the problem by using disruptive tactics. This would include a licensing requirement and the banning of outward displays and literature on growing cannabis. This tactic is similar to the way that sex shops have been regulated [personal communication – law enforcement agencies].

11.2.3 Typology of growers

Hough et al. (2003), in a study looking at the domestic cultivation of cannabis in the United Kingdom, identified five types of cannabis grower; sole-use grower, medical grower, social grower, social/commercial grower and commercial grower (Table 11.1). In their sample, the majority of growers were males in their twenties or thirties who were mostly employed or students.

Table 11.1: Hough et al.'s (2003) typology of growers

| TYPE OF GROWER | DESCRIPTION |
|-------------------|----------------------------------------------------------------------|
| Sole-use | Users who grow for their own use |
| Medical | Grow to provide for medical users |
| Social | Like sole-use but often give to friends or sell for a nominal amount |
| Social/commercial | Grow for profit but sell to social network only |
| Commercial | Grow for profit and will sell to anyone |

Source: Hough et al. 2003

Potter (2007) argues that this typology is over-simplistic and questions the utility of the profit-motivation criterion. Despite this he suggests the use of a motivational spectrum which ranges from altruistic to greed and distinguishes between people who grow for profit and non-profit growers. Non-profit growers include medical growers, those growing for their own personal use and those growing as a form of political activism. His typology of profit growers is more subtle and includes individual grow-ops, co-operatives, franchises and larger operations described as 'corporate', which are often involved in the sale of stimulant drugs.

³¹³ See: http://www.sweetleaf.co.uk/links.php?nav_links=grow_shops.php

11.2.4 Consumer market shares of different cannabis products

Cannabis resin was for a long time the most common type of cannabis in the United Kingdom, much of it originating from North Africa, particularly Morocco but also from the Indian sub-continent and Lebanon. Imported herbal cannabis accounted for about one-quarter of the cannabis market and was mainly sourced from Thailand, Africa and to a lesser extent, the Caribbean³¹⁴. Sinsemilla or 'skunk', as it's known in the UK, was rarely available in the UK prior to the late 1990s.

The Home Office potency study (Hardwick and King 2008) estimated the market share of skunk to be 81% in 2008 based on the proportion of this type of cannabis seized by police when issuing a cannabis warning. The authors found a statistically significant difference in the market share of herbal cannabis across different regions in England and Wales. The report states that, based on previous studies, the market share of skunk has increased markedly over recent years from an estimated 15% in 2002³¹⁵ (Table 11.2).

Table 11.2: Estimated market share of different cannabis types

| YEAR | SINSEMILLA | TRADITIONAL HERBAL | CANNABIS RESIN |
|---------|------------|--------------------|----------------|
| 2002 | 15% | 15% | 70% |
| 2004/05 | 55% | 45%* | |
| 2008 | 81% | 3% | 16% |

*Market share between traditional herbal and resin not stated in study

Source: Hardwick and King 2008; Potter et al. 2008

However, there has been some criticism of the study, with some arguing that it reflects only one aspect of the cannabis market³¹⁶. According to this argument, young males are disproportionately more likely to be stopped by police, and their cannabis smoking habits may differ from other users of the drug.

Indeed estimates differ elsewhere with police sources suggesting that around 60% of the UK cannabis market is skunk, of which an unknown proportion is domestically produced and the remainder imported. Furthermore, in Duffy et al.'s (2008) qualitative study amongst young people, 43% said they usually bought skunk, 33% bought herbal cannabis and 10% bought resin³¹⁷.

Preliminary results from an online survey of cannabis users³¹⁸ found that 60% of respondents usually used skunk with 13% using traditional herbal cannabis and 14% using resin. However, 83% of respondents reported using more than one type of cannabis during the past year with 67% having used resin at some point over the past year. The survey showed that availability was the most important factor in choosing what kind of cannabis to buy (39% gave availability top importance rating) followed by type of high (36% top importance rating) and strength (30% top importance rating). In comparison, 21% of respondents rated price as very important (personal communication – G. Potter).

³¹⁴ See: <http://www.idmu.co.uk/can.htm>

³¹⁵ Methodology for each estimate differs and are all taken from publications where the main focus is on potency.

³¹⁶ See: <http://ukcia.org/wordpress/?p=49>

³¹⁷ 144 young people specified what type of cannabis they bought.

³¹⁸ The survey was carried out by researchers at London Southbank University, University of Kent and Middlesex University using the Bristol Online Survey instrument. Links to the survey were posted on cannabis user forums and social networking sites such as Facebook. Between February and September 2009, 520 cannabis users (use in the last year) completed the survey, the majority of whom (85%) used cannabis monthly or more often. Males (84%) were over-represented in the survey.

Seizure statistics from both police and customs (see below) show a large reduction in cannabis resin seizures. Cannabis users in Ward and Thom's qualitative study (2009) suggest that cannabis resin is now less common. There are suggestions that the increasing dominance of skunk in the cannabis market is supply rather than demand driven. A study by Rethink, the mental health charity, found that three-quarters of recent drug users had used skunk, but only 35% of cannabis users preferred using skunk with 50% preferring to use herbal cannabis (Rethink 2008).

11.2.5 Distribution of cannabis at national level

There are intelligence gaps in law enforcement agencies' knowledge of national level cannabis distribution. Although there is a recognition that South East Asian gangs run many of the large scale growing operations, White British criminals are involved in distribution at a local level. Law enforcement agencies are concentrating current efforts to fill this knowledge gap.

Potter's (2007) ethnographic study of South Yorkshire growers suggests that cannabis distribution is dominated by local networks. However, his study looks at relatively small-scale domestically cultivated cannabis networks only.

11.2.6 Cannabis price and purity

Cannabis wholesale prices

Data from law enforcement agencies show that, in 2008, the typical price of a kilogram of skunk was £2,900, an increase from £2,750 in 2007. The price of traditional herbal cannabis decreased from £1,300 in 2007 to £1,120 in 2008 while cannabis resin increased slightly from £875 to £895. Because of changes in the £/€ exchange rate (2007 £1=€1.46 and 2008 £1=€1.26) over this period it is not meaningful to provide Euro values.

Table 11.3: Cannabis wholesale prices per kilogram in the United Kingdom, 2004 to 2008

| YEAR | SKUNK CANNABIS | | | TRADITIONAL HERBAL | | | CANNABIS RESIN | | |
|------|----------------|--------|---------|--------------------|--------|---------|----------------|--------|---------|
| | Min | Max | Typical | Min | Max | Typical | Min | Max | Typical |
| 2004 | £2,500 | £4,000 | | £900 | £1,200 | | £800 | £1,200 | |
| | €3,685 | €5,896 | | €1,327 | €1,769 | | €1,179 | €1,769 | |
| 2005 | £2,500 | £4,500 | | £800 | £1,200 | | £800 | £1,200 | |
| | €3,657 | €6,583 | | €1,170 | €1,755 | | €1,170 | €1,755 | |
| 2006 | £2,500 | £4,500 | | £600 | £1,000 | | £600 | £1,000 | |
| | €3,668 | €6,602 | | €880 | €1,467 | | €880 | €1,467 | |
| 2007 | £1,500 | £4,750 | £2,750 | £750 | £2,900 | £1,300 | £600 | £1,800 | £875 |
| | €2,193 | €6,944 | €4,020 | €1,096 | €4,240 | €1,900 | €877 | €2,631 | €1,279 |
| 2008 | £850 | £5,000 | £2,900 | £500 | £3,600 | £1,120 | £300 | £3,000 | £895 |
| | €1,070 | €6,294 | €3,651 | €629 | €4,532 | €1,410 | €378 | €3,776 | €1,127 |

Source: Law enforcement agencies

Cannabis street-level prices

Street-level cannabis prices have remained stable over recent years at around £20 (£25 in 2008) for an eighth of an ounce of skunk cannabis (3.54 grams). However, it is common to buy larger amounts, which would reduce the price of this amount. Less potent strains of cannabis such as resin or traditional herbal cannabis are cheaper at around half the price of skunk cannabis.

Cannabis potency³¹⁹

The Home Office potency study carried out in 2008 (Hardwick and King 2008) found that the mean THC concentration of skunk cannabis was 16.2% (range = 4.1 to 46%) with the mean THC of traditional herbal cannabis 8.4% (range = 0.3 to 22%) and cannabis resin 5.9% (1.3 to 27.8%). The mean CBD content of cannabis resin was 3.5% while the CBD content of herbal cannabis was less than 0.1% in almost all samples. However, there was considerable overlap in the range of potencies for each cannabis type.

Concern over the increasing potency of skunk cannabis was a major factor behind the government's decision to reclassify cannabis back to Class B in 2008. Preliminary findings from a study into the effect of intense lighting on cannabis production found that an increase in lighting not only increases yield but also THC concentration. It is suggested that higher potency cannabis may be a consequence of dealers' desire to increase yield (personal communication – D. Potter).

Subjective opinion from the online cannabis user survey³²⁰ shows that the majority (82%) of respondents do not think cannabis is stronger now than five years ago. However, of those who expressed an opinion, 63% thought cannabis was stronger than ten years ago. 70% of respondents reported that they moderate the amount of cannabis they use depending on its strength.

11.2.7 Typology of retail outlets for cannabis sale

A study by Duffy et al. (2008), also reported on in Coomber and Turnbull (2007) found that young people rarely purchased cannabis through formal illicit markets, most accessing the drug from within their social circle. Over half (55%) bought cannabis from a known seller, with 69% of these describing their main seller as a friend. Around a quarter (23%) never bought cannabis themselves but were given it by a friend, a further 16% reported that a friend bought it on their behalf and only six per cent bought from an unknown seller.

A study in Northern Ireland³²¹ reported similar findings with the majority of cannabis users buying cannabis from friends and selling in small amounts to friends themselves (Stevenson 2008). Participants emphasised the social context of cannabis supply and often thought that dealers who sold to strangers had links to organised crime.

The majority of cannabis users in the online user survey³²² usually bought cannabis from a friend/relative/partner. The next most common answers were from 'a dealer whose house you visit' (24%), and a 'dealer who delivers to your home' (12%). Eleven per cent of respondents reported that they usually grew their own cannabis with a further 15% saying they had grown their own in the last year. Only seven per cent reported usually buying cannabis from a dealer on the street although a further 20% had done so in the last year. Users reported having multiple sources with 66% of respondents reporting buying cannabis from three or more sources in the last year.

³¹⁹ Potency of cannabis is defined as the concentration (%) of tetrahydrocannabinol (THC), the main active ingredient of cannabis. Cannabis also contains other cannabinoids, one of which is cannabidiol (CBD). CBD is thought to have anti-psychotic properties.

³²⁰ See footnote 317.

³²¹ In-depth and semi-structured interviews were carried out with 38 cannabis users aged over 18 and recruited via targeted sampling.

³²² See footnote 317.

11.2.8 Cannabis sources and transaction sizes

The most common street deal for cannabis is 1/8 ounce (3.5 grams). Multiples of this amount are sold, most commonly ¼ ounce, ½ ounce, one ounce and nine bar (nine ounces). At wholesale level, transactions are made in kilograms. In the online cannabis user survey³²³, 30% said they usually bought 1/8 ounce, 22% a quarter of an ounce, 14% an ounce and 12% half an ounce. 73% of respondents said the largest amount they had ever bought was one ounce or more with 28% of all respondents having bought nine ounces or more at some point.

11.3 Seizures

11.3.1 Supply reduction organisation and activities

Tackling commercial cannabis cultivation

The primary objective of police with regard to cannabis is preventing organised crime producing and profiting from the supply of cannabis and other serious crime connected to it. This is reflected in the concentration of efforts towards large scale commercial growing operations. Cannabis farm discoveries have been the result of public information and dedicated police operations. Thermal imaging is sometimes used but this is usually in combination with other operations. For example, a police helicopter deployed for an unrelated operation may switch on its thermal imaging equipment on its return journey. Handheld thermal imaging equipment is also used.

Working with other agencies

Other police tactics have involved working with agencies that have an interest in preventing cannabis cultivation. The cost to landlords of damaged properties due to cannabis farms has been stressed and police have attempted to engage with this group. Local guides have been produced by police forces and during the Home Office and ACPO co-ordinated National Tackling Drugs Week in June 2009, the National Landlords Association issued a press release to warn landlords of the danger of not keeping a vigilant eye on their properties³²⁴. One of the largest insurance companies in the United Kingdom also issued a press release in early 2009 warning landlords that they may not be covered for insurance claims if they have not taken reasonable precautions for preventing cannabis cultivation in their properties. They report that, in 2007, there were about 60 claims amounting to €1.5 million (£1m) in total³²⁵. Another tactic has been to remind landlords of the consequences of turning a blind eye and the possibility of prosecution under the Misuse of Drugs Act 1971 for allowing premises to be used for drug production.

While there have not been many cannabis farms identified through intelligence from electricity companies, there are some examples of how working with these companies could help detect cannabis growing operations. In one police force area a calculation of the cost implications of stolen electricity from one farm encouraged the electricity company to buy thermal imaging equipment for the local police force. A Crimestoppers campaign during National Tackling Drugs Week estimated that, in a three-bedroom property, a cannabis farm would steal €33,873 (£30,000) worth of electricity a year by bypassing the meter³²⁶.

³²³ See footnote 317.

³²⁴ See: <http://www.landlords.org.uk/news/pressreleases/2009/pressrelease-20090608cannabis.htm>

³²⁵ See: <http://www.aviva.co.uk/media-centre/story/17510/cannabis-farming-continues-to-rise-warns-norwich-u/>

³²⁶ See: <http://www.crimestoppers-uk.org/how-we-help/our-partners/community-partners/making-communities-safer/national-tackling-drugs-week>

In 2006 Operation League, an intelligence and enforcement operation co-ordinated by Strathclyde Police and involving all police forces in Scotland, the Scottish Crime and Drug Enforcement Agency (SCDEA), the Serious Organised Crime Agency (SOCA), Association of Chief Police Officers in Scotland (ACPOS) and HM Revenue and Customs (HMRC) began. The police used the opportunity provided to them by the compulsory registration of private landlords in Scotland and produced an information leaflet for local authorities to include in landlords' registration packs. They also provided information for commercial and residential letting agents to include on their websites. Other intervention tactics included providing leaflets to local authorities to display in public buildings, working with DIY retailers, articles in retail magazines, working with energy suppliers and Crimestoppers³²⁷. Operation League 2 commenced in September 2008 targeting South East Asian serious organised crime groups involved in the production of cannabis.

Other supply reduction tactics include the appointment in August 2008 of an ACPO National Cannabis Co-ordinator, co-funded by the Home Office with a brief across the whole of the United Kingdom. The role encourages cross-force and cross-regional investigations and promotes intelligence sharing and gathering. ACPO and the Home Office also commissioned the National Policing Improvement Agency (NPIA) to produce a guidance document on tackling commercial cannabis cultivation and head shops, a restricted version of which is available to police forces and an unrestricted version, which has been made available to local authorities (NPIA 2009).

In 2009 the Home Office introduced a National Tackling Drug Supply Award for tackling cannabis cultivation, which was awarded to the Police Service Northern Ireland (PSNI) for their work during Operation Mazurka. The number of cannabis plants seized in Northern Ireland increased from 4,006 in 2007/08 to 30,904 in 2008/09 as a direct result of the activities of Operation Mazurka. It began in March/April 2008 in response to a number of cannabis factory discoveries and ran for six months. Instead of shutting down cannabis farms as they were identified, a risk-assessment was carried out and surveillance used to track the movements of offenders. When a cannabis farm was raided the police used forensic evidence including fingerprints to link individuals to other farms. In response to evidence found at premises, police worked with a large DIY supplier to encourage staff to report any suspicious activity such as the purchasing of a large number of fans. Northern Ireland Electricity also assisted in the identification of suspicious properties and accompanied police at the scene to ensure safety. The operation led to 101 arrests, 82 of whom were charged with cannabis cultivation related offences; the remainder were mainly immigration offences.

11.3.2 Origin of cannabis products

Forensically it is difficult to ascertain the origin of herbal cannabis products. Furthermore, official seizure statistics do not distinguish between traditional herbal cannabis and skunk cannabis. Despite the growing identification of cannabis farms within the United Kingdom since 2004, the quantity of herbal cannabis seized by HMRC has not decreased over the same period. A large proportion of imported herbal cannabis originates in the Netherlands and is of the skunk variety. Traditional herbal cannabis mainly originates from Africa and the Caribbean. Cannabis resin often comes from Morocco with a small proportion originating in South East Asia. While the quantity of herbal cannabis seized by HMRC has not decreased since 2004, the amount of cannabis resin has fallen dramatically from 40,387kg in 2004 to 13,936kg in 2007/08 (Smith and Dodd 2009b). It appears that domestically produced skunk has impacted on the cannabis resin market and the reasons for this merit further examination.

³²⁷ Crimestoppers is an independent charity working to fight crime.

11.3.3 Seizures of plantations

In late 2007, an ACPO survey of police forces in England and Wales found that 1,564 farms had been discovered across 19 areas. In Scotland in 2006/07, 70 factories were discovered, an increase from under ten in 2005/06 (ACMD 2008c). Between 1st April 2007 and 31st March 2008, 3,032 cannabis factories were discovered in the United Kingdom (personal communication – police sources). Trend analysis indicates that the rate of discovery is increasing in 23 force areas, remaining stable in ten and decreasing in 17. Force areas with the highest number of factories discovered were the large urban areas of London, Bristol, Birmingham, Manchester and Liverpool, although this may reflect policing priorities rather than the relative scale of the problem in these areas. For example, Gwent Police found only 11 cannabis farms in 2006. However, in 2007 111 farms were discovered during the course of an investigation into the murder of a Vietnamese national.

Seizure statistics for England and Wales show that seizures of cannabis plants have increased since 2004, both in number and quantity of plants seized (Table 11.4). The average number of plants per seizure has doubled since 2004 reflecting the identification of larger, more sophisticated growing operations.

Table 11.4: Number of seizures and quantity of cannabis plants seized in England and Wales, 2002 to 2007/08

| | 2002 | 2003 | 2004 | 2005 | 2006/07 | 2007/08 |
|---------------------------|--------|--------|--------|---------|---------|---------|
| No. of seizures | 2,201 | 2,680 | 2,780 | 4,098 | 5,497 | 8,102 |
| No. of plants seized | 52,139 | 80,498 | 88,674 | 208,357 | 344,360 | 508,460 |
| Average no. plants seized | 24 | 30 | 32 | 51 | 63 | 63 |

Source: Smith and Dodd 2009b

In 2007/08, the majority (83%) of the 8,102 cannabis plant seizures in England and Wales were of less than 50 plants. This compares to 2004 when 91% of all plant seizures were less than 50 plants (Mwenda and Kaiza 2006). There were 56 seizures of more than one thousand plants, one of which was over ten thousand plants (Table 11.5). Further analysis of seizures data show that 79% of seizures of less than 50 plants involved 10 plants or fewer, accounting for 65% of all seizures [analysis undertaken by the Home Office for the UK Focal Point]. This indicates that the majority of cannabis plant seizures are still for small-scale growing. In Potter's study (2007), he refers to the 'ten plant rule'; ten plants being the threshold where cannabis growers believe they would avoid a custodial sentence.

Table 11.5: Quantity of cannabis plants seized and proportion of all cannabis plant seizures in England and Wales, 2007/08

| | 1-50 | 51-100 | 101-500 | 501-1000 | 1001-10,000 | OVER 10,000 |
|------------------------|-------|--------|---------|----------|-------------|-------------|
| No. of seizures | 6,724 | 340 | 839 | 143 | 55 | 1 |
| Percentage of seizures | 83.0% | 4.2% | 10.4% | 1.8% | 0.7% | 0% |

Source: Smith and Dodd 2009c

It is difficult to estimate potential yield from the number of plants as it depends on the area under cultivation, the type of plant and the intensity of the lighting (personal communication – D. Potter).

11.3.4 Cannabis seizures

It is important to note that seizures often reflect policing priorities rather than availability or the extent of use. This is especially the case with cannabis as the introduction of the cannabis warning has resulted in a large increase in the number of small cannabis seizures.

Amount seized

Data on amount seized is published in supplementary tables to official statistical reports. However, size ranges differ from the sizes requested in the EMCDDA guidelines. HMRC provide aggregated data to the Home Office so this cannot be re-analysed into different amount ranges. Therefore data shown in Table 11.6 are for police seizures only. In 2007/08 the majority of herbal cannabis seizures in England and Wales were under 5g in weight (84%). However only 43% of cannabis resin seizures were under 5g in weight, with 55% between 5g and 150g in weight.

Table 11.6: Number of cannabis seizures by weight and type of cannabis in England and Wales, 2007/08

| | UNDER 1G | 1G – 5G | 5G – 150G | 150G – 1KG | 1KG – 50KG | 50KG + |
|-------------------|----------|---------|-----------|------------|------------|--------|
| Cannabis (herbal) | 25,355 | 81,757 | 19,562 | 816 | 246 | 9 |
| Cannabis resin | 5,293 | 6,960 | 15,854 | 397 | 127 | 6 |

Source: Home Office

The average size of herbal cannabis seizures made by HMRC was 5.8kg and the average size of cannabis resin seizures was 20.3kg. However, the majority of seizures of herbal cannabis and cannabis resin were of amounts between 1g and 500g (77% and 85% respectively).

Type of cannabis seized

Analysis of seizure statistics for England and Wales shows that the proportion of police cannabis seizures involving cannabis resin has fallen since the end of the 1990s from 78% in 1998 to 18% in 2007/08, while the proportion involving herbal cannabis has risen over the same period from 32% to 79%. The change is much greater in police seizures than in Customs seizures since herbal cannabis already accounted for the majority of Customs seizures in 1998 (Table 11.7).

Table 11.7: Percentage of all cannabis seizures by cannabis type in England and Wales, 1998 to 2007/08

| | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006/07 | 2007/08 |
|----------------|------|------|------|------|------|------|------|------|---------|---------|
| Police | | | | | | | | | | |
| Herbal | 32.3 | 25.6 | 31.2 | 39.0 | 49.7 | 41.3 | 51.7 | 62.7 | 75.5 | 79.2 |
| Resin | 78.3 | 62.9 | 63.1 | 63.7 | 60.2 | 51.5 | 43.9 | 34.7 | 22.6 | 17.8 |
| Plants | 3.1 | 2.3 | 2.4 | 2.3 | 3.0 | 3.4 | 3.7 | 3.7 | 4.1 | 5.0 |
| Customs | | | | | | | | | | |
| Herbal | 65.9 | 72.5 | 73.9 | 80.6 | 83.5 | 84.1 | 83.3 | 83.1 | 87.5 | 80.6 |
| Resin | 38.2 | 36.6 | 34.9 | 28.8 | 25.6 | 25.2 | 25.2 | 24.2 | 20.6 | 19.2 |

Source: Smith and Dodd 2009c

The quantity of cannabis resin seized by Customs has fallen since its peak in 2003 (Table 11.8) but is higher than the amount seized in 1998 (3,103 kg) and 1999 (8,492 kg). The quantity of herbal cannabis seized by Customs peaked in 2002 having risen from 3,103 kg in 1998. The quantity of herbal cannabis seized by police, having initially risen in 2000, fell after 2003 despite a large increase in the number of seizures over this period. This reflects the increasing use of the cannabis warning for possession of small amounts of cannabis.

Table 11.8: Quantity of cannabis in kilograms seized by police and Customs in England and Wales, 2002 to 2007/08

| | 2002 | 2003 | 2004 | 2005 | 2006/07 | 2007/08 |
|----------------|--------|--------|--------|--------|---------|---------|
| Police | | | | | | |
| Herbal | 3,823 | 13,909 | 2,789 | 2,905 | 2,731 | 3,073 |
| Resin | 8,657 | 27,861 | 21,676 | 25,045 | 2,305 | 2,632 |
| Customs | | | | | | |
| Herbal | 31,050 | 15,608 | 18,595 | 17,515 | 22,948 | 16,855 |
| Resin | 32,757 | 41,168 | 40,387 | 24,145 | 17,416 | 13,936 |

Source: Smith and Dodd 2009c

In Northern Ireland, as in England and Wales, the number of herbal cannabis seizures has risen since 2004 (from 131 in 2004/05 to 897 in 2008/09). However, while the number of cannabis resin seizures has fallen over this period, the reduction has been small and not as marked as in England and Wales (1,841 in 2004/05 and 1,630 in 2008/09) (PSNI 2007; PSNI 2009b).

Impact of seizures

Using the most recent estimate of cannabis demand in the United Kingdom of 290.1 tonnes in 2006 (see section 11.2.1), and seizures data from the United Kingdom for 2006/07, it is estimated that law enforcement agencies seized cannabis that amounted to 22% of the annual demand in the country³²⁸.

11.4 Offences

11.4.1 Cannabis supply-related offences

Data show that in 2007, there were 6,845 cannabis supply-related offences where the offender was cautioned or appeared in court in England and Wales. This is a 16% increase from 2006 (5,884 cannabis supply-related offences)³²⁹.

Recorded crime

In Scotland, there was a 24% increase between 2007/08 and 2008/09 in the number of recorded crimes for illegal cultivation of drugs; since 2005/06 the number has more than doubled from 297 crimes to 609 (Scottish Government 2009k). This is due to an increase in cannabis cultivation.

³²⁸ This estimate uses FSS data suggesting that each mature cannabis plant produces 40g of usable cannabis.

³²⁹ Data provided before 2006 were on a principal offence basis and cannot be compared with data after 2006 which were on an all offence basis.

12. Problem amphetamine and methylamphetamine use, related consequences and responses

12.1 Epidemiology of amphetamine and methylamphetamine use

12.1.1 History of (methyl)amphetamine use

Amphetamines were first prescribed in the United Kingdom in the 1920s with liberal prescription during the 1940s and ready availability of pharmacy over-the-counter amphetamine-based preparations. In 1957 they were made prescription only but use reached epidemic proportions in the 1960s with diversion from legitimate sources resulting in increased recreational use (Klee 1997a). Amendments to drugs legislation in 1964 and 1967 criminalised the possession and trafficking of amphetamine and the Misuse of Drugs Act 1971 scheduled these drugs as Class B for non-injectable types and Class A for injectable types. There were also reports in the late 1960s of rising intravenous use of methylamphetamine in London, however, this was short-lived.

There is less information about amphetamine use during the 1970s and 1980s due to a focus on heroin use. Nevertheless, amphetamine continued to be popular with increased use amongst those involved in the nightclub scene (ACMD 2005). At this time illicitly manufactured powdered amphetamine replaced tablets as the main type of amphetamine used.³³⁰ The rave scene, which grew in the 1990s provided further opportunity for a growth in amphetamine use. Indeed Klee's (1997b) typology of amphetamine users identified many types of social users including: recreational users who go to clubs; older hippie ravers; and speeding drinkers who take amphetamine to aid alcohol consumption. The typology also identified young mothers who take amphetamine to help them cope with tasks; people who take the drug in isolation: those who have modified their use after experiencing health or social problems; and criminal users.

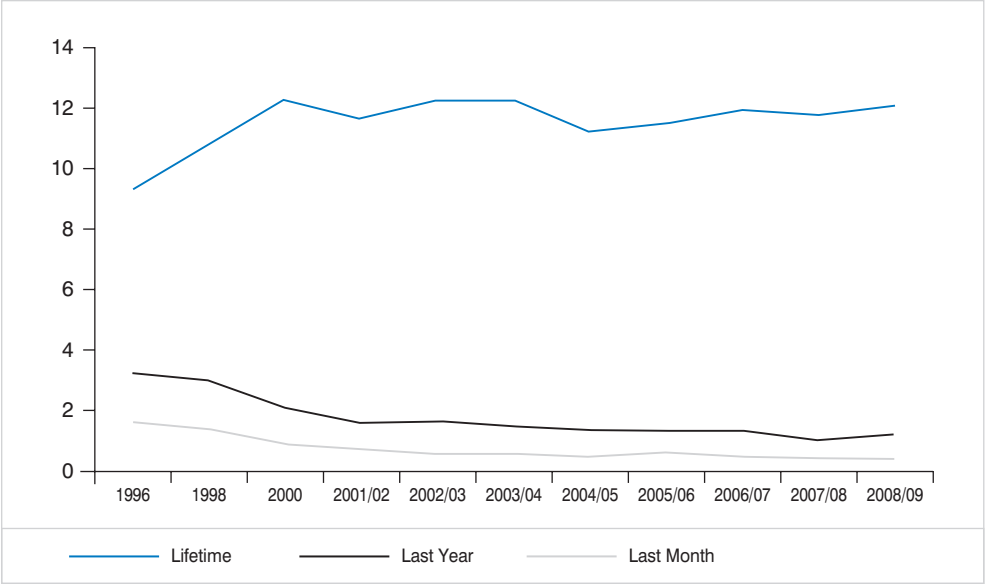
Since the turn of the century there has been reduced focus on amphetamine use due to an increase in the use of other stimulant type drugs like ecstasy and cocaine powder. Despite concerns about the possibility of an increase in methylamphetamine use, at present there appears to be little evidence to suggest anything more than sporadic small-scale use in the United Kingdom, although a recent study among gay men found that 4.7% had used methylamphetamine in the last year (Bonell et al. 2009). Due to low use of methylamphetamine with the United Kingdom, this chapter will focus primarily on amphetamine use.

12.1.2 Trends and patterns of (methyl)amphetamine use

Figure 12.1 shows that between 1996 and 2001/02, there was a large decrease in last year (recent use) and last month (current use) use of amphetamine amongst 16 to 59 year olds in England and Wales. Since then use has been relatively stable with a gradual decrease over the period to 2008/09. While there was a significant decrease in recent and last month use between 1996 and 2008/09, lifetime use increased significantly from 9.3% in 1996 to 12.1% in 2008/09, although it remained relatively stable between 2002/03 and 2008/09. Analysis shows that, in 2008/09, a large majority (92%) of recent amphetamine users aged 16 to 59 reported using at least one other drug in the last year, with many using other stimulant drugs; 70% had also used cocaine powder and 62% had used ecstasy.

³³⁰ See: <http://www.drugscope.org.uk/resources/drugsearch/drugsearchpages/amphetamines.htm>

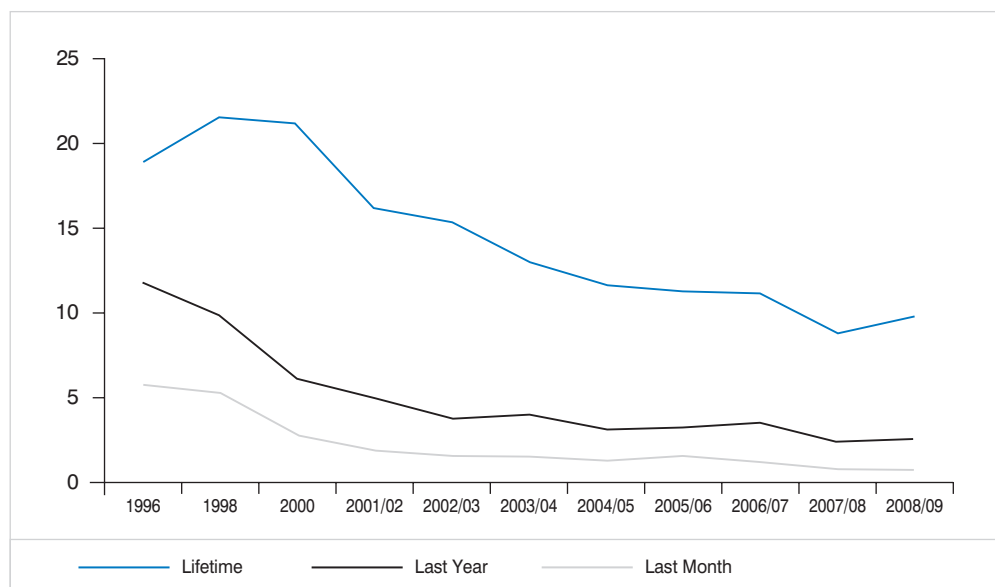
Figure 12.1: Percentage of 16 to 59 year olds reporting lifetime, last year and last month use of amphetamines in England and Wales, 1996 to 2008/09



Source: Hoare 2009

Amongst 16 to 24 year olds, there have been significant decreases in amphetamine use across all recall periods with the largest decreases taking place between 1996 and 2002/03 (Figure 12.2). This demonstrates the decreasing popularity of amphetamine amongst young people. In 2008/09 2.6% reported recent use of amphetamine with other stimulant drugs such as cocaine powder (6.6%) and ecstasy (4.4%) much more prevalent.

Figure 12.2: Percentage of 16 to 24 year olds reporting lifetime, last year and last month use of amphetamines in England and Wales, 1996 to 2008/09



Source: Hoare 2009

In 2008/09 the highest prevalence of amphetamine use amongst 16 to 24 year olds was in the North East of England (5.0%) and Wales (4.9%) and the lowest in London (0.6%). Nineteen per cent of 16 to 24 year old amphetamine users were defined as frequent users³³¹ (Hoare 2009).

Methylamphetamine use

Methylamphetamine use was measured for the first time in the 2008/09 British Crime Survey. Just under one per cent of 16 to 59 year olds (0.9%) reported lifetime use with only 0.1% reporting recent and current use. Amongst 16 to 24 year olds, lifetime use was 0.8%, recent use 0.2%, and current use 0.1%.

12.1.3 Prevalence estimates of problem amphetamine use

A survey of psychiatric morbidity carried out in England in 2007 (Fuller et al. 2009) (see section 2.2.4), found that prevalence of dependence on amphetamine in the general population was 0.2%.

In the New-ADAM survey, seven per cent of all arrestees tested positive for amphetamine (Holloway and Bennett 2004).

³³¹ Use more than once a month.

Problem drug use estimates in the United Kingdom do not include amphetamine. However some areas have estimated local problem use where the need is identified. For example the Devon DAAT's needs assessment refers to amphetamine being a particular problem in their area and estimate that in 2007/08, there were 850 problem amphetamine users (PAU) in the area.³³² A nearby DAAT estimates that there are 563 PAUs although it is not explained how this is derived.³³³

12.1.4 Treatment demand for (methyl)amphetamine use

Amphetamine

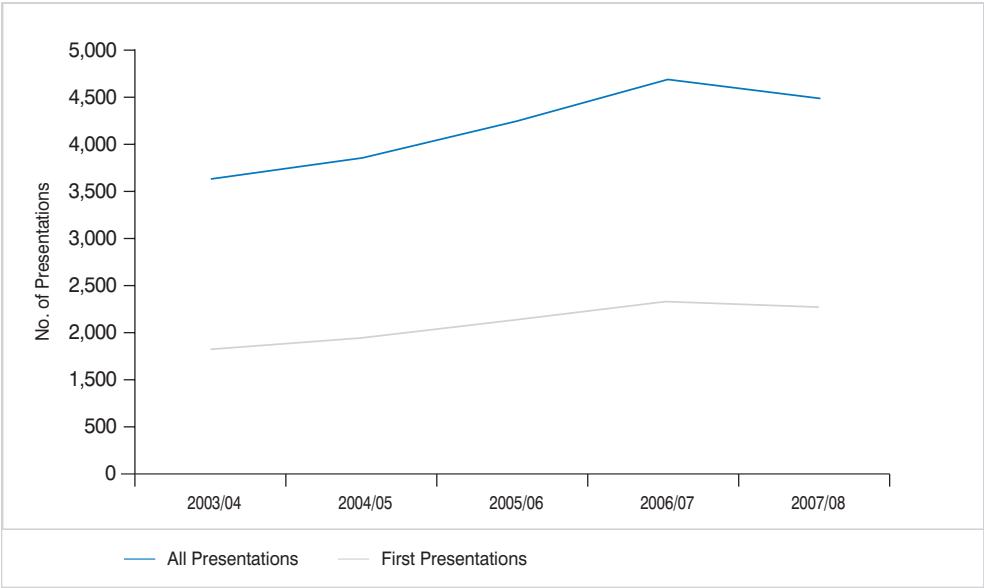
In the United Kingdom during 2007/08 there were 4,416 presentations for primary amphetamine use accounting for 3.5% of all treatment presentations (Figure 12.3). Amongst first treatment presentations, primary amphetamine use accounted for 4.4% (n = 1,976). There were marked differences between countries in the United Kingdom with amphetamine accounting for only 0.8% of first presentations in Northern Ireland, compared to 3.3% in Scotland, 4.5% in England and 7.7% in Wales.

There were a further 4,270 presentations with amphetamine as a secondary drug; just over half (53%) were primary opiate users and 24% were primary cannabis users. Seven per cent of all presentations were either primary or secondary amphetamine users.

Trends

Presentations for amphetamine use have increased since 2003/04 but the proportion of all treatment presentations that are for amphetamine has decreased slightly from 3.7% in 2003/04 to 3.5% in 2007/08. Figure 12.3 shows that presentations to treatment for amphetamine use remained stable in 2007/08.

Figure 12.3: Number of primary amphetamine presentations in the United Kingdom, 2003/04 to 2007/08: all presentations and first presentations



Source: Standard Table 34

³³² See: http://www.nta.nhs.uk/areas/treatment_planning/treatment_plan_archive/treatment_plans_2007_08/docs/devon_trpl1_0708.pdf

³³³ See: <http://www.cornwall.gov.uk/idoc.ashx?docid=c92ce038-d957-408f-926a-9b19db3e0944&version=-1>

Route of administration

The most common route of administration amongst primary amphetamine users entering treatment in 2007/08 was orally (60.4%) followed by injecting (23.2%).

Labour and living status

Data on labour and living status is only available from Scotland. In 2007/08, 67% of primary amphetamine users entering treatment were unemployed, the same proportion as for all clients entering treatment. However, primary amphetamine users were more likely to be employed (20%) than all clients (15%) and live in stable accommodation (88% compared to 82%).

Source of referral

Source of referral amongst primary amphetamine users was similar to all clients (Table 12.1). Around a third of primary amphetamine users were self-referred (32.7%), with the next most common source of referral being court, probation or police (21.9%). This is lower than all clients (25.7%). Primary amphetamine users were more likely to have been referred from social services (3.4%) than all clients (2.0%).

Table 12.1: Percentage of primary amphetamine clients and all clients entering treatment by referral source in the United Kingdom, 2007/08

| SOURCE OF REFERRAL | PRIMARY AMPHETAMINE | ALL CLIENTS |
|-------------------------------|---------------------|-------------|
| Self-referred | 32.7 | 30.4 |
| Family/friends | 1.1 | 0.9 |
| Other drug treatment centre | 7.3 | 8.4 |
| General practitioner | 9.3 | 9.5 |
| Hospital/other medical source | 11.5 | 12.9 |
| Social services | 3.4 | 2.0 |
| Court/probation/police | 21.9 | 25.7 |
| Other | 12.7 | 10.2 |

Source: National Drug Treatment Monitoring System (NDTMS), the Scottish Drug Misuse Database, the Welsh National Database for Substance Misuse; and Northern Ireland Drug Misuse Database

Time since first use

Data are only available from Scotland and Northern Ireland. In 2007/08 primary amphetamine users were more likely to be long-term users than all clients; 66% had used for over 10 years compared to 62% of all clients.

Polydrug use

In 2007/08, 57% of primary amphetamine clients were polydrug users. Of these, 46% were secondary cannabis users and 20% were secondary cocaine powder users. Thirty five per cent were secondary alcohol users.

Methylamphetamine

In 2007/08 19 clients entered treatment for primary methylamphetamine use representing only 0.02% of total clients. There were 20 clients with secondary methylamphetamine use.

12.1.5 Production sites and laboratories, origin of products and trafficking routes, precursors seizures

The *United Kingdom Threat Assessment of Organised Crime 2009/10* (SOCA 2009a) suggests that the majority of synthetic drugs in the United Kingdom, including amphetamine are produced in the Netherlands and Belgium, in collaboration with British organised criminals who organise transportation into the country. BMK (benzyl-methyl-ketone), a precursor used in the manufacture of amphetamine, has been legally produced in Russia since 2004 for use in the polymer industry resulting in increased sourcing of BMK from Russia instead of China. There seems to have been little change in the source of amphetamine with a study profiling amphetamine in the United Kingdom during 1993 finding that nearly all amphetamine had been imported from the Netherlands (King et al. 1994).

Some amphetamines are manufactured in the United Kingdom but this is on a relatively small-scale (SOCA 2009a). Data from the Forensic Science Service (FSS) show a decline over the past 20 years in the number of illicit laboratories discovered in the United Kingdom, most of which are for the synthesis of amphetamines. In the early 1990s around 15 laboratories were seized each year falling to around 11 small-scale labs between 1992 and 1999, 70% of which manufactured amphetamines. In 2000 the FSS examined only five laboratories, four in 2001, one in 2002, and none in 2003 (White 2005). The last amphetamine laboratory discovery in which the FSS were involved was in 2005 (personal communication – FSS).

12.2 Health and social correlates of chronic amphetamine use

12.2.1 Drug-related deaths

In England and Wales during 2008 there were 99 deaths where amphetamines were mentioned on the death certificate, a higher number than in 2004 (n=80). These mentions include MDMA/ecstasy. Forty-four deaths mentioned amphetamines only, a similar number as in 2004 but lower than in previous years (Table 12.2).

Table 12.2: Number of deaths with amphetamines mentioned on the death certificate in England and Wales, 2004 to 2008

| | 2004 | 2005 | 2006 | 2007 | 2008 |
|------------------------------|------|------|------|------|------|
| Total mentions | | | | | |
| All amphetamines | 80 | 103 | 92 | 97 | 99 |
| MDMA/ecstasy | 43 | 58 | 48 | 47 | 44 |
| Mentions without other drugs | | | | | |
| All amphetamines | 45 | 59 | 47 | 56 | 44 |
| MDMA/ecstasy | 24 | 33 | 27 | 28 | 15 |

Source: Wells 2009

Data show that there was a 35% reduction in the number of deaths with amphetamine mentioned in England and Wales between 1999 and 2004 (Morgan et al. 2006).

However the number of amphetamine deaths in Scotland increased from three in 2000 to 12 in 2008 with a large increase in 2002 to 13 deaths (GROS 2009).

12.2.2 Risk behaviours

Amongst respondents in the Unlinked Anonymous Prevalence Monitoring Programme survey of injectors, direct sharing of needles in the last four weeks was more common amongst injecting amphetamine users than other injectors; 27% compared to 17% (HPA et al. 2009)

12.3 Health, social and legal responses addressing amphetamine use or chronic use

In the United Kingdom, guidelines on clinical management of drug misuse and dependence suggest that the mainstay of treatment for stimulant users, including amphetamine users, should be psychosocial and non-pharmacological. Substitute amphetamine prescribing should “not ordinarily be provided” as the evidence of its effect is not convincing (DH et al. 2007). Despite this and the fact that amphetamines are not licensed for treating drug dependence, pharmacotherapy for dependent users of amphetamine has been available in the United Kingdom. However, the extent is unknown since the majority of published studies took place before 2000. One such study involved a postal questionnaire to registered drug services in the Midlands³³⁴, and found that 66% of respondents prescribed amphetamines as a substitution for illicit amphetamine use (Moselhy et al. 2002).

A randomised controlled trial funded by the Department of Health looking at dexamphetamine substitution for the treatment of amphetamine dependence (Merrill et al. 2004) found that prescribing dexamphetamine did not significantly reduce illicit amphetamine use or have a positive impact on reducing injecting behaviour compared to those receiving best available treatment only. However, participants prescribed dexamphetamine showed significant improvements in physical health during the first four months of treatment. The study concluded that the findings provide modest support for the benefits of prescribing dexamphetamine.

Models of Care (NTA 2002a), which set out the framework for the commissioning of adult drug treatment services in England, highlights the need for needle exchange services to take into account the needs of non-opiate users such as amphetamine users. The tendency of amphetamine users to inject more regularly than opiate users is mentioned as one difference which should be addressed.

Of all individuals accessing needle exchange services in Wales during January and February 2008, eight per cent were primary amphetamine users (Smith 2008).

³³⁴ The study took place between November 1999 and May 2000 with a questionnaire sent out to 41 identified statutory and non-statutory drug services. After two mailings, 29 completed forms were returned giving a response rate of 71%.

13. Treatment and care for older drug users

13.1 Age trends in drug users

The United Kingdom has an ageing population. The Office for National Statistics (ONS) has estimated that the mean age of the UK population will increase from 39.6 years in 2006 to 42.6 years by 2031 (ONS 2008). According to the latest population estimates, people aged 40 and over currently account for 49% of the UK population³³⁵ and it is predicted that this proportion will increase substantially over the next 20 years. An ageing population has obvious implications in terms of the increased demands that will be placed on health and support services. As with the general population, there is emerging evidence to suggest that the drug using and treatment population is also ageing. This brings with it specific challenges for specialised drug treatment services and will also increase the burden on wider health, support and care services.

This chapter will focus on drug users aged 40 or over to facilitate comparison with information provided by other European countries. However Crome et al. (2009) note that the term 'older' can mean as low as the age of 40, or as high as 65 in different studies. Analyses of North West treatment data, reported later in this chapter, (Hurst et al. 2008a, 2008b) typically describe older drug users as aged over 45. Beynon et al. (2009) used participants aged over 50 in their research. The differences in definition of what constitutes older drug users make direct comparisons between the available studies difficult (Shah and Fountain 2008).

13.1.1 Drug use in the general population

Several studies have suggested that in the United Kingdom there is an increasing prevalence of drug use amongst older people, both with problem drug users and within the general population (Beynon 2008; Gossop and Moos 2008; Hoare 2009; Hurst et al. 2008a, 2008b; McGrath et al. 2005; Shah and Fountain 2008). Crome et al. (2009) report that members of the 'baby boom'³³⁶ generation in the UK are more likely to be drug users than previous generations.

Trends from the British Crime Survey (BCS)

Data from the latest BCS (see section 2.2.1) show that in terms of last year use of any drug, there was a significant increase in prevalence for the 45 to 54 year old age group between 1996 and 2008/09 (from 2.0% to 3.1%) (Hoare 2009). For the other older age groups there had been little change across the same period of time. Last year use of Class A drugs has increased significantly between 1996 and 2008/09 for the 35 to 44 year old age category. The BCS only records prevalence data for individuals between the ages of 16 to 59.

³³⁵ See: <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15106> for ONS 2008 mid-year estimates. Total UK population is 61,383,100 and people aged 40 and over equate to 30,075,100.

³³⁶ Refers to babies born in the post World War II period when the birth rate increased dramatically in the United Kingdom.

Adult psychiatric morbidity in England, 2007: Results of a household survey

Results from the **2007 Adult Psychiatric Morbidity Survey**, following previous surveys in 1993 and 2000 (Fuller et al. 2009), presented prevalence estimates of illicit drug use and drug dependence³³⁷ in the general population (see section 2.2.4). It included more data about older drug users than those covered by the BCS³³⁸ and reported that between 1993 and 2007, prevalence of dependence on any drug (excluding cannabis³³⁹) increased in the 35 to 44 age category (0.9% to 2.5%) and 55 to 64 age category (0.6% to 1.5%). In the other older age groups, prevalence of dependence stayed the same (65 to 74, 0.3%) or fluctuated (45 to 54, 0.3% in 1993 to 1.2% in 2000 to 0.9% in 2007) between 1993 and 2007.

13.1.2 Drug users in treatment

Trends in Treatment Demand Indicator (TDI)³⁴⁰ data from 2003/04 to 2007/08

Data from the Treatment Demand Indicator (TDI) suggest that there is an ageing treatment population in the United Kingdom. The vast majority of all clients entering treatment between 2003/04 and 2007/08 were under 40 years of age (Figure 13.1), however, the proportion of all clients entering treatment in the 40 and over age group has shown a steady increase between 2003/04 and 2007/08 (from 12% to 17%). Over this time period the 40 to 49 age group has shown the biggest proportional increase and the numbers in this age category have nearly doubled (Table 13.1).

Table 13.1: Number and percentage of all clients in the United Kingdom entering treatment between 2003/04 and 2007/08 by age group and year of treatment³⁴¹

| AGE GROUP | 2003/04 | | 2004/05 | | 2005/06 | | 2006/07 | | 2007/08 | |
|-------------|---------|------|---------|------|---------|------|---------|------|---------|------|
| | n | % | n | % | n | % | n | % | n | % |
| < 40 | 86,087 | 87.8 | 101,875 | 86.5 | 109,614 | 85.5 | 107,610 | 83.9 | 109,544 | 83.0 |
| 40 - 49 | 9,631 | 9.8 | 12,868 | 10.9 | 14,965 | 11.7 | 16,702 | 13.0 | 18,220 | 13.8 |
| 50 - 59 | 2,050 | 2.1 | 2,596 | 2.2 | 3,072 | 2.4 | 3,250 | 2.5 | 3,519 | 2.7 |
| >= 60 | 325 | 0.3 | 438 | 0.4 | 608 | 0.5 | 631 | 0.5 | 709 | 0.5 |
| Sub Total | 98,093 | | 117,777 | | 128,259 | | 128,193 | | 131,992 | |
| Not known | 1,389 | | 4 | | 187 | | 15 | | 11 | |
| Total | 99,482 | | 117,781 | | 128,446 | | 128,208 | | 132,003 | |
| 40 and over | 12,006 | 12.2 | 15,902 | 13.5 | 18,645 | 14.5 | 20,583 | 16.1 | 22,448 | 17.0 |

Source: National Drug Treatment Monitoring System (NDTMS), the Scottish Drug Misuse Database, the Welsh National Database for Substance Misuse; and Northern Ireland Drug Misuse Database

³³⁷ Dependence on drugs was measured by a self-completed section of the survey using questions that were based on the Diagnostic Interview Schedule to identify if respondents displayed signs of drug dependency.

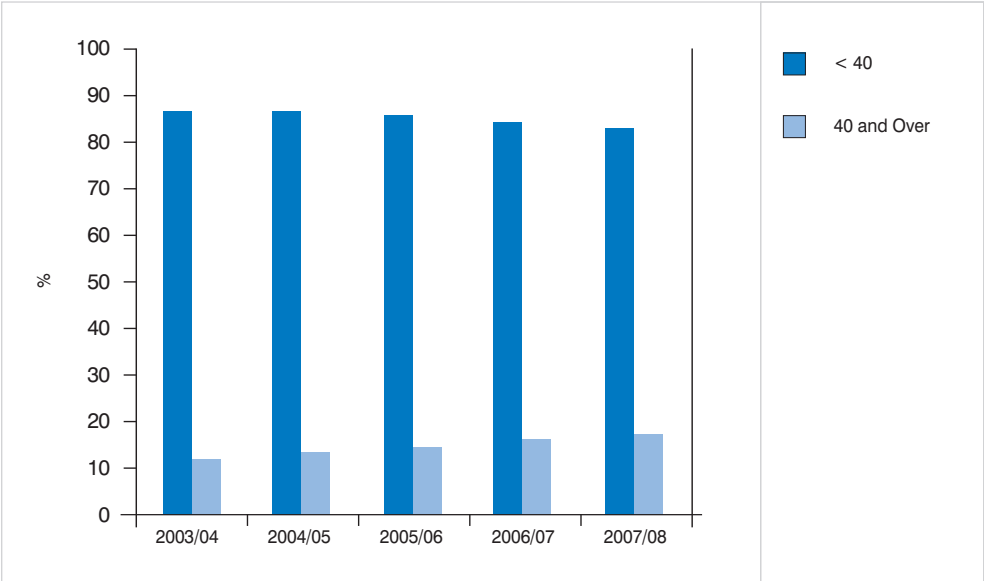
³³⁸ The BCS has an upper age limit of 59, whereas the Adult Psychiatric Morbidity Survey has an over 75 age category.

³³⁹ Drug dependence on cannabis was reported separately by the authors as they considered dependence on cannabis to have its own specific characteristics in relation to other substances.

³⁴⁰ Data are taken from the Treatment Demand Indicator (TDI) standard tables prepared for the EMCDDA each year and the data sources are the National Drug Treatment Monitoring System (NDTMS) in England, the Scottish Drug Misuse Database, the Northern Ireland Drug Misuse Database and the Welsh National Database for Substance Misuse. Continuous national data are only available from 2003/04. TDI provides information on clients entering treatment in a particular year but cannot provide information on clients who are already in treatment within that year. The NDTMS is able to provide this for England.

³⁴¹ This includes all clients with a known primary drug and those with a primary drug not known or missing.

Figure 13.1: Percentage of all clients entering treatment in the United Kingdom, 2003/04 to 2007/08, by age group and year of treatment



Source: National Drug Treatment Monitoring System (NDTMS), the Scottish Drug Misuse Database, the Welsh National Database for Substance Misuse; and Northern Ireland Drug Misuse Database

The vast majority of those entering treatment between 2003/04 and 2007/08 with heroin as the primary drug were under 40 years of age (Table 13.2), the same as for all clients. However, the data suggest that the treatment population, where heroin is the primary drug, is ageing. The proportion of all clients entering treatment in the 40 and over age group has shown a steady increase between 2003/04 and 2007/08 (from 10% to 17%); and over this time period the 40 to 49 age group has shown the biggest proportional increase and has more than doubled in number.

Table 13.2: Number and percentage of primary heroin users entering treatment in the United Kingdom, 2003/04 to 2007/08, by age group

| AGE GROUP | 2003/04 | | 2004/05 | | 2005/06 | | 2006/07 | | 2007/08 | |
|-------------|---------|------|---------|------|---------|------|---------|------|---------|------|
| | n | % | n | % | n | % | n | % | n | % |
| < 40 | 52,781 | 89.7 | 55,114 | 88.2 | 59,107 | 86.7 | 57,957 | 84.2 | 58,160 | 82.7 |
| 40 - 49 | 5,158 | 8.8 | 6,261 | 10.0 | 7,823 | 11.5 | 9,344 | 13.6 | 10,459 | 14.9 |
| 50 - 59 | 849 | 1.4 | 1,009 | 1.6 | 1,149 | 1.7 | 1,421 | 2.1 | 1,566 | 2.2 |
| >= 60 | 73 | 0.1 | 88 | 0.1 | 83 | 0.1 | 126 | 0.2 | 124 | 0.2 |
| Sub Total | 58,861 | | 62,472 | | 68,162 | | 68,848 | | 70,309 | |
| Not known | 767 | | 1 | | 4 | | 4 | | 0 | |
| Total | 59,628 | | 62,473 | | 68,166 | | 68,852 | | 70,309 | |
| 40 and over | 6,080 | 10.3 | 7,358 | 11.8 | 9,055 | 13.3 | 10,891 | 15.8 | 12,149 | 17.3 |

Source: National Drug Treatment Monitoring System (NDTMS), the Scottish Drug Misuse Database, the Welsh National Database for Substance Misuse; and Northern Ireland Drug Misuse Database

Table 13.3 shows the number and percentage of clients entering treatment who were aged 40 and over, by primary drug used. Between 2003/04 and 2007/08 the proportion of clients in the 40 and over age group increased for all types of drug, with the exception of clients entering treatment with cannabis as the primary drug. The proportion for this group remained stable, with slight fluctuations over the period.

Between 2003/04 and 2007/08 the proportion of clients in the over 40 age group:

- increased by 4.8% for all clients (primary drug known and unknown);
- increased by seven per cent for clients with heroin as the primary drug;
- increased by two per cent for clients with cocaine as the primary drug;
- increased by 6.4% for clients with stimulants as the primary drug;
- increased by 5.7% for clients with other known substances³⁴² as the primary drug; and
- increased by 9.3% for clients with primary drug not known.

³⁴² Other known substances included: methadone, 'other' opiates, barbiturates, benzodiazepines, 'other' hypnotics and sedatives, LSD, 'other' hallucinogens, volatile inhalants and 'other' substances.

Table 13.3: Number and percentage of all clients aged 40 and over entering treatment in the United Kingdom, 2003/04 to 2007/08 by primary drug

| YEAR | ALL DRUGS | | HEROIN | | COCAINE | | STIMULANTS | | CANNABIS | | OTHER KNOWN DRUG | | DRUG NOT KNOWN | |
|-----------|-----------|------|--------|------|---------|------|------------|------|----------|-----|------------------|------|----------------|------|
| | n | % | n | % | n | % | n | % | n | % | n | % | n | % |
| 2003/2004 | 12,006 | 12.2 | 6,080 | 10.3 | 1,201 | 14.0 | 502 | 11.8 | 719 | 7.4 | 2,156 | 22.1 | 1,348 | 19.6 |
| 2004/2005 | 15,902 | 13.5 | 7,358 | 11.8 | 1,607 | 14.7 | 774 | 16.1 | 1,168 | 7.9 | 2,804 | 23.8 | 2,191 | 16.9 |
| 2005/2006 | 18,645 | 14.5 | 9,055 | 13.3 | 2,025 | 14.7 | 762 | 15.4 | 1,308 | 7.0 | 3,130 | 23.3 | 2,365 | 25.8 |
| 2006/2007 | 20,583 | 16.1 | 10,891 | 15.8 | 2,507 | 16.2 | 904 | 16.1 | 1,480 | 7.8 | 3,217 | 24.5 | 1,584 | 26.2 |
| 2007/2008 | 22,448 | 17.0 | 12,149 | 17.3 | 2,821 | 16.0 | 999 | 18.2 | 1,536 | 7.3 | 3,598 | 27.8 | 1,345 | 28.9 |

Source: National Drug Treatment Monitoring System (NDTMS), the Scottish Drug Misuse Database, the Welsh National Database for Substance Misuse; and Northern Ireland Drug Misuse Database

Historical data on substitution treatment clients

The proportion of clients who are aged 40 and over in contact with prescribing drug treatment services³⁴³ in the United Kingdom is a little lower in 2007/08 (18.2%) than it was in 2005/06 (20.5%) (Table 13.4).

Table 13.4: Number and percentage of clients in contact with prescribing drug treatment services in the United Kingdom³⁴⁴, 2005/06 to 2007/08, by age group

| AGE GROUP | 2005/06 | | 2006/07 | | 2007/08 | |
|--------------|----------------|--------------|----------------|--------------|----------------|--------------|
| | n | % | n | % | n | % |
| < 40 | 86,437 | 79.5 | 100,454 | 83.1 | 109,038 | 81.8 |
| >= 40 | 22,260 | 20.5 | 20,487 | 16.9 | 24,316 | 18.2 |
| Total | 108,697 | 100.0 | 120,941 | 100.0 | 133,354 | 100.0 |

Source: National Drug Treatment Monitoring System (NDTMS), the Welsh National Database for Substance Misuse; and Northern Ireland Drug Misuse Database

³⁴³ Data from England refer to all clients in contact with specialist prescribing service for drug treatment, most will receive methadone but buprenorphine or other substitution opioids may be prescribed. Wales data are for referrals to agencies who provide substitute prescribing or prescribing services. Data for Northern Ireland are clients prescribed methadone. See section 5.6.3 for further information on substitute prescribing.

³⁴⁴ Data are for England, Wales and Northern Ireland only. No data are available from Scotland. All contributing data based on client registries.

Clients in treatment in England in 2008/09: NDTMS data

In England in 2008/09, data from the NDTMS showed that there was an increase in the proportion of new treatment presentations for heroin and crack cocaine by clients aged 35 and over (an increase of 20% from 20,465 in 2005/06 to 24,414 in 2008/09) (NTA 2009h). In 2008/09, 24% of clients in contact with structured treatment were aged 40 and over (this is compared to 22% in 2007/08 and 20% in 2006/07) (Table 13.5). The average (median) age of clients was 33 years (compared to 32 years in 2007/08 and 31 years in 2006/07) (NTA 2009h; NTA 2008e; NTA 2007).

Table 13.5: Number and percentage of all clients in treatment in England between 2006/07 and 2008/09, by age group and year of treatment

| AGE GROUP | 2006/07 ³⁴⁵ | | 2007/08 ³⁴⁶ | | 2008/09 ³⁴⁷ | |
|--------------|------------------------|--------------|------------------------|--------------|------------------------|--------------|
| | n | % | n | % | n | % |
| < 40 | 155,824 | 79.7 | 158,354 | 78.1 | 157,554 | 75.9 |
| 40 and over | 39,640 | 20.3 | 44,312 | 21.9 | 50,026 | 24.1 |
| Total | 195,464 | 100.0 | 202,666 | 100.0 | 207,580 | 100.0 |

Source: NTA 2009h; NTA 2008e; NTA 2007

In 2008/09 it was reported that the majority (80%, n= 12,900) of drug users aged 40 and over in treatment in England were PDUs (that is users of opiates and/or crack cocaine). Of those aged 40 and over, 42% used opiates only (n=6,783); seven per cent crack cocaine only (n=1,185); and 30% opiates and crack cocaine (n=4,932) (NTA 2009h).

Older people in treatment in the North West of England

Data from a local specialist drug service monitoring system in the North West of England (established in 1998 and therefore able to provide data for a longer time period than national monitoring systems³⁴⁸) demonstrated an increase in the number of older clients accessing treatment between 1998 and 2004/05 and showed that the proportion of clients aged between 40 and 49 increased greatly over the same time period (from 8.1% in 1998 to 19.6% in 2004/05) (Beynon et al. 2007).

Ageing drug treatment population in North West of England

NDTMS treatment data from the North West of England³⁴⁹ (Hurst et al. 2008a) showed that the proportion of clients aged 45 or over in contact with treatment services increased from 6.4% in 2003/04 to 10.1% in 2006/07 (n= 1,773, n=3,776 respectively). Of those clients who were aged over 45, the majority were in the 45 to 49 age group (59.9%, n=2263); 24.1% were aged 50 to 54 (n=908); and less than one per cent (0.5%) were over 70.

³⁴⁵ Client's age at mid-year (30th September 2006).

³⁴⁶ Client's age at mid-year (30th September 2007).

³⁴⁷ Client's age at first point of contact with treatment in 2008/09.

³⁴⁸ Such as the National Drug Treatment Monitoring System (NDTMS).

³⁴⁹ In 2006/07, 37,396 individuals were recorded by the NDTMS as being in contact with structured drug treatment services in the North West of England.

A more recent analysis of North West England treatment data from 2007/08 (Hurst et al. 2008b) provided further evidence of an ageing treatment population. It was reported that there was a significant increase in the proportion of older clients in treatment between 2006/07 and 2007/08. In 2007/08, data from the NDTMS in the North West also showed that:

- the mean age of individuals in treatment was 33.8 years;
- 27.5% (n= 10,590) were aged over 40, (in contrast to the UK 2007/08 TDI figure of 17.0%);
- there has been an increase in the proportion of over 45's since 2003/04 from 6.4% (n= 1,773) to 11.4% in 2007/08 (n=4,387); and
- in 2003/04, 9.5% were aged between 40 to 44; in 2007/08 this proportion had increased to 16.1%.

13.1.3. Estimates of older problem drug use (PDU) in England

The first year results of a three year Home Office study to estimate the prevalence locally and nationally of problem drug use (PDU) in England (Hay et al. 2006) reported that nationally around 35% of problem opiate users were in the 35 to 64 age group in 2004/05. Marked regional differences³⁵⁰ in the proportion of older problem opiate users (aged 35 to 64 years) were reported. In London, 50% of problem opiate users were in the older age category; 40% in the North West; 36% in the South East and 34% in the South West. This is in comparison to 23% of problem opiate users in East Midlands and the North East. There were also marked regional differences reported in the prevalence rate of problem opiate use per thousand population. The average rate of older problem opiate use per thousand population in England was 4.93. In London the rate was 10.03 and in the North West it was 6.47.

Results from the three sweeps of the Home Office PDU study in England (Hay et al. 2008), showed that the prevalence rate of problem drug use³⁵¹ per thousand population increased for older drug users (aged 35 to 64) between 2004/05 and 2006/07 (from 5.77 to 6.36). In the same period the rate per thousand population decreased amongst the 15 to 24 age group (from 11.32 to 9.06) (Table 13.6).

Table 13.6: Estimated rate of problem drug use per 1,000 population in England, 2004/05 to 2006/07, by age group

| YEAR | 15 TO 24 YEARS | 25 TO 34 YEARS | 35 TO 64 YEARS |
|---------|----------------|----------------|----------------|
| 2004/05 | 11.32 | 20.85 | 5.77 |
| 2005/06 | 10.07 | 21.43 | 6.10 |
| 2006/07 | 9.06 | 20.76 | 6.36 |

Source: Hay et al. 2006; Hay et al. 2007 ; Hay et al. 2008

³⁵⁰ Data were analysed according to Government Office Region.

³⁵¹ Defined here as opiate and/or crack cocaine users.

13.1.4 Drug-related Deaths (DRD): trends in age of death

Using the EMCDDA definition for drug-related deaths (see section 6.2) the proportion of drug-related deaths amongst the 40 and over age group increased steadily between 1997 and 2005 in the United Kingdom from 16.9% to 31.6% (Table 13.7). After remaining stable between 2005 and 2007, the proportion increased sharply in 2008 with those aged 40 and over accounting for 36.9% of all drug-related deaths.

The mean age of death has increased from 31.2 in 1997 to 37.3 in 2008.

Table 13.7: Proportion of drug-related deaths (EMCDDA definition) in each age group in the United Kingdom, 1997 to 2008

| AGE | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
|-------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Under 40 | 83.1 | 82.4 | 82.3 | 76.9 | 74.6 | 76.5 | 75.6 | 72.7 | 68.4 | 68.9 | 68.5 | 63.1 |
| 40-49 | 11.8 | 13.1 | 12.1 | 16.9 | 16.3 | 15.0 | 15.0 | 16.9 | 19.5 | 20.2 | 22.1 | 25.6 |
| 50-59 | 2.6 | 2.3 | 3.8 | 3.9 | 5.1 | 5.1 | 5.9 | 6.2 | 7.6 | 7.7 | 6.1 | 8.2 |
| Over 60 | 2.5 | 2.2 | 1.8 | 2.2 | 4.0 | 3.4 | 3.5 | 4.3 | 4.5 | 3.3 | 3.2 | 3.0 |
| Total | 1,258 | 1,445 | 1,644 | 1,707 | 1,995 | 1,863 | 1,595 | 1,691 | 1,812 | 1,800 | 1,972 | 2,231 |
| 40 and over | 16.9 | 17.6 | 17.7 | 23.1 | 25.4 | 23.5 | 24.4 | 27.3 | 31.6 | 31.1 | 31.5 | 36.9 |
| Mean age | 31.2 | 31.7 | 32.3 | 33.8 | 35.0 | 34.4 | 35.0 | 35.9 | 37.0 | 36.5 | 36.3 | 36.3 |

Source: Standard Table 06

13.1.5 Factors related to the ageing and increasing life expectancy of drug users

It has been suggested that improved treatment for problem drug users and the successful implementation of harm reduction interventions, such as syringe exchanges, have contributed to an increased life expectancy for drug users. This has been aided by general advances in medicine outside of specific drug treatments and the introduction of substitute prescribing has played a part in overdose prevention. Furthermore, more people are now maintained in treatment, thus increasing the number of older clients within the treatment population (Beynon 2008; Gossop and Moos 2008).

13.2 Characteristics of current older drug users

13.2.1 Characteristics of clients with heroin as a primary drug entering treatment in 2007/08 from TDI data

To facilitate comparison with other European countries this and the following section focus on heroin users³⁵².

Labour status

In 2007/08, the proportion of heroin users entering treatment in Scotland and Northern Ireland who were economically inactive increased with age and the proportion of unemployed clients decreased with age. A higher proportion of clients aged 40 and over were economically inactive (18% compared to nine per cent of under 40s). A higher proportion of under 40's were unemployed (78% compared to 73% aged 40 and over) (Table 13.8).

³⁵² The EMCDDA guidelines for this chapter require that information on the characteristics of older drug users should focus mainly on opioid users.

Table 13.8: Number and percentage of heroin users entering treatment in Scotland and Northern Ireland³⁵³ 2007/08, by age and labour status

| LABOUR STATUS | < 40 | | 40 - 49 | | 50 - 59 | | >= 60 | | 40 AND OVER | |
|--------------------------------------|--------------|------|------------|------|-----------|------|----------|------|-------------|------|
| | n | % | n | % | n | % | n | % | n | % |
| Regular employment | 673 | 11.5 | 64 | 8.5 | 13 | 16.0 | 1 | 33.3 | 78 | 9.3 |
| Pupil/student | 36 | 0.6 | 2 | 0.3 | 0 | 0.0 | 0 | 0.0 | 2 | 0.2 |
| Economically inactive ³⁵⁴ | 508 | 8.7 | 132 | 17.5 | 15 | 18.5 | 0 | 0.0 | 147 | 17.5 |
| Unemployed | 4,540 | 77.8 | 555 | 73.5 | 53 | 65.4 | 1 | 33.3 | 609 | 72.6 |
| Other | 76 | 1.3 | 2 | 0.3 | 0 | 0.0 | 1 | 33.3 | 3 | 0.4 |
| Sub Total | 5,833 | 100 | 755 | 100 | 81 | 100 | 3 | 100 | 839 | 100 |
| Not known | 468 | | 55 | | 9 | | 0 | | 64 | |
| Total | 6,301 | | 810 | | 90 | | 3 | | 903 | |

Source: Scottish Drug Misuse Database and Northern Ireland Drug Misuse Database

Living status

In Scotland in 2007/08, 82% of heroin users entering treatment aged 40 or over reported living in stable accommodation, a similar proportion to those who were aged under 40 (80%) (Table 13.9).

Table 13.9: Number and percentage of heroin users entering treatment in Scotland³⁵⁵ 2007/08, by age and living status (where)

| LIVING STATUS (WHERE) | < 40 | | 40 - 49 | | 50 - 59 | | >= 60 | | 40 AND OVER | |
|----------------------------------|--------------|------|------------|------|-----------|------|----------|-------|-------------|------|
| | n | % | n | % | n | % | n | % | n | % |
| Stable accommodation | 4,617 | 79.7 | 618 | 81.1 | 77 | 89.5 | 2 | 100.0 | 697 | 82.0 |
| Unstable accommodation | 1,100 | 19.0 | 141 | 18.5 | 9 | 10.5 | 0 | 0.0 | 150 | 17.6 |
| In institutions (prison, clinic) | 76 | 1.3 | 3 | 0.4 | 0 | 0.0 | 0 | 0.0 | 3 | 0.4 |
| Sub Total | 5,793 | 100 | 762 | 100 | 86 | 100 | 2 | 100 | 850 | 100 |
| Not known | 373 | | 30 | | 1 | | 0 | | 31 | |
| Total | 6,166 | | 792 | | 87 | | 2 | | 881 | |

Source: Scottish Drug Misuse Database

³⁵³ Data on labour status amongst the treatment population is not available for England or Wales.

³⁵⁴ Economically inactive includes: pensioners, housewives/househusbands, invalids.

³⁵⁵ Data on living status (where) amongst the treatment population is not available for England, Northern Ireland or Wales.

Older heroin users entering treatment in Scotland and Northern Ireland in 2007/08 were more likely than younger heroin users to live alone and this proportion increased with age. Around a quarter of under 40s lived alone compared to 41% aged 40 and over and 55% of those aged 50 to 59 years. Amongst the under 40 age group, a higher proportion lived with their parents (25% compared to 10% of over 40s). A similar proportion of under 40 and over 40s lived with a partner although a slightly higher proportion of under 40s (10%) lived with a partner and child(ren) than those in the 40 and over age group (seven per cent) (Table 13.10).

Table 13.10: Number and percentage of heroin users entering treatment in Scotland and Northern Ireland 2007/08, by age and living status (with whom)

| LIVING STATUS (WITH WHOM) | < 40 | | 40 - 49 | | 50 - 59 | | >= 60 | | 40 AND OVER | |
|------------------------------|--------------|------|------------|------|-----------|------|----------|------|-------------|------|
| | n | % | n | % | n | % | n | % | n | % |
| Alone | 1,358 | 24.7 | 279 | 39.9 | 41 | 55.4 | 0 | 0.0 | 320 | 41.2 |
| With parents | 1,383 | 25.2 | 69 | 9.9 | 6 | 8.1 | 1 | 33.3 | 76 | 9.8 |
| Alone with child | 152 | 2.8 | 25 | 3.6 | 1 | 1.4 | 0 | 0.0 | 26 | 3.4 |
| With partner (alone) | 1,085 | 19.8 | 133 | 19.0 | 19 | 25.7 | 1 | 33.3 | 153 | 19.7 |
| With partner and child(ren) | 554 | 10.1 | 51 | 7.3 | 1 | 1.4 | 0 | 0.0 | 52 | 6.7 |
| With friends | 12 | 0.2 | 1 | 0.1 | 0 | 0.0 | 1 | 33.3 | 2 | 0.3 |
| Other | 951 | 17.3 | 141 | 20.2 | 6 | 8.1 | 0 | 0.0 | 147 | 18.9 |
| Sub Total | 5,495 | 100 | 699 | 100 | 74 | 100 | 3 | 100 | 776 | 100 |
| Not known | 806 | | 111 | | 16 | | 0 | | 127 | |
| Total | 6,301 | | 810 | | 90 | | 3 | | 903 | |

Source: Scottish Drug Misuse Database and Northern Ireland Drug Misuse Database

Route of administration

Data from the United Kingdom show that, amongst heroin users entering treatment in 2007/08, the route of administration differed only slightly between the under and over 40 age groups. Forty per cent of clients aged under 40 reported that they injected heroin compared to 37% of those aged over 40 with 57% of clients aged 40 and over reporting that they smoked heroin compared to 54% of those aged under 40 (Table 13.11).

Table 13.11: Number and percentage of heroin users entering treatment in the United Kingdom 2007/08, by age and route of administration

| ROUTE OF ADMINISTRATION | < 40 | | 40 – 49 | | 50 - 59 | | >= 60 | | 40 AND OVER | |
|-------------------------|--------|------|---------|------|---------|------|-------|------|-------------|------|
| | n | % | n | % | n | % | n | % | n | % |
| Inject | 22,833 | 40.4 | 3,798 | 38.0 | 510 | 34.6 | 22 | 18.6 | 4,330 | 37.4 |
| Smoke/inhale | 30,280 | 53.6 | 5,649 | 56.5 | 870 | 58.9 | 69 | 58.5 | 6,588 | 56.8 |
| Eat/drink | 938 | 1.7 | 186 | 1.9 | 32 | 2.2 | 1 | 0.8 | 219 | 1.9 |
| Sniff | 455 | 0.8 | 101 | 1.0 | 27 | 1.8 | 4 | 3.4 | 132 | 1.1 |
| Other | 1,946 | 3.4 | 265 | 2.7 | 37 | 2.5 | 22 | 18.6 | 324 | 2.8 |
| Sub Total | 56,452 | 100 | 9,999 | 100 | 1,476 | 100 | 118 | 100 | 11,593 | 100 |
| Not known | 2,352 | | 454 | | 72 | | 3 | | 529 | |
| Total | 58,804 | | 10,453 | | 1,548 | | 121 | | 12,122 | |

Source: National Drug Treatment Monitoring System (NDTMS), the Scottish Drug Misuse Database, the Welsh National Database for Substance Misuse; and Northern Ireland Drug Misuse Database

Source of referral

The proportion of clients who were self-referred was similar in both age groups; 34% of clients aged 40 and over and 32% of those aged under 40. Older clients were more likely to have been referred by a hospital source (17% of clients aged 40 and over compared to 13% of under 40s) and less likely to have been referred by the criminal justice system (CJS) (22% of clients aged 40 and over compared to 28% of under 40s) (Table 13.12).

Table 13.12: Number and percentage of heroin users entering treatment in the United Kingdom 2007/08, by age and source of referral

| SOURCE OF REFERRAL | < 40 | | 40 - 49 | | 50 - 59 | | >= 60 | | 40 AND OVER | |
|-------------------------------|---------------|------|---------------|------|--------------|------|------------|------|---------------|------|
| | n | % | n | % | n | % | n | % | n | % |
| Self-referred | 18,588 | 32.1 | 3,467 | 33.7 | 548 | 35.9 | 42 | 35.3 | 4,057 | 34.0 |
| Family/friends | 175 | 0.3 | 23 | 0.2 | 4 | 0.3 | 0 | 0.0 | 27 | 0.2 |
| Other drug treatment centre | 5,802 | 10.0 | 1,141 | 11.1 | 170 | 11.1 | 11 | 9.2 | 1,322 | 11.1 |
| General practitioner | 5,218 | 9.0 | 967 | 9.4 | 180 | 11.8 | 12 | 10.1 | 1,159 | 9.7 |
| Hospital/other medical source | 7,604 | 13.1 | 1,672 | 16.3 | 295 | 19.3 | 17 | 14.3 | 1,984 | 16.6 |
| Social services | 782 | 1.3 | 83 | 0.8 | 12 | 0.8 | 18 | 15.1 | 113 | 0.9 |
| Court/probation/police | 16,452 | 28.4 | 2,383 | 23.2 | 252 | 16.5 | 16 | 13.4 | 2,651 | 22.2 |
| Other | 3,306 | 5.7 | 544 | 5.3 | 67 | 4.4 | 3 | 2.5 | 614 | 5.1 |
| Sub Total | 57,927 | 100 | 10,280 | 100 | 1,528 | 100 | 119 | 100 | 11,927 | 100 |
| Not known | 877 | | 173 | | 20 | | 2 | | 195 | |
| Total | 58,804 | | 10,453 | | 1,548 | | 121 | | 12,122 | |

Source: National Drug Treatment Monitoring System (NDTMS), the Scottish Drug Misuse Database, the Welsh National Database for Substance Misuse; and Northern Ireland Drug Misuse Database

Age of first use

Seventy nine per cent of clients under 40 reported age of first use as under 20 years of age compared to 60% of those aged 40 and over. The older age groups were more likely to have reported initiation at an older age with nearly a quarter (24%) of those aged 40 or over reporting age of first use at age 30 or older, compared to six per cent of under 40s (Table 13.13).

Table 13.13: Number and percentage of heroin users entering treatment in Northern Ireland, Scotland and Wales 2007/08, by age and age at first use

| AGE AT FIRST USE | < 40 | | 40 - 49 | | 50 - 59 | | >= 60 | | 40 AND OVER | |
|------------------|---------------|------|--------------|------|------------|------|-----------|------|--------------|------|
| | n | % | n | % | n | % | n | % | n | % |
| < 15 | 4,292 | 46.7 | 402 | 33.7 | 31 | 25.2 | 4 | 50.0 | 437 | 33.0 |
| 15 - 19 | 2,926 | 31.9 | 319 | 26.8 | 30 | 24.4 | 1 | 12.5 | 350 | 26.5 |
| 20 - 24 | 960 | 10.5 | 104 | 8.7 | 18 | 14.6 | 0 | 0.0 | 122 | 9.2 |
| 25 - 29 | 496 | 5.4 | 86 | 7.2 | 7 | 5.7 | 1 | 12.5 | 94 | 7.1 |
| >= 30 | 512 | 5.6 | 281 | 23.6 | 37 | 30.1 | 2 | 25.0 | 320 | 24.2 |
| Sub Total | 9,186 | 100 | 1,192 | 100 | 123 | 100 | 8 | 100 | 1,323 | 100 |
| Not known | 1,601 | | 189 | | 19 | | 18 | | 226 | |
| Total | 10,787 | | 1,381 | | 142 | | 26 | | 1,549 | |

Source: Scottish Drug Misuse Database, the Welsh National Database for Substance Misuse; and Northern Ireland Drug Misuse Database

13.2.2 Characteristics of clients with heroin as a primary drug in treatment (NDTMS) in 2007/2008 in England³⁵⁶

Data from the National Drug Treatment Monitoring System (NDTMS) in England of all clients in treatment in 2007/08 show that amongst heroin users, the route of administration follows a broadly similar pattern amongst under and over 40 age groups (Table 13.14).

Table 13.14: Number and percentage of heroin users in treatment in England 2007/08, by age and route of administration

| ROUTE OF ADMINISTRATION | < 40 | | 40 - 49 | | 50 - 59 | | >= 60 | | 40 AND OVER | |
|-------------------------|--------|------|---------|------|---------|------|-------|------|-------------|------|
| | n | % | n | % | n | % | n | % | n | % |
| Inject | 37,561 | 42.3 | 9,313 | 43.1 | 1,843 | 42.6 | 154 | 36.3 | 11,310 | 42.9 |
| Smoke/inhale | 46,125 | 51.9 | 10,868 | 50.2 | 2,141 | 49.4 | 234 | 55.2 | 13,243 | 50.2 |
| Eat/drink | 2,872 | 3.2 | 931 | 4.3 | 176 | 4.1 | 15 | 3.5 | 1,122 | 4.3 |
| Sniff | 924 | 1.0 | 227 | 1.0 | 87 | 2.0 | 11 | 2.6 | 325 | 1.2 |
| Other | 1,311 | 1.5 | 289 | 1.3 | 83 | 1.9 | 10 | 2.4 | 382 | 1.4 |
| Sub Total | 88,793 | 100 | 21,628 | 100 | 4,330 | 100 | 424 | 100 | 26,382 | 100 |
| Not known | 6,209 | | 1,703 | | 429 | | 29 | | 2,161 | |
| Total | 95,002 | | 23,331 | | 4,759 | | 453 | | 28,543 | |

Source: National Drug Treatment Monitoring System (NDTMS)

³⁵⁶ At present, data for all clients in treatment for a particular year are only available for England. See also footnote 340.

A higher proportion of older heroin users in treatment in England in 2007/08 were self-referred compared to younger heroin users; this ranged from 38% of those aged under 40 to 45% of those aged 60 and over. Older clients were less likely to be referred by the criminal justice system (14% of clients aged 40 and over compared to 23% of under 40s) and more likely to be referred by their GP (16% of clients aged 40 and over compared to 12% of under 40s) (Table 13.15).

Table 13.15: Number and percentage of heroin users in treatment in England 2007/08, by age and source of referral

| SOURCE OF REFERRAL | < 40 | | 40 - 49 | | 50 - 59 | | >= 60 | | 40 AND OVER | |
|-------------------------------|---------------|------|---------------|------|--------------|------|------------|------|---------------|------|
| | n | % | n | % | n | % | n | % | n | % |
| Self-referred | 35,229 | 37.8 | 9,193 | 40.3 | 1,977 | 42.6 | 199 | 45.4 | 11,369 | 40.8 |
| Family/friends | 429 | 0.5 | 63 | 0.3 | 9 | 0.2 | 0 | 0.0 | 72 | 0.3 |
| Other drug treatment centre | 8,610 | 9.2 | 1,920 | 8.4 | 373 | 8.0 | 29 | 6.6 | 2,322 | 8.3 |
| General practitioner | 11,397 | 12.2 | 3,482 | 15.3 | 890 | 19.2 | 83 | 18.9 | 4,455 | 16.0 |
| Hospital/other medical source | 10,206 | 10.9 | 2,830 | 12.4 | 621 | 13.4 | 64 | 14.6 | 3,515 | 12.6 |
| Social services | 326 | 0.3 | 69 | 0.3 | 11 | 0.2 | 1 | 0.2 | 81 | 0.3 |
| Court/probation/police | 21,304 | 22.8 | 3,561 | 15.6 | 430 | 9.3 | 28 | 6.4 | 4,019 | 14.4 |
| Other | 5,766 | 6.2 | 1,685 | 7.4 | 328 | 7.1 | 34 | 7.8 | 2,047 | 7.3 |
| Sub Total | 93,267 | 100 | 22,803 | 100 | 4,639 | 100 | 438 | 100 | 27,880 | 100 |
| Not known/missing | 1,735 | | 528 | | 120 | | 15 | | 663 | |
| Total | 95,002 | | 23,331 | | 4,759 | | 453 | | 28,543 | |

Source: National Drug Treatment Monitoring System (NDTMS)

Characteristics of older drug users in treatment in the North West of England

NDTMS treatment data from the North West of England (Hurst et al. 2008a) showed that in 2006/07:

- 72.1% of over 45 year olds in treatment reported problematic heroin use (compared to 67.2% in younger age groups);
- the majority (74.9%) of clients over 45 years old were male (n=2,828);
- older drug users were less likely to report problematic cannabis or cocaine use than younger clients (10.6% and 6.0% respectively compared to 23.5% and 12.6%);
- urban areas with higher levels of deprivation had a higher proportion of older drug users in treatment;
- older drug users in treatment were less likely to have been referred by the criminal justice system (CJS) than those under 45;
- clients over 45 had spent longer in their latest treatment episode, on average, compared to those under 45 (45.9 mean months compared to 23.4 mean months);
- there was a slight difference in successful treatment completion between the over 45 and under 45 age groups; 43.9% of final treatment outcomes resulted in a planned discharge for those over 45, compared to 38.6% of 25 to 44 year olds; and
- over 45s were less likely to have 'prison' as a treatment outcome (3.9%) than younger clients (8.0%).

13.2.3 Patterns of drug use

Initiation into drug use

A small qualitative study with illicit drug users aged 50 and over was carried out in the North West of England in 2008³⁵⁷ (Beynon et al. 2009). It was reported that all but one of the participants in the study had been initiated into drug use when they were teenagers or in their early adult years but there was no common pattern in terms of the drugs consumed and participants had used whatever drugs were available. The participants tended to follow one of three patterns: some had used drugs on a near continuous basis for over 30 years; some had brief periods of abstinence followed by intermittent drug use; and others had abstained from drugs for years at a time. The exception to this was one participant who began drinking heavily in his 30s and then started using heroin in his mid forties. However, given the qualitative nature of the study and the small sample size, the authors were unable to make any broad generalisations from the results regarding patterns of drug use amongst older drug users.

³⁵⁷ Ten participants (nine male and one female) between the ages of 54 and 61 years were interviewed using a semi-structured format about their health and experiences of health related services. All participants were or had been problem drug users at some point and all had used heroin. Their responses were thematically analysed.

13.2.4 Social characteristics

In Beynon et al. (2009) participants who were interviewed as part of the study alluded to social problems and isolation that was often associated with the deaths of (drug using) friends and also their poor mobility and health. Problems were also discussed regarding being older than other drug using associates and thus having difficulties in forming social networks or bonds with these younger people who they may not have much in common with. Conversely, three interviewees had formed symbiotic alliances with much younger drug users, probably out of practical necessity. Stressful events such as a relationship breakdown were also associated with a relapse into drug use in this study, in common with the findings of other research which also cited loneliness and a 'lack of purpose' as reasons to return to drug use in later life (DH et al. 2007).

13.2.5 Health and mental health characteristics

It is believed that common health problems related to ageing can start at an earlier age amongst older drug users and drug use can accelerate the speed at which these problems worsen. Poor nutrition and environmental conditions exacerbate health problems (Beynon 2008; Beynon et al. 2009) and as chronic illness associated with ageing advances the need for medical treatment increases. There are various complications associated with long term drug use including hepatic damage due to hepatitis B or C; HIV infection; chronic airways disease and lung damage; chronic venous and/or arterial damage; cardiac valve destruction; and risk of drug interactions alongside other diseases common in older adults such as hypertension, diabetes and memory loss (DH et al. 2007).

More research into these issues and the development of tailored support and service provision for this population has been recommended in several studies (Beynon et al. 2007; Beynon 2008; Beynon et al. 2009; Crome and Day 1999; Crome and Bloor 2005; Crome and Crome 2005; Crome et al. 2009; Gossop and Moos 2008; McGrath et al. 2005; Shah and Fountain 2009).

Health status and service contact in older drug users

In a qualitative study with drug users aged 50 and over (Beynon et al. 2009) participants discussed a range of health problems that affected them including: hepatitis C; problems with circulation; breathing difficulties; diabetes; pneumonia; liver cirrhosis; vein damage (particularly in the arms leading to 'riskier' injecting practices); poor mental health and memory loss. In this study a common feature amongst those with hepatitis C (who had not already directly suffered any ill effects from the virus) was that they didn't consider it to be a major health concern. Although most participants discussed issues around their own poor health, they commonly had low expectations regarding the health care services available to them (both general and drug services), and in some cases they had experienced poor service from healthcare providers.

Prescription drugs are used by twice as many older people than younger age groups, and potentially this could be a serious problem for older drug users if they mix prescription drugs with illicit substances and alcohol. Crome et al. (2009) report that there is evidence (mainly from the USA) to suggest that treatment can be effective in older opiate users but there has been a dearth of research and interventions aimed at this group. They posit that if specialist treatment services were available to older drug users then their treatment outcomes could improve further. They recommend that services should be tailored in terms of improved accessibility; they should try to break down the stigma associated with older drug use; and should be at least equitable or even superior to the healthcare given to non-drug users in the same age group, as this group often has high levels of dual diagnosis.

Shah and Fountain (2008) propose that doctors may be hesitant to ask older people if they are using illegal drugs because typically, they are under the (false) impression that this group do not take drugs and this could lead to underreporting of substance use in older people. It is also suggested that those who have used drugs in the past are at an increased risk of becoming older drug users and that it is often the case that older users have a long history of drug use. The authors posit that despite a relatively low prevalence of illicit drug use amongst the older population, this figure will increase over time and as such it is a cause for concern. The authors recommend that further research and improvements in services (including age specific diagnostic screening tools and evaluated interventions) are required to understand and meet the needs of what they consider to be a largely hidden population.

Mortality

Crome et al. (2009) report that drug users have increased rates of mortality compared to the general population (ranging from between 12 to 22 times) and older drug 'addicts' are between two and six times more likely to die than their younger counterparts. Amongst drug users, incidence of death by overdose is most often associated with the young and older age groups and can be depicted as a u-shaped curve (DH et al. 2007). Research into mortality patterns amongst drug users in treatment in North West England³⁵⁸ between 2003/04 and 2007/08 showed a significant difference in the age of death between drug-related death cases and clients who were in treatment and died from other causes. On average, drug-related death cases died approximately five years earlier than the other group (Hurst et al. 2009b). This corroborates earlier research using treatment data from 2003 and 2004³⁵⁹ in the North West of England, which reported a significant difference in the age of death between those who died from a non drug-related death and those who died from a drug-related death. Those who died from a non drug-related death were significantly older than the other group. The results showed that amongst those who had died, the majority of deaths (71%) were classified as non drug-related. However, the authors suggest that in most cases these were probably as a result of substance use, in particular caused by infections.

³⁵⁸ Recorded by the National Drug Treatment Monitoring System (NDTMS).

³⁵⁹ Data regarding 27,810 clients in contact with structured treatment services between 2003 and 2004 were analysed and, of them, 103 (0.4%) were confirmed dead with the cause of death available in 102 cases. The majority of deaths were classified as non-drug related (70.6%, n=72). Causes of death included individual causes such as cellulitis, 16 from infection (seven from pneumonia), seven from alcohol related liver disorders and seven suicides. Those dying from non-DRDs were significantly older than those dying of DRD ($p = 0.004$).

13.3 Treatment, management and care of older drug users

13.3.1 Policies

In England, commissioners of drug treatment services within multi-agency drug partnerships, commission care on the basis of annual local assessment of need and development of annual treatment plans (for treatment, reintegration and recovery services in the community and in prison settings). NHS Primary Care Trusts, who are participants within the drug partnerships, also commission health services within the framework of 'World Class Commissioning', which focuses on assessment of need and strategic planning of services. It is within this context of a strong focus on local assessment of need and local commissioning decisions that areas can develop appropriate services to meet the emerging needs of older drug users.

In Northern Ireland older drug users are included within the substance misuse strategy in a list of vulnerable individuals who may be 'at risk' in terms of alcohol and drug misuse. Older people are also mentioned within the strategy in terms of misuse of 'over-the-counter' (OTC) and prescribed medications (DHSSPSNI 2006). The strategy recommends that 'high priority is given to prevention and early intervention, treatment and support and appropriate harm reduction initiatives targeting these groups where the need has been identified'. Short-term regional outputs/outcomes include 'education and training for professionals, carers and families in relation to substance misuse problems in older people to be supported'.

13.3.2 Health and social responses

UK guidelines on clinical management of drug misuse

Drug Misuse and Dependence: UK Guidelines on Clinical Management (DH and the devolved administrations 2007) makes specific reference to older drug users and states that there should be an appreciation of the specific health needs of this group and the development of health complications as a result of chronic use, with specific mention of hepatic damage caused by hepatitis C. It highlights the point that older drug users will have increasing health problems as they age (both related and non-related to drugs). It goes on to say that there is a need for this group to receive the same screening and monitoring that non-drug users of the same age receive. It recommends that care provided to this group should be evidence-based and that clients should be assessed and managed by a range of service providers across disciplines, who should work in partnership with each other. As older drug users are more likely than the general population to have mental health issues and may have experienced service in the past that was not sympathetic to their needs, it is recommended that their lifestyle should be understood by practitioners and the particular problems they face should be taken into account.

In the clinical guidelines issued by NICE³⁶⁰, *Drug Misuse: Psychosocial Interventions* and *Drug misuse: opioid detoxification* (NICE 2007b, 2007c) it is stated that age should be considered when a client's care plan is developed. The guidance also recommends that 'the general principles of treatment are that no single treatment is appropriate for all individuals, treatments should be readily available and begin when the service user presents, and there should be the capacity to address multiple needs. It is also accepted that treatments will change over time'. The NTA/British Psychological Society (BPS) toolkit entitled *Psychosocial interventions in drug misuse: a framework and toolkit for implementing NICE-recommended treatment interventions* (Pilling et al. 2009) is relevant for use with all age groups.

Auditing drug misuse treatment

The NTA published a guide to clinical audit: *Auditing drug misuse treatment* (NTA 2008a) that reflects the recommendations of NICE and the 2007 *UK guidelines on clinical management*, and includes the recommendation that audits should ensure that 'the general and drug-related health needs of older drug users are assessed and treated'.

Screening and diagnosis for older drug users

Some research (Beynon 2009; Crome et al. 2009) reports that current criteria for the screening and diagnosis of drug dependence and other mental health issues (such as DSM IV and ICD 10) were developed with the younger population in mind and therefore have not been validated for older populations and may not be appropriate when applied to older drug users. Dementia and cognitive impairments in older people can also mask drug abuse.

Harm reduction

In England, the *Hepatitis C Action Plan for England* (DH 2004) notes that infection when older (over 40 years) is one of the factors associated with more rapid disease progression. Building on this, responses to *Reducing Drug-related Harm: An Action Plan* (DH and NTA 2007b) has included the 'Harm Reduction Works'³⁶¹ campaign (see section 7.3) which has produced materials specifically targeting older drug misusers and their risk of overdose such as the 'Mr Mange Goes Over' cartoon³⁶².

The *Hepatitis C Action Plan for Scotland Phase I: September 2006 – August 2008* (Scottish Executive 2006b) describes the complexity of the hepatitis C problem within Scotland and emphasises the need for actions to overlap and inter-connect across disciplines and highlights the importance of taking into account the needs of different groups, including older people.

³⁶⁰ In England and Wales health professionals (and their organisations) are expected to take NICE guidance on health technologies and on clinical practice fully into account when exercising their clinical judgement. NICE guidance on public health covers England only. NHS Quality Improvement Scotland (NHS QIS) provides advice to NHS Scotland on the suitability for Scotland of NICE advice and the status of NICE advice in Scotland varies according to product type. For NHS QIS-validated NICE multiple technology appraisals, NHS Scotland will take account of the advice and evidence from NHS QIS and ensure that recommended medicines and treatment are made available to meet clinical need. This status applies to the NICE multiple technology appraisals on methadone and buprenorphine, and naltrexone. NICE single technology appraisals and clinical guidelines currently have no formal status in Scotland and are for information only in NHS Scotland. In Northern Ireland the Department for Health, Social Services and Public Safety reviews NICE guidance for its applicability to Health and Personal Social Services (HPSS) and decides whether it should be endorsed for implementation. NICE health technology appraisals endorsed by the Department will be treated as essential within the Quality Standards for Health and Social Care. The NICE clinical practice guidelines and public health guidance that have been endorsed will be regarded as standards that the HPSS are expected to achieve over time. As in England and Wales, it is expected that endorsed NICE guidance will help health and social care professionals in their work but it does not override clinical responsibility for making decisions in specific circumstances (NTA internal communication).

³⁶¹ See: <http://www.harmreductionworks.org.uk/>

³⁶² See: http://www.harmreductionworks.org.uk/2_films/od_causes.html

Palliative care

Gossop and Moos (2008) suggest that the development of serious and terminal illnesses amongst older drug users is an emerging issue, but go on to say that there is currently a lack of guidance around the best methods of providing palliative care for this group and that they have specific issues pertinent to them such as how to manage pain relief in opiate users. However, immunosuppression occurs as people age, making older drug users more susceptible to both localised and systemic infections.

13.3.3 Quality assurance and best practice

See 13.3.2 for details of *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (DH and the devolved administrations 2007).

Scotland: SDDCare project and 'Focus on Senior Drug Users' conference

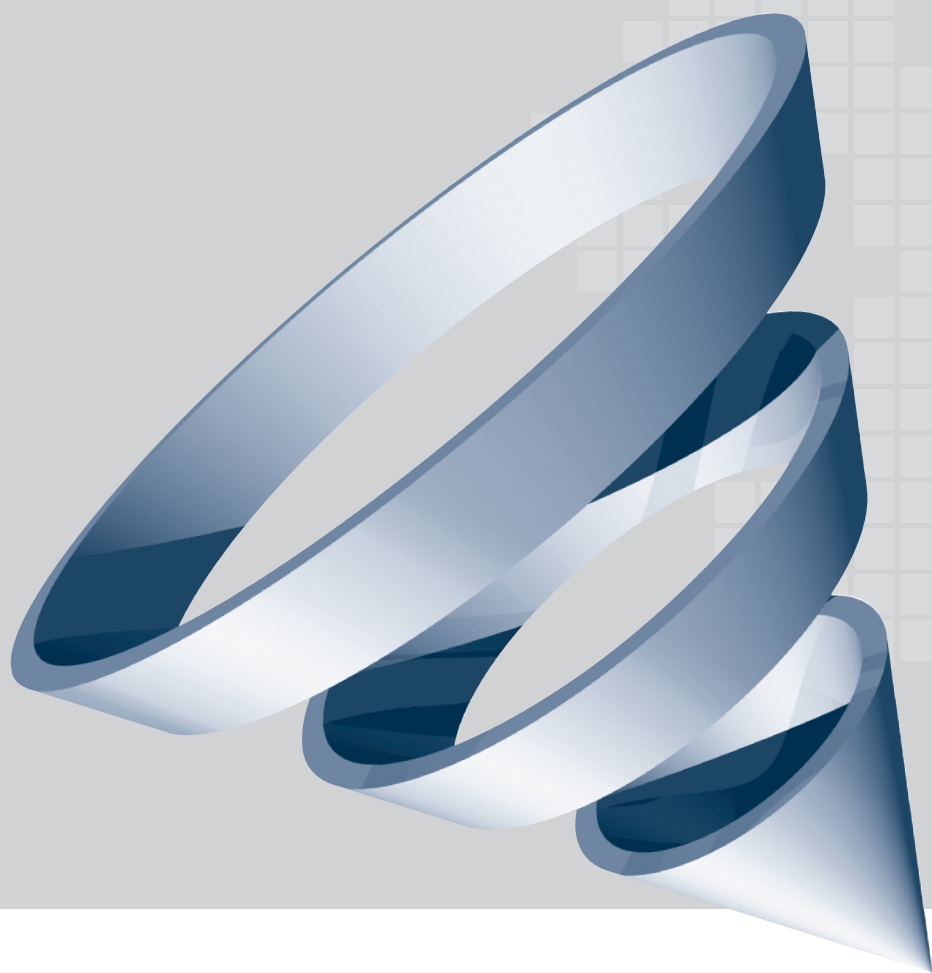
The Scottish Government is part-funding a Senior Drug Dependents and Care Structures (SDDCare) project between the Scottish Drugs Forum and European partners (in Germany, Austria and Poland) to examine the health, care and support needs of older drug users between the ages of 35 and 70. The project is due to report its findings in 2011.

Following the release of the 2008 GRO(S) drug-related death statistics (see section 6.2), which showed an increase in the number of drug-related deaths and an increasing proportion of older drug users accounting for these deaths, the Scottish Drugs Forum (SDF)³⁶³ announced its intention to hold a conference focusing on the current situation in Scotland and also to discuss the SDDCare project.³⁶⁴

³⁶³ See: <http://www.sdf.org.uk/sdf/3149.html> and <http://www.sdf.org.uk/sdf/3089.html> and <http://www.scotland.gov.uk/News/Releases/2009/08/12105412>

³⁶⁴ A further conference on older drug users was hosted by the Centre for Public Health at Liverpool John Moores University in collaboration with the National Treatment Agency and Liverpool Drug and Alcohol Action Team in November 2009. See: <http://www.cph.org.uk/userfiles/file/substanceuse/ageingpopulation.pdf>

Part C: Bibliography and Annexes



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List of abbreviations used in the text

| | | | |
|----------------|------------------------------------------------------|--------------|--------------------------------------------------------------|
| A&E | Accident and Emergency | CARAT | Counselling, Assessment, Referral, Advice and Through-care |
| AACCE | Alcohol, Amphetamines, Cannabis, Cocaine and Ecstasy | CASI | Computer-Aided Self-administered Interviewing |
| ACMD | Advisory Council on the Misuse of Drugs | CBD | Cannabidiol |
| ACPO | Association of Chief Police Officers | CCTV | Closed Circuit Television |
| ADHD | Attention Deficit Hyperactivity Disorder | CET | Cue Exposure Therapy |
| ADPs | Alcohol and Drug Partnerships | CI | Confidence Interval |
| AEU | Annual Evidence Update | CJS | Criminal Justice System |
| AIDS | Acquired Immunodeficiency Syndrome | CLG | Communities and Local Government |
| APMS | Adult Psychiatric Morbidity Survey | COFOG | United Nations Classification of the Functions of Government |
| APT | Addiction Prevalence Testing | CoSLA | Partnership between Scottish Government and Local Government |
| ASB | Anti-Social Behaviour | CPP | Chlorophenylpiperazine |
| ASBO | Anti-Social Behaviour Order | CPR | Cardio-Pulmonary Resuscitation |
| AUDIT | Alcohol Use Disorders Identification Test | CPS | Crown Prosecution Service |
| BCS | British Crime Survey | CRC | Capture, Re-Capture |
| BMA | British Medical Association | CSPs | Community Safety Partnerships |
| BMJ | British Medical Journal | CSP | Centre for Suicide Prevention |
| BMK | Benzyl-methyl-ketone | DAATs | Drug and Alcohol Action Teams |
| BMT | Buprenorphine Maintenance Therapy | DACTs | Drug and Alcohol Co-ordination Teams |
| BOP | Brighton Oasis Project | DAIRU | Drug and Alcohol Information and Research Unit |
| BTEI | Birmingham Treatment Effectiveness Initiative | DATs | Drug Action Teams |
| BZP | Benzylpiperazine | DBZP | Dibenzylpiperazine |
| CAPI | Computer Assisted Personal Interviewing | DCSF | Department for Children, Schools and Families |

| | | | |
|-----------------|--------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------------------------|
| DfES | Department for Education and Skills | ESRC | Economic and Social Research Council |
| DfT | Department for Transport | ESU | Employment Support Allowance |
| DH | Department of Health | EU | European Union |
| DHI | Drug Harm Index | FIP | Family Intervention Projects |
| DHSSPSNI | Department of Health, Social Services and Public Safety Northern Ireland | FSS | Forensic Science Service |
| DIA | Drug Information and Advice giving | GBL | Gamma-butyrolactone |
| DIP | Drug Interventions Programme | GHB | Gamma hydroxybutyrate |
| DORIS | Drug Outcome Research in Scotland | GMR | General Mortality Register |
| DMRI | Drugs Misuse Research Initiative | GP | General Practitioner |
| DRD | Drug-Related Deaths | GROS | General Register Office for Scotland |
| DRR | Drug Rehabilitation Requirement | HAS | Health Advisory Service |
| DSDC | Drugs Strategy Delivery Commission | HBV | Hepatitis B Virus |
| DSMIV | Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition | HCV | Hepatitis C Virus |
| DTTO | Drug Treatment and Testing Order | HEAT | NHS Performance Management Targets |
| DVLA | Driver and Vehicle Licensing Agency | HGVs | Heavy Goods Vehicles |
| DWP | Department for Work and Pensions | HIV | Human Immunodeficiency Virus |
| EDDRA | Exchange on Drug Demand Reduction Action | HIW | Healthcare Inspectorate Wales |
| EMCDDA | European Monitoring Centre for Drugs and Drug Addiction | HM | Her Majesty |
| EMQ | European Modelling Questionnaire | HMRC | Her Majesty's Revenue and Customs |
| EPC | Enhanced Prevention Counselling | HPA | Health Protection Agency |
| ESPAD | European School Survey Project on Alcohol and Other Drugs | HPS | Health Protection Scotland |
| | | IAC | Intensive Alternatives to Custody |
| | | ICD-10 | International Statistical Classification of Diseases and Related Health Problems – tenth edition |
| | | ICIS | Integrated Crime Information System |
| | | IDMU | Independent Drug Monitoring Unit |

| | | | |
|----------------|--------------------------------------------------------------|---------------|-------------------------------------------------------|
| IDTS | Integrated Drug Treatment System | NAS | Neonatal Abstinence Syndrome |
| IDUs | Injecting Drug Users | NCCMH | The National Collaborating Centre for Mental Health |
| IMD | Index of Multiple Deprivation | NDEC | National Drug Evidence Centre |
| IOM | Integrated Offender Management | NDTMS | National Drug Treatment Monitoring System |
| ISCJIS | Integration of Scottish Criminal Justice Information Systems | NESI | Needle Exchange Surveillance Initiative |
| ISD | Information Services Division | NHS | National Health Service |
| ITEP | International Treatment Effectiveness Project | NI | National Indicator |
| JSA | Jobseekers Allowance | NICE | National Institute for Clinical and Health Excellence |
| KPI | Key Performance Indicator | NICS | Northern Ireland Crime Survey |
| LAA | Local Area Agreement | NISRA | Northern Ireland Statistics and Research Agency |
| LHB | Local Health Board | NOMS | National Offender Management Service |
| LSD | Lysergic Diethylamide acid | np-SAD | National Programme on Substance Abuse Deaths |
| LTS | Learning and Teaching Scotland | NPIA | National Policing Improvement Agency |
| mCPP | meta-Chlorophenylpiperazine | NSD | New Strategic Direction for Alcohol and Drugs |
| MDMA | 3,4-Methylenedioxy-n-methylamphetamine | NTA | National Treatment Agency |
| MDT | Mandatory Drug Testing | OCJS | Offending, Crime and Justice Survey |
| MDTA | Mandatory Drug Testing of Arrestees | Ofsted | Office for Standards in Education |
| MHRA | Medicines and Health Care Products Regulation Agency | ONS | Office for National Statistics |
| MHTR | Mental Health Treatment Requirement | OSCHR | Office for Strategic Co-ordination of Health Research |
| MI | Motivational Interviewing | OTC | Over The Counter (medicines) |
| MIM | Multiple Indicator Method | p2w | Progress2Work |
| MRC | Medical Research Council | PCTs | Primary Care Trusts |
| MMT | Methadone Maintenance Therapy | PDI | Partnership Drugs Initiative |
| MOJ | Ministry of Justice | PDTSRG | Prison Drug Treatment Strategy Review Group |
| N-Alive | NALoxone InVEstigation | | |
| NACD | National Advisory Committee on Drugs | | |

| | | | |
|----------------|----------------------------------------------------------------|---------------|-----------------------------------------------------|
| PDU | Problem Drug Users | STI | Sexually Transmitted Infection |
| PHIRB | Public Health Information and Research Branch | STPE | Standard Table on Public Expenditure |
| PNC | Police National Computer | TDI | Treatment Demand Indicator |
| PND | Penalty Notice for Disorder | TFMPP | 3-Trifluoromethylphenylpiperazine monohydrochloride |
| POCAR | Parents of Children at Risk | THC | Tetrahydrocannabinol |
| PSA | Public Service Agreement | THN | Take-home naloxane |
| PSDM | Psych-Stimulant Drug Misuse | TOP | Treatment Outcomes Profile |
| PSHE | Personal, Social and Health Education | UAPMP | Unlinked Anonymous Prevalence Monitoring Programme |
| PSNI | Prison Service Northern Ireland | UCLAN | University of Central Lancashire |
| RIOTT | Randomised Injecting Opioid Treatment Trial | UK | United Kingdom |
| SACDM | Scottish Advisory Committee on Drugs Misuse | UKADCU | United Kingdom Anti Drugs Co ordination Unit |
| SALSUS | Scottish Schools Adolescent Lifestyle and Substance Use Survey | UKDPC | United Kingdom Drug Policy Commission |
| SBU | Special Baby Unit | VSA | Volatile Substance Abuse |
| SCDEA | Scottish Crime and Drug Enforcement Agency | WAG | Welsh Assembly Government |
| SCVS | Scottish Crime and Victimisation Survey | YOT | Youth Offending Team |
| SDDCare | Senior Drug Dependence and Care Structure | YPBAS | Young Person's Behaviour and Attitude Survey |
| SDF | Scottish Drugs Forum | 1,4-BD | 1,4-butanediol |
| SDS | Severity of Dependence Scale | | |
| SEC | Simple Educational Counselling | | |
| SERT | Serotin Transporter | | |
| SHA | Strategic Health Authority | | |
| SMAF | Substance Misuse Action Fund | | |
| SMR | Special Mortality Register | | |
| SOCA | Serious Organised Crime Agency | | |
| SPS | Scottish Prison Service | | |

List of standard tables

| NUMBER | TITLE | SOURCE |
|--------|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ST01 | Basic results and methodology of population surveys on drug use | England and Wales - British Crime Survey (BCS) Scotland – Scottish Crime and Justice Survey (SCJS) Northern Ireland – Northern Ireland Crime Survey (NICS); Drug Prevalence Survey |
| ST02 | Methodology and results of school surveys on drug use | England – Smoking, Drinking and drug use amongst school children in England Scotland – Scottish Adolescent Lifestyle and Substance Use Survey (SALSUS) Northern Ireland – Young Persons Behavioural and Attitudes Survey (YPBAS) |
| ST05 | Acute/direct related deaths | General Mortality Registers (GMRs) for England and Wales, Scotland and Northern Ireland |
| ST06 | Evolution of acute/direct related deaths | General Mortality Registers (GMRs) for England and Wales, Scotland and Northern Ireland |
| ST07 | National prevalence estimates on problem drug use | Home Office; NHS ISD Scotland; DHSSPSNI; Welsh Assembly Government |
| ST08 | Local prevalence estimates on problem drug use | Home Office; NHS ISD Scotland |
| ST09 | Prevalence of hepatitis B/C and HIV infection among injecting drug users | Health Protection Agency (HPA); Health Protection Scotland (HPS); National Public Health Service for Wales (NPHSW); Communicable Disease Surveillance Centre Northern Ireland |
| ST11 | Arrests/Reports for drug law offences | Ministry of Justice; Scottish Government; Northern Ireland Office; Northern Ireland Police Service (NIPS) |
| ST12 | Drug use among prisoners | Scottish Prison Service |
| ST13 | Number and quantity of seizures of illicit drugs | Home Office; Her Majesty's Revenue & Customs (HMRC); Scottish Government; Scottish Crime and Drug Enforcement Agency (SCDEA); Northern Ireland Police Service (NIPS) |
| ST14 | Purity at street level of illicit drugs | Forensic Science Service (FSS); LGC Forensics Ltd |
| ST15 | Composition of tablets sold as illicit drugs | Forensic Science Service (FSS) |
| ST16 | Price in Euros at street level of illicit drugs | Serious Organised Crime Agency (SOCA) |
| ST34 | TDI data | National Drug Treatment Monitoring System (NDTMS) in England, the Scottish Drug Misuse Database, the Welsh National Database for Substance Misuse; and the Northern Ireland Drug Misuse Database |
| STPE | Public expenditure | Government department accounting systems; devolved administrations; estimates |



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