



European Monitoring Centre  
for Drugs and Drug Addiction



Centre for Public Health

**2005 NATIONAL REPORT  
to the EMCDDA  
by the Reitox National Focal Point**

**UNITED KINGDOM  
New developments, trends and in-depth  
information on selected issues**

REITOX



**UK Focal Point**

## United Kingdom drug situation: annual report to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2005

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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. Along with equivalent organisations in other European Union (EU) Member States, the Focal Point provides detailed information to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 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 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.

The UK Focal Point website can be found at [www.ukfocalpoint.org.uk](http://www.ukfocalpoint.org.uk) and is currently under development.

The EMCDDA's website is [www.emcdda.eu.int](http://www.emcdda.eu.int).

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## **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 **overview**. This sets the context for the remainder of the chapter, describing the main features of the topic under consideration within the UK. This may include information about the main legislative and organisational frameworks, sources of data, the broad situation and recent trends revealed by the data and definitions used.

The remainder of each chapter is concerned with **New Developments and Trends** that have not already been reported in previous reports. Generally this includes developments that have occurred in the second half of 2004 or the first half of 2005. Relevant data that has become available during this period will also be discussed although this 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 the European Union and Norway to be published in 2006.

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*The United Kingdom and its constituent countries*



The United Kingdom (UK) population was estimated to be 59.8 million in the middle of 2004 (ONS *et al.* 2005): 83.7 per cent (50.1 million) live in England, 8.5 per cent (5.1 million) in Scotland, 4.9 per cent (3.0 million) in Wales and 2.9 per cent (1.7 million) in Northern Ireland.

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## SUMMARY

### Main Findings

#### 1. National policies and context

The *Drugs Act 2005* amends sections of the *Misuse of Drugs Act 1971* and the *Police and Criminal Evidence Act 1984* strengthening police powers in relation to drug use. It allows for drug testing on arrest and makes it an offence to supply magic mushrooms (psilocin or psilocybin).

A review of the Northern Ireland Drug and Alcohol Strategies began in January 2005.

The Drug Strategy progress report *Tackling Drugs. Changing Lives. Keeping Communities Safe from Drugs* highlighted achievements since the launch of the Updated Drug Strategy in 2002.

The *Drug Harm Index*, developed to capture the harms generated by the problematic use, combines national indicators into a single-figure time-series index. It suggests that by the end of 2004, harms caused by drug use had fallen by nine per cent, since the launch of the Updated Drug Strategy in 2002.

Direct expenditure for tackling drugs in 2004/05<sup>1</sup> was budgeted at €2,000 million<sup>2</sup> (£1,344 million) (DSD 2002a).

#### 2. Drug use in the population

Prevalence of drug use amongst the adult population in the United Kingdom is estimated to be:

- 34.1 per cent have one or more drugs in their lifetime;
- 11.8 per cent have used one or more drugs in the last year; and
- 7.1 per cent have used one or more drugs in the last month.

Prevalence of drug use in England and Wales and in Northern Ireland has not changed significantly. However, in Scotland the decline in prevalence seen in the previous survey (from 2000) has not been sustained.

The highest prevalence level for lifetime use is now amongst 16 to 34 year olds, although young people aged 16 to 24 years old continue to show the highest levels of recent and current use. Prevalence rates are:

- 45.4 per cent of young people aged 16 to 24 years old had used one or more drugs in their lifetime, 46.9 per cent of those aged 16 to 34 years old had done so;
- 27.2 per cent of young people aged 16 to 24 years old had used one or more drugs in the last year, 21.4 per cent of those aged 16 to 34 years old had done so;
- 16.9 per cent of young people aged 16 to 24 years old had used one or more drugs in the last month, 13.1 per cent of those aged 16 to 34 years old had done so.

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<sup>1</sup> UK Government financial years run from the start of April to the end of March. So regarding the financial year 2005/06, the year starts on 1 April 2005 and ends on 31 March 2006. Some data in this report relate to calendar year, whilst others relate to financial year. Similar references are used to refer to financial year.

<sup>2</sup> All conversion rates used in this report will use the exchange rate of £1 equals €1.4881 euros as of 30 June 2004 unless otherwise stated. (Please see <http://www.bankofcanada.ca/en/rates/exchform.html> for further details of exchange rates).

Cannabis continues to be the most commonly used drug, followed by ecstasy and cocaine; the latter, with magic mushrooms, showing an increase in use over recent years.

Males remain significantly more likely to use drugs than females.

Drug use amongst school age children has decreased.

### *3. Prevention*

The needs of vulnerable young people have become a focus of policy attention. The *Children Act 2004* embodies legislation that seeks to ensure all children are able to reach their potential. This should provide for the needs of those at risk of drug misuse or affected by the drug use of others.

In England, the *Young People Substance Misuse Partnership Grant* of €87.7 million (£58.9 million) will be used by Drug (and Alcohol) Action Teams (D(A)ATs), and Crime and Disorder Reduction Partnerships (CDRPs) to deliver the young people aim of the National Drug Strategy.

More than 50,000 vulnerable young people have participated in the Positive Futures programme since its launch in 2000.

### *4. Problem drug use*

The estimated number of problem drug use in Scotland has fallen from 55,800 in 2000 to 51,582 in 2003.

A study using capture-recapture methods and the multivariate indicator method is being carried out to provide local estimates for all 149 Drug Action Team areas of England and thus a national estimate.

A capture-recapture study is also currently being undertaken in Northern Ireland.

### *5. Treatment*

Expanding treatment remains a key priority of the UK Drug Strategy.

Provisional figures for England published in July 2005 suggest that 125,500 clients were assessed for treatment, and that there were 160,050 treatment episodes in 2004/05.

The Healthcare Commission has included drug treatment as one of the eight key targets used to assess the performance of Primary Care Trusts in England.

A review of treatment and rehabilitation services was undertaken in Scotland and an Action Plan developed to improve access to, and effectiveness of treatment.

The provision of treatment for young people, both those who are problem drug users and those who are vulnerable to becoming problem drug users, has been given priority and is a focus of UK Government's strategy on drug prevention.

In England, 30 per cent of treatments are drug free, offering either rehabilitation, structured counselling or structured day care; 3 per cent of known treatments involved inpatient detoxification. Substitution treatment remains the main treatment (63% of treatments); methadone remains the drug of choice.

A change in regulations to enable the prescribing and dispensing of diazepam in instalments for treating drug addiction came into force in 2005.

In December 2004 the Department of Health announced a shortage of injectable heroin; this is not expected to be resolved until early 2006.

#### *6. Health related correlates and consequences*

Latest information for drug-related deaths is for 2003. The total number of deaths in the UK was 1,416, continuing the fall from 2000. The male:female ratio continues to decline and in 2003 was 4.11:1. The average age of death for females was considerably higher than that for men. The overall average age at death rose to 35.3 years old, having fallen in the previous two years. Opiates accounted for the majority of deaths.

There were 51 deaths associated with volatile substance abuse in 2003, the lowest figure since 1982.

HIV prevalence amongst current injecting drug users (IDUs) in England and in Wales in 2004 was 1.5 per cent; the highest level since 1992. In London, the incidence was 3.4 per cent, higher amongst injecting crack-cocaine users, this groups being more likely to engage in risk behaviour. There is evidence to suggest an increasing proportion of IDUs may be unaware of their HIV infection.

Four in ten IDUs are infected with hepatitis C in the UK. Evidence suggests that prevalence has increased, although there is marked variation within the UK: 59 per cent in the North West of England and 62 per cent in Greater Glasgow; crack-cocaine injectors have higher prevalence.

#### *7. Responses to health related correlates and consequences*

In Scotland, a National Investigation into Drug Related Deaths in 2003 was published and in England a Volatile Substance Abuse Framework was adopted.

In Scotland in 2005, prosecution policy was revised to allow test purchasing of age-restricted goods by children and young people under the age of 18 years old.

Ambulance technicians as well as paramedics can now administer naloxone to overdose victims.

A UK wide audit of syringe exchange began in autumn 2004 to investigate in detail the nature of provision; to identify areas of innovative practice in this area; and to identify the barriers and difficulties in providing a needle exchange service.

In July 2005 Government outlined plans for further reform of mental health legislation.

The Advisory Council on the Misuse of Drugs (ACMD), which advises the Government, will make a formal study of the evidence, which has been published subsequent to reclassification, on cannabis and its association with mental health problems.

The website, [www.drugdrive.co.uk](http://www.drugdrive.co.uk), was relaunched to raise awareness of the impairment effects of drugs when driving.

### *8. Social correlates and consequences*

A number of studies have been published which highlight the association between truancy, school exclusion and drug use. There has also been a number of studies looking at the impact of drug use on the families of drug users.

The number of offenders for drug offences brought before the courts continues to rise. The number of people found guilty, cautioned or compounded for drug offences in England, Scotland and Wales increased by 14 per cent between 2000 and 2003 (from 102,196 to 116,429). The number arrested for cannabis possession has halved following the reclassification of cannabis.

Amongst those tested through Mandatory Drug Tests in prisons in England and Wales, 11.6 per cent were positive; in Scotland, the proportion was 18 per cent.

Approximately 66 per cent of prisoners in a survey in England reported using drugs prior to prison. In Scotland, 50 per cent of prisoners reported having used drugs while in prison.

The cost model of Class A drugs, developed in 2002, is to be updated.

### *9 Responses to social correlates and consequences*

The third and final phase of Progress2Work (p2w), an employment initiative in England, Scotland and Wales for former drug users was, in place in 2004. By March 2005, 20,350 individuals had engaged with p2w. Of these, 4,022 individuals (20%) had obtained jobs and of these 1,215 (30%) had remained in work.

It is reported that acquisitive crime, to which drug-related crime makes a substantial contribution, fell by 12 per cent in the year to April 2005.

More than 63,000 drug tests for heroin, crack and cocaine on offenders charged with a trigger offence were undertaken between April 2004 and March 2005 (an average of 5,312 per month). On average, around 50 per cent tested positive for heroin or cocaine or both.

Voluntary drug testing has been introduced in prisons in Northern Ireland.

A further €148.8 million (£100 million) is being spent to provide housing related support to groups who are particularly at risk of homelessness, such as victims of domestic violence and people with drug and alcohol problems. Guidance for commissioners on meeting the housing needs of drug users is now available.

A new National Offender Management Service (NOMS), which joins the work of the Prison Service and the Probation Service, is to focus on the end-to-end management of the offender. This should have a positive impact on problem drug users.

Counselling, assessment, referral, advice and throughcare services (CARATs) expected to engage with 47,000 drug users in custody in England and Wales in 2004/05 but had already engaged with 53,396 between April 2004 and February 2005.

In 2003/04, 7,119 drug users began treatment programmes in prison in England and Wales, 65 per cent were completed (4,600).

The Drug Interventions Programme now covers all of England. There will be an investment of €245.5 million (£165 million) in the Drug Interventions Programme (DIP) 2005/06. Over 14,000 people have entered treatment through this programme. Case management and aftercare for DIP was established throughout England and Wales during 2004/05.

In Scotland Drug Testing and Treatment Orders are now available nationally.

Ten D(A)AT areas are currently piloting child and youth-centred models of arrest referral for 10 to 17 year olds.

### *10. Drug Markets*

In general, the number and quantity of seizures are decreasing in the UK. However, seizures of crack cocaine are increasing.

Overall in 2003, the average price of illegal drugs continued to fall.

The purity of brown heroin fell (to 33%), Cocaine purity higher than previously (51%); crack stayed the same (70%). Purity of amphetamines fell (to 10%).

Operation Crackdown, a three month campaign targeting Class A drug dealers closed 70 crack houses, took drugs with a value of over €19.79 million (£13.3 million) off the streets, and arrested more than 3,400 suppliers.

The summary for Part 2 is presented at the beginning of that section.

### **Most relevant developments and trends**

The *Drugs Act 2005*, allowing drug testing on arrest, will strengthen the ability of the criminal justice system to identify problem users and get them into treatment, through programmes such as the Drug Interventions Programme in England and Wales.

The *Drugs Act*, with its presumption that those caught in possession of more drugs than considered reasonable for personal use are intending to supply, will ensure a tougher approach to dealing. In addition, with the Act, dealers targeting young people, may face harsher sentence as the law now enables the courts to take into account aggravating factors for those who deal near schools and those who use school children as drug couriers.

The *Drugs Act* also clarifies the law on magic mushrooms, making raw psilocin/psilocybin mushrooms (in addition to prepared mushrooms) a Class A Drug.

There is a new focus on vulnerable young people with *The Young Peoples Drugs Delivery Plan* being implemented in England and Wales to increase selected and indicated prevention programmes for young people and services to provide treatment for those with a drug problem.

With access to treatment greatly improved over recent years, treatment services are now to focus on their effectiveness.

Drug use within the population is stabilising, although use of cocaine (and magic mushrooms) continues to rise.

There are indications, from Scotland, of a decrease in problem drug use.

Drug-related deaths continue to fall.

There have been increases in infectious disease amongst drug users, notably for those who use crack cocaine.

Government is seeking to improve services for those with co-morbidity with changes in the Mental Health Act being proposed.

Greater emphasis is being placed upon undermining the drugs market at the lower end of the supply chain as well as at the international level.

### **Consistency between indicators**

Population surveys in the UK suggest that for the most part drug use is stabilising. However, Scotland shows an increase in drug use, and across the UK, cocaine and magic mushrooms are increasing in prevalence albeit from a very low base.

While treatment presentations for problem drug use increased, this is more likely to be associated with increased capacity and cannot be seen to be attributed to an increase in problem use. The results from the latest research undertaken to provide an estimate of problem drug use in Scotland, suggests a decrease in the latter, although as this is at the 93 per cent level, results should be treated with caution.

Opiates continue to be the main drug for most treatment presentations in the UK, although there are variations between the different administrations. Seizures of heroin fell slightly in 2003, which could relate to the activity by Police and Customs, but might also be associated with increased access to treatment, reducing the demand for opiates, and even a fall in problem drug use, as suggested by the latest estimates of problem prevalence in Scotland. There has also been a reduction in the number of persons found guilty or cautioned for drug offences in the UK, and a reduction in the number of deaths.

Use of cocaine has increased within the general population. Without sufficient data over time with respect to the numbers of problem drug users presenting to treatment reporting cocaine as main drug, it is difficult to make assertions about its relative rise or fall amongst the treatment population. However, the number of seizures of cocaine has clearly risen, as have the number of persons found guilty or cautioned for cocaine offences in the UK. Deaths associated with cocaine have fallen. Seizures and offences involving crack have increased.

With respect to injecting, there are insufficient data over time with respect to the numbers of those presenting to treatment who inject, to make assertions as to a rise or fall in injecting drug use. However, there are indications of increased infections amongst injecting drug users. HIV, while remaining very low amongst injecting drug users has increased slightly. Prevalence amongst current IDUs in England in Wales (1.5%) is the highest level seen amongst current IDUs in this survey since 1992. Crack injectors report higher levels of risk behaviours than other IDUs. There are also indications that there has been an increase in the prevalence of IDUs exposed to hepatitis C infection.

Recent and current prevalence of ecstasy is stable amongst the adult population. The number of persons found guilty or cautioned for ecstasy offences in the UK has remained stable. Seizures have fallen and there has also been a fall in deaths associated with ecstasy.

Lifetime prevalence of cannabis use is stable in the adult population and there is a slight decrease in use amongst school children in England and Wales. However, the number of persons found guilty or cautioned for cannabis offences in the UK rose; this is based on 2003, too early to reflect changes in the classification of cannabis.

Amphetamine use has fallen considerably over time amongst the general population; this is consistent with a continuing fall in seizures and offences. Seizures remain low and there has only been a small increase in offences.

# PART A

New developments and trends

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## 1. National policies and context

### 1.1 Overview

The *Misuse of Drugs Act 1971* divides controlled drugs into three classes (A, B and C) depending on their potential for harm and there is a graded scale of penalties for possession and supply. Some important changes came into force in 2004 including the reclassification of cannabis from Class B to Class C and an increase in penalties for drug trafficking. Use of controlled drugs *per se* is not an offence in the UK; however, since 1995, drug use in prisons has been against prison rules (HM Prison Service 1995; HM Prison Service 2004a).

The UK Drug Strategy was launched in 1998 (UKADCU 1998) with four principal aims: preventing drug use amongst young people, safeguarding communities, providing treatment and reducing availability. These are to be achieved through education, prevention programmes, expanded treatment, legal sanctions and the expansion of legal opportunities. The Strategy was updated in 2002 with an increased emphasis on reducing the use of Class A drugs (DSD 2002a). Each of the devolved administrations (Northern Ireland, Scotland and Wales) has its own strategy, reflecting the aims of the UK Strategy, but tailored to their individual circumstances (NIO 1999; Scottish Office 1999; National Assembly for Wales 2000).

Delivering the Strategy is a cross-government responsibility and since 2001, the Home Secretary has taken lead responsibility as Chair of the Cabinet Ministerial Sub-Committee on Drugs Policy. The Drugs Strategy Directorate of the Home Office is responsible for co-ordinating the Drug Strategy and ensuring its delivery. In England and Scotland, delivery is through local drug partnerships, Drug (and Alcohol) Action Teams (D(A)ATs)<sup>3</sup>. In addition, Crime and Disorder Reduction Partnerships (CDRPs) in England and Community Safety Partnerships in Wales work with the police and communities to tackle local drug problems and associated crime. In Wales, responsibility for tackling drug use has been transferred to the 22 Community Safety Partnerships. The Welsh Assembly has four Substance Misuse Action Teams to ensure the implementation of the Welsh Substance Misuse Strategy. In Northern Ireland, a Regional Drug and Alcohol Strategy Co-ordinator is responsible for driving forward delivery (DHSSPSNI 2003), and four Drug and Alcohol Co-ordination Teams bring together local agencies.

### 1.2 Legal framework

#### 1.2.1. Drugs Act 2005

The *Drugs Act 2005*<sup>4</sup> amends sections of the *Misuse of Drugs Act 1971* and *Police and Criminal Evidence Act 1984*. It will strengthen police and court powers in relation to drugs, and increase the effectiveness of the Drug Interventions Programme (DIP; see Section 9.3.3) by getting more offenders into treatment. Specifically it:

- allows police to test drug offenders on arrest, instead of on charge;
- requires those testing positive to undergo an assessment;

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<sup>3</sup> A number of local teams tackle both drugs and alcohol, but some are also drug only.

<sup>4</sup> For more information, please see <http://www.drugs.gov.uk/NationalStrategy/DrugsAct2005>.

- allows for an ‘intervention order’ to run alongside drug-related Anti-Social Behaviour Orders (ASBOs)<sup>5</sup>, providing a requirement of drug counselling attendance;
- enables courts to remand those in police custody who swallow drugs in secure packages for up to a further 192 hours<sup>6</sup> (to increase the likelihood of recovering evidence);
- allows a court or jury to consider occasions when a person refuses without a good reason an intimate body search, x-ray or ultrasound scan;
- creates the presumption of intent to supply when a specified quantity<sup>7</sup> of controlled drugs are found;
- requires courts to account for aggravating factors (such as supplying drugs near a school<sup>8</sup>) when sentencing;
- amends the *Misuse of Drugs Act 1971*, classifying those fungi containing psilocin or psilocybin (magic mushrooms) as Class A drugs except where they are growing wild or being picked for destruction;
- amends the *Anti-Social Behaviour Act 2003* so that the police can issue closure notices to buildings such as crack houses; and
- repeals section 38 of the *Criminal Justice and Police Act 2001*, which criminalised occasions when an individual knowingly permits the use of illegal drugs on premises<sup>9</sup>.

### 1.2.2 Laws implementation

The *Drugs Act 2005* will be implemented in stages (see Table 1).

Table 1: The implementation stages of the *Drugs Act 2005*

Provision of Act	Implementation
New civil order for adults	Planned commencement: April 2006
Enhancing police and court powers	Planned commencement: 1 December 2005
New presumption of intent to supply	Planned commencement: 1 December 2005
Legislation surrounding fungi containing Psilocin or Psilocybin	Commenced 18 July 2005
Repeal of section 38 of the Criminal Justice Act 2003	Commenced 1 September 2005

Source: *Drugs Act 2005*

<sup>5</sup> Anti-Social Behaviour Orders aim to protect the public from behaviour that causes or could cause harassment, alarm or distress. They forbid the offender from specific acts or locations for a minimum of two years. For more information, please see <http://www.crimereduction.gov.uk/asbos9.htm?fp>.

<sup>6</sup> Under the *Police and Criminal Evidence Act 1986*, an individual can normally only be held for up to 24 hours without charge. Differences do exist in the devolved administrations; for more information, the Citizen’s Advice Bureau has established the following website: <http://www.advice.org.uk>.

<sup>7</sup> The particular amount is to be decided by the Secretary of State, following a consultation with the Advisory Council for the Misuse of Drugs. It is possible that the level set will be different according to the type of drug, please see [http://www.publications.parliament.uk/pa/ld199900/ldhansrd/pdvn/lds05/text/50404-18.htm#50404-18\\_head0](http://www.publications.parliament.uk/pa/ld199900/ldhansrd/pdvn/lds05/text/50404-18.htm#50404-18_head0) for more details.

<sup>8</sup> The Home Office is drafting guidance on this. See <http://www.drugs.gov.uk/NationalStrategy/DrugsAct2005/IntheVicinity> for more information.

<sup>9</sup> This could have been problematic for drug workers.

### 1.3 Institutional framework, strategies and policies

#### 1.3.1 Co-ordination arrangements

The Audit Commission (2004) assessed the local impact of the Drug Strategy. It suggested that while treatment has improved, organisations responsible for providing housing, social care and other support services need to ensure that their services are appropriate and help the individual become employed, housed and more self-sufficient. The report suggests that those locally responsible for such services must do more to deliver coherent and tailored services but that they face short-term funding and a disjointed regulatory framework. Because health services, local authorities, the police and probation services are now preparing the drug component of their crime and disorder strategies for 2005 to 2008, this is an opportunity for developing strategies that will give drug users an effective pathway to recovery.

#### 1.3.2 National plan and/or strategies

The UK Drug Strategy now aims to reduce the harm caused by illegal drugs (see Section 1.3.3).

##### *England*

In England, the Government White Paper *Choosing Health* sets out the key principles for supporting the public to make more informed and positive choices about their health (DH 2004a). However, illegal drugs are not a focus within this policy document, being addressed instead of by other initiatives (see Section 12.3.4 for further discussion).

##### *Northern Ireland*

A review of and e-consultation on the Northern Ireland Drug and Alcohol Strategies, the Northern Ireland Drug and Alcohol Campaign and the structures established under the former Northern Ireland Executive began in January 2005 (DHSSPSNI 2005).

##### *Wales*

The Welsh Assembly Government (2003a) has launched a strategic agenda to create a sustainable future for Wales. Officials are working with the Welsh Assembly Government Advisory Panel on Substance Misuse to review the objectives of the 2000 strategy (Welsh Assembly Government, internal communication). It has also launched an agenda for public services (Welsh Assembly Government 2004a), highlighting their intention to deliver, with partners, public services that reflect the nature, needs and values of Wales.

#### 1.3.3 Implementation of policies and strategies

##### *Public Service Agreements*

The Government's *2004 Spending Review* (HM Treasury 2004a) set out departmental spending plans for the financial years<sup>10</sup> 2005/06 to 2007/08. Associated with this are Public Service Agreements (PSAs), which commit Government Departments to particular objectives and targets. These include targets that aim to reduce the harm caused by illegal drugs to individuals, their families and the community by (HM Treasury 2004b):

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<sup>10</sup> UK Government financial years run from the start of April to the end of March. So regarding the financial year 2005/06, the year starts on 1 April 2005 and ends on 31 March 2006. Some data in this report relate to calendar year, whilst others relate to financial year. Similar references are used to refer to financial year.

- reducing drug use amongst young people and preventing problematic drug use, especially amongst the most vulnerable;
- having a long-term impact on the supply of Class A drugs;
- using the Criminal Justice System to target drug-using offenders, engaging them in treatment and reducing drug-related crime; and
- increasing the numbers in treatment by 100 per cent by 2008 (from a baseline of 100,000 in 1998), and to yearly increase the proportion successfully being retained or completing treatment.

#### *Cannabis legislation*

After the reclassification of cannabis from Class B to C in 2004<sup>11</sup>, to reinforce that cannabis remains illegal and explain any related health risks, the Cannabis Health Information Campaign was launched in July 2004<sup>12</sup>. It was later expanded with further information targeting young people, and then heavy cannabis users.

#### *Magic mushrooms legislation*

Ten thousand leaflets have been distributed to vendors and users to clarify the new legislation surrounding the classification of magic mushrooms<sup>13</sup>. It states that “The Government has made it clear it will not allow the sale of fresh magic mushrooms and we expect people to follow the spirit of the law”<sup>14</sup>. An individual would not be offending solely through a naturally occurring substance (the mushroom) growing in their garden if they can prove their lack of knowledge (under the section 28 of the *Misuse of Drugs Act 1971*).

### 1.3.4 Impact of policies and strategies

#### *The reclassification of cannabis*

In 2004, the Metropolitan Police Authority (MPA 2004) published a report examining the impact of the change in legislation surrounding cannabis in London. The report suggested that although the number of cannabis offenders dealt with has increased by 31 per cent (from 6,231 over the period April to August 2003 to 8,148 over the same period in 2004), the number of offenders who are arrested has decreased by 53 per cent (from 6,231 to 3,307). Since the change in legislation, offenders are increasingly managed through alternative means such as formal warnings. A similar trend is emerging in the rest of England and Wales and it has been estimated that this change is saving approximately 199,000 hours of police time in a year (Home Office 2005a).

However, Warburton *et al.* (2005) suggest that even before the reclassification, the police were using their own discretion in managing incidents of cannabis possession. Their interviews with 150 officers in England (before reclassification) showed that 69 per cent had managed at least one such incident without arresting the individual during their career (through measures such as informal or formal warnings, or ignoring the incident). Using such methods was seen as a way of saving police time. Warburton *et al.* predicted that in the future, either the police would dispose of informal methods to use on-the-spot warnings or that informal action would become more commonplace. They suggest that the new system needs to be monitored

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<sup>11</sup> This occurred under the *Misuse of Drugs Act 1971 (Modification) (No. 2) Order 2003* - see Focal Point Report 2004, Chapter 1.2.1.

<sup>12</sup> For further information, please see <http://www.drugs.gov.uk/Campaign/Cannabis>.

<sup>13</sup> Please see <http://www.drugs.gov.uk/NationalStrategy/DrugsAct2005/MagicMushroomFAQ> for further details.

<sup>14</sup> Please see <http://www.drugs.gov.uk/NationalStrategy/DrugsAct2005/1116427341> for further details.

closely, for example, to examine regional variations and to check for disparities in numbers of arrests amongst specific groups (for example, ethnic minorities).

### *Tackling Drugs. Changing Lives. Keeping Communities Safe from Drugs*

The Drugs Strategy Directorate produced a progress report at the end of 2004 on the Drug Strategy, *Tackling Drugs. Changing Lives: Keeping Communities Safe from Drugs* (DSD 2004a). Its launch was used to hold a series of regional events for practitioners working in the drugs field. The report highlighted the achievements made since the launch of the Updated Drug Strategy in 2002<sup>15</sup>:

- Young People: Overall Class A drug use among young people has been stable since 1998 (see Section 2.3 for details of prevalence and Chapter 3 for information on drug prevention).
- Drug-related crime: Acquisitive crime<sup>16</sup> decreased by 12.9 per cent in England and Wales between April 2003 and June 2004 (see Section 9.3.3 for information on the Drug Interventions Programme or DIP).
- Reducing supply: Between April 2002 and December 2003, UK enforcement agencies seized over 26,000 kilograms of cocaine and 11,000 kilograms of heroin, and disrupted over 330 “organised crime groups”.
- Treatment: 54 per cent more drug users were in contact with drug treatment services in 2003/04 compared to 1998 and the proportion of individuals successfully completing treatment rose from 57 per cent in 2002/03 to 72 per cent in 2003/04 (NTA 2004a) (see Chapter 5 for details on the numbers in treatment).

The report also stated the Directorate’s aims for the years leading up to 2008:

- Further reduce the availability of drugs through disrupting traffickers, collaborating with other countries and inter-agency working.
- Further reduce the numbers using drugs through education, support and targeted interventions.
- Rehabilitate existing users through prompt and effective treatment, aftercare and rehabilitation.
- Encourage more people out of crime and into treatment by, for example, extending DIP.

### *Measuring the impact of the Drug Strategy*

The Government’s success in delivering the aims of the Drug Strategy are measured in England firstly through the targets set in the PSAs (see Section 1.3.3). The Drugs Strategy Directorate (DSD) is also seeking to improve the estimates of the number of problematic drug users. These indicators will be considered alongside the Drug Harm Index (DHI).

#### *The Drug Harm Index*

The DHI helps to measure the impact of the Drug Strategy in England and Wales by assessing the harms<sup>17</sup> generated by problematic drug use of any illegal drug (MacDonald *et al.* 2005). The relative importance of each harm indicator will be estimated by its generated economic and social costs. Any change in the Index will be due to the level or volume of harms (e.g. the number of new HIV cases) and the change in their economic or social cost (e.g. the change in the expected cost per new HIV case). However, caution will be required as different harm categories may

<sup>15</sup> For details of the Updated Drug Strategy, see Drugs Strategy Directorate (DSD 2002a).

<sup>16</sup> To which drug-related crime particularly contributes (DSD 2004a).

<sup>17</sup> For example, drug-related crime, health consequences, community perceptions of drug problems and public nuisance issues.

evolve differently and no single index will capture this diversity. So, MacDonald *et al.* suggest that the DHI should be considered alongside other indicators.

The target is to lower the Index from its baseline in 2002 (DHI value of 113.2) by 2007/08 (Home Office 2004a). By the end of 2004, the DHI's value was 102.9, a nine per cent fall (MacDonald *et al.* 2005).

## 1.4 Budget and public expenditure

### 1.4.1 In law enforcement, social and health care, research, international actions, co-ordination, national strategies.

Direct expenditure for tackling drugs in 2004/05 was budgeted at €2,000 million<sup>18</sup> (£1,344 million) (DSD 2002a). For specific areas of the Drug Strategy, the 2004/05 budget was as follows:

- Protecting young people                   €230.7 million (£155 million);
- Reducing supply                            €565.5 million (£380 million);
- Safeguarding communities            €442.0 million (£297 million); and
- Drug treatment                            €761.9 million (£512 million).

In Scotland, a recent review of drug treatment and rehabilitation (see Section 5.2.2) announced that the amount of funding invested into treatment would increase by €3.6 million (£2.25 million) a year from 2004 on top of the €8.9 million (£6 million) additional investment planned for 2005/06, bringing the total to €48.4 million (£32.5 million) a year (Scottish Executive 2004a).

In Wales, from April 2003, specific funds for drug use (including alcohol) services were allocated as being 0.4 per cent of the Local Health Boards' discretionary allocations (NHS Finance Division 2004). This was raised by 5.04 per cent for 2004/05<sup>19</sup>. To enforce this spending, from 2004/05 onwards, Community Safety Partnerships will confirm that agreement has been reached locally on the planned expenditure and that it complements the delivery of the local drug use strategy (Welsh Assembly Government, internal communication).

The Substance Misuse Action Fund in Wales will increase from €4.9 million (£3.3 million) in 2002/03 to €27.4 million (£18.4 million) by 2007/08 (Welsh Assembly Government 2004b). As such, €16.5 million (£11 million) will be available for the 3 year period 2005/06 to 2007/08 to fund capital projects to improve substance misuse treatment facilities (Welsh Assembly Government, internal communication).

Additionally in Wales, the Building Safer Communities funding is shared between the 22 Community Safety Partnerships for projects which focus on youth crime and disorder or which link in with other partnerships' and agencies' community safety strategies and initiatives, with a particular emphasis on work in deprived communities; €12.1 million (£8.1 million) will be distributed to the Partnerships as follows:

- €1.5 million (£1.2 million) in 2003/04;
- €4.2 million (£2.8 million) in 2004/05; and
- €6.4 million (£4.3 million) in 2005/06.

<sup>18</sup> All conversion rates used in this report will use the exchange rate of £1 equals €1.4881 euros as of 30 June 2004 unless otherwise stated. (Please see <http://www.bankofcanada.ca/en/rates/exchform.html> for further details of exchange rates).

<sup>19</sup> In 2003/04 in Wales, Local Health Boards' discretionary allocation was £1,857 million, in 2004/05 this has been raised to £2,185 million (NHS Finance Division 2004).

## 1.4.2 Funding arrangements

NO NEW INFORMATION

Please see UK Focal Point Report 2004, Section 1.4.2.

## 1.5 Social and cultural context

### 1.5.1 Public opinion of drug issues

The reaction to the decision to reclassify cannabis was mixed. For example in January 2005 the Chief Executive of DrugScope said,

*“We supported and continue to support the reclassification of cannabis and it is encouraging that cannabis usage is stable. The real win is for our communities as police have been able to divert an estimated 199,000 police hours to policing other crimes. The reclassification of cannabis was in recognition that all drugs are not the same. Young people respond well to accurate and balanced information but are sceptical of scare stories. Most young people know that cannabis is illegal and can be harmful but we need a much greater focus on drug education and prevention.”* (DrugScope 2005).

However, the Headteachers Association of Scotland presented an opposing viewpoint, stating that, “The decision to reclassify cannabis was wrong because the message they seem to be sending to children is that the drug is safe” (Musson 2005).

The British Crime Survey<sup>20</sup> (BCS) asks respondents about their experiences of drugs. The 2003/04 findings reported that the proportion of respondents who perceive drug users or suppliers to be a very or fairly big problem decreased from 32 to 25 per cent since 2002/03 (Dodd *et al.* 2004). This stabilised in 2004/05 at 26 per cent; however, levels vary regionally with London respondents reporting the highest proportion at 34% compared to a fifth of respondents in the East of England, the region with the lowest proportion (Nicholas *et al.* 2005).

Findings from the 2003 Scottish Crime Survey suggest that 91 per cent of respondents<sup>21</sup> felt drug abuse to be an ‘extremely’ or ‘quite’ serious issue (Scottish Executive 2005a). The Scottish Executive’s (2005b) attitude survey found similar results<sup>22</sup>. In addition, the latter survey also found that:

- Eighty-three per cent of respondents were aware that cannabis remained illegal after the reclassification.
- Sixty-seven per cent had seen or heard recent prevention materials on drug use (compared to 60% in 2002, and 75% for 16 to 25 year olds in 2004).
- Forty-one per cent believed the Government to be doing enough to discourage drug use (compared to 53% in 2003).

In addition, the university magazine ‘Student’ examined 500 questionnaires from Edinburgh students (Friedman 2005) (see Section 2.3.3). Students reporting illegal drug use were asked whether they considered drugs to be a positive force on their lives; the following responded that they were:

- cannabis: 42 per cent;
- ecstasy: 75 per cent;
- magic mushrooms: 54 per cent; and

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<sup>20</sup> The British Crime Survey interviewed 45,120 people aged 16 years old or over living in private households in England and Wales.

<sup>21</sup> In total, 5,041 respondents were involved aged 16 years old or over.

<sup>22</sup> For this evaluation, 1,001 participants aged 16 years old and over were interviewed.

- cocaine: 48 per cent.

### 1.5.2 Attitudes to drugs and drug users

See Section 1.5.1.

### 1.5.3 Initiatives in parliament and civil society

*Together We Can*, the UK Government's action plan to get citizens and public bodies working together, was launched in June 2005 (HM Government 2005). Programmes such as Positive Futures and Blueprint already enable community development to play an integral part in drug prevention but this action plan also reflects the UK Government's commitment to ensuring that community involvement is part of the action against Class A drug-related crime. For example, activity by local partners and community engagement underpinned the delivery of a crack house campaign, Operation Crackdown (Home Office 2005b; see Section 10.2.1).

Improving and increasing regional communications are central to *Tackling Drugs. Changing Lives* (DSD 2004a; see Section 1.3.4). The overall objective is to communicate more effectively that local action taken to tackle drugs is having a positive impact, and that a tangible difference is being felt in communities. To this end, the DSD (2005a) has created guidance for regional D(A)ATs on how to run a local media campaign.

A Ministerial event in September 2005 was attended by over 90 drug strategy stakeholders. These included representatives of state bodies, enforcement agencies, non-governmental organisations, community groups and the voluntary sector. The Home Office is also running a series of public-facing regional events designed to provide local communities (including tenants groups, faith groups, police authorities, and local councillors) with the opportunity to hear what the Government is doing to tackle drugs. Delegates also have the chance to put questions to a Minister. A critical success factor will be to secure enthusiasm among local communities for the work being done to tackle drugs.

For many people, involvement in a community group or a voluntary organisation enables an opportunity to be included in community decisions (HM Government 2005). These groups are key partners in the delivery of the UK Drug Strategy (delivering drug treatment services and drug services for young people, in particular) and the Home Office is committed to involving their expertise and networks more. As such, the Drugs Strategy has created a Voluntary and Community Sector Forum to provide an ongoing opportunity to:

- help shape priorities, by allowing early consultation on developments in drug policy;
- support delivery by gaining feedback on the experience of local organisations in delivery of the strategy, and developing recommendations for strengthening the delivery framework; and
- take full account of the interests, capacity and expertise of the voluntary and community sector: a particular focus of the forum will be ensuring that small community and user groups have a voice in the UK Drug Strategy.

The first meeting of the Drug Strategy Diversity Forum will be held in October 2005. Chaired by the Director of the Home Office's Drug Strategy Directorate, the Diversity Forum is being established to:

- identify issues arising among minority communities that would have relevance to the implementation and development of the Drug Strategy;



- ensure that policy developments do not have a disproportionate impact on members of minority communities; and
- provide guidance on cross-cutting issues that will inform the ways in which the Drug Strategy is delivered with regard to minority communities.

Membership will include representatives of black and minority ethnic groups; refugees and asylum seekers; gypsy and traveller communities; the lesbian, gay, bisexual and transgender community; and disabled people (including those with mental disabilities and mental illnesses).

The UK's cross-governmental drug website<sup>23</sup> is a key resource in the drug sector. The website - which receives up to 45,000 hits every month (DSD, internal communication) – will be re-launched in October 2005. It provides:

- the latest government policy, research and legislation;
- information on events and conferences;
- details of good practice and guidance; and
- a user forum aimed at those working in the drugs field.

#### 1.5.4 Media representations

Representation of the Drug Strategy and its delivery has been generally positive in the media, with regional coverage more positive than national (Home Office 2005c). The introduction of the *Drugs Bill* generated many headlines and coverage was positive. Conversely, the potential effects of cannabis on users' mental health (for example, regarding schizophrenia) have generated negative coverage of cannabis' reclassification, and the Home Secretary's recent decision to refer its classification to the Advisory Council on the Misuse of Drugs received wide coverage and was broadly welcomed. Drugs therefore retain a high profile in the media and remain a controversial topic.

Shortly after Sir Ian Blair assumed his new role as the Chief Commissioner for the Metropolitan Police in London in January 2005, he announced his intention to clamp down on 'middle-class cocaine users' (Leppard 2005), stating,

*"People seem to think the price of a wrap of cocaine is 50 quid [pounds], but the cost is misery on estates here and a trail of blood back to Colombia. Someone has died to bring it to a dinner party. People who wouldn't dream of having a non-organic vegetable don't seem to notice the blood on their fingers"* (Leppard 2005).

This intention sparked much debate in the media and in online forums for several weeks afterwards about the legitimacy of this claim and how easy it will be to tackle (BBC 2005a; Benedictus 2005; Douglass 2005; Pilger 2005; Steelem 2005).

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<sup>23</sup> Please see <http://www.drugs.gov.uk>.

## 2. Drug use in the population

### 2.1 Overview

Prevalence of use of any drug amongst adults has fluctuated but has remained relatively stable over the last few years in much of the United Kingdom, although use of cocaine and ecstasy, both Class A drugs has increased<sup>24</sup>. Prevalence is highest in England and Wales where around a third of those aged 16 to 59 years old have ever used illicit drugs. In Northern Ireland, prevalence had been relatively low until the 1990s, but by 2002/03 one fifth of adults reported lifetime use.

Young adults under 35 are significantly more likely to use drugs; in most of the UK, lifetime prevalence for this age group is 45 per cent (although it is less than a third in Northern Ireland). Amongst those who are under 25 years old, prevalence rates are even higher. However, throughout most of the UK, there has been a gradual but significant decline in the use of any drug amongst 16 to 24 year olds in the last five years; though Class A drug use has remained stable, except for cocaine and ecstasy. Of note is that the age band with the highest prevalence is widening as young people continue to use into their thirties. Amongst school children drug use increased markedly, doubling between 1998 and 2002 to around 20 per cent (based on lifetime prevalence), but appears to have stabilised over recent years<sup>25</sup>.

Men are more likely to report drug use than women but the difference varies according to age group.

Cannabis continues to be the most commonly used drug across all age groups in the UK; last year use in England and Wales being around 11 per cent although it is lower in Scotland and Northern Ireland at 7% and 6% respectively. Prevalence of all other drugs is considerably lower; no more than three per cent for last year use. There has been a steady increase in the use of cocaine, crack and magic mushrooms; this increase partly accounts for increased use of Class A drugs. There has been a decrease in recent (last year) and current (last month) use of amphetamines and LSD.

Prevalence is particularly high in certain groups, such as young offenders, children in need, care leavers, homeless young people (Lloyd 1998; Gilvarry 2001; DrugScope and DPAS 2002), and children of drug-using parents (ACMD 2003). Not only are they more likely to use, but they are more likely to use a wider range of drugs, and to use them more often.

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<sup>24</sup> In the UK, the primary sources of information about prevalence of drug use amongst the adult population are from crime and victimisation surveys. Please see Chapter 2.2 for more details of these.

<sup>25</sup> Amongst the school age population, surveys of drug use prevalence are undertaken in schools. In England, a survey of the prevalence of smoking, drinking and drug use amongst young people (11 to 15 year old school children), has been undertaken annually since 1998. The *Young Person's Behaviour and Attitudes Survey*, which was undertaken in Northern Ireland in 2000 for the first time, and repeated in 2003. It will run every three years thereafter. In Scotland, the *Scottish Schools Adolescent Lifestyle and Substance Use Survey* (SALSUS) is undertaken annually. The *Health Behaviour in School Age Children Survey* (HBSC) provides Welsh data and is undertaken every four years with a two-year interim survey. The most recent survey, the sixth in the series, was conducted in 2001/02.

## 2.2 Drug use in the general population

The British Crime Survey (BCS)<sup>26</sup> for 2003/04, covering England and Wales, the Northern Ireland Crime Survey (NICS)<sup>27</sup> for 2003/04, and the Scottish Crime Survey (SCS)<sup>28</sup> for 2003 have been published in the last year (Scottish Executive 2005a; Chivite-Matthews *et al.* 2005; McMullan and Ruddy 2005). Surveys have been completed in England and Wales for 2004/05 and in Scotland for 2004; however, the final results are not due until late autumn 2005. Revised data from the 2002/03 Northern Ireland Drug Prevalence Survey (NACD and DAIRU 2005), which were described in last year's Focal Point report, have recently been published.

### 2.2.1 Prevalence estimates in the United Kingdom

By combining the information from the BCS, SCS and Northern Ireland's data from the All Ireland Drug Prevalence Survey, an estimate has been produced for 15 to 64 year olds in the UK (Hay 2005a; see Figure 1 and see table in Appendix 1)<sup>29</sup>. This estimates that:

- 34.1 per cent reported using one or more drug in their lifetime;
- 11.8 per cent reported use of one or more drug in the last year; and
- 7.1 per cent reported drug use in the last month.

Prevalence in the UK is highest in England and Wales, and lowest in Scotland across various different drug types (see Figure 1 and table in Appendix 1).

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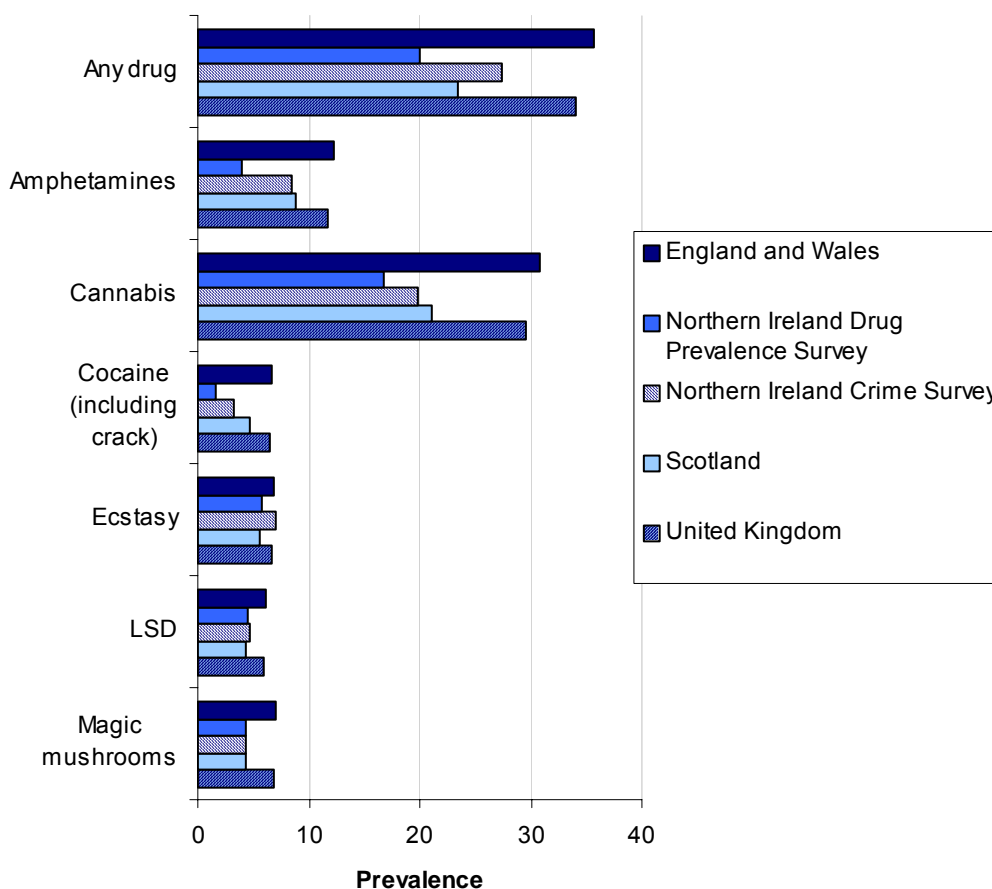
<sup>26</sup> In England and Wales, the British Crime Survey (BCS) is a crime and victimisation survey. It questions respondents, aged 16 to 59, about a number of crime-related topics including their experience of illicit drugs. In 2002, it became a continuous survey, reporting quarterly. The sample size for the drugs module was 24,422.

<sup>27</sup> The Northern Ireland Crime Survey (NICS) is a crime and victimisation survey. It is undertaken every few years. In addition, a Drug Prevalence Survey (using the EMCDDA model questionnaire and recommended methodology) was conducted for the first time in 2002/03 in association with the Republic of Ireland. This survey will be repeated in 2005/06 subject to funding. In total, 2,121 people completed the Drug Prevalence Survey and 3,104 people completed the drugs component of the Northern Ireland Crime Survey.

<sup>28</sup> The Scottish Crime Survey (SCS) is a crime and victimisation survey. It asks comparable questions to those in the BCS but surveys all adults aged 16 years and over. The latest survey is for 2003. Overall, 4,665 people completed the drugs section of the survey.

<sup>29</sup> This estimate has been derived by using data from EMCDDA Standard Tables, completed for UK Focal Point by the data analysts in the Home Office, Scottish Executive and Northern Ireland Office. It must be noted that these Standard Tables have not been otherwise published and will not necessarily be consistent with published data. For Scotland the data provided for UK Focal Point is for 16 to 64 years.

Figure 1: Percentage prevalence of illicit drug use in the United Kingdom by country and by drug



Data for Scotland are for 2003, data for England and Wales for 2003/04, crime survey data for Northern Ireland are for 2003/04 and drug prevalence survey data for Northern Ireland are for 2002/03. Data for England and Wales, and from the Northern Ireland Crime Survey are for 16 to 59 year olds; for Scotland for 16 to 64 year old; data from the Northern Ireland Drugs Prevalence Survey are for 15 to 64 year olds.

Figures for the Northern Ireland Crime Survey for cocaine do not include data for crack.

Source: Chivite Mathews *et al.* (2005); Hay (2005a); McMullan and Ruddy (2005); National Advisory Committee on Drugs and Drug and Alcohol Information Research Unit (NACD and DAIRU 2005); Northern Ireland Office (NIO 2005); Scottish Executive (2005a).

#### Northern Ireland: the Drug Prevalence Survey and the Crime Survey

It is of note that estimates resulting from the NICS are significantly higher than those obtained in the Drug Prevalence Survey reported for Northern Ireland in last years report and shown in Figure 2 and Appendix 1 to allow comparison. The results from the latter suggesting prevalence as follows:

- 20.0 per cent had used one or more drug in the their lifetime;
- 6.4 per cent used one or more in the last year; and
- 3.4 per cent in the last month (NACD and DAIRU 2005).

This might suggest that prevalence results from victim surveys produce higher estimates than results obtained from the European Model Questionnaire. The difference could be because of differences in sampling period, the age ranges used,

the surveys' approaches, and the definitions of 'any illegal drug' compared to 'any drug'<sup>30</sup>.

### *Drugs used overall in the United Kingdom*

Cannabis continues to be the most commonly used drug, with a considerably higher prevalence than for any other drug (10.8% for last year prevalence in the UK), followed by ecstasy (2.0%) and cocaine (1.5%) (see Appendix 1).

### 2.2.2 Trends in reported drug use prevalence

As this is the first time that an estimate of prevalence for the UK as a whole has been produced it is necessary to look at the different surveys separately to get a picture of trends over time.

#### *England and Wales*

Trend data for England and Wales show that reported drug use prevalence in 2003/04 has not changed significantly since 2000, although it has increased overall since 1996 (see Table 2).

*Table 2: Percentage prevalence of use illicit drug use in England and Wales from 1996 to 2003/04 amongst 16 to 59 year olds*

<b>Prevalence</b>	<b>1996</b>	<b>1998</b>	<b>2000</b>	<b>2001/ 02</b>	<b>2002/ 03</b>	<b>2003/ 04</b>
Lifetime	30.5	33.6	35.7	34.0	35.7	35.6
Last year	11.1	12.1	11.9	11.9	12.2	12.3
Last month	6.7	7.1	7.2	7.4	7.4	7.5
<b>Total sample size</b>	<b>10,940</b>	<b>9,984</b>	<b>13,018</b>	<b>20,146</b>	<b>23,586</b>	<b>24,222</b>

Source: Chivite-Matthews *et al.* (2005).

LSD has seen a slight increase in reported lifetime use but has decreased notably in reported last year and last month use (see Table 3). There has also been a large increase in the use of magic mushrooms; 5.3 per cent of people reported lifetime use of magic mushrooms in 1996 compared to 7.1 per cent in 2004/05 (an increase of 33%). However, the most significant increase is the use of cocaine in the previous year, a 295 per cent increase between 1996 and 2003/04.

<sup>30</sup> Tranquilisers, methadone and steroids are excluded from the definition of 'any illegal drug' in the Drug Prevalence Survey but included in the NICS definition of 'any drug'. Given the prevalence rates recorded for each of these in the NICS they could also account for higher overall rates recorded.

Table 3: Percentage prevalence of illegal drug use in the last year in England and Wales amongst 16 to 59 year olds by drug, from 1996 to 2003/04

Illegal drug	1996	1998	2000	2001/02	2002/03	2003/04	Percentage change from 1996 to 2003/04
<i>Lifetime prevalence</i>							
Amphetamine	9.3	10.8	12.3	11.6	12.3	12.3	31
Cannabis	23.5	26.8	29.5	28.9	30.6	30.8	31
Cocaine (not including crack)	3.0	3.7	5.5	5.1	6.1	6.7	123
Ecstasy	3.8	4.2	5.3	5.9	6.6	6.9	79
LSD	5.4	5.6	6.2	5.4	5.9	6.1	12
Magic mushrooms	5.3	6.0	7.0	6.1	6.8	7.1	33
<i>Last year prevalence</i>							
Amphetamine	3.2	3.0	2.1	1.6	1.6	1.5	-52
Cannabis	9.5	10.3	10.5	10.6	10.9	10.8	14
Cocaine (not including crack)	0.6	1.2	2.0	2.0	2.1	2.4	295
Ecstasy	1.7	1.5	1.8	2.2	2.0	2.0	15
LSD	1.0	0.8	0.7	0.3	0.3	0.2	-77
Magic mushrooms	0.7	0.9	0.7	0.5	0.6	0.8	24
<i>Last month prevalence</i>							
Amphetamine	1.6	1.4	0.9	0.7	0.6	0.6	-64
Cannabis	5.5	6.1	6.4	6.6	6.7	6.5	18
Cocaine (not including crack)	0.2	0.4	0.7	0.9	0.9	1.1	376
Ecstasy	0.7	0.5	0.9	1.1	0.9	0.9	22
LSD	0.3	0.1	0.1	0.1	0.1	0.1	-72
Magic mushrooms	0.1	0.1	0.2	0.2	0.1	0.3	86
<b>Total sample size</b>	<b>10,940</b>	<b>9,984</b>	<b>13,018</b>	<b>20,146</b>	<b>23,586</b>	<b>24,222</b>	

Source: Chivite-Matthews *et al.* (2005).

#### Northern Ireland

According to the Northern Ireland Crime Survey, levels of reported drug use prevalence have increased slightly since 1998 (see Table 4). Whilst lifetime prevalence is considerably lower than in England and Wales (very low levels of drug use were reported in the 1990s; House of Commons Northern Ireland Committee 2003), last year and last month prevalence is similar to that reported in England and Wales.

Table 4: Percentage prevalence of illegal drugs in Northern Ireland amongst 16 to 59 year olds, from 1998 to 2003/04

Prevalence	1998	2001	2003/04
Lifetime	24.0	26.0	27.4
Last year	9.0	11.0	9.7
Last month	5.0	6.8	6.2
<b>Total sample size</b>	<b>2,277</b>	<b>2,037</b>	<b>3,516</b>

Source: Hague *et al.* (2000); McMullan and Kerr (2003); McMullan and Ruddy (2005).

Data for individual drugs in Northern Ireland shows a decrease in reported cannabis and ecstasy use in the last year (see Table 5).

*Table 5: Percentage prevalence of illegal drug use in the last year in Northern Ireland amongst 16 to 59 year olds by drug, in 2001 and 2003/04*

Illegal drug	2001	2003/04
Amphetamine	1.2	0.9
Cannabis	7.3	6.4
Cocaine (not including crack)	0.5	1.1
Ecstasy	3.0	1.9
LSD	0.5	0.0
Magic mushrooms	0.2	0.5
<b>Total sample size</b>	<b>2,037</b>	<b>3,516</b>

Source: McMullan and Kerr (2003); McMullan and Ruddy (2005).

### Scotland

Prevalence levels for adults have increased since 1996, following a decrease in 2000 (see Table 6)<sup>31</sup>.

*Table 6: Percentage prevalence of illegal drugs in Scotland amongst adults, from 1996 to 2003/04*

Prevalence	1996	2000	2003
	16-59 year olds	16-59 year olds	16-64 year olds
Lifetime	22.5	19.2	23.4
Last year	9.0	6.6	8.5
<b>Total sample size</b>	<b>3,175</b>	<b>2,886</b>	<b>4,665</b>

Source: Fraser (2002); Scottish Executive (2005a).

For reports of individual drug use in Scotland, overall increases since 1996 can be seen in reported cocaine use for both lifetime and last year prevalence (see Table 7). In comparison, reported levels of LSD and magic mushroom use have decreased.

<sup>31</sup> Data for 1996 and 2000 are for those aged 16 to 59, for 2003 data are for those aged 16 to 64 and are derived from the Standard Table.

Table 7: Percentage prevalence of illegal drug use in Scotland amongst 16 to 59 year olds by drug, from 1996 to 2003

Illegal drug	1996	2000	2003
	16-59 year olds	16-59 year olds	16 to 64 year olds
<i>Lifetime prevalence</i>			
Amphetamine	7.3	6.3	8.9
Cannabis	19.0	17.4	21.0
Cocaine (not including crack)	2.6	2.5	4.6*
Ecstasy	4.0	3.7	5.5
LSD	5.5	4.1	4.3
Magic mushrooms	5.1	3.6	4.3
<i>Last year prevalence</i>			
Amphetamine	3.1	0.5	1.3
Cannabis	8.2	5.5	7.4
Cocaine (not including crack)	1.0	0.7	1.4*
Ecstasy	2.1	1.0	1.5
LSD	1.3	0.7	0.1
Magic mushrooms	1.3	0.1	0.2
<b>Total sample size</b>	<b>3,175</b>	<b>2,886</b>	<b>4,665</b>

Data for 1996 and 2000 are for those aged 16 to 59 reported by Fraser (2005), for 2003 data are for those aged 16 to 64 and are derived from the Standard Table.

\*Cocaine data for 2003 include crack.

Source: Fraser (2002); Scottish Executive (2005a).

### 2.2.3 Further discussion of general prevalence rates

- Overall, males are significantly more likely to report drug use than females: reported lifetime prevalence of any illicit drug being 39.9 per cent for males and 28.2 per cent for females (Hay 2005a). (Please see Chapter 11 for a more detailed discussion of gender differences.)
- The majority of those reporting use in the last month (75%) in the British Crime Survey have only used one type of drug (Chivite-Mathews *et al.* 2005).
- Based on the British Crime Survey, the most common age at which respondents reported starting to use illicit drugs is 18 years old.

### Geographical variations

The BCS considered geographical variations and found that overall, reported drug use was higher amongst those living in inner city areas and lowest in rural areas (Chivite-Mathews *et al.* 2005). More specifically, those living in affluent areas of cities and towns had the highest levels of use (20.5% reported use of any drug in the last year), compared to those living in 'Thriving areas'<sup>32</sup> affluent suburban areas (who reported the lowest levels at 9.7% for use in the last year). Overall, London had the highest prevalence of drug use (14.7% for use in the last year) compared to 12.3 per cent for the whole of England and Wales.

<sup>32</sup> This includes 'wealthy achievers in suburban areas, affluent greys in rural communities and prosperous pensioners in retirement areas' (Chivite-Mathews *et al.* 2005).



### *Socio-economic and lifestyle factors*

The BCS examined socio-economic and lifestyle factors (Chivite-Mathews *et al.* 2005) and noted that:

- single respondents (24.7%) and those who were cohabiting (18.4%) were more likely to report drug use in last year than other groups;
- those who were privately renting reported high levels of drug use (23.9% for use in the last year) compared to those who were owner occupiers (9.4%);
- those who were unemployed were more likely to report drug use in the last year (23.5%); and
- there was a higher prevalence of drug use amongst those who had recently been to a club or a disco compared to those who had not (see Chapter 13 for more details on recreational settings).

### *Risk factors for drug use*

In England and Wales, Chivite-Mathews *et al.* (2005) reported that those factors strongly associated with class A drug use were: being young, male, single (not including being a widow/er), divorced, cohabiting; visiting pubs or wine bars three times or more a week or visiting a nightclub; and living in a terrace or flat/maisonette, or in a household with no children or as single adult with child(ren).

## **2.3 Drug use amongst young adults**

### **2.3.1 Estimates for the United Kingdom**

Estimates of prevalence of drug use in the UK amongst young people are as follows:

- 45.4 per cent of young people aged 16 to 24 had used one or more drug in the their lifetime, 46.9 per cent of those aged 16 to 34;
- 27.2 per cent of young people aged 16 to 24 had used one or more drug in the last year, 21.4 per cent of those aged 16 to 34; and
- 16.9 per cent of young people aged 16 to 24 had used one or more drug in the last month, 13.1 per cent of those aged 16 to 34 (see Table 8 and 9) (Hay 2005a).

Table 8: Percentage prevalence of illegal drugs in the United Kingdom by drug and country amongst 15 to 24 year olds

Illicit drug	British Crime Survey	Northern Ireland Crime Survey	Northern Ireland Drug Prevalence Survey	Scottish Crime Survey	United Kingdom estimate
	16-24 year olds	16-24 year olds	15-24 year olds	16-24 year olds	15-24 year olds
<i>Lifetime prevalence</i>					
Any drug	46.6	40.1	28.5	39.8	45.4
Amphetamine	12.4	14.1	6.5	13.0	12.3
Cannabis	41.3	30.0	24.0	37.7	40.4
Cocaine (including crack)	9.1	5.4*	2.6	10.8	9.0
Ecstasy	10.7	15.0	10.2	14.3	11.0
LSD	9.2	4.9	7.8	6.1	4.5
Magic mushrooms	6.6	4.2	4.9	5.6	6.4
<i>Last year prevalence</i>					
Any drug	27.8	24.0	14.5	25.9	27.2
Amphetamine	4.0	1.7	2.0	3.0	3.8
Cannabis	24.8	18.6	12.1	23.1	24.3
Cocaine (including crack)	5.0	2.5*	1.4	5.1	4.9
Ecstasy	5.3	7.1	4.8	3.9	5.3
LSD	0.8	0.0	0.2	0.3	0.8
Magic mushrooms	2.7	0.7	0.7	0.3	2.4
<i>Last month prevalence</i>					
Any drug	17.3	16.2	14.5	25.9	27.2
Amphetamine	1.6	0.1	2.0	3.0	3.8
Cannabis	15.6	2.6	12.1	23.1	24.3
Cocaine (including crack)	2.7	0.3*	1.4	5.1	4.9
Ecstasy	2.5	1.2	4.8	3.9	5.3
LSD	0.4	0.0	0.2	0.3	0.8
Magic mushrooms	0.8	0.2	0.7	0.3	2.4
<b>Total sample size</b>	<b>5,429</b>	<b>286</b>	<b>768</b>	<b>619</b>	<b>Not known</b>

Data for Scotland are for 2003, data for England and Wales for 2003/04, crime survey data for Northern Ireland are for 2003/04 and drug prevalence survey data for Northern Ireland are for 2002/03.

\* The cocaine figures for the Northern Ireland Crime Survey do not include data for crack.  
Source: Chivite Mathews *et al.* (2005); Hay (2005a); McMullan and Ruddy (2005); National Advisory Committee on Drugs and Drug and Alcohol Information Research Unit (NACD and DAIRU 2005); Northern Ireland Office (NIO 2005); Scottish Executive (2005a).

Table 9: Percentage prevalence of illegal drugs in the United Kingdom by drug, country and age group

Illicit drug	British Crime Survey	Northern Ireland Crime Survey	Northern Ireland Drug Prevalence Survey	Scottish Crime Survey	United Kingdom estimate
	16-34 year olds	16-34 year olds	15-34 year olds	16-34 year olds	15-34 year olds
<i>Lifetime prevalence</i>					
Any drug	48.2	41.7	30.9	38.5	46.9
Amphetamine	18.4	15.8	7.2	16.5	17.9
Cannabis	43.4	33.1	25.1	35.9	42.3
Cocaine (including crack)	11.6	5.9*	2.9	8.7	11.1
Ecstasy	13.6	15.7	11.4	12.5	13.4
LSD	4.3	9.4	5.9	7.8	9.0
Magic mushrooms	9.7	6.3	6.4	7.0	9.4
<i>Last year prevalence</i>					
Any drug	22.1	18.3	11.6	18.0	21.4
Amphetamine	3.0	2.2	1.5	2.3	2.9
Cannabis	19.5	13.8	9.8	16.5	19.0
Cocaine (including crack)	4.9	2.5*	1.0	3.2	4.7
Ecstasy	4.1	4.5	3.3	3.8	4.1
LSD	0.5	0.1	0.1	0.2	0.5
Magic mushrooms	1.8	0.4	0.5	0.4	1.6
<i>Last month prevalence</i>					
Any drug	13.6	12.1	9.0	10.4	13.1
Amphetamine	1.1	0.5	0.3	0.7	1.0
Cannabis	12.0	8.8	5.4	14.3	11.6
Cocaine (including crack)	2.4	1.5*	0.2	0.9	2.2
Ecstasy	1.9	2.5	2.0	1.6	1.8
LSD	0.2	0.0	0.0	0.0	0.2
Magic mushrooms	0.5	0.2	0.0	0.0	0.5
<b>Total sample size</b>	<b>10,922</b>	<b>817</b>	<b>1,550</b>	<b>1,407</b>	<b>Not known</b>

Data for Scotland are for 2003, data for England and Wales for 2003/04, crime survey data for Northern Ireland are for 2003/04 and drug prevalence survey data for Northern Ireland are for 2002/03.

\*The cocaine figures for the Northern Ireland Crime Survey do not include data for crack.  
Source: Hay (2005a); Home Office (2005d); National Advisory Committee on Drugs and Drug and Alcohol Information Research Unit (NACD and DAIRU 2005); Northern Ireland Office (NIO 2005); Scottish Executive (2005a).

### 2.3.2 Trends in drug use among young people

Again, as this is the first time that an estimate of prevalence in the UK as a whole has been produced it is necessary to look at each of the three surveys in order to consider trends. Evidence from England and Wales for 16 to 24 years olds shows that current use of any drug by young people has fluctuated slightly but on the whole remained stable since 1996 (see Table 10). Lifetime and current prevalence levels amongst those aged 16 to 34 (where data is only available for the last two surveys) have been stable over the last two years, though recent use has increased.

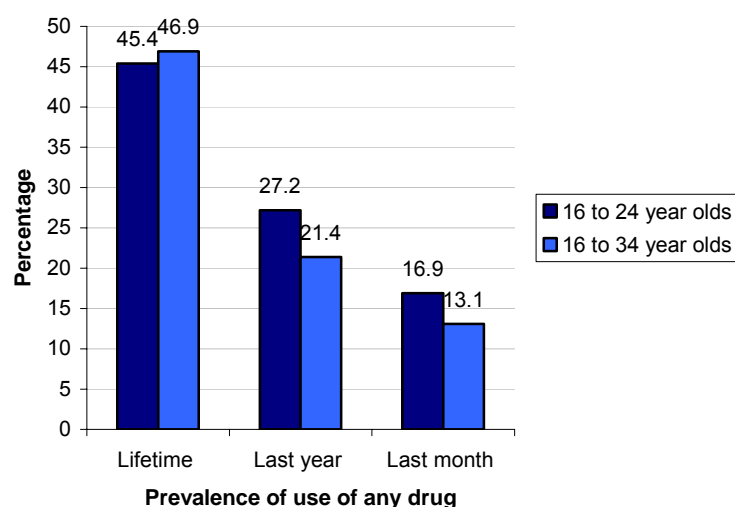
Table 10: Percentage prevalence of illegal drugs in England and Wales by age group, from 1996 to 2003/04

Age group	1996	1998	2000	2001/02	2002/03	2003/04
<i>Lifetime prevalence</i>						
16 to 24	48.6	53.7	52.0	48.8	47.3	46.6
16 to 34	No data	No data	No data	No data	48.3	48.2
<i>Last year prevalence</i>						
16 to 24	29.7	31.8	29.9	29.6	28.1	27.8
16 to 34	No data	No data	No data	No data	22.2	22.1
<i>Last month prevalence</i>						
16 to 24	19.2	20.8	19.0	18.8	17.6	17.3
16 to 34	No data	No data	No data	No data	12.2	13.6

Source: Chivite-Matthews *et al.* (2005).

Based on figure for 2003/04, prevalence levels of use of any drug amongst 16 to 34 year olds is slightly higher than amongst 16 to 24 year olds but levels are relatively similar across lifetime, last year and last month prevalence levels (see Figure 2).

Figure 2: Prevalence of drug use of any drug amongst young aged 16 to 24 and 16 to 34 years old in 2003/04 in England and Wales



Source: Chivite-Matthews *et al.* (2005).

In Scotland, the decrease in drug use, primarily amongst 20 to 24 year olds, reported in the 2000 Scottish Crime Survey (Fraser 2002; Scottish Executive 2005a) did not continue; last year prevalence amongst this age group returned to a similar level at 28.4 per cent.

### 2.3.3 Drugs used

As with the total survey population, cannabis continues to be the most used drug (see Table 8 and 9). Again, to understand trends, it is necessary to look at the different surveys. Long-term trend data are most readily available for England and Wales. Table 11 shows that amongst both age groups between 1996 and 2003/04 there has been a notable increase in cocaine use. Since 2002/03, there has been a significant decrease in the use of hallucinogens, particularly LSD, although the use of magic mushrooms has increased considerably.

Table 11: Percentage prevalence drugs use by 16 to 24 year olds and 16 to 34 year olds in England and Wales 1996 to 2003

Drug	1996	1998	2000	2001/02	2002/03		2003/4	
	16 – 24	16 – 24	16 – 24	16 – 24	16 - 24	16 - 34	16 - 24	16 – 34
<i>Lifetime prevalence</i>								
Amphetamine	18.8	21.5	21.2	15.9	14.3	18.6	12.4	18.4
Cannabis	39.6	45.4	46.2	44.2	42.7	43.4	41.3	43.4
Cocaine (not including crack)	4.3	6.8	10.4	8.4	8.5	10.0*	8.8	11.6*
Ecstasy	11.7	10.8	11.7	12.0	11.6	13.0	10.7	13.6
LSD	13.1	12.3	11.4	6.8	5.5	9.1	4.3	9.2
Magic mushrooms	9.8	11.2	10.2	6.4	6.3	9.3	6.6	9.7
<i>Last year prevalence</i>								
Amphetamine	11.8	9.9	6.2	5.0	3.7	3.1	4.0	3.0
Cannabis	26.0	28.2	27.0	26.9	25.8	20.0	24.8	19.5
Cocaine (not including crack)	1.3	3.1	5.2	4.9	4.7	4.3*	4.9	4.9*
Ecstasy	6.6	5.1	5.6	6.8	5.4	4.3	5.3	4.1
LSD	4.5	3.2	2.5	1.2	0.8	0.6	0.8	0.5
Magic mushrooms	2.3	3.9	2.4	1.5	1.7	1.3	2.7	1.8
<i>Last month prevalence</i>								
Amphetamine	5.7	5.3	2.9	2.0	1.7	1.2	1.6	1.1
Cannabis	16.1	18.0	17.4	17.1	16.2	12.4	15.6	12.0
Cocaine (not including crack)	0.5	0.9	1.8	2.1	1.9	1.9*	2.6	2.4*
Ecstasy	2.9	2.2	3.2	3.6	2.6	1.8	2.5	1.9
LSD	1.1	0.4	0.6	0.3	0.3	0.2	0.4	0.2
Magic mushrooms	0.4	0.3	0.7	0.5	0.5	0.3	0.8	0.5

Figures for 16 to 34 year olds are from Standard Tables

\*As data for 16 to 34 year olds are from the Standard Tables, figures for cocaine include crack and may therefore be higher than if they were for cocaine, not including crack.

Source: Chivite-Matthews *et al.* (2005); Home Office (2005d).

### Gender differences

As with the adult population as a whole, gender differences exist amongst younger people, although they are less wide (Chivite-Matthews *et al.* 2005; McMullan and

Ruddy 2005; Scottish Executive 2005a). Gender differences in Scotland amongst these age groups are notable. There are differences in lifetime prevalence for use of any drug (44% of males amongst the younger group compared with 36% of females, and 45 and 33 per cent respectively amongst the wider age group). However, recent use differences are the most acute, with males more than twice as likely to use (22% and 10% amongst the younger group and 15% and 6% amongst the wider age range).

### *Drug Use amongst university students*

Friedman (2005) published a survey of 500 students in Edinburgh. It was reported that:

- 59 per cent of students have smoked cannabis;
- 28 per cent have taken magic mushrooms;
- 36 per cent had taken ecstasy; and
- 23 per cent cocaine.

## **2.4 Drug use in the school and youth population**

Because of the methodological differences between the schools surveys in the UK and because only English and Scottish surveys have reported in the last year, it is not possible to provide an up-to-date UK prevalence estimate for the school and youth population.

### **2.4.1 School survey for England**

Surveys of smoking, drinking and drug use prevalence have been undertaken in schools in England annually since 1998 amongst 11 to 15 year olds. The latest was undertaken in 2004<sup>33</sup> (NatCen/NFER 2005). This is the first survey since the reclassification of cannabis (see Section 1.1). Key findings suggest:

- in 2004, 10 per cent of pupils had taken illegal drugs in the last month (compared to 12%, as reported from 2001 to 2003 – Boreham and McManus 2003) and 18 per cent in the last year (21% in 2003).
- prevalence levels in the last year and last month were slightly higher among boys than girls (18% of boys had used drugs in the last year, 11% in the last month; corresponding figures for girls were 17% and 9%). This pattern was evident in earlier surveys (DH 2000; Boreham and McManus 2003).
- as in previous years (DH 2000; Boreham and McManus 2003), prevalence levels in the last year increased with age, from five per cent of 11 year olds to 32 per cent of 15 year olds.
- one per cent of pupils reported using drugs most days, a further one per cent used them at least once a week, and another three per cent did so at least once a month.

When addressing individual drugs, the survey suggested:

- in 2004, as in previous years (DH 2000; Boreham and McManus 2003), cannabis was the most common drug reported: 11 per cent of 11 to 15 year olds had used cannabis in the last year (13% in 2001 to 2003);
- prevalence of reported cannabis use in the last year was higher among boys (12%) than girls (10%), and increased according to age (1% of 11 year olds compared to 26% of 15 year olds);

---

<sup>33</sup> Just under 10,000 pupils in 313 schools across England completed questionnaires in the autumn term.

- six per cent reported volatile substance<sup>34</sup> use in the last year in 2004 (8% in 2003, 6% in 2002);
- Three per cent reported sniffing “poppers” (amyl nitrates, butyl nitrates, isobutyl nitrates) in the last year in 2004 (which is similar to findings in 2002 and 2003).
- Among 11 and 12 year olds, reported volatile substance use in the last year was more common than that of cannabis, following the trend of previous years (DH 2000; Boreham and McManus 2003) (4% of 11 year olds had used volatile substances in the last year and 1% had used cannabis; corresponding figures for 12 year olds were 5% and 2%).
- The prevalence of Class A drug use in the last year (4%) has remained stable since 2001 (1% of 11 to 15 year olds had used heroin and 1% had used cocaine).

#### 2.4.2 Northern Ireland

There is no new information for Northern Ireland. The latest *Young Person's Behaviour and Attitudes Survey* (undertaken in Northern Ireland in 2000 for the first time) in 2003 was discussed in the 2004 UK Focal Point Report. It is due to run every three years. However, Percy *et al.* (2005) examined the reliability of young people's reports of drug use through a longitudinal study<sup>35</sup> in Northern Ireland. The study showed that of the 4,729 reports of lifetime drug use (across 13 drug categories), 789 (17%) were recanted the following year. Levels of recanting were lowest among alcohol, tobacco, cannabis and poppers.

#### 2.4.3 Scotland

The Scottish *Schools Adolescent Lifestyle and Substance Use Survey's* (SALSUS) report on drug use in 2004<sup>36</sup> was published in 2005 (Corbett *et al.* 2004). It showed that drug use prevalence was higher amongst 15 year olds than 13 year olds, and that some prevalence levels particularly amongst 15 year olds have decreased slightly since 2002 (see Table 12).

Table 12: Percentage prevalence of illegal drugs in Scotland by age group in 2002 and 2004

Prevalence	13 year olds		15 year olds	
	2002	2004	2002	2004
Lifetime	13	13	37	35
Last year	11	11	33	31
Last month	8	7	23	20
<b>Total sample size</b>	<b>10,853</b>	<b>3,599</b>	<b>9,761</b>	<b>3,453</b>

Source: Child and Adolescent Health Research Unit (CAHRU 2003); Corbett *et al.* (2005).

In addition, prevalence of drug use in the last month among 15 year old boys declined from 24 per cent in 2002 to 21 per cent in 2004<sup>37</sup>. This is lower than 1998's baseline figure of 26 per cent, but it is not clear yet if this is a short-term change or the start of a trend (Corbett *et al.* 2004).

The most common drug reported was cannabis: 6 per cent of 13 year olds and 19 per cent of 15 year olds reported having used it the last month (see Table 13).

<sup>34</sup> Including gas, glue, aerosols or solvents.

<sup>35</sup> Questionnaires were completed by 3,843 year 8 pupils. Of these, 3,336 (87%) completed a second questionnaire the following year.

<sup>36</sup> 3,451 13 years olds and 3,315 15 years old were sampled; the survey was carried out in Spring 2004.

<sup>37</sup> Reported last month use for 25 year old girls was 21 per cent and 20 per cent for 2002 and 2004 respectively.

Table 13: Percentage prevalence of illegal drugs in Scotland by age group and drug in 2004

Illegal drug	13 year olds	15 year olds
<i>Lifetime prevalence</i>		
Cannabis	12	34
Cocaine (not including crack)	1	3
Ecstasy	2	5
Magic mushrooms	1	3
Volatile substances	3	6
<i>Last year prevalence</i>		
Cannabis	10	28
Cocaine (not including crack)	1	2
Ecstasy	1	3
Magic mushrooms	1	2
Volatile substances	2	4
<i>Last month prevalence</i>		
Cannabis	6	19
Cocaine (not including crack)	0	1
Ecstasy	1	2
Magic mushrooms	0	1
Volatile substances	1	1
<b>Total sample size</b>	<b>3,599</b>	<b>3,463</b>

Source: Corbett *et al.* (2005).

Most young people reported that they had never tried any illegal drug (86% of 13 year olds and 65% of 15 year olds). In comparison, one per cent of 13 year olds and four per cent of 15 year olds used drugs most days (see Table 14).

Table 14: Frequency of illegal drug use in Scotland amongst 13 and 15 year olds in 2004 as a percentage

Prevalence	13 year olds	15 year olds
Never used	86	65
Only used drugs once	6	10
Used to take drugs	2	6
A few times a year	2	6
Used once or twice a month	2	6
At least once a week	1	3
Most days	1	4

Source: Corbett *et al.* (2005).

Since 2000, the number reporting that they had been offered drugs (the most common drug offered being cannabis) has decreased from 44 per cent to 33 per cent for 13 year olds and from 70 per cent to 63 per cent for 15 year olds.

#### *Socio-economic indicators*

- Lower family affluence was associated with drug use.
- Eighteen per cent of 15 year olds who lived with both parents reported using drugs in the last month compared to 25 per cent of those in single parent families.



- Pupils reporting drug use in the last month were more likely to perceive low levels of parental monitoring<sup>38</sup>. Sixty-nine per cent of 15 year olds using drugs in the last month had a lower than median level of maternal monitoring.
- Twenty-five per cent of 15 year olds who reported using drugs in the last month reported spending every evening with their friends.

#### 2.4.4 Wales

There is no new information about illegal drug use amongst this population in Wales. Latest available information is for 15 year olds from the Health Behaviour in School Aged Children (HBSC) survey for 2001/02, which suggest that 26 per cent of boys and 24 per cent of girls had used cannabis in the last year (Clements *et al.* 2004). This was discussed in the 2004 UK Focal Point report.

### 2.5 Primary School Children

Research was undertaken in Northern Ireland to consider the feasibility of developing an appropriate survey to provide evidence of the prevalence of drug use (including solvents and alcohol) and related knowledge amongst primary school children (McCrystal and Thornton 2004). It was recommended that a small-scale study of eight to 11 year old children should be undertaken using both quantitative and qualitative techniques.

### 2.6 Drug use among specific groups

#### 2.6.1 Drug use among vulnerable groups of young people

The *Crime and Justice Survey*<sup>39</sup> has analysed patterns of drug use (especially Class A drugs) amongst young people identified as vulnerable (Becker and Roe 2005). Five groups were identified: those who have ever been in care, those who have ever been homeless, truants, school excludees and serious or frequent offenders. Key findings were that:

- although those identified as vulnerable represented only 28 per cent of young people in the sample, they accounted for more than half (61%) of those using Class A drugs in the last year;
- five per cent of those who were not identified as vulnerable used drugs frequently during the last year compared to 24 per cent for those identified as vulnerable;
- those identified as being in more than one vulnerable group had higher levels of drug use than those in just one vulnerable group. So, frequent drug use in the last year for the former was 39 per cent, compared to 18 per cent for the latter; and
- those who had been in care or had been homeless reported the lowest levels of drug use while serious or frequent offenders and truants showed the highest. So, Class A drug use in the last year was five per cent for the former group, but 13 per cent for serious or frequent offenders and 16 per cent for truants.

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<sup>38</sup> A parental monitoring score assessed the level of knowledge that the pupils perceived their parents to have regarding their friends and activities.

<sup>39</sup> The 2003 Crime and Justice Survey had a nationally representative sample of 10,079 respondents in England and Wales aged 10 to 65 years old. This study focused on responses of the 4,574 10 to 25 year olds within the sample.

### *Young refugees and asylum seekers*

Patel *et al.* (2004) examined the vulnerability of young refugees and asylum seekers to drug use<sup>40</sup>. Approximately one third of their interviewees reported lifetime use of an illegal drug and only three were aware of the drug services available in the UK. The researchers also highlighted that this population are at risk of problematic drug use because of the risk factors often present in their situation (for example, barriers in accessing education and employment, poor accommodation, lack of family support and difficulties in establishing social networks).

#### 2.6.2 Predictive and risk factors amongst vulnerable young people

Beckett *et al.* (2004)<sup>41</sup> suggested a relative hierarchy of such factors, which predict increased levels of problematic drug use among young people:

1. perceived lack of parental discipline;
2. whether the respondent's peers are using drugs;
3. their age during the interview;
4. whether they have a history of running away from home;
5. if there is a parental lack of concern about smoking or alcohol issues;
6. if there are problems in the area (such as assault or burglary);
7. perceived lack of local amenities;
8. the age at which substance use began;
9. if they have a poor school attendance (or left school before they were 16 years old); and
10. if they are not living in a household with adults;

#### 2.6.3 Drug use among workers

Smith *et al.* (2004) surveyed 4,620 workers in Wales and highlighted that 13 per cent reported drug use in the last year. Drug use was associated with factors such as heavy drinking, smoking, being male, being under 25 years old, and living in a more affluent area.

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<sup>40</sup> Patel *et al.* (2005) interviewed 67 young people (aged between 16 and 25 year olds) who were born in countries such as Nepal, Iraq or Zimbabwe and who had been in the UK for between six months and 13 years.

<sup>41</sup> 103 young drug users (response rate 95%) completed a structured questionnaire in two study centres in England. Forty-six parents (response rate 70%) were also interviewed.

## 3. Prevention

### 3.1 Overview of the situation before 2004

Drug prevention among young people, especially those who are vulnerable, is a key element of the Drug Strategy (DSD 2002a; 2004a).

Drug education in schools is a key component of prevention. It aims to develop young peoples' knowledge, skills, attitudes and understanding about drugs to build their resistance. In England and Northern Ireland it is a statutory part of the national curriculum and in Scotland, where there is no statutory curriculum, the majority of schools provide drug education programmes using the 5-14 guidelines<sup>42</sup> (Scottish Executive 2003a). Information campaigns such as those focused on the young and their parents also form part of the prevention strategy<sup>43</sup>.

Vulnerable young people are seen as being at risk of using drugs and of problematic drug use (Cusick *et al.* 2003; Hammersley *et al.* 2003; Ward *et al.* 2003; Wincup *et al.* 2003), and drug prevention in areas of social disadvantage is seen as being part of the wider need to address social deprivation (DSD 2002a). Because these groups cannot always be reached through the school setting (for example, in the case of truants or school excludees), initiatives such as Positive Futures are based in the community.

In England, Wales and Northern Ireland, the Building Safer Communities (BSC) programme<sup>44</sup> supports local action (Home Office 2004b). In Scotland, the Scottish Drugs Forum (SDF)<sup>45</sup> works to develop communities' capacity and Scotland Against Drugs (SAD)<sup>46</sup> provides support to community-based initiatives aimed at drug prevention

### 3.2. Universal prevention

Universal prevention targets the general population regardless of individual levels of risk<sup>47</sup>, for example through the classroom setting.

As discussed in Section 1.3.3, the 2004 Spending Review Public Service Agreement (PSA) states that by 2008 there should be a reduction of Class A drug use and the frequency of use of any illicit drugs among all those under 25 years old, especially among the most vulnerable. Universal prevention will play a key part in this (DSD 2004a).

The Home Secretary has overall responsibility for the Drug Strategy, with involvement from organisations. The Secretary of State for Education and Skills leads on policy for preventing young people from becoming problematic drug users and shares responsibility with the Home Secretary for the delivery of this PSA's component.

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<sup>42</sup> Please see [www.ltscotland.org.uk/5to14/guidelines](http://www.ltscotland.org.uk/5to14/guidelines) for more details.

<sup>43</sup> See <http://www.talktofrank.com> and <http://www.knowthescore.info> for more details.

<sup>44</sup> In England and Wales, Communities Against Drugs (CAD) has now been subsumed under the Building Safer Communities programme (BSC).

<sup>45</sup> For more information, please see <http://www.sdf.org.uk>

<sup>46</sup> For more information, please see <http://www.sad.org.uk>

<sup>47</sup> See <http://www.publichealth.nice.org.uk/page.aspx?o=504111> for more information.

### *Every Child Matters*

In December 2003, the Government published the Green Paper *Every Child Matters*<sup>48</sup> (HM Treasury 2003). The Paper sets out the need to ensure that every child is properly protected from risk and is supported in reaching their full potential. The *Children Act 2004* will help to embed its principles in legislation. Although the Paper and the legislation go beyond drug prevention, the Paper's five key outcomes<sup>49</sup> are also important in preventing drug use (DSD 2004a; DfES 2005). The Paper is part of the *Every Child Matters: Change for Children Programme*, which is the responsibility of DfES.

Following the Paper's publication, the programme entered a consultation process. It highlighted that the aims of the Green Paper were strongly supported across the different sectors (DfES 2004a).

The Department for Education and Skills *et al.* (DfES *et al.* 2005) have outlined the Government's strategy of linking the delivery of *Every Child Matters* to the National Drug Strategy by developing universal, targeted and specialist services to prevent drug harm and to ensure that children and young people are able to reach their potential. The approach has three main objectives:

- Reforming delivery and strengthening accountability.
- Ensuring provision is built around the needs of vulnerable children and young people through a greater focus on prevention and early intervention by all agencies providing services for children.
- Building service and workforce capacity.

This is a joint approach between the DfES, the Home Office and the Department of Health, which is to be implemented nationally. Locally, Local Authorities are expected to progress towards meeting the required objectives. It also requires Drug (and Alcohol) Action Teams (D(A)ATs) and Directors of Children's Services to agree priorities and set targets with respect to young people. These will be included in the *Children and Young People's Plan* to be produced in 2006. Following the establishment of this joint approach, the Young People's Substance Misuse Grant was agreed in 2004. It will be used to develop drug intervention programmes for young people.

Joint teams<sup>50</sup> based in Government Offices (GO) will help local areas implement this approach (DfES *et al.* 2005). They will identify local problems and challenges, provide performance management and interventions, and negotiate local targets.

### *Youth Matters*

Following on from *Every Child Matters*, the Government has now published a Youth Green Paper called *Youth Matters* (HM Treasury 2005). The Paper seeks to improve outcomes for all young people (13 to 19 year olds), especially those who are vulnerable. It aims to restructure young people's services so that they have more choice and influence, encourage young people to participate in voluntary and community work, provide better information to them on the subjects that interest them and in a way that suits them, and to provide better support to those who need it.

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<sup>48</sup> For more information, please see <http://www.everychildmatters.gov.uk>.

<sup>49</sup> Being healthy, staying safe, enjoying and achieving, making a positive contribution to the community and society, and economic well-being (HM Treasury 2003).

<sup>50</sup> With staff from Government Office drug and crime teams, the DfES, the Youth Justice Board, the National Treatment Agency, Public Health and various regional bodies.

### 3.2.1 School

The Office for Standards in Education (Ofsted 2005) believes that standards in drug education have notably improved since 1997 regarding drug education planning, achievement, teaching quality and the number of schools with what are seen as effective procedures for managing drug-related incidents. However, there are also several issues which need addressing: in a number of schools, drug education continues to be taught through teachers without subject knowledge; poor assessment of drug education; and the need to develop a better understanding of pupil needs.

Guidance on drug education for schools in England (DfES 2004b) and in Northern Ireland (DENI 2004) was published in 2004 (see UK Focal Point Report 2004).

Her Majesty's Inspection of Education in Scotland (HMIE 2004) published their inspection report on Scottish schools' progress towards providing all pupils with appropriate drug education in November 2004. The report concluded that there has been a considerable increase in the provision of drug education, however there were areas which still need to be addressed, such as: partnership with other agencies; staff development; self-evaluation to improve learning; identifying pupils' needs; and building on prior learning.

#### *All Wales Schools Programme*

The Police-led All Wales Schools Programme encourages Police School Liaison Officers to work together with schools and Personal Social Education teachers to educate young people in an interactive and imaginative way about lifestyle risks<sup>51</sup>. It covers drug use, social behaviour and community safety. Those leading the project work alongside Community Safety Partnerships. Just under €3.0 million (£2 million) has been set aside for this project to run for three years from September 2003.

#### *Blueprint*

Launched in 2003, Blueprint is continuing to examine the effectiveness of a multi-component approach to drug education (see UK Focal Point Report 2004). In 2004, the project researchers interviewed teachers and assessed the impact of Blueprint on Year seven pupils (those aged 11 to 12 years old)<sup>52</sup>. The first research findings are due to be published in 2007. However, the National Children's Bureau will be publishing the Blueprint magazine and a booklet on Blueprint called Pupil Voice from the summer of 2005<sup>53</sup>. These will enable the participating children to share their experiences.

#### *Drug testing in schools*

The overwhelming majority of England's 25,000 schools are not planning to use methods such as drug tests or drug dogs (Ofsted 2005). As such, only one state school has introduced drug testing (BBC 2005b; Press Association 2005). The scheme randomly selects 20 pupils to be tested each week. Those with positive results will not necessarily be expelled unless they are supplying drugs. However, there has been little evaluative research on the impact of such schemes and the existing evidence lacks methodological rigour (McKeganey 2005). As such, Ofsted (2005) states that the use of these methods needs to be subject to an independent evaluation.

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<sup>51</sup> See <http://www.wales.gov.uk/subisocialjustice/content/grants/guidefeb05-sjr-e.htm> for further details.

<sup>52</sup> For more information, please see <http://www.drugs.gov.uk/NationalStrategy/YoungPeople/Blueprint>.

<sup>53</sup> See [http://www.ncb.org.uk/projects/project\\_detail.asp?ProjectNo=305](http://www.ncb.org.uk/projects/project_detail.asp?ProjectNo=305) for more information.

### *Education sector initiative*

The Education Sector Initiative (ESI) in Scotland was designed to systematically address the needs of secondary school teachers providing drug education (Lowden and Quinn 2004). Lowden and Quinn (2004) identified that 87 per cent of teachers<sup>54</sup> believed that the programme would help their school to promote more effective drug education and that 78 per cent thought that the training would help them to develop useful links between their school and such relevant services.

### *National Healthy School Standard*

In England, all schools in the most disadvantaged areas are to become 'Healthy Schools' by 2006 with all schools working towards Healthy School status by 2009/10 (see UK Focal Point Report 2004). The percentage of schools achieving the National Healthy Schools Standard (NHSS)<sup>55</sup> is one of the Key Performance Indicators of *Every Child Matters* (DfES *et al.* 2005).

Blenkinsop *et al.*'s (2004) evaluation of NHSS identified several key findings:

- Schools value their involvement in NHSS.
- Participation improved health-related work in schools.
- Active participation by children and young people is essential.

The Department of Health (DH) issued €6.1 million (£4.12 million) in 2003/04 to local education and health partnerships to develop drug education in NHSS primary schools. One hundred and thirty projects were funded in primary schools that encourage primary care teams to be involved in developing drug education work as part of the wider Personal Social and Health Education programme.

Northern Ireland runs a similar initiative through its Health Promoting Schools<sup>56</sup>. An evaluation of this is due in 2005.

The Welsh Network of Healthy School Schemes (WNHSS)<sup>57</sup>, launched in 1999 to encourage local healthy school schemes to develop within a national framework. All 22 local schemes have been accredited by the Welsh Assembly Government. The Welsh Assembly Government (2005) aims to have three quarters of schools involved by March 2008 and all schools to be involved by March 2010. At present 1,076 schools are involved, over half of the schools in Wales (Welsh Assembly Government, internal communication).

### *Online information*

Launched in May 2003, the FRANK campaign in England and Wales provides information about drugs to young people and their families. In its first year, 407,457 calls were made to its helpline, it distributed 22,590,000 campaign materials<sup>58</sup> and there were 1.5 million visits to its website<sup>59</sup> (Home Office *et al.* 2004a). FRANK is

<sup>54</sup> Questionnaires were completed by 1007 teachers and 106 probation teachers.

<sup>55</sup> The NHSS aims to support schools in creating an enjoyable, safe and productive learning environment. It covers eight areas: Personal, Social and Health Education (PSHE); citizenship; drug education (including tobacco and alcohol); emotional health and well being (including bullying); healthy eating; physical activity; safety; sex and relationship education; and local healthy school programmes. Health partnerships support schools in enabling them to become healthier places. Please see <http://www.standards.dfes.gov.uk> for further details.

<sup>56</sup> For more information, please see <http://www.investingforhealthni.gov.uk/schools.asp>.

<sup>57</sup> For more information, please see <http://www.cmo.wales.gov.uk/content/work/schools/wnhss-e.htm>.

<sup>58</sup> Such as leaflets, toolkits and Action Updates.

<sup>59</sup> See <http://www.talktofrank.com>.

planning to continue to build awareness of its brand, ensuring that the population knows about FRANK, knows what it offers and are able to access its resources.

Action packs are also issued through FRANK, which provide updates on local actions, information and advice, ideas for local action and activities, and press release templates (Home Office *et al.* 2004b, 2004c, 2004d). These cover specific issues such as the summer, crack cocaine and the family and are issued to prevention practitioners such as teachers and D(A)ATs. Although FRANK focuses on England, those in the devolved administrations can access the website or help line. Some publicity campaigns and publications also penetrate parts of the UK outside England.

The Scottish Executive runs a similar campaign through Know the Score<sup>60</sup>. In 2004, an evaluation was published assessing its success and showed that:

- awareness levels have declined slightly over the last two years (see Table 15);
- levels of awareness are noticeably higher amongst those in the campaign's target population of young people (89% of 16 to 25 year olds recognised a slogan or catchphrase compared to 60% of those aged over 16 years<sup>61</sup>); and
- 90 per cent of 16 to 25 year olds had seen at least one of the television adverts, and 80 per cent agreed that the adverts 'make you think about the consequences of drugs'.

*Table 15: Evaluating the Know the Score campaign amongst those aged over 16 years old in Scotland by year*

Level of awareness	2003	2004
Aware of a recent slogan or catchphrase – spontaneous awareness	10%	7%
Recognised a recent slogan or catchphrase – prompted awareness	67%	60%
<b>Number completing the questionnaire</b>	<b>1007</b>	<b>1001</b>

Source: Scottish Executive (2005b).

#### *Young People Substance Misuse Partnership Grant*

Various funding streams in England from the Department of Health, DfES, Home Office, the Youth Justice Board and the Spending Review were pooled in 2004 to form the Young People Substance Misuse Partnership Grant (YPSMG)<sup>62</sup>. In total for 2004/05, €87.6 million (£58.9 million) has been made available. The money is to be used by D(A)ATs and Crime and Disorder Reduction Partnerships (CDRPs) to deliver the young people aim of the National Drug Strategy<sup>63</sup>, for example through providing universal drug education, treatment, Young Person's Arrest Referral (within some areas) (see Chapter 9), training, and early prevention for vulnerable groups.

<sup>60</sup> Northern Ireland's equivalent is the National Drugs helpline (please see UK Focal Point Report 2004).

<sup>61</sup> Researchers surveyed 1001 people aged 16 and over, and within that population 317 were aged between 16 and 25 years old.

<sup>62</sup> For more information, please go to [http://www.drugs.gov.uk/WorkPages/CoreDocuments/PartnershipGrantGuidance/YPSMPPguidance\\_dp.V2.21-05-04.doc](http://www.drugs.gov.uk/WorkPages/CoreDocuments/PartnershipGrantGuidance/YPSMPPguidance_dp.V2.21-05-04.doc).

<sup>63</sup> To prevent young people from becoming problem drug users (DSD 2002a).

In Wales, the Building Safer Communities Funding of €12.1 million (£8.1 million) over 3 years, focuses on youth crime and disorder or which link in with other partnerships' and agencies' community safety strategies and initiatives, with a particular emphasis on work in deprived communities. (See Section 1.5.3 for more details on this.)

### 3.2.2 Family

Parental involvement in drug education can be very important (DfES 2004a, 2005). The FRANK campaign has developed an action pack for D(A)ATs and prevention practitioners on how to reach the family (Home Office *et al.* 2004d). However, Ofsted (2005) noted that despite the efforts of many schools to involve parents in their children's drug education, advice evenings have often been poorly attended. Those parents who live in rural areas, fathers, those who use drugs themselves, those from ethnic minorities and those with special needs have been especially difficult to reach. Such events are important because parents may lack drug knowledge, which will hamper effective drug-related communication with their children (DrugScope 2004).

DrugScope (2004) examined five different parent-orientated projects in England and Scotland. Their research suggests that:

- a needs assessment is essential for any project targeting parents to establish their needs and level of knowledge;
- involving local organisations can help to increase interest;
- working with volunteers can help to create levels of sustainability (although training and support will be needed);
- it can be advantageous to employ workers from the same community to improve credibility and understanding;
- outreach work may be required;
- using a more holistic programme can lead to increased levels of interest from parents, as DrugScope believes that the parents are less likely to feel intimidated.

### 3.2.3 Community

Shiner *et al.* (2004) examined the processes by which local communities are involved in drug and alcohol-related fields<sup>64</sup>. They concluded that the community element of the Drug Strategy should be re-examined. The notion of community is often tied to the criminal justice system and, where wider community engagement exists, it is often limited to supporting the former. However, in practice formal community involvement is more likely to focus on education, support for users and carers, and campaigning. Further, any approach treating communities as 'free-standing entities' will only provide a limited solution. Instead, 'community engagement' should be located within a broader perspective addressing the wider social forces that affect communities (such as employment policies, the impact of relative disadvantage or the effects of geographic isolation).

#### *Volatile Substance Abuse campaign*

In March 2005, the Scottish Executive (2005c) launched a campaign on Volatile Substance Abuse (VSA). Leaflets, posters and window stickers will aim to raise awareness among shop workers that it is an offence to sell butane gas lighter refills to those who are under 18 years old.

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<sup>64</sup> Preliminary interviews were conducted with seven key informants to identify the key issues. The survey then covered a representative sample of 37 Drug (and Alcohol) Action Teams (D(A)AT) areas in England and Community Safety Partnership areas in Wales. The case studies focused on specific projects for a more detailed examination of the issues identified.



### 3.3 Selective/indicative prevention

Selective or indicative prevention initiatives target those groups identified as being high risk such as truants or young offenders<sup>65</sup>.

#### 3.3.1 Recreational settings

Please see Chapter 13: Developments in drug use within recreational settings.

#### 3.3.2 At risk groups

The Drugs Strategy Directorate (DSD 2004a) emphasises that support and early interventions are needed for the key risk groups – the children of drug users, school excludees and truants, and young offenders. In addition, the Health Development Agency (now part of the National Institution for Clinical and Health Excellence, NICE) review of drug use prevention among young people identified looked-after children, young homeless and sex workers as vulnerable (Canning *et al.* 2004).

The National Collaborating Centre for Drug Prevention (NCCDP) published a review of the literature surrounding vulnerable young people in 2005 pulling together the evidence from these groups (Edmonds *et al.* 2005). This review revealed from the literature that:

- school is seen as an important setting for both protective reasons against drug use and for a setting in which to deliver drug education;
- training is needed for non-drug specialists (such as teachers or youth workers);
- young people should be assessed for drug-related needs as a matter of routine when they are in contact with non-drug agencies.

The following sections detail new information, where it is available, for most of the identified groups.

#### *Children of drug users*

In 2003, the Advisory Council on the Misuse of Drugs (ACMD) published a report on the needs of children of drug users. It estimated that there are between 250,000 and 300,000 children of problem drug users in the UK (that is one for every problem drug user) and suggested that reducing the harm caused to these children should be a priority in policy and practice.

The Government accepts the vast majority of the recommendations suggested by the ACMD, and intends to respond to them (see Section 7.6).

#### *Looked after children*

DfES *et al.* (2005) are developing a Key Performance Indicator (KPI) on drug use in this population. Data collection for this will begin in late 2005.

#### *School excludees and truants*

DfES *et al.* (2005) will explore the feasibility of developing a drug use KPI for excludees and truants. This will be implemented in 2005/06.

In addition, DfES (2004b) guidance for schools directs teachers to focus on the drug education needs of this group, and recommends that they:

- focus on harm reduction;
- involve a range of external contributors so additional approaches are offered;
- link with tier two and three services (such as young people's drugs services) for education, advice and support;

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<sup>65</sup> Please see <http://www.publichealth.nice.org.uk/page.aspx?o=504111> for further details.

- provide a variety of engaging activities focusing on life skills (such as through media or music);
- organise access to diversionary activities that focus on life skills and develop pupils' self-esteem and basic skills such as numeracy; and
- help pupils access further information and support.

### *Young offenders*

Early drug interventions are seen as being a priority for Youth Offending Teams (YOTs) (DSD 2004a). As part of the KPIs for *Every Child Matters*, all young offenders are to be screened for drugs so that their needs can be identified and appropriate interventions provided (DfES *et al.* 2005).

In addition to the vulnerable groups described above, work is also being done to stop drug use becoming problematic amongst heavy cannabis users. DSD (2004b) has developed guidance aimed at 16 to 24 year old heavy cannabis users to encourage them to re-assess their use. It also provides tools to control their dependence.

### *General strategies targeting at-risk groups*

DH (2004b) is funding the alliance of five children's charities<sup>66</sup> to work together on drug prevention. The project's three aims are to:

- develop the capacity of such charities to deliver support in drug prevention to those working with vulnerable children and young people;
- increase the levels of multi-agency working between such charities, D(A)ATs and children and young people's drug use services; and
- increase the levels of communication between charities and mainstream children's services for children and young people who have drug-related needs.

### *Every Child Matters*

*Every Child Matters* notes that services should be built around the needs of children and young people, especially around those who are vulnerable to drugs. As such, it has identified several key targets.

- All young people are to be able to access core services such as health and education services.
- Early assessment of all vulnerable children and young people to identify any drug-related issues so that the appropriate intervention can be involved.
- Agencies should have integrated information systems.
- Protocols are to be established that enable prompt access to services if required.

In Scotland, guidance was published on assessing the needs of both young drug and/or alcohol users, or those at risk of becoming so (EIU 2004a):

- Effective engagement with young people is key. Workers must be sensitive to their needs and must be aware that first impressions can determine whether the young person engages effectively.
- Continual assessment will help provide evidence to support need identification, and to inform the design of future interventions and approaches.

### *Positive Futures update*<sup>67</sup>

More than 50,000 vulnerable young people have participated in Positive Futures since its launch in 2000 (DSD 2004a).

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<sup>66</sup> Barnado's, the National Society for the Prevention of Cruelty to Children, the National Children's Bureau, the Children's Society and the National Children's Home.

<sup>67</sup> The closest equivalent in Scotland to Positive Futures is Sportscotland. However, it is not directly linked to drug prevention, aiming instead to involve all young people in sport.

Positive Futures staff will include more drug use interventions within the programme (DSD 2005b). Interventions are usually delivered jointly by both specialist agencies and the lead Positive Futures agency. However, interventions are increasingly being delivered in-house because confidence has increased through training and increased involvement of the D(A)ATs.

The programme has reported success in educational reintegration: between February and October 2004, 493 young people who were participating regularly returned to full-time education, 2,423 were doing better at school and 515 had achieved other educational improvements (DSD 2005b).

### 3.3.3 At-risk families

Because of the impact of drug use on the family, the Effective Interventions Unit (EIU 2004b) published a review on supporting the families and carers of drug users. It provided several recommendations for family support services:

- They should focus on the needs of the family and the carer.
- They should be open, accessible and non-judgemental.
- They should participate in needs assessment and in designing services.

Please also see Section 3.2.2 for details on providing information to hard to reach parents, and Section 3.2.2 for information on the children of drug using parents.

### 3.4 Future actions

DSD (2004a) aims to:

- Improve identification and assessment of children and young people's drug use needs, especially for those in known risk groups.
- Increase services to vulnerable young people through programmes such as Positive Futures (see Section 3.3.2).
- Support those schools in the most disadvantaged areas to become a Healthy School (see Section 3.2.1) by 2006 and all schools by 2009/10.
- Continue to provide information about drugs to young people and parents through FRANK (see Section 3.2.2) and through schools.
- Ensure those working with children and young people have the appropriate skills to identify risk factors and drug use as early as possible.
- Provide further support to those areas with the highest need.

## 4. Problem drug use

### 4.1 Overview

Population-based surveys<sup>68</sup>, because of the often hidden nature of problem drug use, are considered to be of limited use in estimating the full extent of problem drug use. More reliable estimates can be derived from alternative methods, with the multivariate indicator method being one such approach (Hickman *et al.* 2004). This combines local prevalence estimates<sup>69</sup> with routinely available indicator data. Based on these, and reported in the UK Focal Point report for 2004, the estimate for problematic drug users was 9.35 per thousand (with a Confidence Interval or CI of 8.99 to 9.79 per thousand), with a total problem drug use population estimated at 360,811. For injecting drug use, the estimate was 3.2 per thousand (123,498 with a CI of 3.07 to 3.34 per thousand population aged 15 to 64 years). These rates varied across the UK (see Table 16).

Table 16: National prevalence estimates for problem drug use in the United Kingdom

Country	Year	Problem drug use		Injecting drug use	
		Number	Rate per thousand population	Number	Rate per thousand population
England	2000/01	287,670	8.91 95% CI= 8.53 to 9.29	93,185	2.89 95% CI= 2.87 to 2.91
Northern Ireland	2000	828	0.76 95% CI= 0.63-0.93	No estimate	No estimate
Scotland	2000	55,800	16.65 95% CI= 16.45 to 17.53	24,696	7.737 95% CI= 5.87 to 8.58
<b>UK</b>	<b>2000/1</b>	<b>360,811</b>	<b>9.35</b> <b>95%</b> <b>CI=8.99 to</b> <b>9.79</b>	<b>123,498</b>	<b>3.2</b> <b>95% CI=</b> <b>3.07 to 3.34</b>

Source: Information Services Division (ISD 2002)<sup>70</sup>; McElrath (2002)<sup>71</sup>; Frischer *et al.* (2004)<sup>72</sup>; Hay (2005b).

At the local level, estimates of problem drug use in Scotland range from 2.9 in the Orkney Isles to 30.8 per thousand (CI = 26.6-36.7) in Glasgow (ISD 2002). In Greater Manchester, estimates of local prevalence of problem drug use are 13.9 per

<sup>68</sup> Such as the British Crime Survey, Northern Ireland Crime Survey or Scottish Crime Survey.

<sup>69</sup> Local estimates are usually derived from specific research studies that employ slightly different definitions of what constitutes problem drug use. The capture-recapture method is the most widely used to provide local prevalence estimates.

<sup>70</sup> ISD (2002) derived their national estimate through using the sum of the 32 local prevalence estimates. Here, problem drug use is defined as opiate and/or benzodiazepine use.

<sup>71</sup> McElrath (2002) used the capture-recapture method for Northern Ireland. Here, problem prevalence is defined as heroin use.

<sup>72</sup> Frischer *et al.* (2004) used information gathering to collect the data for England.

thousand of the population aged 16 to 54 years old (19,255, 95% CI of 18,731-21,853; Millar *et al.* 2004).

There have been variations between countries regarding the characteristics of clients presenting to treatment. On the whole, heroin is the main drug used although there has been a rise in cocaine-based drugs. In Scotland, however, while heroin has been the most common main drug of use, diazepam (rarely reported elsewhere in the UK) has been the second most commonly used drug. In Northern Ireland, just over a quarter reported the use of opiates as their primary drug, and nearly half reported cannabis (cannabis as the primary drug used by those presenting to services is rarely reported elsewhere in the UK). Injecting as main route of administration also varies between countries; with just over a quarter of clients reporting having ever injected in Northern Ireland and Scotland, but a much higher level of 59 per cent in England and Wales.

For all new presentations (presentations where the individual has not previously been in treatment during the reporting period), approximately a third are under 24 years of age and a quarter of clients are aged between 25 and 29 years old; approximately three quarters are male (see UK Focal Point report for 2004 and for 2003).

## **4.2 Prevalence and incidence estimates**

### **4.2.1 National estimates**

Following on from previous research in 2000, a study in Scotland examined national and local estimates of the prevalence of problem drug use and drug injecting in 2003 using the capture-recapture method (Hay *et al.* 2004). Overall, the estimated prevalence of problem drug use dropped from 55,800 in 2000 to 51,582 in 2003 (this was approaching significance at the 95% level, at 93%).

Currently a research study using capture-recapture and the multivariate indicator method is being used to provide a national estimate and local estimates for each of the 149 Drug (and Alcohol) Action Team (D(A)ATs) areas of England. The researchers will provide estimates by age group (covering the overall age range of 15 to 64 years old, which is compatible with the EMCDDA guidelines), and the estimates will be for the three successive years starting from 2004/05. A capture-recapture study is also currently being undertaken in Northern Ireland.

### **4.2.2 Local estimates**

There have been a few local prevalence studies, using capture-recapture methods, carried out in parts of England and Wales in the last year. In Sandwell<sup>73</sup>, the prevalence of opiate and/or cocaine use was estimated to be 21.12 per thousand of the population aged 15 to 64 (3,773 with a 95% CI 15.93 to 28.84) (Quigley 2005).

## **4.3 Profile of clients in treatment**

Information on clients in treatment is for the financial year 2003/04<sup>74</sup>. Data from across the UK have been combined to provide a national picture of clients<sup>75</sup>. Number of presentations for each country is shown in Table 17.

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<sup>73</sup> A metropolitan borough in the West Midlands in England.

<sup>74</sup> From 1 April 2003 to 31 March 2004.

<sup>75</sup> Data are provided by the National Drugs Evidence Centre, Information and Statistics Division in Scotland, Department for Health Social Services and Public Safety Northern Ireland, and Health Solutions Wales.

Table 17: Number of presentations for treatment in the UK in 2003/04 by country

Presentation status	England	Northern Ireland	Scotland	Wales	UK
<i>Outpatients</i>					
First presentations	19,921	984	5,635	1,357	27,897
Previous presentations	26,836	425	5,468	818	33,547
Not known	28,270	N/A	N/A	1,945	30,215
<b>Total</b>	<b>75,027</b>	<b>1,409</b>	<b>11,103</b>	<b>4,120</b>	<b>91,659</b>
<i>Inpatient</i>					
First presentations	748	No data available	109	No data available	857
Previous presentations	1,121	No data available	228	No data available	1,349
Not known	1,832	No data available	N/A	No data available	1,832
<b>Total</b>	<b>3,701</b>	<b>N/A</b>	<b>337</b>	<b>N/A</b>	<b>4,038</b>
<i>GP</i>					
First presentations	499	No GP treatment provided	620	No data available	1,119
Previous presentations	1,414	No GP treatment provided	527	No data available	1,941
Not known	906	No GP treatment provided	N/A	No data available	906
<b>Total</b>	<b>2,819</b>	<b>N/A</b>	<b>1,147</b>	<b>N/A</b>	<b>3,966</b>
<i>Total presentations</i>					
First presentations	21,168	984	6,364	1,357	29,873
Previous presentations	29,371	425	6,223	818	36,837
Not known	31,008	N/A	N/A	1,945	32,953
<b>Total</b>	<b>81,547</b>	<b>1,409</b>	<b>12,587</b>	<b>4,120</b>	<b>99,663</b>
Percentage of clients who are outpatients	92.0%	N/A	88.2%	N/A	92.0%
Percentage of clients who are inpatients	4.5%	N/A	2.7%	N/A	4.1%
Percentage of clients who see General Practitioners	3.5%	N/A	9.1%	N/A	4.0%

Definitions of first and previous presentations vary according to country.

For England and Wales, new presentations refer to those presentations that were started in 2003/04 and previous presentations refer to those who began their treatment episode before 2003/04. For Northern Ireland and Scotland, new presentations refer to those who have never been in treatment before or for whom it has been at least six months since their last attendance and previous presentations apply to those who are continuing their treatment episode or whose last treatment episode was within the previous six months.

Source: National Drugs Evidence Centre, Information Services Division, Scotland; Department for Health Social Services and Public Safety Northern Ireland, Health Solutions Wales.

#### 4.3.1 By substance used

Two thirds of clients (66.2%) presenting to treatment in the UK use opiates as their main drug (see Figure 3 and Table 18). However, variations are apparent across the individual countries, for example:

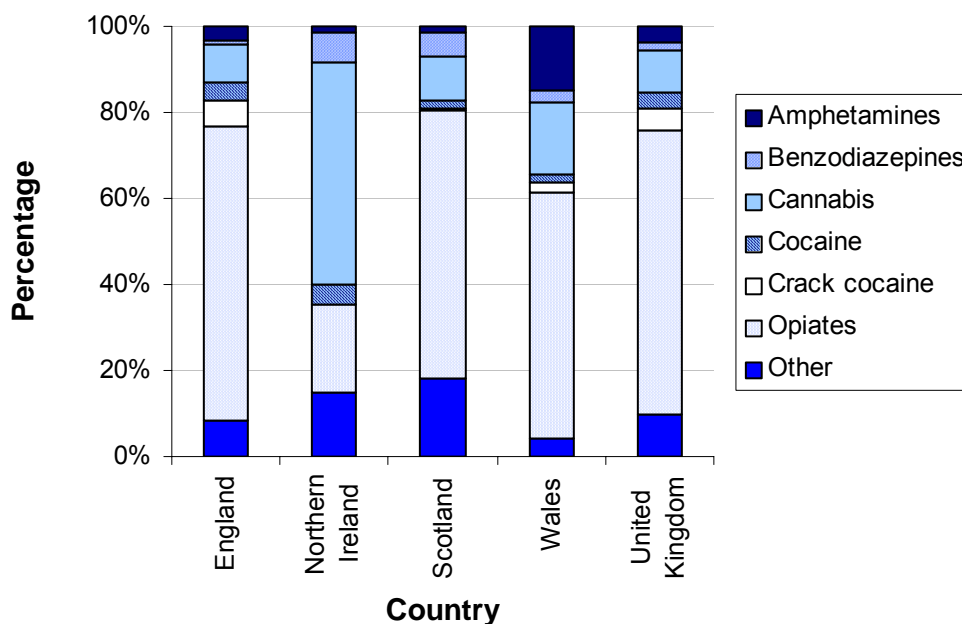
- in Northern Ireland only 20.3 per cent report opiate use, instead the most commonly reported drug is cannabis (51.7%);
- in Wales, amphetamines are much more commonly reported as a primary drug of use than elsewhere in the UK (14.8%);
- England shows the highest levels of reported use of crack cocaine as a primary drug (6.0%).

*Table 18: Number and percentage of treatment presentations in 2003/04 by primary drug of use and by country*

Primary drug of use	England (%)	Northern Ireland (%)	Scotland (%)	Wales (%)	UK (%)
Amphetamines	2,643 (3.2%)	19 (1.4%)	203 (1.6%)	609 (14.8%)	3,474 (3.5%)
Benzodiazepines	1,015 (1.2%)	97 (6.9%)	698 (5.5%)	119 (2.9%)	1,929 (1.9%)
Cannabis	7,165 (8.8%)	727 (51.7%)	1,262 (10.0%)	695 (16.9%)	9,849 (9.9%)
Cocaine	3,342 (4.1%)	68 (4.8%)	249 (1.9%)	80 (1.9%)	3,739 (3.8%)
Crack cocaine	4,859 (6.0%)	3 (0.2%)	35 (0.3%)	83 (2.0%)	4,980 (5.0%)
Opiates	55,531 (68.1%)	286 (20.3%)	7,836 (62.3%)	2,359 (57.3%)	66,012 (66.2%)
Other / unknown	6,989 (8.6%)	209 (14.9%)	2,304 (18.3%)	175 (4.2%)	9,680 (9.7%)
<b>Total</b>	<b>81,547</b>	<b>1,409</b>	<b>12,587</b>	<b>4,120</b>	<b>99,663</b>

Source: National Drugs Evidence Centre, Information Services Division, Scotland; Department for Health Social Services and Public Safety Northern Ireland, Health Solutions Wales.

Figure 3: Percentage of treatment presentations by country and by drug in the United Kingdom



Source: National Drugs Evidence Centre, Information Services Division, Scotland; Department for Health Social Services and Public Safety Northern Ireland, Health Solutions Wales.

#### *Cocaine and crack users reporting for treatment*

Neale and Robertson (2004)<sup>76</sup> examined 585 new treatment clients in Scotland and found that those who had recently used cocaine and/or crack had distinct characteristics as they were more likely to:

- have used non-prescribed benzodiazepines in the previous 90 days;
- be seeking residential treatment;
- have recently committed an acquisitive crime;
- have been robbed, attacked or assaulted in the last six months;
- have a spouse or partner; and
- have a longer history of problematic drug use.

#### 4.3.2 Centre type

The majority of treatments (93%) are undertaken through community based specialist drug services (outpatient treatment).

#### 4.3.3 Gender

Across the UK, 72 per cent of treatment clients are male and 28 per cent are female (see Table 19). This difference has been the same for a number of years. However, in Scotland, the proportion is very different with 57 per cent of clients being male.

<sup>76</sup> This research has been carried out as part of the Drug Outcome Research in Scotland (DORIS) (please see Chapter 5.2.6 for more details on DORIS). For this study, 1,007 drug users starting a new episode of drug treatment were recruited from services across Scotland, including the Scottish Prison Service (SPS) and the primary care sector.



Table 19: Percentage of male and female clients presenting to treatment in the United Kingdom in 2003/04 by country

Gender	England	Northern Ireland	Scotland	Wales	UK
Female	28	24	34	27	28
Male	72	75	57	73	72

Source: National Drugs Evidence Centre, Information Services Division; Department for Health Social Services and Public Safety Northern Ireland, Department of Health.

#### *Gender differences in clients entering treatment*

Neale (2004a)<sup>77</sup> examined the characteristics between men and women beginning a new treatment episode in Scotland. For example, women were more likely to: be younger than men (24 years old compared to 28); have been involved with social services; have been dependent on state benefit; sell sex; be in arrears with rent; live in a poorly maintained building; have at least one child living with them; or have been physically or sexually abused by a partner, a relative or family friend.

Men displayed other characteristics such as being more likely to: have considered their cannabis use to be problematic; to have used injecting equipment after someone else; have undertaken education or training in the six months before interview; have earned money from informal or cash-in-hand employment and to have had legal employment in the six months prior to interview; have begged or sold the Big Issue<sup>78</sup>; have reported illegal debts; have sold or supplied drugs; have stolen from a person, house or home or vehicle; have caused criminal damage; have committed assault; or have stayed with relatives or had slept rough.

(See Chapter 11 for a full report on gender differences.)

#### 4.3.4 Physical and sexual abuse amongst clients

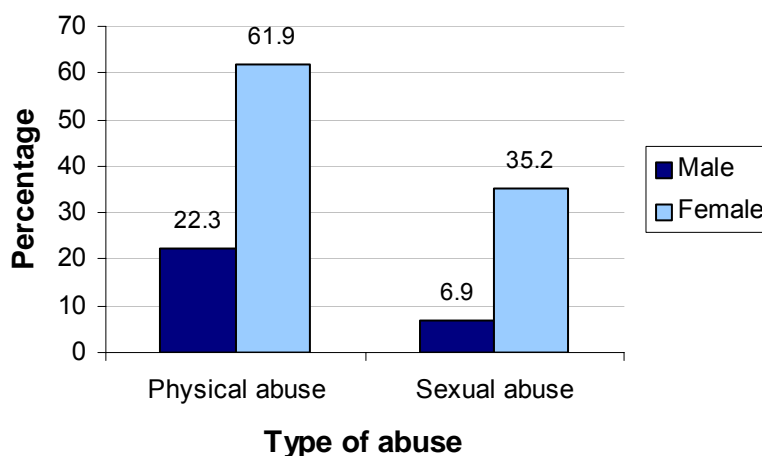
McKeganey *et al.* (2005)<sup>79</sup> noted that a considerable proportion of those in treatment have been physically or sexually abused, and that women are more likely to have been abused than men (see Figure 4). Past abuse was associated with younger age at onset of drug problems, suicide or self-harm attempts, overdose and involvement in prostitution in the last 12 months.

<sup>77</sup> This research was part of DORIS, where 1,033 treatment clients were interviewed in Scotland. (Please see Chapter 5.2.6 for more details on DORIS.)

<sup>78</sup> The *Big Issue* is a street newspaper published on behalf of and sold by homeless people.

<sup>79</sup> This research was part of DORIS, where 1,033 treatment clients were interviewed in Scotland. (Please see Chapter 5.2.6 for more details on DORIS.)

Figure 4: The percentage of those in drug treatment in Scotland who have been physically or sexually abuse by gender



Source: McKeganey *et al.* (2005).

#### 4.4 Main characteristics and patterns of use from non-treatment sources

Shewan and Dalgarno (2005) suggest that heroin can be taken in a controlled, non-intrusive fashion for an extended period – without the negative health and social outcomes normally associated with use<sup>80</sup>. Key points from the research included:

- 74 per cent were employed and well represented at the higher end of the employment sector – 27 per cent were placed in occupational class I or II;
- 81 (64%) had progressed to educational levels beyond secondary school, with only 6 (5%) reporting no educational qualifications;
- full-time higher education students made up 11 per cent of the group; and
- 15 per cent were unemployed.

<sup>80</sup> The longitudinal study focused on 126 long-term heroin users, who had never received specialist treatment for any drug use (including alcohol) or served a custodial sentence. All participants had illicitly used opiates at least ten times in each of the last two years. Participants had been using heroin for an average of seven years.

## 5. Drug-related treatment

### 5.1 Overview

UK drug strategies identify treatment as being effective in tackling problem drug use and, therefore, indicate a need to increase its availability and quality (NIO 1999; Scottish Office 1999; National Assembly for Wales 2000; DSD 2002a). In seeking to ensure quality treatment in 2000, the Effective Intervention Unit (EIU) was established to identify and disseminate effective practice in Scotland. In 2001, the National Treatment Agency for Substance Misuse (NTA) was established in England to increase the availability, capacity and effectiveness of drug treatment. The Department of Health, Social Services and Public Safety, Northern Ireland (DHSSPSNI), and the Welsh Assembly Government are responsible for similar arrangements.

While the ultimate goal of treatment has been abstinence, the *Updated Drug Strategy* in 2002 emphasised the need to reduce the harms associated with problem drug use (DSD 2002a). Treatment providers are to offer advice and information, needle exchange, care planned counselling, structured day care programmes, community prescribing, inpatient drug treatment and residential rehabilitation. In addition, drug users are to be offered relapse prevention and aftercare programmes, hepatitis B vaccinations, and testing and counselling for hepatitis B and C, and HIV (DH 2002a). With regards to prescribed treatment, oral methadone maintenance is the most common method used in treating heroin addiction, although recently buprenorphine has been introduced (injectable heroin and methadone are also available). Pilots for specialist crack treatment have been introduced as part of the National Crack Plan (DSD 2002b).

In the UK, the majority of treatment for problem drug users has been through specialist community-based treatment services with open referral, and increasingly through General Practitioners (GPs). Treatment is provided free of charge. GPs have been encouraged (DH 2002a) to provide treatment, and this is usually undertaken through shared care arrangements with specialist community-based services. Inpatient care is reserved for those drug users with particularly acute problems, for rehabilitation or for detoxification (although the latter is now more commonly undertaken in the community).

Referral into treatment through the criminal justice system and whilst in prison, is a further component of UK Drug Strategy (see Chapter 9).

### 5.2 Treatment system

#### 5.2.1 Treatment effectiveness in England

##### *Treatment expansion*

Expanding treatment remains a key priority in the UK. The Healthcare Commission has included drug treatment as one of the eight key indicators used to assess the performance of Primary Care Trusts in England<sup>81</sup>. In addition, latest directives from the Drug Strategy Directorate state (DSD) that:

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<sup>81</sup> Please see <http://www.nhs.uk/england/aboutTheNHS/starRatings/pctPI.cmsx> or [http://ratings2005.healthcarecommission.org.uk/Trust/Overview/pct\\_overview.asp](http://ratings2005.healthcarecommission.org.uk/Trust/Overview/pct_overview.asp) for further details.

*Effective treatment helps individual drug misusers escape from addiction and crime, and improves their health and their lives. Effective treatment helps communities as the link between drug misuse and offending is broken and fewer crimes are committed. Effective treatment helps society as the costs of drug misuse are reduced (DSD 2004a).*

As such, treatment has been expanded, and in England:

- since 1998, the number of drug users in treatment had increased by 54 per cent in 2003 (from a baseline of 100,000) (DSD 2004a); and provisional figures for 2004/05 suggest that 160,050 clients were in contact with treatment services in England (NTA 2005a), a 27 per cent increase on 2003/04<sup>82</sup>;
- waiting times have been reduced by 72 per cent compared to 2001 (so that average waiting times are now two to four weeks or less in the highest crime areas, compared to six to 12 weeks) (DSD 2004a); and
- over half of all clients entering treatment (52%) in 2003/04 were retained in treatment for twelve weeks or more<sup>83</sup>.

#### *Improving treatment effectiveness*

In June 2005 in England, the NTA (2005b) launched a strategy to improve treatment effectiveness. It aims to:

- provide quick access to structured treatment (that is within three weeks<sup>84</sup>) - with faster access for some such as pregnant women or offenders; and
- retain clients for at least 12 weeks so they receive the maximum benefits.

Guidance has been published for managers and commissioners of services on retaining clients in treatment (NTA 2005c). This provides information, advice, research, evaluated best practice and guidance on performance management concerning retention. It suggests that a number of factors can help in retaining clients, including:

- reminders to encourage clients to keep coming to appointments;
- motivational interventions;
- quicker entry into treatment;
- client induction, so that the client understands what to expect of drug treatment.

The NTA (2005d) has also published guidance relating to nurse prescribing.

#### **5.2.2 Treatment effectiveness in Scotland**

*A Partnership for a Better Scotland* committed the Scottish Executive to reviewing and investing additional resources in drug treatment and rehabilitation services across Scotland (Scottish Executive 2004a). This reflected concerns about the continuing rise in drug-related deaths (DRDs) in Scotland and unacceptably long waiting times for drug services. The review recognised that a number of issues needed to be addressed, including:

- waiting times remaining high in some parts of Scotland;
- the need for more crisis/respite beds;
- the need for further and faster progress in the delivery of integrated care;
- the need to ensure care offered reflects appropriate, evidence based practice;

<sup>82</sup> This is due both to increases in the number of clients in contact with treatment services but also to improvements in the National Drug Treatment monitoring system.

<sup>83</sup> For more details, please see

<http://www.nta.nhs.uk/frameset.asp?u=http://www.nta.nhs.uk/home/main.htm>.

<sup>84</sup> If this does not happen, the NTA have stated that there should be a local investigation.

- while noting that DRDs fell in 2003, more needs to be done to reduce loss of life; and
- the need to ensure current and future investments get through to frontline services and produce results, noting that the lines of accountability between the Executive, Drug (and Alcohol) Action Teams (D(A)ATs) and local service providers has become blurred and information systems need to be made fit for purpose.

As such, an Action Plan to improve services called for (Scottish Executive 2004a):

- improving access and increasing options through: reducing waiting times; improved service integration and information sharing; ensuring D(A)ATs have realistic timetables for individuals accessing treatment; widening and improving the range of services available; funding the roll-out of Drug Treatment and Testing Orders (DTTOs) so that they are in place across Scotland by June 2005; and improving the links between the community and prisons;
- improving service quality and consistency through: developing National Care Standards; performing an external service audit; providing improved training; supporting D(A)ATs to monitor services and emphasise best practice guidance;
- integrating service delivery through: improving links between treatment and services offering aid, for example, regarding housing or employment; promoting interventions which help drug users into employment; and supporting drug services in identifying children of drug-using parents;
- reducing DRDs through: supporting the national investigation into drug-related deaths and its recommendations; developing a targeted campaign emphasising the risks of injecting; monitoring progress made abroad; approaching the Scottish Advisory Committee on Drug Misuse regarding the possibility of widening Naloxone availability; and supporting the Scottish Drugs Forum's First Aid training; and
- increasing funding and improve accountability through: increased investment in treatment (see Section 1.4); linking treatment funding to capacity and quality; re-examine existing treatment and rehabilitation targets to focus on capacity, access and outcomes; and review the work of the Scottish D(A)ATs.

### 5.2.3 The Welsh treatment system

A Welsh standardised data collection and reporting system has been developed to underpin a performance management framework for drug use treatment services<sup>85</sup>. Once the database has been established, stage two will involve producing key performance indicators. Stage three will deliver a research and evaluation programme.

In September 2003, development began of the Substance Misuse Treatment Framework for Wales (Welsh Assembly 2003b). It will imitate the professional consensus on what works best for drug users (including alcohol misusers). Its development has been informed by *Models of Care* (DH 2002a) and will be completed by March 2009.

### 5.2.4 The provision of treatment for young people

#### *England*

Providing drug services for young people is a priority in the UK Drug Strategy (DSD 2002a). As such, the Home Office, Department for Education and Skills (DfES), Department of Health (DH) and the Office of the Deputy Prime Minister (ODPM) have

<sup>85</sup> For more information, please see <http://www.hsw.wales.nhs.uk> and <http://www.wales.gov.uk/subicsu/content/substance/pmframework/pid-e.htm>.

developed the Young People's National Delivery Plan for 2004 to 2008. It aims to ensure that drug use issues are identified among vulnerable young people as early as possible and that individuals have access to the appropriate services and interventions<sup>86</sup> (see Chapter 3 for more details on prevention).

In April 2005, the NTA (2005e) published guidance establishing the types and standards of services that should be available in young people's treatment services. This document highlights the Key Performance Indicator, which has been set:

*increase the participation of young problem drug users (under 18 years of age) in treatment programmes by 50 per cent between 2004 and 2008.*  
(NTA 2005e).

In addition (NTA 2005e):

- the DSD is producing an online commissioning toolkit<sup>87</sup>;
- the DSD is developing guidance on the Young People's Substance Misuse Partnership Grant (YPSMG; see Section 3.2.1), and commissioning in children's services and in relation to performance management framework; and
- the NTA is developing models of integrated care pathways to aid referral into young people's treatment services.

### *Scotland*

During 2004, the EIU (2004a) produced guidance for commissioners and providers on identifying young people's drug-related needs in designing their effective assessment. A consultation was subsequently held with a range of stakeholders including young people and their families (EIU 2004c).

### *Wales*

As part of the Substance Misuse Treatment Framework for Wales (Welsh Assembly 2003b), work has commenced on the production of a Children and Young People's module. This will contain guidance on education, prevention and treatment services. Publication of the consultation document is anticipated in March 2006.

## 5.2.5 Referral into treatment through the criminal justice system

The Drug Interventions Programme (DIP) was referred to in the 2004 UK Focal Point Report (see Section 9.3.3). In September 2004, it was reported that €266.4 million (£179 million) extra funding would be made available for the treatment of problematic drug users and will be targeted at the most seriously affected drug users (that is, those with the most complex problems who are the most likely to drop out of treatment<sup>88</sup>) (DH 2004c). These extra funds should allow for an extra 40,000 drug users to be treated by 2008 and an expansion in treatment for those under 18 years of age.

## 5.2.6 Research

A number of pieces of research, commissioned to help in improving treatment outcomes were completed during 2004/05.

*Drug Outcome Research in Scotland:* The Drug Outcome Research in Scotland (DORIS) study is based at the University of Glasgow's Centre for Drug Misuse. It is examining the effectiveness of Scotland's drug treatment services and how evidence

<sup>86</sup> For more information, please see

<http://www.dfes.gov.uk/datastats1/guidelines/children/pdf/2005%2006%20OC2%20letter.pdf>.

<sup>87</sup> This will be available on [www.drugs.gov.uk](http://www.drugs.gov.uk).

<sup>88</sup> This includes persistent offenders and drug offenders with associated alcohol and mental health problems.

of what works can be incorporated into treatment. The researchers have recruited 1,007 drug users who are starting a new drug treatment episode from across Scotland<sup>89</sup>. As part of DORIS, McKeganey *et al.* (2004) noted that 56.6 per cent of their sample of 1,007 drug users in treatment identified abstinence as the only goal they sought to achieve (others sought reduced or stabilised drug use, and 1% sought safer use).

*Drug Treatment Outcomes Research Study:* The National Drug Evidence Centre (NDEC) was commissioned by the Home Office in June 2005 to investigate treatment outcomes (University of Manchester 2005). This research, the Drug Treatment Outcomes Research Study (DTORS), will follow 3,000 drug users from across England for an initial 12 months, examining how treatment influences factors such as levels of drug and alcohol use, offending behaviour, health issues and other social outcomes. A cost-benefit analysis will also be undertaken.

#### *Treatment retention*

NDEC (2004)<sup>90</sup> has found that the strongest predictor of treatment retention or completion is not a characteristics of the clients, but rather is related to the nature of agency that they attend. Those clients who received both counselling and prescribing were the most successful (regarding retention or completion), implying that services providing a package of prescribing and psychosocial support are more likely to be effective.

#### *Treatment outcomes*

Gossop (2005a) reviewed four major national drug treatment outcome studies: the National Treatment Outcome Research Study (NTORS) in the UK and three American studies<sup>91</sup>. These studies showed that treatment clients displayed considerable reductions in illegal drug use and improvements in injecting risk behaviours. Length of time in treatment was associated with better treatment outcomes. However, overdose remained a serious problem and many clients continued to drink heavily.

In addition, Gossop's (2005b) review examined the relationship between treatment and crime. He noted that effective drug treatment can facilitate crime reduction, so benefiting society by reducing the costs of crime.

*The effectiveness of psychological therapies:* Wanigaratne *et al.* (2005) suggested that there is a substantial evidence base for the effectiveness of psychological interventions with drug users. Programmes such as family interventions, motivational interviewing and relapse prevention appear to be effective across a range of substances. They noted that community reinforcement and contingency management are rarely used in the UK and could be developed further.

*Substance use nurses:* Matheson *et al.* (2004)<sup>92</sup> highlighted consistency of practice between substance use nurses across Scotland with high levels of consultation with other colleagues. Nurses felt a substantial part of their role to rest in counselling, yet

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<sup>89</sup> For more information, please see <http://www.gla.ac.uk/centres/drugmisuse/DORIS.html>.

<sup>90</sup> This was based on information collected from treatment services in the North West of England from April to September in 2001 and 2,616 clients from community-based services.

<sup>91</sup> The American studies involved were the Drug Abuse Reporting Programme (DARP), Treatment Outcome Prospective Study (TOPS) and Drug Abuse Treatment Outcome Study (DATOS).

<sup>92</sup> Matheson *et al.* interviewed 29 nurses, received 192 questionnaires from nurses working in substance use and performed observational fieldwork.

there are questions about their individual level of competency. The report recommended further exploration of which counselling models could be used to assess whether current training procedures are adequate.

#### *Research from the Drug Misuse Research Initiative*

The Drug Misuse Research Initiative (DMRI) is a €3.6 million (£2.4 million) programme of research running from 2000 to 2005<sup>93</sup>. It comprised 14 studies in the areas of drug treatment and prevention, some of which were reported by the 2004 UK Focal Point report. Those not previously reported, are detailed below.

*The effects of time on a waiting list on clinical outcomes in opiate addicts:* Research found that while reduced waiting times was associated with more successful treatment entry, it did not improve treatment retention (Ridge *et al.* 2004)<sup>94</sup>.

*The needs and views of drug service users:* Moring *et al.* (2004)<sup>95</sup> looked at treatment pathways for new clients. Their findings reiterated those of previous studies, which have shown that service culture and staff attitude can affect retention.

*The effectiveness and cost effectiveness of cognitive behaviour therapy:* Drummond *et al.* (2005)<sup>96</sup> examined the differences between cognitive behaviour therapy (CBT) and methadone maintenance treatment (MMT). They found that there was no significant difference in treatment outcome and both were identified as being cost effective.

*Dexamphetamine substitution:* Merrill *et al.* (2004)<sup>97</sup> undertook a two-centre randomised controlled trial of dexamphetamine substitution for amphetamine dependence. The study observed that dexamphetamine prescribing did not significantly reduce illicit amphetamine use or reduce injecting behaviour compared to drug-free methods. In addition, some evidence suggested poly drug use in the prescribed group. However, those prescribed dexamphetamine showed significant improvements in physical health. The researchers suggested that dexamphetamine may be suitable for treating cocaine dependence.

### **5.3 Drug free treatment**

The NTA estimates that about 30 per cent of treatments in England could be identified as drug free in that they offer either rehabilitation, structured counselling or structured day care (although medication may still be involved as part of the treatment). Figures for 2004/05 suggest that of 163,985 treatment episodes in England, 4,148 (2.5%) were in residential rehabilitation, 13,161 (8.0%) were in

<sup>93</sup> Please see <http://www.mdx.ac.uk/www/drugsmisuse/index.html> for further details.

<sup>94</sup> The study recruited drug users attending a drop-in assessment service for methadone prescribing. Patients were randomly allocated into either 'fast-track' structured drug treatment (around two weeks after first contact) or a 'standard' wait (lasting approximately 8 weeks on average but this changed substantially).

<sup>95</sup> The researchers performed semi-structured interviews with 46 service users and 51 drug service providers across the North of England.

<sup>96</sup> The study was based on a randomised, parallel group design comparing cognitive behavioural therapy with methadone maintenance against methadone maintenance alone. Outcome assessments were performed twice a year with 60 clients in 10 community based clinics in three English regions.

<sup>97</sup> Fifty-nine participants fulfilling DSM IV criteria for amphetamine dependence were recruited from two centres in England and Wales. Participants were randomly assigned to dexamphetamine or drug-free treatment.



structured day care and 39,348 (24.0%) were in structured counselling (Best and Abdulrahim 2005).

### 5.3.1 Inpatient treatments

#### *Inpatient provision in England*

In a needs assessment of current inpatient provision, Best *et al.* (2005) suggest that at least 24,500 inpatient and residential places are needed in England to meet demand (comprising approximately 16,390 in inpatient detoxification services and 8,190 in residential rehabilitation - an increase of 90% and 34% respectively). Improvements are also required in the management of existing services to ensure flexibility and sufficient support after inpatient treatment has ended.

#### *Client retention in residential rehabilitation services*

A survey of client retention in residential rehabilitation services in England found that 48 per cent of those admitted in 2004 completed treatment, 32 per cent quit and 19 per cent were discharged for disciplinary reasons (Meier 2005)<sup>98</sup>. Increased levels of client retention were associated with fewer beds, less housekeeping duties, higher service fees and providing between one and two hours of individual counselling per week.

#### *Detoxification and rehabilitation services in Scotland*

The EIU (2004d) reviewed residential services in Scotland. Key findings included:

- Twenty-one residential detoxification and rehabilitation units were identified in Scotland, with 329 beds for adult drug users<sup>99</sup>. However, there is no comprehensive directory of residential services in Scotland.
- Approximately 1,294 Scottish drug users were admitted to residential treatment between April 2003 and March 2004 (905 in 2002/03), although these figures are likely to be an underestimate.
- Completion rates for residential detoxification programmes were around 75 to 80 per cent. However, relapse was also common. In comparison, residential rehabilitation programmes have low levels of client retention, with 25 per cent leaving after two weeks, and 40 per cent leaving within three months.
- Detoxification programmes have better long-term outcomes if they are followed up by structured aftercare.
- Four main factors influencing the effectiveness of residential rehabilitation programmes are: time in treatment (those programmes lasting at least 3 months are more likely to be effective), retention, client characteristics and aftercare provision.
- On average, a week in residential rehabilitation programme costs between €461.3 (£310) and €632.5 (£425), although some cost much more. The cost of residential detoxification may be at least double this because of the clinical input required.

### 5.3.2 Outpatient treatments

#### *Treatment for crack users*

Following the pilot services for crack users in 2003, guidance for those working with crack in primary care was issued by the Royal College of General Practitioners and Substance Misuse Management in General Practice (Shapiro 2004)<sup>100</sup>.

<sup>98</sup> Fifty-seven of 87 (65%) residential services identified in England responded to a postal questionnaire replied to the survey.

<sup>99</sup> This does not include residential crisis services or supported accommodation services.

<sup>100</sup> See [www.rcgp.org.uk/drug/index.asp](http://www.rcgp.org.uk/drug/index.asp) for more details.

An impact evaluation of pilot service specification and treatment delivery models has been completed (NTA 2005f)<sup>101</sup>. It aimed to improve the availability and quality of drug treatment for crack/cocaine users. The research covered 13 drug services across 11 cities in England. The study concludes that those exposed to the intervention tools were positive about their utility and impact, with associated gains in health and social engagement. However there was little evidence of service re-design or efforts to embed changed practices among the participating services.

## **5.4 Medically assisted treatment**

### **5.4.1 Withdrawal Treatment**

#### *Inpatient detoxification*

Of 163,985 treatment episodes in England in 2003/04, 3,466 (2.1%) involved inpatient detoxification (Best and Abdulrahim 2005).

In a review of opiate detoxification, Day (2005) suggested rates of successful completion are higher in inpatient settings.

#### *Community based drug detoxification*

The EIU (2004e) published guidance to inform evidence-based practice in planning and delivering community-based drug detoxification. It suggests that various key issues need to be addressed when developing a person-centred integrated-care pathway including assessment of the individual's needs and aims, sharing information between partner agencies and continually monitoring the service.

### **5.4.2 Substitution treatment**

Substitution treatment remains the main treatment in the UK<sup>102</sup>. Of 163,985 treatment episodes in England in 2004/05, 20,686 (12.6%) involved GP prescribing and 60,292 involved specialist prescribing (36.8%) (Best and Abdulrahim 2005).

The National Institute for Health and Clinical Excellence (NICE) is producing appraisals for substitute prescribing. These will cover the effectiveness and cost effectiveness of methadone and buprenorphine (Welsh Assembly Government 2004c; House of Commons 2005).

#### *Prescribing of diazepam*

A change in regulations to enable the prescribing and dispensing of diazepam in instalments for treating drug addiction came into force in April 2005; guidance is to be issued<sup>103</sup>.

#### *Prescribing of injectable diamorphine*

In December 2004 the Department of Health announced a shortage of injectable diamorphine (DH 2004d). Although the numbers requiring injectable diamorphine are low<sup>104</sup>, it is suggested that those for whom it is prescribed are among the most vulnerable, and for whom other interventions have not been successful (Cook *et al.*

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<sup>101</sup> Over a hundred crack users, predominantly white were recruited into the study, of whom a large proportion was successfully followed up.

<sup>102</sup> However, as reported in last year's report, substitute prescribing was only initiated in April 2004 for the first time in Northern Ireland (DHSSPSNI 2004).

<sup>103</sup> Please see [http://www.psn.org.uk/index.php?type=more\\_news&id=1590&k=9](http://www.psn.org.uk/index.php?type=more_news&id=1590&k=9) for more details.

<sup>104</sup> The NTA (2003) estimates the number to be around 450.

2005). As such, the NTA have prepared a briefing for service users to explain the problem and provide advice (NTA 2005g).

#### *The costs of methadone*

A Scottish report suggested that the average cost per patient per year of methadone hydrochloride, in 2003, was €906.3 (£609); this includes only the cost of the medication and dispensing (ISD 2005a).

#### 5.4.3 Other medically assisted treatment

Only prescribed treatments are offered with medical assistance.

## 6. Health correlates and consequences

### 6.1 Overview

#### 6.1.4 Drug related deaths

- Drug-related deaths (DRDs)<sup>105106</sup> in the UK rose steadily from 1996 until 2001, but have since fallen. In Scotland, according to the ONS definition, deaths continued to rise until 2002.
- Males are more likely to suffer DRDs than females, by over 4:1 (which is not dissimilar to the gender ration for problematic drug users), with the difference closing over the last decade.
- The overall average age at death (which rose from 33.7 years in 1996 to 35.2 years in 2000) fell in 2001 and 2002 to 34.0 years. The age at death for females has been considerably higher than that for men, ranging from an excess of 4 to 9 years in different years.
- Males are more likely to die at a younger age of drug dependence through non-dependent abuse of drugs, and females at an older age by means of intentional/undetermined poisoning.
- Most deaths are associated with opiates (chiefly heroin/morphine and methadone), often in combination with other drugs and/or alcohol. Large numbers of deaths also involve benzodiazepines such as temazepam and diazepam. However, the non-opioid drugs most often mentioned are antidepressants and paracetamol - either alone or in compound preparations.
- The number of cases implicating methadone peaked in 1993, having fallen since then.
- In Scotland, diazepam is more likely to be involved than elsewhere in the UK (for example in 2001, it was involved in 47% of the 332 DRDs recorded by the General Register Office for Scotland; GROS 2002).

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<sup>105</sup> There are two main types of source in the UK for information on 'acute' deaths: three General Mortality Registers (GMRs - the General Register Offices for England and Wales (GRO), Scotland (GROS), and Northern Ireland (GRONI)) and one Special Mortality Register (SMR - the National Programme on Substance Abuse Deaths or np-SAD) based at St George's Hospital Medical School, University of London. The General Mortality (GMR) data are derived from medical death certificates. Whilst the GMRs for England and Wales, and Scotland have established special databases to monitor DRDs, this has not yet happened in Northern Ireland. The UK-wide use of ICD-10 in coding DRDs provides consistency in approach. There are three different definitions that are used in the UK when discussing drug-related deaths: that of the Office for National Statistics (ONS), that of the UK Drug Strategy and that of the European Monitoring Centre for Drugs and Drug Addiction. However, the adoption of a common definition for the Drug Strategy baseline figure means that valid comparisons are now possible between different parts of the UK.

<sup>106</sup> Because of differences in the information published by ONS (who publish GRO data), GRONI and GROS, it is impossible to derive UK statistics from published sources. However, statistics from all three GMRs have been collated by the UK Focal Point Expert on DRDs since 2000. This means that UK figures using all three definitions are available on the EMCDDA Standard Tables 5 and 6.

### 6.1.2 Blood borne infectious diseases

HIV<sup>107</sup> prevalence among injecting drug users (IDUs) in the UK has remained at less than or around one per cent since the mid-1990s, although in London it has been higher, at or near, four per cent. At the end of 2002, there were an estimated 1,400 people living with HIV infection acquired through injecting drug use, of whom 300 were thought to be undiagnosed. Prevalence of hepatitis C (HCV) has been much higher at around 40 per cent of IDUs, and there is evidence of increased incidence (Health Protection Agency 2004a). Prevalence of antibodies for hepatitis B (anti-HBc) has declined, levelling off at 20 per cent. Outbreaks of hepatitis A and other infections among IDUs have been increasingly reported<sup>108</sup>, following reported increases in injecting risk behaviour (Hope *et al.* 2002).

### 6.1.3 Dual diagnosis

Prevalence and attribution of dual diagnosis remain difficult to estimate. Depression, anxiety disorders, personality and psychotic disorders are commonly reported, although prevalence varies with setting and specific sub-populations. It has been suggested that that from 1993 to 1998 there were at least 195,000 comorbid patients and 3.5 million general practitioner (GP) consultations involving such patients in England and Wales (Frischer *et al.* 2003). Eighty to 90 per cent of patients consulting for both drug abuse and mental illness do so for the first time. The level of comorbidity is increasing at a higher rate among younger patients, which indicates that comorbidity may increase in future years. Approximately one-third of psychiatric discharges involve a supplementary rather than a main diagnosis of drug use. In these cases, the most common diagnoses were: schizophrenia, mood (affective) disorders, and alcohol misuse.

There is also increasing information regarding the association of mental health issues with cannabis (Patton *et al.* 2002) and ecstasy use (MacInnes *et al.* 2001), although this needs further investigation.

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<sup>107</sup> Data on the prevalence of blood borne infectious diseases amongst injecting drug users (IDUs) are provided by a number of sources. The Unlinked Anonymous Prevalence Monitoring Programme's (UAPMP) surveys of IDUs in contact with drug services in England, Wales and Northern Ireland (Hope *et al.* 2001; Unlinked Anonymous Steering Group 2002); the Centre for Research on Drugs and Health Behaviour's surveys of IDUs recruited from community settings in England (Hunter *et al.* 2000); and the Scottish Centre for Infection and Environmental Health's (SCIEH) surveys of IDUs attending community and drug agency settings in Glasgow (Taylor *et al.* 2000). SCIEH also holds anonymous epidemiological data on all those who have had a named HIV antibody test in Scotland since 1989 (on the HIV Denominator Database). All collect behavioural data and oral fluid for testing for antibodies to hepatitis C (anti-HCV). The main sources of information on newly diagnosed HIV/AIDS infections are from voluntary cases reporting from laboratory reports of newly diagnosed infections by microbiologists and clinicians. For England, Wales and Northern Ireland, reports are made to the Health Protection Agency's Communicable Disease Surveillance Centre (CDSC) whilst new diagnoses in Scotland are reported to Health Protection Scotland. Laboratory report data for England and Wales, Scotland, and Northern Ireland are available from the following websites: <http://www.hpa.org.uk> for England and Wales, <http://www.hps.scot.nhs.uk/> for Scotland and <http://www.cdscni.org.uk> for Northern Ireland.

<sup>108</sup> Methicillin resistant *Staphylococcus aureus* (MRSA) as a cause of IDU-related sepsis (CDR Weekly 2003) and other serious Clostridial infections acquired through contaminated drugs have been reported (Jones *et al.* 2002; McGuigan *et al.* 2002).

### 6.1.4 Other health correlates and consequences

While a number of other physical health problems are associated with problem drug use<sup>109</sup>, evidence of the extent of problems is not readily available.

Maternal drug use can have a significant impact on unborn children (through, for example, early pregnancy loss, placental disruptions and low birth weight babies). However, withdrawal from maternal drug use can also be problematic for babies, particularly due to benzodiazepines (DH *et al.* 1999). Benzodiazepines are linked to “floppy infant syndrome”, major malformations such as cleft palate, and deviation in neurological development during their first 18 months (which can result in behavioural problems, dyslexia and attention-deficit disorder - problems may not come to light until puberty) (Bibby 2000). Cleft palate is also associated with amphetamine use (Bibby 2000) and evidence has emerged that children whose mothers used cocaine during pregnancy are at risk of haemorrhaging as they grow older (DH *et al.* 1999). There is also concern about birth defects linked to ecstasy use (Ho *et al.* 2001). However there is little information about the nature and extent of these problems.

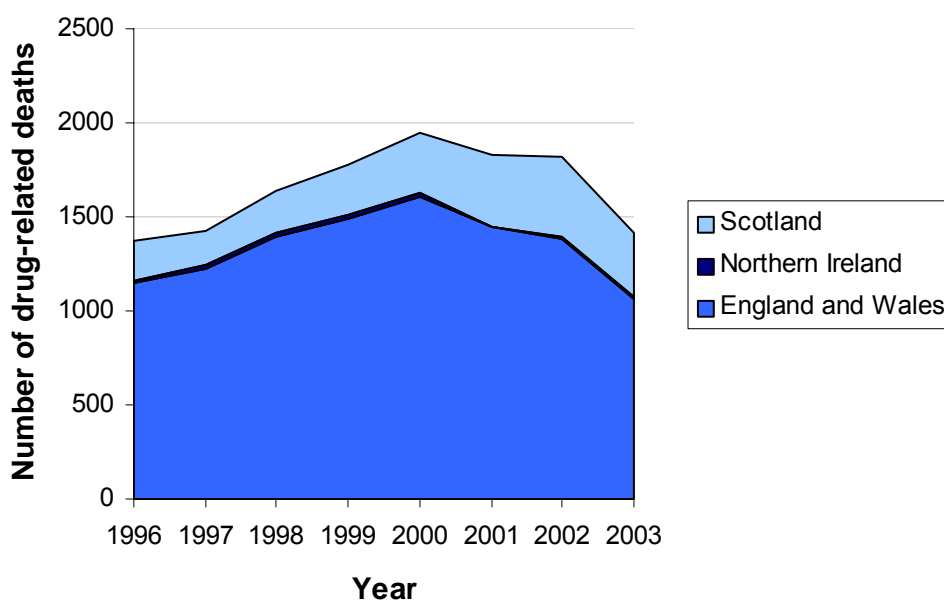
In the UK, there is little evidence of HIV transmission to babies through maternal infection specifically associated with drugs, but there is a risk of hepatitis transmission, particularly HCV, where the risk of transmission amongst babies whose mothers test positive is six per cent (DH 2002b; Siney 2001).

## 6.2 Drug-related deaths and mortality of drug users

### 6.2.1 Direct overdoses (differentiated) indirect drug-related deaths

Latest available data for DRDs are from 2003. The total number of deaths in the UK was 1,416 (Figure 5 and Appendix 2); a fall of 27.2 per cent since the peak in 2000.

*Figure 5: Number of deaths in the United Kingdom using the European Monitoring Centre for Drugs and Drug Addiction’s drug-related deaths definition from 1996 to 2003, by country*



Source: Corkery (2005).

<sup>109</sup> This includes thrombosis, blood clots and gangrene (ACMD 2000) as well as health problems that are associated with problem drug users’ lifestyles including poor diet.

The number of deaths per 100,000 of the population shows that differences exist between the different countries in the UK: in 2003 the rate in Scotland was 6.79 compared to 2.02 in England and Wales and 0.23 in Northern Ireland. The UK average was 2.38.

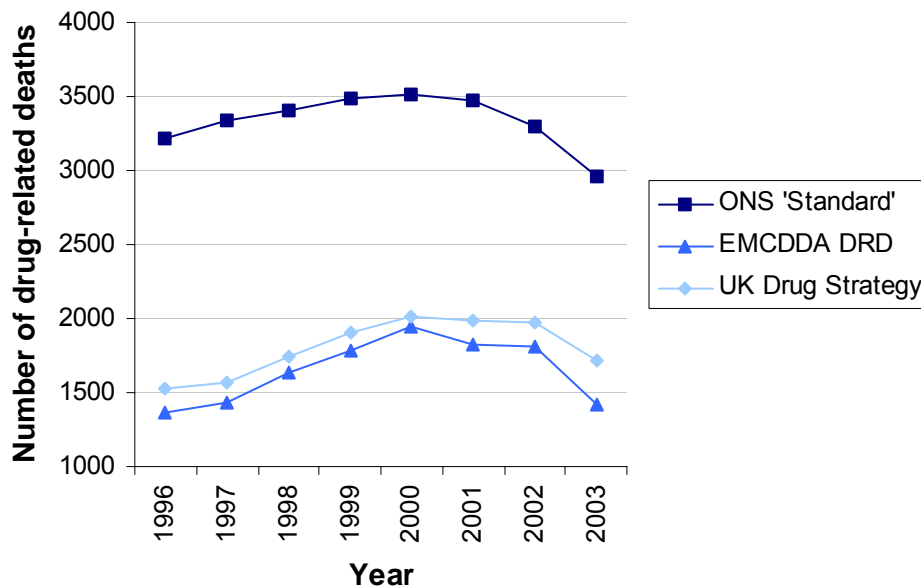
Gender differences also exist (see Chapter 11 for a full discussion on gender in the UK). Of the DRDs in the UK in 2003, 80.4 per cent (1,139) were male and 19.6 per cent (277) were female (a male:female ratio of 4.11:1, continuing the decline from previous years). The highest proportion of males was 80.7 per cent in England and Wales and the lowest in Northern Ireland at 75.0 per cent (Figure 2).

The average age of those dying was 35.3 years (Standard Deviation or SD is 12.6), a rise from the previous two years, with males (34.2 years, SD 11.1) tending to be about 5 years younger than females (39.4 years, SD 17.6). Age at death tended to be higher in Northern Ireland than in the rest of the UK. Overall, most deaths occurred in the 30 to 34 year old age group (for both males and females).

#### *Drug-related deaths by definition*

To obtain a comprehensive understanding of DRDs in the UK, it is necessary to look at data derived from other definitions (see Figure 6 and Appendix 2). The definition used by the Office for National Statistics (ONS) is much broader than the other two and so the totals produced are different, although the trend followed is reasonably similar.

*Figure 6: The number of drug-related deaths in the United Kingdom from 1996 to 2003 according to the definition*



Source: Corkery (2005).

#### *Drug-related deaths by drug implicated*

In England and Wales using the ONS definition from 1993 to 2003, more than one drug was mentioned on the death certificate in 23.7 per cent (7,022 out 29,659 over the 11 year period) of DRDs, and alcohol in 22.9 per cent (6,792) of drug poisoning deaths in England and Wales. In England and Wales most deaths were associated with opiates: heroin and/or morphine were implicated in 55 per cent (591) of reports

and methadone in 20 per cent (216) in England and Wales in 2003. After a substantial rise in cocaine deaths to 171 mentions on death certificates in 2002, these fell to 113 (mentioned in 11 per cent of death certificates). Deaths involving ecstasy, accounting for only 0.8 per cent of drug-related deaths, also fell from 55 in both 2001 and 2002 to 33 in 2003.

In Scotland diazepam was involved in 31 per cent and methadone in 18 per cent of cases. The number of DRDs involving heroin and/or morphine trebled from 1996 to 2002, but fell by 27 per cent in 2003 (being implicated in 35%). As in England and Wales the mention of ecstasy on death certificates fell.

The number of DRDs in Northern Ireland is very low and has been without any discernible trend from year to year. The DRDs involve mostly opiates and related narcotics. The first death in the Province involving oxycodone was recorded in 2003.

In the UK, the number of deaths attributed to volatile substance abuse continued to decline in 2003 to 51 (65 in both 2002 and 2001). This is the lowest figure since 1982 and compares with the peak of 152 in 1990 (Field-Smith *et al.* 2005).

### 6.2.2 Mortality and causes of deaths among drug users

In 2003 in England and Wales, the largest proportion of deaths related to drug poisoning (using the ONS definition) was described as intentional/undetermined poisoning (1,159 out of 2,445 or 47.4%), followed by mental & behavioural disorders (655 or 26.8%) and then accidental poisonings (626 or 25.6%) (Griffiths 2005).

#### *AIDS deaths*

Deaths of IDUs from AIDS accounted for 7.6 per cent of the total number of AIDS deaths in England and Wales up to the end of December 2004<sup>110</sup>. In Northern Ireland, the figure was 5.1 per cent, but in Scotland it was 51.0 per cent. The decline in the number of deaths of IDUs from AIDS seen in recent years has continued: in 2003, 65 IDUs died from AIDS compared to 80 in 2002, and 212 in 1995.

#### *A case-control study of illness and death amongst IDUs in Glasgow*

Taylor *et al.* (2005a) highlighted that *Clostridium novyi* and other bacteria were important agents in 60 deaths and illnesses amongst injecting drug users in Scotland. They also noted that muscle-injecting cases were significantly more likely to inject larger amounts of heroin per average injection than controls.

#### *Drug related suicides*

Nicoll *et al.* (2003) found that of the suicides and undetermined deaths in the Grampian region of Scotland, a greater proportion of those with previous psychiatric contact were drug users between 1991 and 1999 than between 1974 and 1990 (odds ratio or OR = 3.75, 95% Confidence Interval or CI [2.7, 5.2]).

#### *Fatal poisoning*

A study of fatal poisonings between 1983 and 1999 in England, Scotland and Wales found that chloral hydrate, clomethiazole, barbiturates and related sedatives had much higher fatal toxicity indices than anxiolytics such as benzodiazepines, buspirone, zolpidem and zopiclone (Buckley and McManus 2004). There was also a substantial reduction in the annual number of deaths from sedative drug poisoning due to a sustained reduction in prescriptions for high toxicity drugs.

<sup>110</sup> Data were provide to John Corkery from the Health Protection Agency via a personal communication.



### *The role of methadone in fatalities*

Corkery *et al.* (2004) reviewed the effects of methadone (such as renal failure, respiratory depression and cardiac problems) and their role in related fatalities. They suggested that methadone-related deaths can be averted if individuals' tolerance levels are considered and polydrug use is avoided.

### 6.2.3 Research into drug-related deaths

#### *National Programme for Substance Abuse Deaths*

Data from the National Programme for Substance Abuse Deaths (np-SAD)<sup>111</sup> database are broadly consistent with those from ONS. Reports show that (Ghodse *et al.* 2004):

- seventy to seventy-five per cent of cases are male and about 75 per cent are under 45 years of age;
- from 1997 to 2003, two-thirds of cases had a history of drug abuse or dependence, and on average death was 10 years or more earlier than for this group than for those without such a history;
- deaths involving methadone were more likely to be the result of possibly illicit (60% or more) rather than prescribed drugs;
- in 2003, 46 per cent of those who died were unemployed (40% lived alone and 5 to 6% were of no fixed abode); and
- In 2003, about two-thirds of cases died in a defined residential address, a quarter in hospital, and seven to eight per cent elsewhere (e.g. a public place).
- GHB was implicated in two cases in 2003.

#### *The effect of legislation limiting the size of analgesic packs*

Two studies examined the effect of legislation change in September 1998 to limit the size of analgesic packs sold over the counter. Hawton *et al.* (2004) found that suicidal deaths from paracetamol and salicylates decreased by 22 per cent in the year in England and Wales following the change, and that the numbers continued to fall in the next two years<sup>112</sup>.

In Scotland, deaths from paracetamol poisoning fell by 45 per cent in the year following the legislative changes, but rose in the following three years to reach the same levels as before the legislative change (Inglis 2004). These results suggest further limitations and public education are needed to sustain the benefits achieved.

#### *Populations at risk*

Data from the Special Mortality Register show that most male accidental poisoning deaths occur amongst young age groups who consume illicit drugs, whereas most female deaths involve deliberate overdoses on antidepressants and (opioid) analgesics. It also shows geographical differences (both locally and between administrations) in the types of drug and mode of administration. Therefore, local interventions should be based on local patterns of consumption and knowledge of the phenomena specific to the locale.

<sup>111</sup> The np-SAD coroners' database provides a useful crosscheck on ONS data. It acts as a complementary source of information since it collects data on a wider range of variables and continues to expand its coverage across the UK.

<sup>112</sup> In 1996-98, there were 364 deaths related to any paracetamol or salicylate in England and Wales, compared to 284 in 1998-99 and 274 in 1999-2001.

### *Cohort mortality studies*

The Drug Treatment Outcome Research Study (DTORS) will be monitoring mortality amongst its 3,000 subjects across England during the last 3 months of 2005 (see Section 5.2.6).

A cohort study of 667 IDU patients in a large Edinburgh family General Practitioner (GP) practice found that there had been changes in the cause of deaths between 1980 and 2001 (Copeland *et al.* 2004). Death rates peaked in the early to mid-1990s, reflecting the development of advanced HIV from the early 1982-4 epidemic (the onset of antiviral chemotherapy in the late 1990s helped to lower the number of deaths). The principal cause of death was overdose in the early years, HIV/AIDS in later years, and towards the end of the study period HCV emerged as a cause of death. Drug deaths and suicides tended to occur in younger subjects.

#### **6.2.4 Methodological issues in the monitoring of DRDs**

A number of inquiries and reviews investigating DRDs were completed in 2003 to 2005 (GRO 2003; Home Office 2003a; NIO 2003a, 3003b; Shipman Inquiry 2003; TSO 2003; Home Office 2004c; NICS 2005). These could impact significantly not only on how DRDs are investigated but also on what information is recorded and by whom. If the principal recommendations are acted upon, it is anticipated that there will be:

- a more consistent approach toward death certification, investigation and registration will be in place, with guidelines and codes of good practice.
- an increase in use of toxicology in the future (potentially increasing the number of DRDs identified).
- changes to the roles of coroners and their organisation so that jurisdictions align to the suggested new geographic units.

Full details are expected to be included in a White Paper on a new death certification and investigation service for England and Wales. A draft Bill was included in the background papers to the Queen's Speech 17 May 2005, but little detail was given.

### **6.3 Drug-related infectious diseases**

Infectious disease continues to be a cause of considerable levels of morbidity and mortality among IDUs in the UK.

Initial results from the Unlinked Anonymous Prevalence Monitoring Programme (UAPMP) enhancement pilot study are now available, this study recruited IDUs in community settings at five locations in England and collected dried blood spot samples (n=952). They are presented alongside those from the UAPMP agency survey 2004 (n=2,686 of which 1,625 were current IDUs, i.e. had injected in the preceding month) and other data on infections among IDUs in the current Shooting Up report (Health Protection Agency 2005a). A summary of key trends and new data is discussed in Section 6.3.1 and 6.3.2.

#### **6.3.1 HIV**

Various reports were published in 2005, which provided an estimate of HIV prevalence amongst IDUs.

- A recent analysis<sup>113</sup> permitted a closer examination of trends in HIV infection among current IDUs in England in Wales between 1990 and 2003. It showed that HIV prevalence declined in the early 1990s from 5.6 per cent in 1990 to 0.6 per cent in 1996 and then increased in recent years to 1.4 per cent in 2003 (Hope *et al.* 2005).
- The prevalence amongst current IDUs participating in the UAPMP agency survey in England in Wales in 2004 was 1.5 per cent (Health Protection Agency 2005a). This is the highest level of prevalence amongst current IDUs in this survey since 1992 when it was 2.0 per cent.
- A cohort study of IDUs was recently undertaken in London and, to a lesser extent, Brighton to estimate the rate of HIV infection among new IDUs (Judd *et al.* 2005). The study found an incidence of 3.4 per cent among the 428<sup>114</sup> HIV negative IDUs in this study; levels were higher amongst those reporting (during the follow-up interview) that they injected crack-cocaine. The UAPMP enhancement pilot study supports this, as those participants who had injected crack-cocaine also had a higher prevalence of HIV than those who had not (1.3% and 0.4% respectively) (Health Protection Agency 2005a).

These higher prevalence levels amongst those reporting crack cocaine injecting may be linked to evidence showing that this population demonstrate have higher levels of risk behaviours. Those participants in the UAPMP enhancement pilot reporting injecting crack-cocaine (two-fifths had) were more likely to have engaged in sharing needles and syringes in the last month (42% compared to 29% of those not injecting crack cocaine). They were also more likely to have used their last needle at least five times (15% compared to 8% for those not injecting crack-cocaine) (Health Protection Agency 2005a).

The UAPMP agency survey suggests that an increasing proportion of IDUs may be unaware of their HIV infection (Health Protection Agency 2005a). In 2004, 37 per cent of those participating in this survey reported never having had a voluntary confidential test for HIV, and only 50 per cent of those who had antibodies to HIV were aware of their infection. This is the lowest level of awareness seen in this survey since the question was first asked in 1995.

Although the rate of HIV infection in the UK remains low, it is considerably higher in London, among all the participants in the UAPMP agency survey HIV prevalence was 3.9 per cent in London compared with 0.6 per cent elsewhere; whilst combining data for 2003 and 2004 the prevalence in Northern Ireland was 2 per cent (n=153) (Health Protection Agency 2005a). However, a high proportion of IDUs are also accessing needle exchange services – 88 per cent (2,326 of 2,644) of IDUs in the UAPMP agency survey report lifetime use of a needle exchange service.

### 6.3.2 Viral hepatitis

In 2004, 45 per cent of the current IDUs<sup>115</sup> in the UAPMP agency survey have been infected with HCV (Health Protection Agency 2005a), increasing from 40 per cent of current IDUs in 1998 (Hope *et al.* 2001). However, there are marked regional variations in HCV prevalence that have been sustained over time. For example,

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<sup>113</sup> This analysis combined data from IDUs participating in the UAPMP agency survey with data from IDUs recruited through surveys undertaken by the Centre for Drugs and Health Behaviour.

<sup>114</sup> The participants were under 30 years old and an injecting history of six years or less – all had injected in four weeks before the study.

<sup>115</sup> Current injecting drug users are defined as those who had injected drugs in the four weeks prior to participating in the survey.

combined data from the IDUs who participated in the UAPMP agency surveys of 2003 and 2004 show that HCV prevalence was 18 per cent in Wales, and 25 per cent in Northern Ireland (Health Protection Agency 2005a). In England, prevalence levels ranged from 20 per cent in the North East to 55 per cent in London and 59 per cent in the North West<sup>116</sup>. In Scotland, the prevalence of HCV among those IDUs who had undergone a voluntary confidential HIV test in 1999/2000 varied from 23 per cent in Forth Valley to 62 per cent in Greater Glasgow (Hay *et al.* 2001).]

Initial results from the UAPMP enhancement pilot study found that 54 per cent had antibodies to HCV (anti-HCV)<sup>117</sup> (Health Protection Agency 2005a). Those who had injected crack-cocaine were found to have a higher prevalence than those who had not (67% and 45% respectively).

The cohort study of IDUs in London, and to a lesser extent Brighton, estimated the annual incidence of HCV to be 41.8 per cent (Judd *et al.* 2005; see Section 6.3.1). This incidence is similar to prevalence levels, suggesting that transmission may have recently increased.

During 2004, a community-wide survey of 531 current IDUs in Glasgow found the prevalence of HCV was as high as 77 per cent (Taylor, internal communication). Among the 55 IDUs who had commenced injecting in the previous two years, the prevalence of HCV was 51 per cent; this prevalence was higher than that detected among equivalent IDUs surveyed in 1999 (24%) and 2001 (43%).

Recent work has estimated that approximately 50,000 persons were infected with HCV in Scotland (representing 1% of the population) in 2004 (Scottish Executive 2005d). Of these it was estimated that 37,500 (75%) were chronically infected (comprising 33,000 individuals who have ever injected drugs) and 30 to 40 per cent had been diagnosed with their infection. Of the 33,000 ever IDUs living in Scotland with chronic HCV in 2004, it was estimated that 22,800, 8,400 and 1,800 had mild, moderate and severe (cirrhosis) HCV respectively.

### 6.3.3 Sexually Transmitted Infections

NO NEW INFORMATION

### 6.3.4 Tuberculosis

NO NEW INFORMATION

### 6.3.5 Other infectious morbidity

There is a continuing problem with bacterial infections among IDUs, including ongoing problems with group A streptococcal infections. The UAPMP enhancement pilot found that 58 per cent of the participating IDUs reported having a possible symptom of an injecting site infection or reaction<sup>118</sup> in the last year, and 36 per cent reported having an abscess, sore or open wound at an injecting site in the last year (Health Protection Agency 2005a). Of these, 53 per cent sought medical attention. Those who had injected crack-cocaine were more likely to have had an abscess, sore, or open wound at an injecting site (45% of those injecting crack cocaine reported this in the last year compared to 30% of those not injecting crack cocaine).

<sup>116</sup> See [http://www.hpa.org.uk/infections/topics\\_az/hiv\\_and\\_sti/hiv/epidemiology/ua.htm](http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/hiv/epidemiology/ua.htm).

<sup>117</sup> This is comparable to the UAPMP agency survey, after allowing for the differences in test sensitivity and recruitment areas.

<sup>118</sup> Symptoms include redness, swelling or tenderness.

These findings could reflect poor general hygiene, as only 33 per cent of participants reported always swabbing injection sites.

There has also been a continuing occurrence of wound botulism cases among IDUs (Akbulut *et al.* 2005). Between 2000, when the first reported cases occurred, and the end of 2004, 85 cases had been reported in the UK. Overall, 70 of the cases occurred in England, 12 in Scotland, and two in Wales. In 2004, there were 40 cases, the largest annual number of cases so far.

#### 6.3.6 Research

There are number of new and ongoing research projects:

- A cohort study of IDUs in Wales will estimate the incidence of HCV (it is led by National Public Health Service Wales (NPHSW), the Centre for Research on Drugs and Health Behaviour (CRDHB) and the Health Protection Agency).
- DORIS (see Section 5.2.6) looking at prevalence and incidence of HCV among IDUs attending drug services in Scotland.
- The CRDHB and Health Protection Agency are examining whether the collection of dried blood samples rather than full blood will increase the uptake of HCV testing among IDUs in England.
- The CRDHB and Health Protection Agency are collecting dried blood spot (DBS) samples from IDUs in prisons and low threshold services in England. This will explore combining named voluntary counselling and testing for HCV, HBV and HIV with an unlinked anonymous survey.
- Two studies are being completed by the University of Paisley and CRDHB, which video taped injecting events.
- A pilot companion UAPMP survey is currently being developed in Scotland by Health Protection Scotland (HPS) with the University of Paisley and the Health Promotion Agency, which will focus on those using needle exchanges.

#### 6.4 Psychiatric comorbidity (dual diagnosis)

In the last year, several articles have been published addressing co-morbidity:

- Best *et al.* (2004) examined 43 deaths involving drug use that had occurred in police custody between 1998 and 2002, in England and Wales<sup>119</sup>. In 18 of these cases (42%), there was evidence of mental illness (psychosis, self-harm or suicide attempts, or anxiety or depression).
- The COSMIC<sup>120</sup> study was performed in four urban areas: Brent, Hammersmith and Fulham, and the inner city areas of Nottingham and Sheffield (Weaver *et al.* 2004). The study found that 44 per cent of the 400 individuals surveyed who were in contact with Community Mental Health Teams reported problem drug use and/or alcohol use in the last year, and that 74.5 per cent of the 353 clients surveyed who were in contact with drug services had experienced a psychiatric disorder in the last year.
- Keene (2005) studied the comorbid population of a health authority area in England. She found that the proportion of clients from mental health services who are in contact with drug agencies (1.7%) is notably higher than the proportion of the general population who are in contact with drug agencies (0.2%). A similar pattern was found for drug agency clients in contact with mental health services (see Table 22).

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<sup>119</sup> All deaths assessed had been supervised by the Police Complaints Authority.

<sup>120</sup> This refers to the Comorbidity of Substance Misuse and Mental Illness Collaborative Study.

Table 20: The number and percentage of clients of drug services or mental health services being treated by mental health services or drug services respectively compared to the general population in a county in England

	Mental health services clients	Drug agency clients	Total population
Number in contact with a drug agency	331	N/A	1,206
Percentage in contact with a drug agency	1.7%	N/A	0.2%
Number in contact with mental health services	N/A	331	19,029
Percentage in contact with mental health services	N/A	27%	3%
<b>Total population</b>	<b>19,029</b>	<b>1,206</b>	<b>646,239</b>

Source: Keene (2005).

## 6.5 Other drug-related health correlates and consequences

### 6.5.1 Somatic comorbidity (as abscesses, sepses, endocarditis, dental health etc.)

See 6.3.5 for information on injecting site infections or reactions.

Research by Neale (2004b)<sup>121</sup> in Scotland suggested that, based on self report, drug users health was consistently worse than the general population on entry into treatment (based on perceptions of, for example, physical and social functioning, role limitation due to physical and emotional problems, mental health, energy and general health).

### 6.5.2 Non-fatal drug emergencies

Neale and Robertson (2005)<sup>122</sup> noted that of the 793 primary heroin users entering treatment in 2000/01 in Scotland, 11.5% (91) reported taking at least one overdose.

### 6.5.3 Driving and other accidents

Neale (2004c) considered the prevalence of drug driving among drug users entering treatment. Ninety-five (16.2%) of the 585 new drug treatment clients in Scotland who completed the questionnaire had driven whilst under the influence of drugs in the previous 90 days.

### 6.5.4 Pregnancies and children born to drug users

Data on maternities involving maternal drug use are an underestimate of the actual situation; however, figures are available for England and Scotland. In England, hospital episode statistics show that in 2003/04, there were 495 foetus and newborn affected by maternal drug use or drug addiction and 3,148 neonatal withdrawal symptoms from maternal use of drug addiction (DH 2005a).

<sup>121</sup> This is part of DORIS. The research used the results from the Health Status Questionnaire completed by a sample of the UK general population (see Jenkinson *et al.* 1993) to compare perceptions of health with 990 individuals who were starting a new treatment episode.

<sup>122</sup> This study was part of DORIS.

In Scotland, the latest information is for 2002/03 and suggests that there were 334 maternities involving maternal drug use (6.7 per thousand maternities), compared to 241 in 2001/02 (4.8 per thousand) (ISD 2005b). Just under 140 drug using mothers were aged between 20 and 29 years old (see Table 21). Opioids were the most common drug recorded (see Table 22).

*Table 21: Number of maternities recording drug use in Scotland in 2002/03 by age (the mothers' age at the point of delivery)*

Age	Number
Under 20 years	26
20-24 years	120
25-29 years	119
30-34 years	49
35-39 years	18
40-44 years	<5
45 years and over	0

Source: Information Services Division (2005b).

*Table 22: Number of maternities recording drug use in Scotland in 2001/02 and 2002/03 by drug*

Drug	2001/02	2002/03
Opioids	148	187
Cannabinoids	8	13
Sedatives/hypnotics	17	22
Cocaine	0	<5
Other stimulants (including caffeine)	<5	0
Hallucinogens	<5	<5
Volatile solvents	<5	<5
Multiple/others	82	116
<b>Total</b>	<b>241</b>	<b>334</b>

Source: Information Services Division (2005b).

## 7. Responses to health correlates and consequences

### 7.1 Overview

Drug-related deaths (DRDs), infectious diseases, comorbidity and other health consequences are key policy issues within the UK Drug Strategy (DSD 2002a).

#### 7.1.1 Drug related death

A Government target to reduce DRDs by 20 per cent by 2004 from an English baseline of 1,568 deaths was set in 1999. A strategy for England and Wales was published in 2001. This was accompanied by guidance for both generic and specialist services, and a range of materials and training for drug users<sup>123</sup> (DH 2001a).

#### 7.1.2 Drug related infectious disease

In the 1980s, UK drug policy was led by a public health approach aimed at containing HIV transmission (this was led by the Department of Health). The subsequent action is regarded as having been successful in containing HIV amongst injecting drug users (IDUs) by harm reduction approaches such as providing free needles and syringes, and promoting the safe disposal of used equipment (Stimson 1995; McVeigh *et al.* 2003). Other actions to reduce infection include: information campaigns on safer sex and safer injecting; and HIV/AIDS, hepatitis B (HBV) and C (HCV) counselling, support and testing. The *Hepatitis C Action Plan for England* was developed in 2004, prioritising prevention of infection and disease progression (DH 2004f). 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 (in 2004, NICE developed guidelines for this). 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.

#### 7.1.3 Psychiatric comorbidity (dual diagnosis)

Because of the need to provide services for problem drug users with mental health problems, standards for their care were agreed in 2001 (HAS 2001), and guidance on good practice (DH 2002c) and the provision of services (DH 2002a) were developed in England. The Department of Health (DH 2002a) highlighted the need for generic mental health services to work in partnership with other agencies, such as drug services. Local Implementation Teams (LITs) implement the policy requirements described in the guidance, and work in partnership with Drug (and Alcohol) Action Teams (D(A)ATs).

#### 7.1.4 Other health correlates and consequences

Maternity services are expected to provide appropriate facilities for the needs of pregnant women drug users and their babies, although the approach is inconsistent across the country. The Advisory Council on Misuse of Drugs (ACMD 2003) has highlighted concerns, and guidance has been issued locally (for example, NHS Borders 2004).

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<sup>123</sup> See <http://www.nta.nhs.uk/programme/drd3.htm>.



## 7.2 Prevention of drug-related deaths

### 7.2.1 Overdose prevention

In late 2004, further guidance on preventing DRDs was provided for A&E staff in hospitals (NTA 2004b) and for telephone helplines (NTA 2004c).

#### *National Programme on Substance Abuse Deaths*

In April 2004, the Department of Health (DH) provided funding for three years to the National Programme on Substance Abuse Deaths (np-SAD) so that it can supply accurate and timely information on DRDs in England and Wales. Data suppliers in the Isle of Man, Guernsey and Jersey also contribute.

#### *National Investigation into Drug-Related Deaths*

An action plan for Scotland based on the Scottish Advisory Committee on Drug Misuse (SACDM 2005) recommendations will be published in 2005. Until then, the Scottish Executive (2005e) is aiming to reduce the number of DRDs by:

- funding a First Aid project to train drug users, their families/friends and service providers;
- raising awareness through the First Aid project, a DVD and a Know the Score campaign; and
- funding the Royal College of General Practitioners to train General Practitioners, nurses and pharmacists on drug use management.

### 7.2.2 Safer use training

See above.

### 7.2.3 First aid training

See above.

### 7.2.4 Consumption rooms

There are no plans to provide consumption rooms in the UK.

### 7.2.5 Antagonists

A consultation by the Medicines and Health Care Products Regulation Agency (MHRA 2004) on the proposal to add Naloxone to the range of prescription only medicines that can be administered in an emergency (enabling ambulance technicians as well as paramedics to administer it) showed that it was widely supported (MHRA 2005).

### 7.2.6 Volatile substances

The DH (2005b), with the Home Office and the Department for Education and Skills (DfES), has published a framework for Volatile Substance Abuse (VSA) outlining the key priorities:

- Providing effective VSA education to all children and young people.
- Providing effective targeted interventions for all those abusing or at risk of abusing volatile substances.
- Reducing the availability and accessibility of volatile substances.
- Strengthening the ability of parents, carers and practitioners to identify and work effectively with those who are abusing or at risk of abusing volatile substances.
- Increasing the evidence base with regard to what works in the prevention of VSA.

In Scotland in 2005, policy was revised to allow test purchasing of age-restricted goods by those under 18 years old (Scottish Executive 2005f). A campaign to raise

awareness among shop workers of the law around the sale of butane gas lighter refills and other solvents to children was rolled out in March 2005 (Scottish Executive 2005c). The Scottish Executive is currently looking at the scope for action on VSA under their Know the Score Communication Strategy.

### 7.3 Prevention and treatment of drug-related infectious diseases

#### 7.3.1 Prevention

The publication of the *Hepatitis C Action Plan for England* (DH 2004f) was referred to in last year's report, as was Department of Health's funding of €1.5 million (£1 million) in 2003/2004 to the National Treatment Agency for Substance Misuse (NTA) for local projects connected with increasing HCV testing of IDUs. Further funding has since been made available, €74,400 (£50,000) in 2004/2005 and €119,000 (£80,000) in 2005/2006, for work in this area and a national audit of needle exchange schemes.

Northern Ireland has launched an Action Plan for reducing HCV (DHSSPSNI 2004). This Action Plan specifically targets IDUs through:

- an information campaign aimed at IDUs on blood borne viruses;
- training for drug workers to enable them to raise awareness of such viruses;
- development of guidelines for drug workers;
- publication of a leaflet to inform drug workers

The Scottish Executive (2005d) launched a consultation on a proposed HCV Action Plan for Scotland in 2004. It will aim to reduce incidence among IDUs through actions such as:

- revising the current guidelines (see DH *et al.* 1999);
- providing improved training for GPs and health professionals;
- raising awareness of hepatitis among IDUs and potential IDUs;
- reducing the sharing of injecting equipment through targeted interventions; and
- developing interventions to target potential IDUs to resist injecting.

In autumn 2004, a publicity campaign was instigated to raise awareness by addressing how to avoid the risk of infection, together with testing and treatment. In addition, national standards for commissioning, delivery and monitoring of the syringe exchange services are being established (NTA, internal communication).

#### *National syringe exchange audit*

A UK wide audit of syringe exchange began in autumn 2004 to investigate in detail the nature of service provision. The overall aims of the audit are:

- to investigate the extent and nature of provision of needle exchange and wider harm reduction facilities;
- to assess data reporting systems; and
- to investigate issues relating to the delivery, commissioning and planning of needle exchange and harm reduction and blood borne virus prevention services.

The programme incorporated research and consultation with commissioners, service managers, syringe exchange co-ordinators, practitioners and service users, utilising questionnaires, qualitative interviews and focus groups.

Interim findings suggest that:

- there is needle exchange provision in all English D(A)ATs (pharmacy and non-pharmacy outlets). Usually both pharmacy and non-pharmacy services are available;

- the majority of non-pharmacy needle exchange services are located within wider drug treatment services, with a minority of services 'dedicated' to needle exchange only;
- more than half of non-pharmacy facilities exchange syringes in more than one way/setting (e.g. from the agency and through outreach);
- despite notable exceptions the commissioning of needle exchange services by D(A)AT commissioning groups has to be strengthened;
- data collection by services is much stronger than data management by D(A)ATs;
- there are wide variations between services, D(A)ATs and Regions. This includes variations in:
  - number of clients and level of contact with clients;
  - paraphernalia distribution;
  - blood borne virus prevention measures available on site in the agency (including HCV and HBV antibody testing and hepatitis B immunisation); and
  - policies on needle distribution and return.

#### *Provision of syringes in Police stations – Scotland*

Prisoners are to be given free needles upon their release from custody by the Police in the Lothian and Borders region in Scotland (Edwards 2005). It is hoped that by doing this, prisoners will be more willing to surrender any used needles, so protecting Police Officers from injury by hidden needles during searches.

#### *Research*

##### *The uptake of hepatitis B vaccination*

Whilst the prevalence of oral fluid antibodies to hepatitis B core antigen (a marker of current or past infection) remains stable among IDUs in England, Wales and Northern Ireland, the Unlinked Anonymous Prevalence Monitoring Programme (UAPMP) agency survey's (see Section 6.3.1) participants showed that the proportion reporting uptake of the HBV vaccine more than doubled from 25 per cent in 1998 to 56 per cent in 2004 (Health Protection Agency 2005a). Of those reporting vaccination, 55 per cent reported receiving three or more doses. A similar trend can be seen in Scotland, where a survey of community-recruited IDUs who had injected for 5 years or less in Glasgow showed an increase in reported HBV vaccinations from 16 per cent (of 166) in 1993 to 52 per cent (of 387) in 2001/02 (Hutchinson *et al.* 2004). During 2004, a further increase in HBV vaccine uptake was detected among this group to 65 per cent. These results, together with the decreasing number of laboratory reports of HBV diagnoses among IDUs, indicate that the prison and targeted community vaccination programmes have had a major impact on vaccination uptake among IDUs.

##### *Distribution of needles and syringes*

Taylor *et al.* (2005b) have evaluated the Lord Advocate's<sup>124</sup> guidance on the distribution of sterile needles and syringes to IDUs in Scotland (Taylor *et al.* 2005b). This guidance, published in 2002, increased the number that could be distributed<sup>125</sup>. However, the study found that over a year later and after a targeted campaign, only

<sup>124</sup> The Lord Advocate is the main Law Officer of the Crown in Scotland, and is the legal and constitutional adviser to the Government. For more details, please see <http://www.scotland.gov.uk/deleted/library/documents/lord-adv.htm>.

<sup>125</sup> The number of needles and syringes that could be distributed was increased to a maximum of 20 sets for new clients (previously 5), 60 for any following visits (previously 15) and 120 in exceptional circumstances (previously 30). For details of the guidance, please see [http://www.show.scot.nhs.uk/sehd/mels/hdl2002\\_90.pdf](http://www.show.scot.nhs.uk/sehd/mels/hdl2002_90.pdf).

27 per cent of the 296 IDUs surveyed in Glasgow were aware of the change (this figure remained constant both before and after an awareness campaign).

### *Foresight*

The Department of Trade and Industry (DTI) is managing a series of projects under the umbrella of Foresight<sup>126</sup>. One of these projects is addressing infectious disease and aims to develop a long-term vision for the detection and identification of such diseases. A second project is addressing addiction and drugs, and how scientific developments may influence our understanding of these in the future.

### 7.3.2 Counselling and testing

Data on the uptake of HIV testing can be found in Section 6.3.1.

The *Hepatitis C Action Plan for England* aims to increase the proportion of IDUs that are aware of their infection through improved uptake of voluntary confidential testing (DH 2004f). It sets a national standard of good practice that all those attending drug treatment services should be offered hepatitis C testing routinely. In 2004, although most of the IDUs who participated in the UAPMP agency survey<sup>127</sup> reported having taken an HCV test, 33 per cent of IDUs (n=2,351) reported that they had never had one (compared to 51% of 2,998 participating IDUs in 2000) (Health Protection Agency 2005a). Of the 945 who were infected, 49 per cent were unaware of their infection, compared to 60 per cent in 2000 (n=2,998). In 2003/04 in Wales, 54 per cent of the 91 UAPMP participants reported not having taken a test, and in Northern Ireland, 23 per cent had not done so (n=37).

### 7.3.3 Infectious disease treatment

In 2004, in England, Northern Ireland and Wales, 40,265 patients were seen for statutory medical HIV care (Health Protection Agency 2005b). Of these, 2.4 per cent (974) were infected through injecting drug use. This can be compared to 969 (2.7% of 35,428) in 2003 (Health Protection Agency 2004c).

## 7.4 Interventions related to psychiatric comorbidity

In July 2005, the Government outlined plans for the *Mental Health Bill*, which will reform mental health legislation (DH 2004g). It will prohibit clinicians from compulsorily treating individuals whose sole mental disorder is alcohol or drugs dependency.

### *Cannabis and mental health*

The ACMD will examine the evidence on cannabis and its association with mental health published since the reclassification (see Section 1.1). The review will be completed in November 2005.

### *Research*

The Centre for Addiction Research and Education will assess existing service provision in Scotland for those with co-existing mental health problems and drug use<sup>128</sup>. This will be completed in late summer 2005.

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<sup>126</sup> For more details, please see <http://www.foresight.gov.uk>. Foresight has been developed through several phases or rounds, whereby each round (lasting approximately four or five years) concentrates on a number of topics. The latest round (commencing in 2002) is addressing public health topics such as obesity and infectious diseases.

<sup>127</sup> See Chapters 6.3.1 and 6.3.2 for more details on this.

<sup>128</sup> Please see [http://www.dundee.ac.uk/psychiatry/res\\_addictions/CurRes\\_000.htm](http://www.dundee.ac.uk/psychiatry/res_addictions/CurRes_000.htm) for more information.

## 7.5. Interventions related to other health correlates and consequences

### 7.5.1 Somatic co-morbidity

NO NEW INFORMATION

### 7.5.2 Non-fatal emergencies and general health-related treatment

NO NEW INFORMATION

### 7.5.3 Prevention and reduction of driving accidents related to drug use

The Drug Drive website<sup>129</sup> was relaunched to raise awareness of the effects of drugs and how they can affect driving. It is aimed at 17 to 30 year olds.

In Scotland, leaflets providing information about Police powers with regard to drug driving and the penalties faced by offenders are distributed by Police forces to licensed premises and local drug action groups.

### 7.5.4 Other health consequences reduction activities

#### *Care of drug users in acute hospitals*

In Scotland, the Effective Interventions Unit (EIU 2005a) has produced guidance on the care of people with drug problems in acute hospital settings. It aims to assist practitioners, managers and commissioners in reviewing how they design, record and deliver screening and assessment services to people with drug problems.

## 7.6 Interventions concerning pregnancies and children born to drug users

Following the ACMD's (2003) report examining the situation faced by children of drug using parents, the Government published its response to the recommendations given in the report (DfES 2005; see Table 23).

*Table 23: The Government's response to the Hidden Harm report*

Advisory Council on the Misuse of Drugs' recommendation	Responding body	Response
Problem drug/alcohol use by pregnant women should be recorded by antenatal clinic. These data should be linked to those on stillbirths, congenital abnormalities in the newborn, and subsequent developmental abnormalities in the child. Epidemiological studies would then be able to examine the links between the two.	Department of Health	The pregnant woman often holds the primary antenatal record during her care (DfES 2005). This will be established as the preferred way of record keeping and so that there is a single dataset. The preferred content is shown by the Perinatal Institute's Antenatal Record, whose data items would meet the recommendation.

<sup>129</sup> Please see <http://www.drugdrive.co.uk>.

Advisory Council on the Misuse of Drugs' recommendation	Responding body	Response
The Department of Health and the devolved administrations should ensure that all maternity units and social service teams record problem drug/alcohol use by parents or a pregnant mother (whilst respecting confidentiality but enabling assessment of the family and evaluation of the services).	Department of Health	<i>The National Service Framework</i> notes the importance of adequate service provision for pregnant drug users and their partners (DH and DfES 2004). An integrated multidisciplinary and multi-agency team should provide their care (this should include a midwife and/or obstetrician with specialist drug knowledge). Collecting data enables effective planning and evaluation of all maternity services, including drug use services. Assimilating the antenatal record into the health record at birth enables this data to be analysed whilst respecting confidentiality. This will be supported by the National Health Service Care Records Service.
Every maternity unit must provide an accessible and non-judgemental service, offering high quality care to minimise the effects of maternal drug use. Evidence-based protocols should address the clinical management of drug use during pregnancy and neonatal withdrawals.	Department of Health	<i>The National Service Framework</i> establishes standards of care for antenatal, delivery and postnatal services (DH and DfES 2004). It assesses how maternity services can improve their flexibility, accessibility and appropriateness.
Pregnant drug users should be routinely tested (with informed consent) for HIV, hepatitis B and hepatitis C, and appropriate clinical management should be provided for all babies.	Department of Health	Guidance in the <i>Hepatitis C Action Plan for England</i> discusses antenatal services as a chance to test pregnant women at increased risk of hepatitis C (DH 2004f). National Health Service policy offers HIV and hepatitis B antenatal screening so appropriate measures can be taken. The UK National Screening Committee advises not to have routine antenatal hepatitis C screening as current evidence does not support its use.
Primary care teams offering services for drug users should ensure that their children's well-being is being met, in partnership with the school health service, children and family teams and other services. Primary Care Trusts or the equivalent in the administrations must have clear arrangements for ensuring that these children benefit fully from the appropriate services.	Department for Education and Skills, and Department of Health	Primary Care Trusts assess and commission services to meet their population's health needs. Children of drug/alcohol users should be identified within their needs assessments and appropriate services should then be commissioned. <i>The National Service Framework</i> (DH and DfES 2004) establishes standards for health and social care services for children, young people and pregnant women.
Training on problem drug use management by primary care staff should include information about the importance of identifying and meeting the health needs of the children of problem drug users.	Department of Health	The Royal College of General Practitioners delivers training through the <i>Management of Drug Misuse in Primary Care</i> programme, which includes the needs of children whose parents are problem drug users. They have also run special interest classes on pregnancy and drug use, and on young people and drugs.

Advisory Council on the Misuse of Drugs' recommendation	Responding body	Response
All education services and schools should have plans for liaison with social services teams and child protection committees if there are concerns about the impact of parental problem drug/alcohol use on the child(ren).	Department for Education and Skills	The <i>Education Act 2002</i> strengthens arrangements for safeguarding children. New guidance was published in 2004 (DfES 2004c). It clarified specific roles of those in Local Education Authorities and schools. Those providing day care for children aged under eight years old must comply with national standards under the <i>Children Act 1989</i> , which include requirements relating to child protection. Guidance has also been published on discovering that a child is being abused (DH <i>et al.</i> 2003).
All women's prisons be able to allow pregnant drug users to receive antenatal care and treatment of drug dependence of an equal standard to that in the community	Home Office	Further improvements are needed cfES 2005b). This will occur as part of the partnership with the National Health Service. Until then, the Prison Service aims to keep pregnant drug users in remand prisons which have medical links with the National Health Service..

Source: Advisory Council for the Misuse of Drugs (ACMD 2003); Department for Education and Skills (DfES 2004c); Department for Education and Skills (DfES 2005); Department of Health (DH 2004f); Department of Health and Department for Education and Skills (DH and DfES 2004); Department of Health *et al.* (DH *et al.* 2003).

#### *Hidden Harms – the response from Northern Ireland*

In Northern Ireland, a draft strategy for children and young people completed its consultation period in February 2005 (DfES 2005). This strategy will aim to co-ordinate, monitor and promote children's services and rights within Government, including those children whose parents are drug users.

#### *Hidden Harms – the Scottish Executive's response*

Prior to the UK response, the Scottish Executive (2004b) had published its own full and separate response document in October 2004. This document demonstrated that there was a good deal of action underway to develop services and to apply good practice in response to the needs of this client group. The report acknowledged, however, that there was still much more to be done. This has been followed up with a Scotland-wide consultation process to agree priorities for taking the agenda forward. An Action Plan is to be published in spring 2006.

In Scotland the Effective Interventions Unit published guidance on problem drug use in pregnancy and reproductive health (EIU 2005b).

#### *Hidden Harms – the Welsh Assembly Government's response*

The Welsh Assembly Government Advisory Panel on Substance Misuse presented a framework for action for progressing work on the recommendations to the Cabinet of the Welsh Assembly Government (2005). The Cabinet has approved the paper and agreed that the Cabinet Sub Committee for Children and Young People should consider the cost of its implementation before referring the matter back to Cabinet. This is now underway.

## 8. Social Correlates and Consequences

### 8.1 Overview

#### 8.1.1 Social exclusion

The social correlates and consequences associated with problem drug use include street homelessness (Randall and DrugScope 2002); begging (Jowett *et al.* 2001); selling sex on the street (Hester and Westmarland 2004); unemployment (Klee *et al.* 2002); and the lack of educational achievement, truancy and school exclusion (Goulden and Sondhi 2001; Boreham and McManus 2003). Drug problems can be the most serious where social exclusion is acute, and where people do not have the resources to manage drug problems (DSD 2002a).

#### 8.1.2 Drug-related crime

Drug use per se is not a crime in the UK; possession, dealing and trafficking are under the *Misuse Act of Drugs Act 1971*. The number found guilty of drug offences has continued to rise (the number of known drug offenders has risen from 82,890 in 1994 to 110,400 in 2002), although the number of heroin offenders appears to have stabilised (remaining at approximately 10,000 to 11,000 since 1998) (Mwenda and Kumari 2005). Changes in the classification of cannabis to Class C (see Section 1.1.1) and the anticipated increased Police concentration on offences for Class A drugs may influence these figures (Home Affairs Committee 2001).

#### 8.1.3 Drug use in prison

Between one half and two thirds of those in custody are reported to be problematic drug users (HM Prison Service 2004b; ISD 2005b), the proportion is lower in Northern Ireland (House of Commons Northern Ireland Affairs Committee 2003).

#### 8.1.4 Other social correlates and consequences

Drug use can give rise to dangers associated with safety in the workplace and productivity (DSD 2004c). However, the full nature and extent of the problem is unknown in the UK. In addition, inappropriate disposal of certain items of used drug paraphernalia (such as needles or syringes) can cause distress to communities (Burgess 2004).

#### 8.1.5 Social costs

Latest cost estimates are based on the study by Godfrey *et al.* (2002) and are for 2000. They estimated that drugs cost UK society between €16.5 and €29.8 billion (£11.1 and £20 billion) a year.

### 8.2 Social Exclusion

#### 8.2.1 Homelessness

In 2004/05, various data were published showing the association between homelessness and drug use:

- Fountain *et al.* (2004) surveyed 389 rough sleepers in London. Eighty-three per cent of them had used a drug in the last month and 80 per cent were dependent on their main drug of use (including alcohol).
- The Scottish Drug Misuse Database indicates that of those entering treatment in 2003/04, 12 per cent (of the 11,757 for whom information is available) were in temporary or unstable accommodation and two per cent were roofless (ISD 2005b).



- In Northern Ireland, Deloitte MCS Ltd (2004) showed that 54 per cent of the 154 homeless people interviewed were current drug users.

In 2004, the Office for the Deputy Prime Minister (ODPM 2004) published a policy briefing on addressing the needs of the homeless. It emphasised the need for joint working and highlights examples of good practice in local projects (for example, the Clock Tower Surgery in Exeter or the Handel Street Centre in Nottingham – see ODPM 2004).

### 8.2.2 Unemployment

Eighty-five per cent of those accessing treatment services (of the 11,627 for whom information is available) in Scotland reported being unemployed in 2003/04, and 73 per cent had been unemployed for one year or longer, or had never been employed (ISD 2005b)

As part of DORIS (see Section 5.2.6), Kemp and Neale (2005) found that just four per cent of their sample of individuals in treatment were in legal paid employment at the time of their research (13% in the previous 6 months)<sup>130</sup>. This low level of employment could be because drug users face barriers in finding employment including poor health, inebriation, withdrawal symptoms, lack of concentration and punctuality, and homelessness (20% of those in the study were homeless).

### 8.2.3 School Drop out

In the last year, several studies were published that highlight the association between truancy or exclusion and drug use in young people:

- Market and Opinion Research International (MORI 2004)<sup>131</sup> found that of 19 per cent of excluded young people in a sample in England and Wales reported lifetime use of a Class A drug (compared to 4% of young people in school). Fifteen per cent reported lifetime ecstasy use and 10 per cent cocaine use (compared to 3% and 2% respectively for school children).
- Twenty per cent of 15 year olds participating in the school survey in Scotland reported lifetime use of any illegal drug (n=3,453) (Corbett *et al.* 2005). Of these, 78 per cent had truanted in the current school year (compared to 34% of those who had never used drugs). Also, it noted that 30 per cent of 15 year olds who had reported drug use in the last month had been excluded (compared to 7% of those who had never used drugs).
- The Edinburgh Study of Youth Transitions and Crime<sup>132</sup> found that in the third year of secondary school, 52 per cent of the 1,729 pupils reporting truancy<sup>133</sup> also reported lifetime drug use, compared to 16 per cent of non-truants (McAra 2004). They were also more likely to be involved in the sale of drugs (14% compared to 2%). While the prevalence of exclusion was relatively low (7% or 247) for third year pupils, such pupils did report a significantly higher prevalence of drug use (57% compared to 31% for non-excluded pupils). They were also more likely to have sold drugs (although the numbers are very small).

<sup>130</sup> From a sample of 1,033 drug users starting a new drug treatment episode.

<sup>131</sup> They conducted two studies. The first was with 4,417 school pupils aged 11 to 16 years old. A second survey was conducted with 687 young people aged between 11 and 17 years of age who have been excluded from mainstream school.

<sup>132</sup> The study follows a single year group of approximately 4,300 young people who started secondary school in Edinburgh in 1998. The researchers plan to interview them on their lives every year until they reach 30 years old. See: <http://www.law.ed.ac.uk/clis/esytc/>.

<sup>133</sup> This refers to those who had truanted in the previous school year.

### 8.2.4 Financial problems

The Drugs Strategy Directorate (DSD 2004d) suggests that drug agencies should integrate money and debt work into their services so that clients are less reliant on begging.

### 8.2.5 The effect of substance abuse on the family

Research into the experiences of young people (aged 15 to 27 years old) affected by parental drug and/or alcohol use found that all of the 38 young people involved, despite the variety of their experiences, found ways to deal with their difficulties, showing resilience and the ability to adapt (Bancroft *et al.* 2004).

Research on the impact on parents and siblings of drug users (Barnard 2005)<sup>134</sup> found that families reported stress, conflict and anxiety as a consequence of trying to protect the family member from drug-related harms, and to limit the damage arising from their behaviour towards the rest of the family.

In Scotland, the Substance Misuse Research Team have commissioned a scoping study on parental drug use to examine the impact of parental drug use, families' needs, how these needs are being met and details of best practice<sup>135</sup>.

In addition, Mentor UK (2005) launched an intervention in January 2004 to support grandparents who are raising grandchildren seen to be at risk of drug use. They aim to identify the information and services that grandparents and their grandchildren need; and to develop a training pack, resource pack and support group.

## 8.3 Drug related crime

### 8.3.1 Drug offences

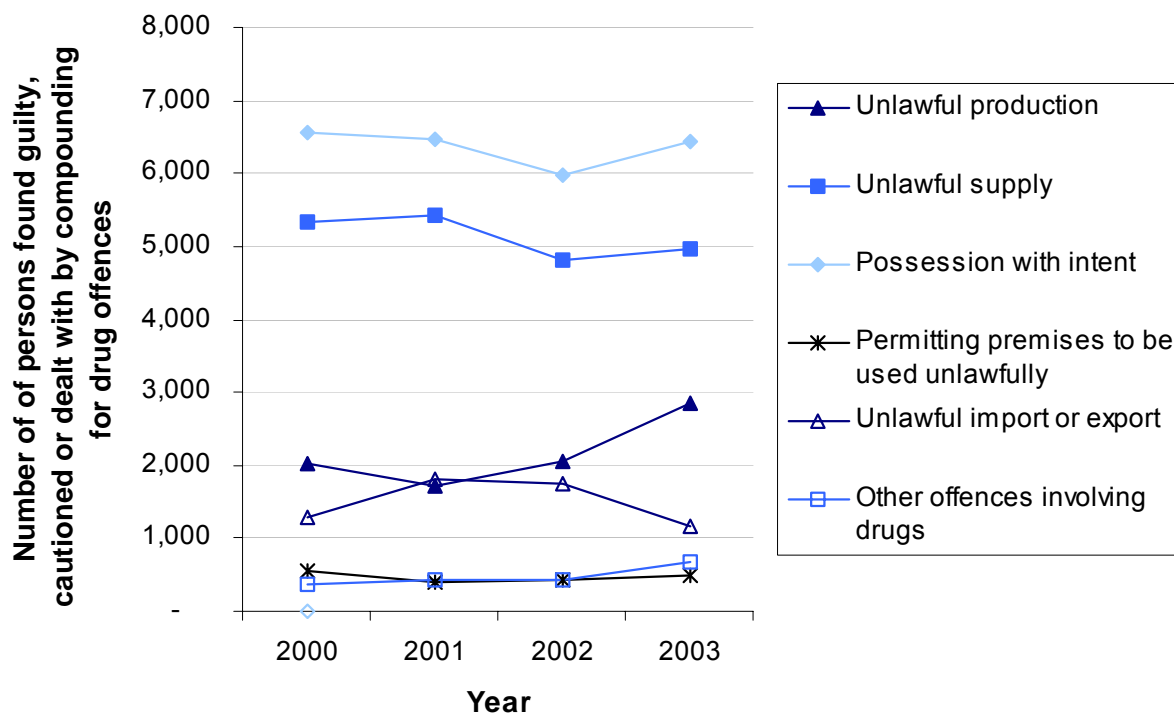
Overall, the number of people found guilty, cautioned or dealt with by compounding for drug offences in England, Scotland and Wales increased by 14 per cent between 2000 and 2003 (from 102,196 to 116,429) (Mwenda 2005). So, for example, the number of individuals dealt with for unlawful production has increased by 41 per cent overall (from 2,028 to 2,865) and the number dealt with for unlawful possession has increased by 14 per cent (from 91,479 to 104,336) (see Figure 7 and Appendix 4). However, other offences have shown overall decreases, despite the figures fluctuating in the given period. The number of individuals dealt with for permitting premises to be used unlawfully has decreased by 14 per cent (from 558 to 479) and the number for unlawful import or export of illegal drugs has decreased by nine per cent (from 1,292 to 1,173).

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<sup>134</sup> The research took place in Greater Glasgow and involved qualitative interviews with 24 problem drug users, 20 parents and 20 younger siblings. Where possible, these were members of the same family. Additionally, 10 interviews were carried out with practitioners whose area of work was directly or indirectly concerned with problem drug users and their families.

<sup>135</sup> For more information, please see <http://194.83.73.129/research/cr/eoi-substancemisusingparents.cfm>.

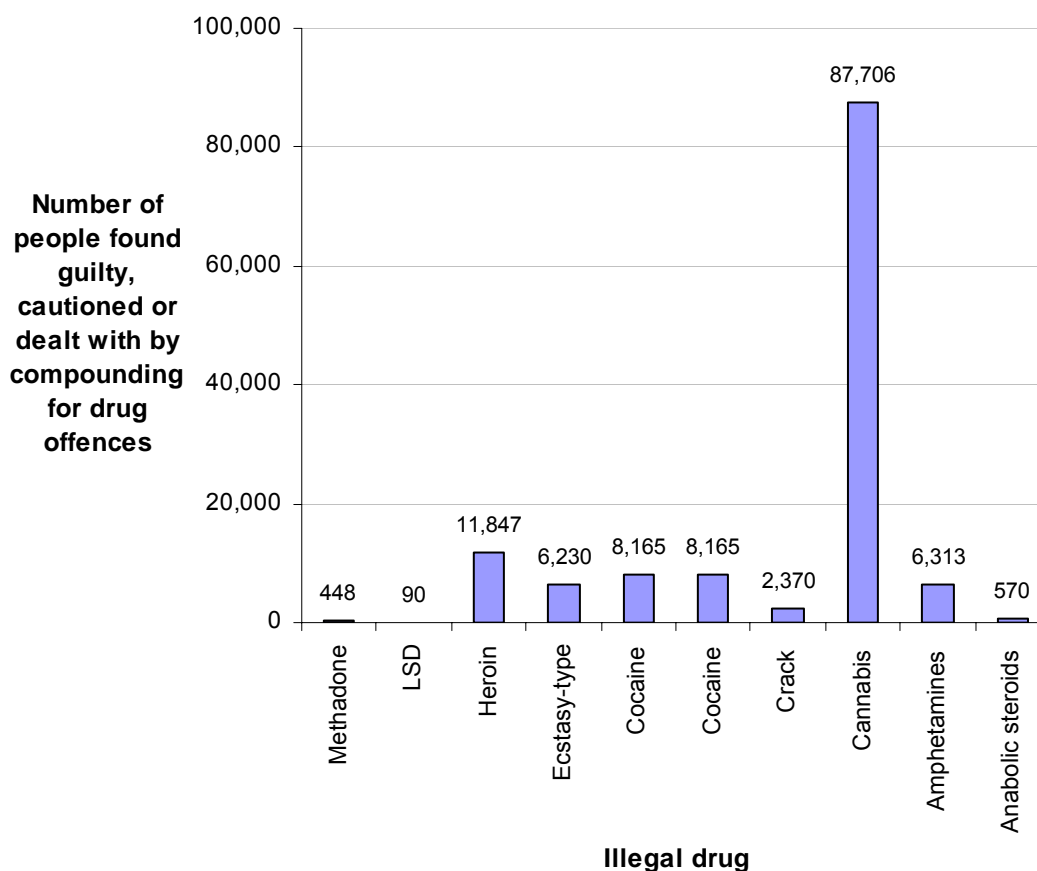
Figure 7: Number of people found guilty, cautioned or dealt with by compounding for drug offences in England, Scotland and Wales from 2000 to 2003 by offence



Source: Mwenda (2005).

In 2003, 87,706 people were found guilty, cautioned or dealt with by compounding for cannabis-related offences in England, Scotland and Wales (see Figure 8). In comparison, only 90 were dealt with for LSD-related offences.

Figure 8: Number of people found guilty, cautioned or dealt with by compounding for drug offences in England, Scotland and Wales in 2003, by drug



Source: Mwenda (2005).

The National Treatment Outcome Research Study (NTORS) highlighted that just over 1,000 drug users reported committing 27,000 acquisitive and 40,000 drug supply offences in the 90 days prior to starting treatment (Gossop 2005b). However, not all of the individuals were involved in such acts (less than one third reported supplying drugs).

The British Transport Police<sup>136</sup> reported a 31 per cent increase in drug offences from 2003/04 to 2004/05 (from 2,451 to 3,211).

### 8.3.2 Other drug-related crime

More than 63,000 drug tests for heroin, crack and cocaine were carried out amongst offenders charged with a trigger offence<sup>137</sup> in 2004/05 (an average of 5,250 per

<sup>136</sup> The British Transport Police are the national police force for the railways in England, Scotland and Wales (including the London Underground and a number of local transport systems, as well as railway property such as car parks). Please see <http://www.btp.police.uk/> for more information.

<sup>137</sup> These are defined as: theft, attempted theft, robbery, attempted robbery, burglary; attempted burglary, aggravated burglary, deception, attempted deception, handling stolen goods, attempted handling stolen goods, taken without consent, aggravated taken without consent, going equipped, begging, persistent begging, production of specified Class A drugs, supply of specified Class A drugs, and possession of specified Class A drugs.

month) (Home Office 2005e). From these tests, and as part of the Drug Interventions Programme (DIP; see Section 9.3.3), over 1,900 offenders entered treatment.

### *Prostitution*

Sex and drug markets are seen as interconnected, so much so that when a Police operation focusing on the crack market arrested 118 prostitutes, many were referred to drug treatment services (Home Office 2004d). Between 1985 and 2002, the number convicted for prostitution offences<sup>138</sup> decreased by 73 per cent (from 10,193 to 2,717) in England and Wales.

### *Prescription offences*

The Medicines and Healthcare products Regulatory Agency (MHRA) prosecutes those cases brought forward under medicines legislation. In 2004, four cases were successfully prosecuted with penalties given ranging from a fine to five years' imprisonment<sup>139</sup>.

### *Driving offences*

In 2003, approximately 105,700 people were dealt with by official Police action because of offences relating to 'driving etc. after consuming alcohol or taking drugs' in England and Wales (Fiti *et al.* 2003). This represents an decrease of 2,700 compared to 1996, but an increase of 3,600 compared to 2002.

### *Violence under the influence*

In the British Crime Survey, Nicholas *et al.* (2005) asked those respondents who reported being the victims of violent crime in England and Wales in 2004/05<sup>140</sup>, if they perceived that the offender had been under the influence of drugs. Those who reported being the victim of a violent crime were the most likely to report the perception that the offender had been under the influence of drugs (see Table 24).

*Table 24: Violent crime victims in the British Crime Survey 2004/05 and their perceptions of the offender involved*

Offence	Participants who reported being the victim of a violent crime (%)	Violent crime victims who perceived that their offender had been under the influence of drugs (%)
Acquaintance violence	1.2	22
Domestic violence	0.5	11
Mugging	0.7	25
Stranger violence	1.4	14

Source: Nicholas *et al.* (2005).

### *Drug Related Litter*

In the UK, littering is a crime and is subject to a maximum fine of €3,700 (£2,500) under the *Environment Protection Act 1990*. It is also a nuisance and can be a public health issue (for example, if needles or syringes are abandoned). Hauck (2004) has

<sup>138</sup> Procuring, soliciting and brothel-keeping.

<sup>139</sup> For more information, please see

[http://www.mhra.gov.uk/home/idcplg?IdcService=SS\\_GET\\_PAGE&useSecondary=true&ssDocName=CON009782](http://www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&useSecondary=true&ssDocName=CON009782).

<sup>140</sup> The British Crime Survey carried out 45,120 interviews with adults aged 16 years old and over. Overall 3.6 per cent of the participants reported having been the victim of a violent crime (this includes domestic violence, mugging, stranger violence and acquaintance violence).

explored public attitudes towards drug-related litter. Findings and recommendations include:

- drug litter is seen as a symptom of more serious drug problems;
- there is a lack of faith in the ability of the authorities to act and public services need to be seen to be taking action;
- apathy can be a barrier and prevent the public from reporting drug litter;
- safety concerns can motivate the public to report drug litter, particularly relating to abandoned needles or syringes; and
- public information should be hard hitting to provoke action, with clear simple messages about what action to take.

## 8.4 Drug use in prisons

### *England and Wales*

Sixty-six per cent of respondents in a survey of prisoners reported drug use in the month before coming into prison (Singleton *et al.* 2005a)<sup>141</sup>. Use of drugs while in custody was reported by 25 per cent of respondents. Sixteen per cent reported drug use in the last week, an estimate which correlates with the results of the Mandatory Drug Tests (MDT). In England and Wales in 2003/04, 11.6 per cent of these proved positive. This is a reduction from the previous year (12.3%) (HM Prison Service 2005). (Please see Section 9.3.1 for more details on Mandatory and Voluntary Drug Tests.)

Payne-James *et al.* (1994, 2005) compared populations in Police custody in London in 1992 and 2003. They noted that patterns of drug use amongst this population have changed considerably with, for example in 2003, 87 per cent of the participants reporting crack cocaine use compared to 30 per cent in 1992 (see Table 25).

*Table 25: Drug use amongst Police custody populations in London in 1992 and 2003*

	1992	2003
Crack cocaine use	30	87
Heroin use	77	73
Injecting drug use	72	56
Use of a shared needle	41.6	25
<b>Sample size</b>	<b>150</b>	<b>115</b>

Source: Payne-James *et al.* (1994); Payne-James *et al.* (2005).

### *Scotland*

In Scotland, 55 per cent reported having ever used an illegal drug whilst in prison (SPS 2004)<sup>142</sup>. Cannabis is the drug that is most likely reported to have been used in the last month whilst in prison (see Table 26). Five per cent reported injecting in the last month, and of these 69 per cent reported sharing injecting equipment in the last month<sup>143</sup>.

<sup>141</sup> Singleton *et al.* (2005) surveyed 2,270 prisoners across England and Wales aged 16 years old and over.

<sup>142</sup> 6,189 prisoners were surveyed, 4,793 responded.

<sup>143</sup> These figures have not been verified by the Scottish Prison Service.

Table 26: Percentage prevalence of drug use in the last month whilst in prison in Scotland in 2004

Drug used	Percentage
Amphetamines	6
Ecstasy	12
Benzodiazepines (e.g. valium, ativan)	36
Cannabis	78
Cocaine	14
Methadone (not on prescription)	13
Heroin	63
Temazepam	12
Other opiates (e.g. Temgesic, Dihydrocodeine)	26

Source: Scottish Prison Service (SPS 2004)<sup>144</sup>.

### 8.5 Social Costs

York University has been contracted to update the cost model of Class A drugs published in 2002 (Godfrey *et al.* 2002). This is expected to provide updated and improved estimates of drug use, as well as simulations of changes. An online report is due in autumn 2005.

<sup>144</sup> Data provided by the SPS has not yet been verified.

## 9. Responses to Social Correlates and Consequences

### 9.1 Overview

#### 9.1.2 Social Reintegration

Social reintegration is a key element of the national Drug Strategy (DSD 2002a) and responsibility for responding to the social correlates and consequences discussed in Chapter 8 rests with a number of Government departments and agencies, for example:

- Government departments are responsible for key areas of social reintegration, such as the Department for Education and Skills (DfES);
- the Neighbourhood Renewal Unit is developing the overall National Strategy for Neighbourhood Renewal (Social Exclusion Unit 2001);
- the National Treatment Agency for Substance Misuse (NTA) supports elements of social reintegration, for example through residential treatment and counselling;
- the Homelessness Directorate, set up in 2002, coordinates policy nationally (DTLR 2002) and is working with the NTA to build treatment services that respond to the needs of the homeless (Randall and DrugScope 2002). Homelessness issues are also addressed in the UK Drug Strategy and the Strategy on Rough Sleepers; and
- in Scotland, the Homelessness Task Force is aiming to improve interventions for drug users.

Various projects have been established, such as:

- progress2work (p2w), initiated in 2002, supports those who are drug free or stabilised, but whose history of drug use can be a significant factor in preventing them from getting or keeping a job. Led by the Department of Work and Pensions (DWP), it is a cross Government initiative and has representatives from the Home Office, Her Majesty's (HM) Prison Service, NTA, Welsh Assembly and Scottish Executive;
- the Building Safer Communities Fund aims to build communities that are resistant to drugs; and
- social inclusion programmes such as Positive Futures can bridge the gap between universal and targeted services (see Section 3.3.2).

The Social Exclusion Unit (established in 1997) and the Drug (and Alcohol) Action Teams (D(A)AT)s are coordinating the responses.

In Scotland, each D(A)AT reports annually in its Corporate Action Plan and plans to help recovering drug users enter education, skills training and employment. In Scotland, also, local D(A)ATs inform the multi-agency Homelessness Strategy of each Local Authority and the Homelessness and Health Action Plan of each Health Board concerning measures to include people with drug problems.

#### 9.1.2 Prevention of drug related crime

The Drug Interventions Programme (DIP)<sup>145</sup> was established in England and Wales in 2003 to reduce drug-related crime. It is a major initiative designed not only to ensure offending problem drug users access treatment services, but also related services concerned with for example housing and employment etc. to assist reintegration. Schemes based on similar principles have been established elsewhere in the UK.

<sup>145</sup> Previously known as the Criminal Justice Intervention Programme.



### 9.1.3 Drug use in prison

Drug strategies have existed in prison services for a number of years (SPS 2000; NIPS 2003; HM Prison Service 2004c). These seek to prevent drug use in custody and help drug users become drug free.

The main focus of treatment in prison has been on abstinence. The programmes available include: intensive drug treatment programmes (such as cognitive-behavioural treatment, 12-Step and Therapeutic Communities or TCs); a high intensity Short Duration Drug Treatment Programme (SDP) for those imprisoned for a short time; and counselling, assessment, referral, advice and throughcare services (CARATS). Maintenance treatment has been introduced in a few prisons and there are a number of harm reduction measures, including vaccination for hepatitis. However, needle and syringe exchange services are not available.

### 9.1.4 Other responses to social correlates and consequences

There is a range of public services (from street cleansing to needle exchange schemes) that tackle inappropriate disposal of drug paraphernalia. A cross-government working group is dealing with the impact of drug-related litter on communities and it feeds into the Cleaner Safer Greener Communities programme<sup>146</sup>.

## 9.2 Social Reintegration

### *Involving local communities*

Research by Shiner *et al.* (2004) aimed to identify community responses to drug-related problems and to consider what influenced their success or failure<sup>147</sup>. They concluded that the community element of the Drug Strategy should be reconsidered. Community is mostly limited to education or prevention, support for users and carers, and campaigning. There is little evidence of involvement in strategic decision-making. Instead, community engagement should address, for example, housing allocation, employment and transport policies; the effects of poverty and relative disadvantage; and the influence of economic, social and geographic isolation.

The Scottish Executive's (2004c) *Criminal Justice Plan* emphasises the need to protect and support communities through, for example, community wardens, increased Police funding, the *Anti-Social Behaviour etc. (Scotland) Act (2004)*<sup>148</sup> and Community Safety Partnerships.

### *Change for Children*

The *Children Act 2004* forms the legislative background on which Government aims to ensure that young people are better equipped to resist drugs. *Every Child Matters: Change for Children* sets out the national framework for local change programmes to build services around needs of children and young people (HM Government 2004 – see Section 3.3.2).

### *Targeted interventions with vulnerable young people*

See Section 3.3.2 for more details.

<sup>146</sup> For more information see <http://www.cleanersaferegreener.gov.uk>.

<sup>147</sup> A survey was administered to 155 people from 34 Drug (and Alcohol) Action Team areas in England and Wales. Most respondents had some kind of professional involvement in the drug and alcohol fields. Case studies were also used.

<sup>148</sup> This is similar to the *Anti-Social Behaviour Act* introduced in 2003 (see UK Focal Point Report for 2004, Chapter 13 for details).

### 9.2.1 Housing

The Office of the Deputy Prime Minister (OPDM 2005) has published a new strategy on homelessness. It noted that in 2004/05, under the Supporting People Programme in England<sup>149</sup>, approximately €525.32 million (£353 million) was used to support 17,000 families, 47,000 single people (who have experienced homelessness or are at risk of it), and 1,600 former rough sleepers. A further €148.8 million (£100 million) is providing housing-related support to those who are at risk of homelessness (such as victims of domestic violence and people with drug or alcohol problems).

In addition, the ODPM and Drugs Strategy Directorate (DSD) have published guidance for Supporting People Commissioners on meeting the housing needs of drug users (ODPM and DSD 2005). It suggested that appropriate and sustainable housing is the first step for the successful rehabilitation of drug users, and is necessary to sustain employment, drug treatment, family support and finances. This is particularly important for those leaving prison and residential rehabilitation. Specific guidance to meet the housing needs of DIP clients has also been published (DSD *et al.* 2004).

In 2003/04, Supporting People in Scotland provided housing support for 3,500 people with drug or alcohol problems (Scottish Executive, internal communication). In addition, 19,000 people who had been homeless or sleeping rough were also helped to lead more stable lives and maintain tenancies (Scottish Executive 2005g).

#### *Accommodation for young people with drug use problems*

In Wales, €4.5 million (£3 million) per annum has been allocated from 2004/05 onwards to help provide accommodation for young people with drug use problems (Welsh Assembly Government, internal communication).

#### *Begging*

The Home Office has published guidance to support the development of services that successfully engage and sustain contact with drug users who beg (Davies and Waite 2004).

### 9.2.2 Education and training

In 2004, the final year of Scottish Enterprise's New Futures Fund<sup>150</sup>, €8.9 million (£6 million) per annum supported 72 projects of which 23 were drug services engaging some 2,000 drug users in confidence building, education, training and employment (Scottish Executive, internal communication).

For the period 2003-07, the Big Lottery, in partnership with local D(A)ATs, has invested €14.9 million (£10 million) to fund 60 specialist drug projects across Scotland with one of the key aims being to support recovering drug users access education, training and employment<sup>151</sup>.

### 9.2.3 Employment

The third and final phase of p2w was rolled out to all districts in England, Scotland and Wales in 2004. The Jobcentre Plus service suggests that by March 2005, 20,350 individuals had approached p2w. In total, 4,022 individuals (20%) had

<sup>149</sup> Please see Chapter 9.2.1 of 2004's UK Focal Point Report for more details.

<sup>150</sup> For more information please see [http://www.scottish-enterprise.com/sedotcom\\_home/stp/extra-support/newfuturesfund1.htm?siblingtoggle=0](http://www.scottish-enterprise.com/sedotcom_home/stp/extra-support/newfuturesfund1.htm?siblingtoggle=0).

<sup>151</sup> Please see <http://www.nof.org.uk/default.aspx?tc=57&tct=2&fc=250&fct=1> for further details.

obtained jobs and of these, 1,215 (30%) had remained in work (Jobcentre Plus, internal communication).

In Scotland, the Scottish Centre for Healthy Working Lives<sup>152</sup> has been established with a remit that extends to the implementation and development of drug policies across the Scottish business community (Scottish Executive 2005h). This will include co-ordinating and supporting activities that encourage employers to offer employment opportunities to reforming drug users.

For further information regarding Scotland, please see Section 9.2.2.

#### 9.2.4. Basic social assistance

##### *Advocacy for drug users*

The Effective Interventions Unit (EIU 2004f) has published guidance to help D(A)ATs and local partners examine how advocacy could be included in the development of Integrated Care.

### 9.3 Prevention of Drug-Related Crime

#### 9.3.1 Assistance to drug users in prison

In England and Wales, the National Offender Management Service (NOMS) was created in 2004. It aims to tackle the needs of problem drug users and reduce harm caused to themselves and others by integrating the work of the Prison Service and the Probation Service to enable end-to-end management of the offender (NOMS 2005). It will design interventions that aim to reduce re-offending.

CARATs is expected to engage with 47,000 drug users in custody in England and Wales in 2004/05 (HM Prison Service and National Probation Service 2004), but had already engaged with 53,396 by February 2005, two months prior to the end of the financial year.

Research Development and Statistics-National Offender Management Service (RDS-NOMS) is monitoring the profile of prisoners accessing CARATs, and will provide information for the Prison Service and D(A)ATs. Findings will be available in the autumn of 2005.

##### *Harm reduction*

Disinfecting tablets are being introduced in prisons in England and Wales to enable shared needles to be disinfected before use (NOMS 2005).

##### *Treatment*

To improve prisoners' health services, the responsibility of these services in England is being transferred to local Primary Care Trusts (PCTs) (DH 2005c). By April 2005, 86 prisons had completed this transfer. In Wales, the prisons are developing their partnerships with the local health boards.

In 2003/04, 7,119 drug users began treatment programmes in prison in England and Wales, 64.6 per cent were completed (4,600) (HM Prison Service 2005).

*Short duration drug treatment programme:* SDP, a high intensity programme, has been introduced to cater for the drug needs of those offenders who are serving short

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<sup>152</sup> For more information see <http://www.healthscotland.com>.

sentences (Joint Committee on Human Rights 2005). In March 2005, 24 SDPs were running and the programme will be rolled out across England and Wales.

*Clinical Services:* In 2004/05 in England and Wales, prison health care services expected to provide clinical services for 27,000 drug users, but actually provided services for 49,197. The Prison Service in England and Wales aimed to provide 6,500 rehabilitation places by the end of 2004/05, and had provided for 6,110 by February 2005. In total, 4,124 completed the programme.

Various research projects have been published in 2004/05 or are ongoing, including:

- Neale and Saville (2004) compared the effectiveness of community-based drug treatments with those based in prisons in Scotland, as part of DORIS<sup>153</sup>. They found that the clients attending the former showed increased levels of employment and decreased levels of drug use.
- The Home Office RDS division is undertaking a pilot survey assessing prisoners' problems and needs on reception. The results of the main study are expected in late 2005.
- In Wales, the Transitional Support Scheme (Mentoring Service) will support those prisoners who have been discharged after serving less than 12 months and who have an acknowledged problem with drugs or other substance<sup>154</sup>. It is hoped that this will prevent drug-related deaths, and assist in finding employment and education.
- A report on throughcare and aftercare approaches was published in 2005 (Fox *et al.* 2005). It highlighted that individuals need to be assessed as soon as possible after they enter custody or rehabilitation, that collaboration is needed between the different agencies involved, and that it is important to maintain contact with individuals after they are released.
- In Scotland, the Interim Care Scheme is used to manage the transition between prison and the community<sup>155</sup>. Its evaluation found that 28 per cent of ex-prisoners had met with their Transitional Care worker at least once since their release (EIU 2004g).

### *Prevention*

*Supply reduction:* In England and Wales, NOMS (2005) highlights the need for measures such as: CCTV surveillance of all visits areas; low-level fixed furniture in visit areas to obstruct drug smuggling; sanctions to tackle visitors who attempt to smuggle drugs (such as visit bans or Police arrest); Mandatory Drug Testing (MDT); close working with Police to block supply; and perimeter and physical security to prevent drugs coming in over the wall. In Northern Ireland, passive drug dogs are being used, for example, to monitor drug smuggling when prisoners return from home leave (NIPS 2005).

*Mandatory drug testing:* In 2003/04, HM Prison Service for England and Wales aimed to reduce the proportion of positive results from MDT to 10 per cent. Although the proportion has continued to decrease (by 50 per cent in comparison to five years

<sup>153</sup> They surveyed 487 clients of community-based drug treatment agencies and 229 clients of prison-based drug treatment agencies.

<sup>154</sup> For more information, please see <http://www.wales.gov.uk/subicsu/content/substance/sub-misuse-team-e.htm>.

<sup>155</sup> Transitional Care was introduced in 2001 to support those in prison for less than four years and remand prisoners with a drug use problem. In total, 158 survey interviews and 37 in-depth interviews were conducted with ex-prisoners around 4 months after their release. In addition, 177 ex-prisoners who had been released seven months earlier completed questionnaires.

previously), the target has still not been met with 11.6 per cent of results being positive in 2004/05 (HM Prison Service 2005). In comparison, the Scottish Prison Service (SPS 2005) reported 18 per cent of MDT tests were positive (against a target of 15%)<sup>156</sup>. The SPS's (2004) prison survey showed that over four in five prisoners (85%) who report using drugs in prison indicated a change in their drug use while in prison<sup>157</sup>. Of these, 73 per cent reported a decrease in their drug use and 17 per cent reported an increase. Research into the impact and effectiveness of MDT (Singleton *et al.* 2005)<sup>158</sup> suggests that about 16 per cent of prisoners reported using drugs in the week before interview. Cannabis and opiates (usually heroin) were the drugs most commonly used. The research concluded that MDT results generally underestimate the level of drug use as reported by prisoners, but that the current numbers of random tests are sufficient to track annual changes in drug use in prisons.

*Voluntary drug testing:* With a target of 28,000 Voluntary Drug Testing (VDT) compacts, 32,907 were made by February 2005 in England and Wales. VDT was introduced in 2004 in Northern Ireland. From August 2004 to March 2005, 3,652 tests were performed (NIPS 2005). However, the results are not yet available.

Two notable research project that are ongoing are:

- RDS-NOMS are undertaking research into the prison drugs supply/markets study. Publication is expected in September 2005.
- In Scotland, research is being conducted on the impact of offending behaviour programmes, methadone maintenance in prison, and drugs pathways and progression (SPS 2005).

### 9.3.2 Alternatives to prison for drug users

In the UK, if an offence is seen as warranting a custodial sentence, the offender will enter custody. However, sanctions such as the Drug Treatment and Testing Orders can be used where appropriate (DTTOs) (see Section 9.3.3).

### 9.3.3 Other interventions for prevention of drug related crime

#### *Drug Interventions Programme*

The DIP, which was discussed in last year's report (see Section 12.2.1) now covers all of England and €245.5 million (£165 million) will be invested into it in 2005/06<sup>159</sup>. This is on top of the additional funding for treatment through the Pooled Treatment Budget and funding for additional measures, such as the increased target for commencing DTTOs (Home Office, internal communication). In addition, work is underway to increase and develop the workforce to meet future demands.

In February 2005 alone over 1,800 offenders from DIP intensive areas entered treatment. Waiting times for treatment in the 'intensive' DIP areas have fallen significantly over the past year.

The extension of trigger offences<sup>160</sup> (to include handling stolen goods, attempted

<sup>156</sup> These figures have not been verified by the Scottish Prison Service.

<sup>157</sup> These figures have not been verified by the Scottish Prison Service.

<sup>158</sup> A survey of over 2,000 prisoners was carried out in 2001–2002 by the Office for National Statistics and other data were also analysed.

<sup>159</sup> Please see <http://www.drugs.gov.uk/drug-interventions-programme/> for further details.

<sup>160</sup> These now are defined as: theft, attempted theft, robbery, attempted robbery, burglary; attempted burglary, aggravated burglary, deception, attempted deception, handling stolen goods, attempted handling stolen goods, taken without consent, aggravated taken without

acquisitive crime and begging) became operational in July 2004, expanding the scope of DIP.

#### *Interventions within the criminal justice system*

*Drug testing on arrest:* New measures in the *Drugs Act 2005* will give Police the power to test for drugs on arrest rather than charge. This means that more people can be directed into treatment earlier. The Act will also require those testing positive for Class A drugs to have an assessment with a suitably qualified person, and that they attend a follow-up assessment if appropriate.

*Drug Testing on Charge:* Drug Testing on Charge is now fully operational in 97 "intensive" DIP Basic Command Units (BCUs) and in over 170 custody suites across 22 Police forces (see Section 8.2).

*Restriction on bail:* Restriction on bail (RoB) provision was originally implemented in May 2004 with pilots in Nottingham, Salford and Manchester (Hucklesby *et al.* 2005). It has given new powers to courts to order assessment and drug treatment as conditions of bail. In April 2005, RoB was expanded to a further 33 D(A)AT (47 areas in total). Since the start of the programme, 720 people have received RoB conditions in the three original sites. In January alone, over 300 people received RoB conditions. Ninety-one per cent of defendants were recommended some form of treatment at assessment and 76 per cent of defendants were attending assessment in March 2005. Very few have been remanded in custody for breaching conditions.

*Conditional Cautioning:* Conditional cautioning has begun in five out of six early implementation areas in England and Wales. For the first time, this allows conditions to be attached to a caution given to adult offenders as part of the *Criminal Justice Act 2003*, including a requirement to attend a drug rehabilitation programme (Home Office 2004e). Failure to comply with conditions may result in the offender being charged with the original offence.

*Prolific and Priority Offenders:* Prolific and other Priority Offenders (PPOs) schemes were launched in England and Wales in September 2004 (Home Office 2005e). DIP plays a key role in addressing their drug-related treatment and support needs as in many areas up to 85 per cent of identified PPOs are problem drug users. Guidance to support effective working partnerships between Criminal Justice Intervention Teams and PPO schemes has been issued<sup>161</sup> and additional DIP funding (of just over €2.2 million or £1.5million) has been allocated across 12 D(A)AT areas to enable them to develop these partnerships intensively. Their work will be evaluated and findings will inform future plans.

*Drug Treatment and Testing Orders:* In total, 8,514 DTTO (DTTOs) were made in 2003/04, against target of 9,000. However, over 9,000 DTTOs were made between April 2004 and January 2005. Research shows that offenders completing DTTOs have significantly lower levels of reconviction: 53 per cent of the 49 who had completed their DTTO were reconvicted within two years compared to those whose orders were revoked (91% of 108) (Hough *et al.* 2003).

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consent, going equipped, begging, persistent begging, production of specified Class A drugs, supply of specified Class A drugs, and possession of specified Class A drugs.

<sup>161</sup> See <http://www.crimereduction.gov.uk/ppominisite05.htm> for details of guidance that have been issued.

*Drug Interventions Programme - throughcare and aftercare:* Case management and aftercare services were made available across England and Wales during 2004/05. Phased implementation of throughcare and aftercare will continue in 2004/05 with €81.9 million (£55 million) being made available to D(A)ATs partnerships. All D(A)ATs in England can make and receive referrals to and from all prisons. Nineteen out of 22 D(A)ATs are now involved in Phase II and 17 of the non-intensive D(A)ATs. Twenty-four hour, 7 days a week client phone support is available in all Phase 1 areas except London.

### *Scotland*

Following an evaluation of DTTOs in Scotland (Eley *et al.* 2002), they are now available nationally.

Arrest referral schemes are now available in six areas of Scotland funded on a pilot basis by the Scottish Executive; the Scottish Executive views Arrest Referral as being potentially a crucial part of the overall strategy for tackling the drugs problem in Scotland<sup>162</sup>.

### *Wales*

In Wales, the Turnabout Project aims to support young people, aged 14 to 19, who are engaged in significant drug use and who offend back into mainstream education and training. Young people involved demonstrated a considerable increase in their ability to control their anger, deal with disappointment and express emotion on leaving the project compared to when they first joined. On project completion, 80 per cent of the young people immediately entered work, full time education, training or work-experience. The project will receive €1.8 million (£1.2 million) over three years.

### *Research*

Key findings from recent research shows:

- Household acquisitive crime as reported to the British Crime Survey decreased by 53 per cent between 1995 and 2003/04 (Nicholas *et al.* 2005).
- Gossop (2005b) reviewed four national drug treatment outcome studies examining treatment and crime (see Section 5.2.6).

The Home Office has also recently commissioned several studies including:

- a linking study (between the National Treatment Outcome Research Study or NTORS and the Offenders Index) to examine whether the reductions in rates of crime reported by the NTORS cohort are reflected in reduced levels of conviction following treatment entry.
- a systematic review of drugs-crime literature to examine the links between drug use and offending, and the effectiveness of interventions to break these links.
- an analysis of data sources to develop drug-related crime trajectories and to produce sub-national estimates of drug-related crime.

### *Other interventions for the prevention of drug related crime*

#### *Young People*

Ten D(A)AT areas in England are piloting youth-centred models of Arrest Referral for those aged 10 to 17 years old<sup>163</sup>. In addition, 22 custody suites based within these

<sup>162</sup> For more details, please see

<http://www.scotland.gov.uk/Topics/Justice/criminal/16928/7127>.

<sup>163</sup> Further details can be accessed through <http://www.drugs.gov.uk/drug-interventions-programme/strategy/children-yp/>.

D(A)ATs began piloting drug testing on charge for 14 to 17 year olds charged with those crimes that are most often linked to drugs.

Matrix Research and Consultancy's (2005) preliminary findings from its evaluation of DIP services for young people has highlighted several key issues as important for its ongoing development including:

- being clear about objectives sought;
- having the capacity to fulfil objectives; and
- consideration of how to co-ordinate with other agencies.

#### 9.4 Other responses to social consequences

##### *Drug related litter*

Burgess (2004) notes that the Home Office is taking action on drug-related litter in the form of:

- educating drug users about drug-related litter;
- improving collection, cleaning and reporting;
- helping needle exchanges to minimise drug-related litter;
- educating the general public.

Pilot projects in the south west of England have led to guidance being published (DEFRA 2005).

##### *Drug Misuse in the workplace*

The Home Office (2005f) has issued an updated Training Pack on Substance Misuse and the Workplace.

##### *Drug driving*

Following the changes in 2003 to the *Road Traffic Act 1998* (which enabled the Police to perform three preliminary drug tests to establish whether a driver is under the influence of drugs), a new Code of Practice was introduced in 2004 detailing the tests that can be administered (DfT 2004). Campaigns have also been run in 2005 to raise awareness of the effects of drugs on driving<sup>164</sup> (DOE 2004).

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<sup>164</sup> For more information, please see [http://www.srsc.org.uk/publicity/drug\\_driving/drug\\_driving\\_2005.asp](http://www.srsc.org.uk/publicity/drug_driving/drug_driving_2005.asp) and [http://www.dft.gov.uk/stellent/groups/dft\\_rdsafety/documents/page/dft\\_rdsafety\\_039950.hcsp](http://www.dft.gov.uk/stellent/groups/dft_rdsafety/documents/page/dft_rdsafety_039950.hcsp).



## 10. Drug markets

### 10.1 Overview

#### 10.1.1 Importation and distribution routes

Information from the National Criminal Intelligence Service (NCIS 2005a) suggests that it remains difficult to provide reliable information about the availability and supply of drugs. Quantities can only be inferred from the data available (for example on seizures, other law enforcement interventions or treatment figures) and so the exact relationship between supply and demand remains unclear.

Widespread poly-drug use and the convergence of various drug trades in countries such as the Netherlands or Spain provides an incentive for traffickers to engage in multi-drug trafficking (NCIS 2005a). However, the largest importers of heroin and cocaine tend to concentrate on a single commodity. These drugs then enter the UK market through a variety of different routes (see Table 27).

*Table 27: Importation routes of some illegal drugs entering the United Kingdom*

Drug	Origin	Importation route	Major regional hub	Further details
Cocaine	Mainly Columbia, Peru and Bolivia.	Shipped across the Atlantic to the Iberian Peninsula, the Netherlands or increasingly to Central and Eastern Europe. Shipments are concealed in heavy goods vehicles and routed overland to the Channel and North Sea ports. It is also smuggled into the UK by air couriers and by post, direct from South and Central America, and from the Caribbean.	London in particular but also Birmingham, Bristol and Merseyside	Many of those involved also import and distribute other drugs, as well as cigarettes.
Crack cocaine	It was thought that it was produced in the UK in small street-level quantities but there is now intelligence that it is being imported from the West Indies.	Evidence suggests the involvement of British Caucasians, West Africans and South Asians working both independently and collaboratively.	In particular Birmingham, Liverpool, London and Wolverhampton but also Bristol, Nottingham and Leeds.	Intelligence indicates that the UK crack trade is becoming complex and dynamic, and that crack is often sold with heroin.
Ecstasy-type substances	Eighty per cent of MDMA distributed internationally is produced in the Netherlands and Belgium but some ecstasy and other synthetic drugs are produced in the UK.	Ecstasy enters the UK market through the ferry ports, airports and the Channel Tunnel.	Birmingham, Bristol, London, Manchester, and Merseyside.	Ecstasy is exported to Australia, Malaysia, South Africa and locations popular with British clubbers e.g. Ibiza.

Drug	Origin	Importation route	Major regional hub	Further details
Heroin	Mainly Afghanistan and the 'Golden Triangle'.	Much arrives via Northern Cyprus and Turkey into the UK through ports in the South East of England, in freight and passenger vehicles. The Channel Tunnel and air couriers are also used.	East London in particular but also Birmingham, Bristol, Merseyside, Glasgow.	Crack is often sold with heroin.

Source: National Criminal Intelligence Service (NCIS 2003; 2005a).

### *Cocaine*

British criminals are significantly involved both in the importation and distribution of cocaine (NCIS 2005a).

### *Crack cocaine*

The crack trade involves West Indian groups, British Caucasians, West Africans, and South Asians who work both independently and collaboratively (NCIS 2005a). West African groups, mainly based in the South East of England, appear to play an increasingly important role in the supply of both cocaine and crack. There is evidence of crack being distributed at a wholesale level, although this is in small amounts.

### *Ecstasy-type substances*

British Caucasian groups mainly control distribution in the UK. Ecstasy-type substances are distributed to groups or individuals operating regionally or locally who also supply other drugs such as cocaine and cannabis resin.

### *Heroin*

Turkish groups in the Netherlands, north Cyprus, and Turkey dominate the UK heroin trade with Turkish groups in the UK (although other groups are becoming more significant including British Caucasians and South Asians) (NCIS 2005a). Albanians, Bulgarians, Macedonians, Kosovans, Romanians, Bosnians and Serbs are involved moving Turkish heroin through the Balkans but the extent of this involvement is not known. The UK groups buy heroin in the UK on a large scale for distribution, and are increasingly involved in importing their own deliveries (sometimes with other drugs).

Turkish groups based in London dominate distribution but other cities are also significant. For example, Merseyside is an important source for the North West of England, Scotland and Northern Ireland.

### 10.1.2 Purity and price

In general, the quantity of seizures have been rising in the UK. However seizures of LSD are falling<sup>165</sup>. Overall, brown heroin has shown an increase in purity whilst the purity of amphetamines, cocaine and brown heroin has fluctuated over the last few years<sup>166</sup>. The prices of ecstasy, heroin and cocaine have been falling since 1998 although prices of cannabis leaves and resin, amphetamines and crack have remained largely similar<sup>167</sup>.

<sup>165</sup> Information about seizures is provided by the Home Office Research and Statistics Directorate who collate figures provided by Customs and Excise, and the police.

<sup>166</sup> Information on the average purity at street level of certain drugs and the content of tablets is provided by the Forensic Science Service (FSS).

<sup>167</sup> Information on the average price of drugs is provided by the National Criminal Intelligence Service (NCIS).

### 10.1.3 Further details on the drug market

The latest estimate of the value of the UK drug market is for 1998 (Bramley-Harker 2001). They suggested a total value of around €9.8 billion (£6.6 billion). This estimate is being reconsidered in light of newly available data.

Ease of access is often tied closely to patterns and levels of use, where the most commonly used drugs are usually also the most accessible (Condon and Smith 2003).

## 10.2 Availability of drugs (perceived availability/access in population, other indicators)

The schools survey in England and Wales in 2004 asked pupils aged between 11 and 15 years old whether they had been offered any drugs (NatCen/NFER 2005)<sup>168</sup>: It showed that:

- thirty six per cent of pupils reported having been offered at least one drug during their lifetime (42% in 2003);
- boys were more likely to have been offered drugs than girls (39% compared to 34%);
- cannabis was the most common drug that pupils reported having ever been offered (25%); and
- in 2004, 14 per cent of pupils reported ever being offered volatile substances.

In Scotland, pupils aged 13 and 15 were also asked about accessing drugs (Corbett *et al.* 2005). Forty-six per cent of 13 year olds and 28 per cent of 15 year olds did not know where they could access drugs. Of the remaining pupils 31 per cent of 13 year olds and 58 per cent of 15 year olds felt it would be easy or fairly easy.

### 10.2.1 Production, sources of supply and trafficking patterns within countries as well as from and towards other countries

Latest available information from the National Criminal Intelligence Service (NCIS 2005a) suggests that Turkish groups in the Netherlands, North Cyprus and Turkey continue to dominate heroin importation. With regards to crack cocaine, Colombian groups are becoming involved in production and wholesale supply.

#### *Disrupting local markets*

Operation Crackdown was launched in January 2005 and targeted local Class A drug markets (Home Office 2005b). Thirty-two Police forces worked together to close drug dens, disrupt local drug markets, seize illegal firearms and convict drug suppliers. At the end of the three month campaign, the Police forces had:

- closed 170 crack houses;
- seized over 100 kilograms of cocaine, 3 kilograms of crack cocaine, 100 kilograms of heroin and over 86,000 ecstasy tablets;
- charged 1,471 people with supplying class A drugs;
- seized 483 firearms and 3,402 rounds of ammunition; and
- seized €4.8 million (£3.2 million) in cash assets.

#### *Research*

The Home Office has commissioned several research studies examining the UK drug market:

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<sup>168</sup> Just under 10,000 pupils in 313 schools across England completed questionnaires in the autumn term.

- an examination of rolling-quarterly estimates of the size of the markets for heroin, cocaine and crack using a consumption-based approach to be published in autumn 2005;
- an examination of British South Asian drug trafficking groups aimed at understand drug dealing networks in these groups; and
- a process, impact and economic evaluation of Merseyside Middle Market Drugs Unit (MMDU)<sup>169</sup> is also being undertaken.

### 10.3 Seizures

Latest information on seizures in the UK is for England, Scotland and Wales for 2003 (Home Office 2005d). Data for Northern Ireland is unavailable (although it has accounted for a very small proportion of seizures in past years). The available data show that in 2003, the total number of illegal drug seizures appears to have fallen overall since 2000 (by 13% from 136,150 to 117,962), although there were increases in 2001 and 2002. The quantity of drugs seized has fluctuated since 2000, but overall has decreased (see Table 28).

*Table 28: Number of and quantities of illicit drugs seized by all law enforcement agencies in England, Scotland and Wales, 2000-2003*

Drug	2000		2001		2002		2003	
	Number	Quantity (Kg)	Number	Quantity (Kg)	Number	Quantity (Kg)	Number	Quantity (Kg)
Amphetamines	7,080	1,775	6,830	1,726	6,990	1,406	6,798	1,635
Cannabis	93,750	73,861	96,460	85,747	102,390	79,188	78,520	99,773
Cocaine	6,010	3,948	6,980	2,841	6,630	3,577	7,627	6,858
Crack cocaine	2,770	26	3,690	56	4,260	58	4,810	252
Ecstasy-type substances	9,790	6,552,000 (Kg tablets)	10,410	7,669,000 (Kg tablets)	8,300	5,852,000 (Kg tablets)	7,246	6,912,000 (Kg tablets)
Heroin	16,450	3,387	18,170	3,929	15,360	2,730	12,831	2,753
LSD	300	25,000 doses	170	36,000 doses	50	17,000 doses	130	29,000 doses

Source: Home Office (2005d).

Data for individual drugs present a slightly different picture, as although most drugs follow a similar pattern to seizures overall (see Table 28), seizures for cocaine and crack cocaine having increased considerably (by 27% and 74% respectively since 2000).

### 10.4 Price/purity

#### 10.4.1 Price of drugs at street level

Generally, in 2003, the average price of illegal drugs had decreased compared to 2001, especially for cannabis resin, cocaine and LSD (see Table 29). However, the levels shown are affected by the prevailing exchange rate. In Euros, it appears as

<sup>169</sup> Middle Market Dealers mainly operate above street dealers but below the level of importation into the UK, although some function at all three levels at different times. They often supply more than one type of drug or often any other profitable illegal commodity (imported tobacco, human trafficking, firearms etc.).

though the price of heroin decreased between 2002 and 2003, but the price in Pounds showed that it in fact stayed the same at £61. However, the table shows that there were no increases in the price of any illegal drugs shown, whether in Euros or in Pounds.

*Table 29: Prices of illegal drugs in euros in the United Kingdom, from 2001 to 2003*

Illegal drug	2001	2002	2003
	Exchange rate: €1.57 = £1	Exchange rate: €1.5 = £1	Exchange rate: €1.42 = £1
Amphetamines	€14.13 £9	€13.5 £9	€12.78 £9
Cannabis herb	€4.43 £2.82	€4.39 £2.93	€3.8 £2.68
Cannabis resin	€4.37 £2.78	€4.13 £2.75	€3.46 £2.44
Cocaine	€95.77 £61	€87 £58	€78.1 £55
Crack (per rock)	€32.97 £21	€31.5 £21	€26.98 £19
Ecstasy-type substances (per tablet)	€10.99 £7	€10.5 £7	€7.1 £5
Heroin	€103.62 £66	€91.5 £61	€86.62 £61
LSD	€6.25 £3.98	€5.25 £3.5	€4.26 £3

Source: National Crime Intelligence Service (NCIS 2005b).

#### 10.4.2 Purity of drugs at street level and composition of drugs/tablets

Overall since 1998, the purity of illegal drugs (as shown in Table 30 and Figure 9) has fallen. However, for most, purity has fluctuated considerably (for example, purity for cannabis resin has fluctuated between 2% and 18.1%), and for cannabis leaves and brown heroin, purity has increased.

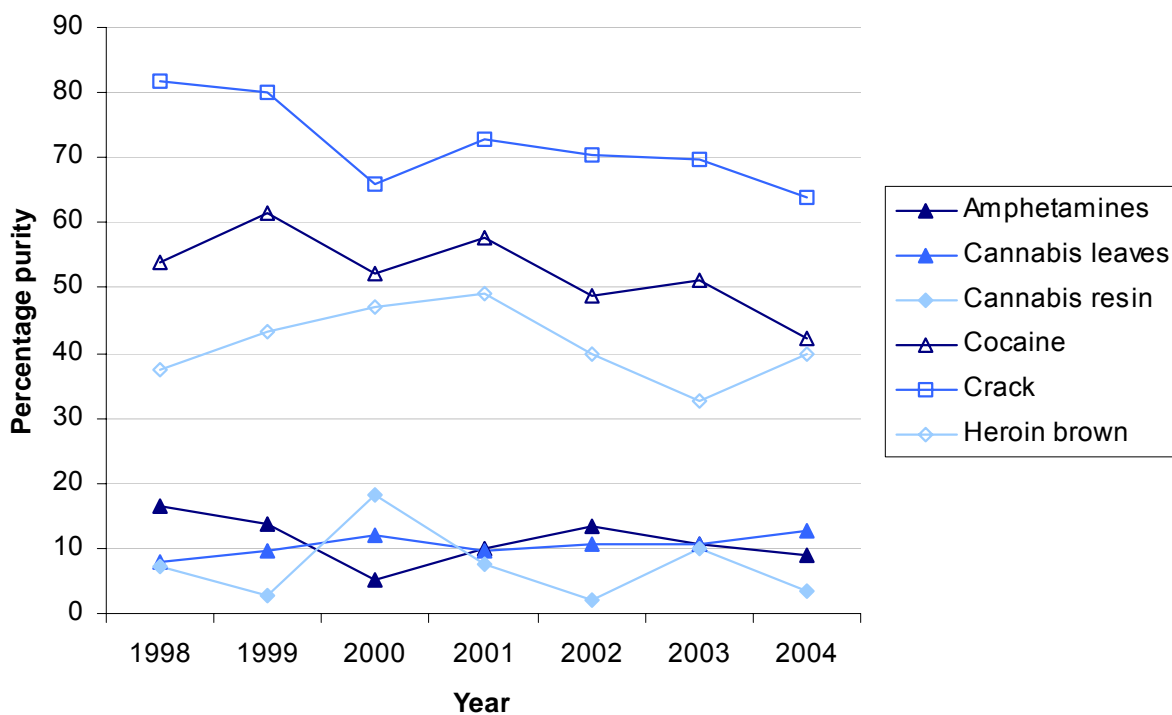
*Table 30: Street level average percentage purity of illegal substances in England and Wales, 1998 to 2004*

Illegal drug	1998	1999	2000	2001	2002	2003	2004
Amphetamines	16.4	13.7	5	10.1	13.4	10.8	9
Cannabis leaves	7.9	9.5	12	9.5	10.8	10.7	12.7
Cannabis resin	7.3	2.6	18.1	7.4	2	9.8	3.4
Cocaine	53.9	61.6	52.3	57.7	48.7	51.2	42.4
Crack	81.7	80.2	65.9	72.8	70.3	69.6	63.8
Heroin	37.3	43.3	46.9	49.2	40	32.7	39.9

For cannabis products, the % THC content is shown; for other illicit drugs, the % of pure substance is shown.

Source: Forensic Science Service (FSS 2005).

Figure 9: Street level average percentage purity of illegal substances in England and Wales, from 1998 to 2004



For cannabis products, the percentage tetrahydrocannabinol (THC) content is shown; for other illicit drugs, the percentage of pure substance is shown.  
 Source: Forensic Science Service (FSS 2005).

# PART B

Selected issues

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## SUMMARY

### 11. Gender differences

#### *Prevalence*

In the general population, men are more likely to use drugs than women, the differential increasing with age. In 2003/04, lifetime use amongst adults was 3.4 per cent for males and 1.4 for females. Males are also more likely to use drugs problematically, the ratio being approximately 3:1.

#### *Treatment*

The ratio of males to females in treatment services is approximately 3:1 and there are other differences including referral source, age at referral, drugs used and family circumstances.

#### *Infectious Diseases*

Prevalence of HIV and hepatitis C are similar, hepatitis B is lower among women.

#### *Crimes and arrests*

Female arrestees are significantly more likely to test positive for methadone and cocaine (including crack), amphetamines and benzodiazepines than males.

#### *Responses*

There are few gender specific responses; those which are tending to relate to gender specific issues such as sex work and pregnancy. There are mother and baby units in a few drug services.

### 12. European drug policies: extended beyond illicit drugs?

#### *Official endorsement by the National Drug Strategy*

Only in Wales does the strategy covers both drug and alcohol use.

#### *Genesis and rationale*

In Wales, the rationale was that use of any substance results in similar physical, psychological and social problems, requiring similar responses.

#### *Responsibilities and competencies (Coordination)*

In Wales responsibility lies with the Welsh Assembly Government and at the local level through local partnerships. In the rest of the UK, Drug Action Teams increasingly tackle alcohol misuse as well as drugs. In Northern Ireland there is a Drugs and Alcohol Co-ordinator responsible for both areas.

In the rest of UK there are policies in to tackle alcohol and tobacco but they are outside the competency of the Drug Strategy Directorate.

### 13. Developments in drug use within recreational settings

#### *New findings*

Routine population surveys indicate that people consume drugs in a number of recreational settings such as nightclubs, bars, pubs and music events. Those who attend such events or venues are more likely to use drugs more frequently, in larger quantities, and to be poly-drug users. However, levels and patterns of drug use can vary according to the venue, highest at established dance/gay clubs. In addition, certain music styles are associated with the use of specific drugs.



*New trends in available drugs*

There is evidence of increased use of 4-MTA (*p*-methylthioamphetamine or 4-methylthioamphetamine), ketamine, magic mushrooms and methamphetamine.

*Responses, national policies and legal aspects*

Responses to recreational drug use tend to follow a harm reduction or targeted prevention approach. To address the safety of the venue as a physical environment (by tackling issues such as overcrowding and overheating), various guidelines have been produced for venue managers and promoters, Drug (and Alcohol) Action Teams, licensing officers and those providing outreach services. The industry itself has also developed a Code of Practice for members of the Bar Entertainment and Dance Industry.

All door supervisors at clubs, pubs and bars must have a Security Industry Authority Licence, under the *Private Security Act 2001*.

*National policies and legal developments to address drug use*

In 2003, GHB became a Class C controlled drug under the *Misuse of Drugs Act 1971*.

The *Drugs Act 2005* clarified the legal position on magic mushrooms, making them a Class A drug, regardless of whether or not they have been prepared.

The Advisory Council on the Misuse of Drugs Technical Committee has recommended that ketamine should be controlled as a Class C drug.

## 11. Gender differences

### 11.1 Situation

An analysis of gender differences should take account of issues such as societal construction of the terms man and woman; the different roles expected of them; and the different norms applied to them (Thom 2003). However, much of the research and discussion in the United Kingdom tend to focus around the distinction of sex rather than gender.

Notable differences exist between the situations of men compared to women regarding drugs. More men use drugs, are problematic users, die from drug-related reasons, are arrested for drug-related offences, and more men enter treatment. In comparison, female drug users are more likely to have:

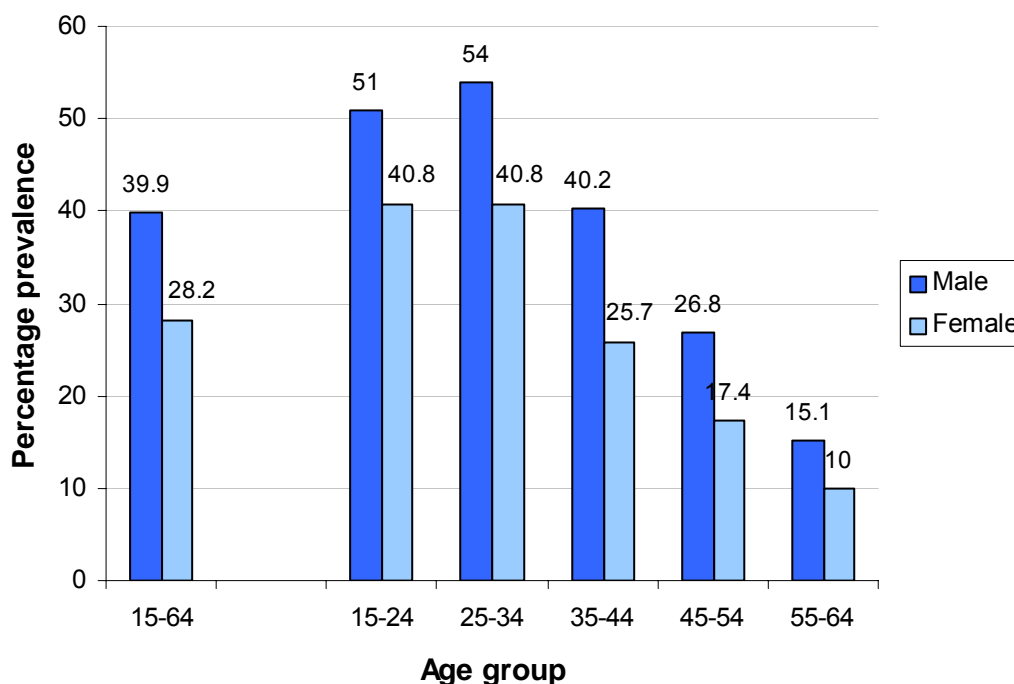
- a drug-using partner (Gilbert *et al.* 2000; Neale 2004a).
- experienced domestic violence (Gilbert *et al.* 2000; Powis *et al.* 2000);
- a history of abuse (Wallen and Berman 1992; Becker and Duffy 2002; Neale 2004a);
- low self esteem (Swift 1996); and
- mental health needs (Becker and Duffy 2002).

#### 11.1.1 Prevalence amongst the general population and young people

##### *General prevalence*

Population prevalence surveys have highlighted that men report higher prevalence levels of drug use across all age groups and a variety of different drugs (see Figures 10 and 11). However, the percentage difference is variable. For example, 54 per cent of male 25 to 34 year olds and 40.8 per cent of females reported using any illegal drug in their lifetime (13.2% difference). This can be compared to 55 to 64 year olds where 15.1 per cent of males and 10 per cent of females reported lifetime prevalence (5.1% difference).

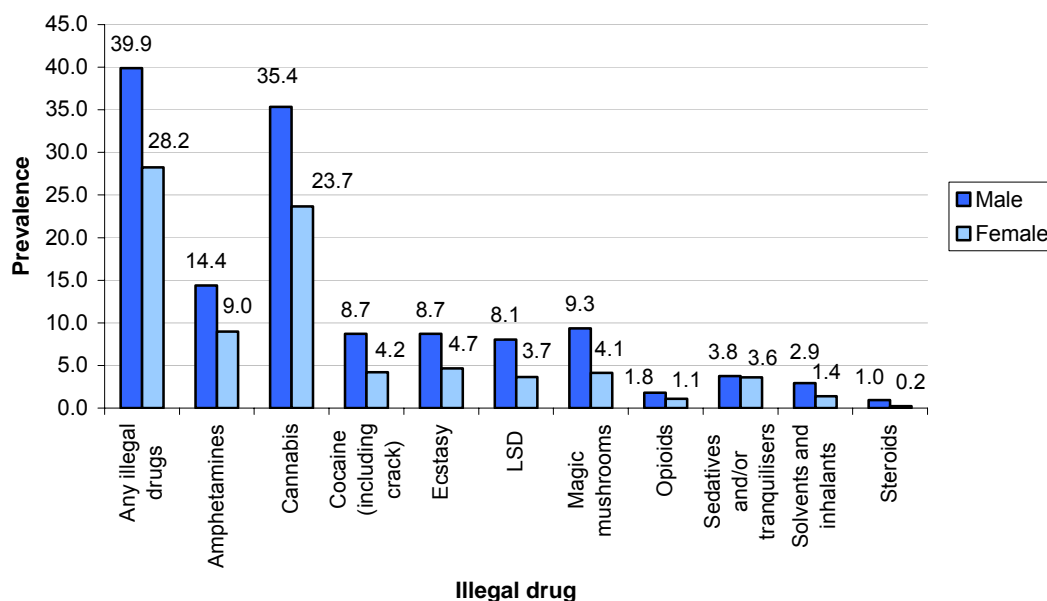
Figure 10: Lifetime percentage prevalence of use of any illegal drug amongst 15 to 64 year olds in the United Kingdom by age



Data for England and Wales is for 16 to 59 year olds, 16 year olds and over for Scotland and 15 to 64 year olds for Northern Ireland. In England and Wales, data refer to 2003/04, in Northern Ireland the data are from 2002/03 and in Scotland, they are from 2003. Source: Chivite-Matthews *et al.* (2005); Hay (2005a); Home Office (2005d); National Advisory Committee on Drugs and Drugs and Alcohol Information Research Unit (NACD and DAIRU 2005); Scottish Executive (2005a).

Variations can also be seen when looking at drug type as, of those surveyed men report much higher lifetime use of magic mushrooms, cocaine (including crack) and LSD than women, but surveys show more similar levels between men and women for drugs such as sedatives and/ or tranquilisers (see Figure 11).

Figure 11: Lifetime percentage prevalence of use of any illegal drug amongst 16 to 64 year olds in the United Kingdom by drug



Data for England and Wales is for 16 to 59 year olds, 16 year olds and over for Scotland and 15 to 64 year olds for Northern Ireland. In England and Wales, data refer to 2003/04, in Northern Ireland the data are from 2002/03 and in Scotland, they are from 2003.

Source: Chivite-Matthews *et al.* (2005); Hay (2005a); Home Office (2005d); National Advisory Committee on Drugs and Drugs and Alcohol Information Research Unit (NACD and DAIRU 2005); Scottish Executive (2005a).

Further studies have shown other gender differences of note:

- Riley *et al.* (2001) noted that women used more drugs on average than men (female mean was 4.77, male mean was 3.72) in their study of 122 drug users at dance events in Scotland.
- The Office for National Statistics (ONS 1999) surveyed prisoners in England and Wales and found that women's use of and dependence on drugs was approximately level with that of men's. However, they were more likely to report opiate dependence, and reported less cannabis use.

#### *Prevalence among young people*

School surveys show that boys are only slightly more likely to report drug use than girls. For example, 31 per cent of males aged 11 to 15 years old report illicit drug use during their lifetime compared to 30 per cent of females in England (Boreham and Blenkinsop 2004)<sup>170</sup>.

Sweeting and West's (2003) research in Glasgow<sup>171</sup> shows that in 1987, young males were more likely to have tried an illicit drug (11%) than females (6.4%); however, by 1999, this gender difference had become less marked (42% males; 38.5% females). They partly attribute this to the constraints being lifted on young women's lives enabling them to participate more fully in the public arena and in risk-taking.

<sup>170</sup> This study had a sample size of approximately 10,000 pupils in England.

<sup>171</sup> They issued very similar questions to 1,009 15 year olds in Glasgow in 1987, and then in 1999 to 2,196 15 year olds.

### Prevalence of problematic drug use

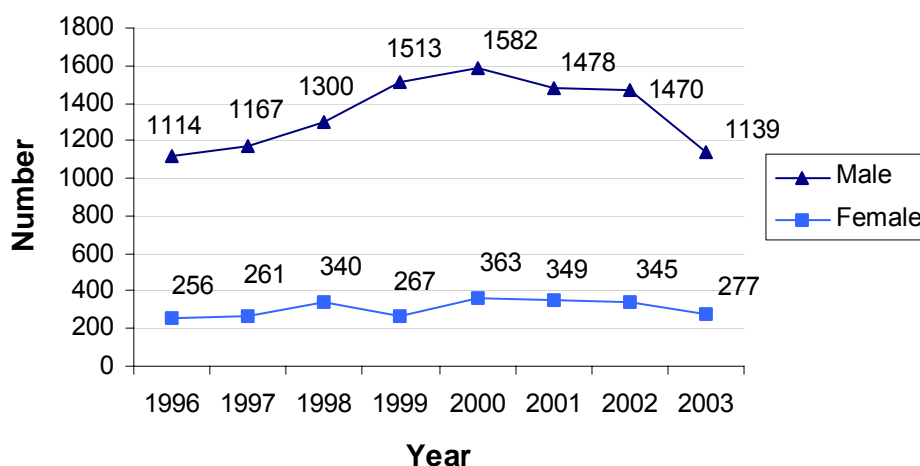
Hickman *et al.* (2004) used capture-recapture methods to estimate the prevalence of problematic drug use in three cities in England. The ratio of male to female problematic drug use overall was approximately 2.7:1.

In Scotland in 2003, 51,582 individuals were estimated to be misusing heroin and/or benzodiazepines. Of these, 69 per cent are male and 31 per cent are female (Hay *et al.* 2004).

#### 11.1.2 Drug-related deaths

Significantly more men have suffered drug-related deaths (DRDs) than women in the UK (see Figure 12)<sup>172</sup>. The trends for male and female DRDs have followed a similar pattern since 1996, peaking in 2000 and decreasing since then.

Figure 12 The number of drug-related deaths by gender in the United Kingdom using the European Drug Monitoring Centre for Drugs and Drug Addiction standard definition, 1996-2003

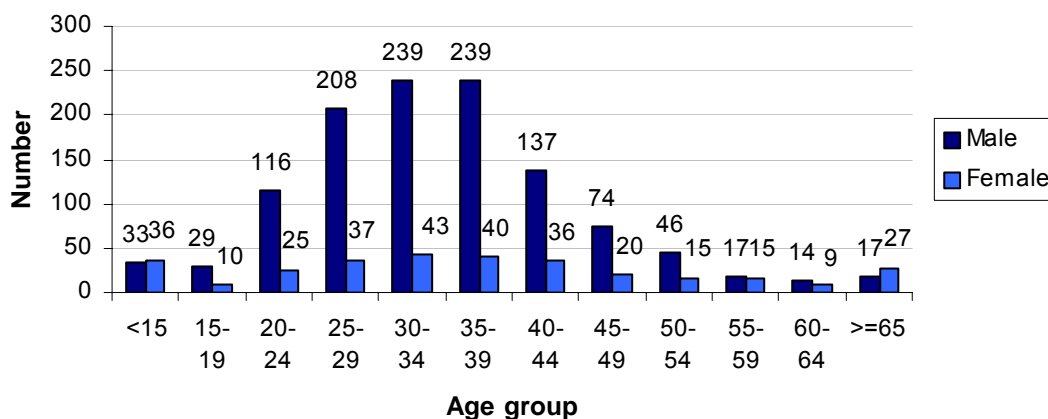


Source: Health Statistics Quarterly, Numbers 5, 7, 9, 11, 13, 17, 21 & 25; ONS 2000, 2001, 2002, 2003, 2004 & 2005.

The mean age at death also shows gender differences: on average, men die from drug-related reasons at 34.2 years old, compared to 39.4 years for women. Figure 13 highlights that the differences are most pronounced for 20 to 49 year olds where male DRDs are substantially in the majority. For those under 15 years, however, the figures are notably similar (33 males and 36 females), and for those over 65 years, more female DRDs occurred than male (17 males and 27 females). However, caution is required when interpreting these data as numbers are relatively low and figures relating to the number of deaths as a percentage of all drug users are not available.

<sup>172</sup> This could be because men are more likely to use illicit drugs (see Chapter 11.1.1) and are more likely to be 'at risk' from associated harms (Thom 2003).

Figure 13 The number of drug-related deaths by age and gender, according to the European Monitoring Centre for Drugs and Drug Addiction standard definition in 2003

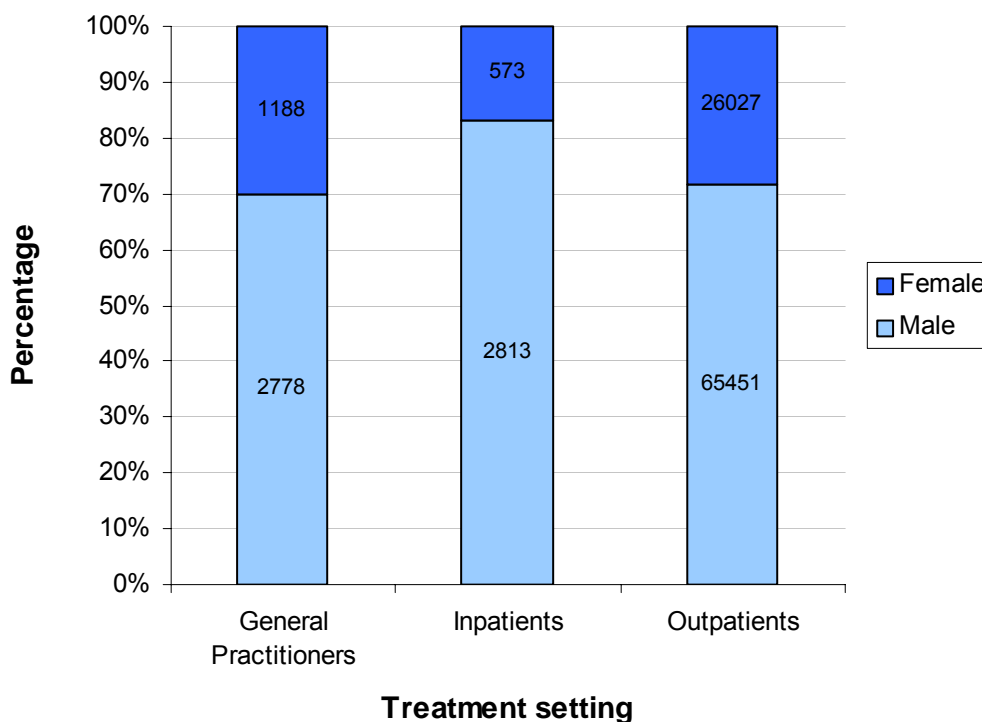


Source: Corkery 2005.

### 11.1.3 Treatment demand data

The latest treatment data for the UK show that there are more men than women in treatment in the UK across different treatment settings (see Figure 14). Men represented 70.3 per cent of all treatment episodes in the General Practitioner (GP) setting, 83.1 per cent in inpatient settings and 71.5 per cent in an outpatient setting in 2003/04. This ratio reflects the ratio of men to women estimated to be problem drug users (see Section 11.1.1). The English data show that further gender differences are apparent in treatment modality (see Table 31). Here, the ratio of men to women ranges from 2.3:1 for those in structured counselling to 2.7:1 for those in structured day care. The lower proportions and numbers of women in inpatient settings, in residential rehabilitation and in structured counselling could be linked to the different situation that women experience. For example, their family commitments (Stewart *et al.* 2002) could obstruct them from accessing treatment types that would require them to find substantial amounts of childcare (see Section 11.2.3).

Figure 14: Percentage and number of gendered treatment episodes in the United Kingdom by treatment setting in 2003/04



Data for General Practitioners and inpatient settings are for England and Scotland only.

Source: National Drugs Evidence Centre, Information Services Division, Scotland; Department for Health Social Services and Public Safety Northern Ireland, Health Solutions Wales.

Table 31 The number of drug users in treatment in England by treatment modality and gender in 2004/05 (provisional data)

Treatment modality	Number of male drug users	Number of female drug users	Ratio of men to women
Inpatient detoxification	2,482	984	2.5:1
Residential rehabilitation	3,000	1,148	2.6:1
Special prescribing	42,725	17,567	2.4:1
General Practitioner prescribing	14,882	5,804	2.6:1
Structured counselling	27,557	11,971	2.3:1
Structured day care	9,650	3,511	2.7:1
Other interventions	16,525	6,359	2.6:1
<b>TOTAL</b>	<b>116,821</b>	<b>47,164</b>	<b>2.5:1</b>

Source: Best and Abdulrahim (2005).

A number of other studies addressing gender in treatment have also been published:

- Differences are apparent regarding referral source, with just under one third of all self-referrals, GP referrals and other referral sources being for women, whereas men make up almost three-quarters of all criminal justice referrals (Best and Abdulrahim 2005).
- Women in treatment tend to be younger, have used drugs for a shorter length of time and have less delay in taking up treatment (Meier *et al.* 2000).

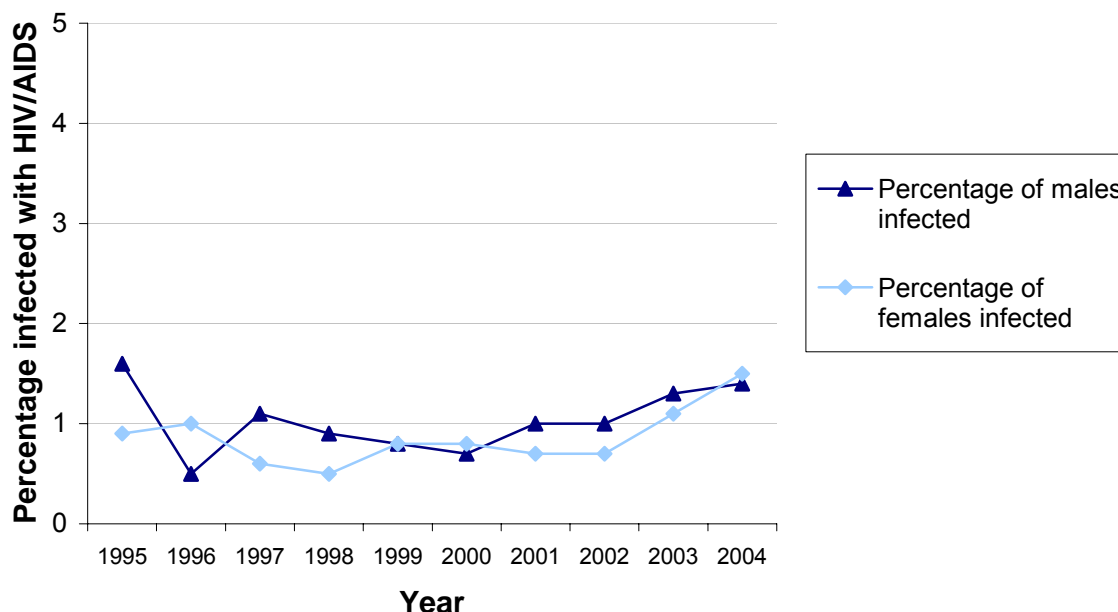
- Stewart *et al.* (2002) interviewed National Treatment Outcome Research Study (NTORS) clients (552 men and 201 women) and found that women reported greater health problems, were more likely to have a drug-using partner, and were more likely to be responsible for children.
- Neale (2004a) surveyed 715 male and 318 female drug users accessing treatment in Scotland as part of Drug Outcome Research in Scotland (DORIS - see Section 5.2.6 for more details). She sees the lives of this population as heterogeneous. However, she did find some gender-specific results with men more likely to have illegal debts<sup>173</sup>, to have been in prison<sup>174</sup> and to be less reliant on state benefits<sup>175</sup>.

#### 11.1.4 Infectious Diseases

Because of differences in methodologies between the devolved administrations, it is not possible to provide UK estimates of prevalence. Therefore, this section will focus on England and Wales, as this dataset is the largest.

Prevalence levels of HIV<sup>176</sup>, hepatitis B and C<sup>177</sup> are similar amongst men and women (see Figures 15 and 16). However, there has been evidence of a lower level of prevalence of hepatitis B amongst women in recent years.

Figure 15: Percentage of male and female injecting drug users diagnosed with HIV in a representative cross sectional survey in England and Wales, 1995-2004



Source: Health Protection Agency *et al.* (2005a).

<sup>173</sup> Males' increased likelihood to have illegal debts equated to 25.3 per cent of the male sample compared to 17.4 per cent of females ( $p \leq 0.05$ ).

<sup>174</sup> Males' increased likelihood to have been in prison equated to 78.1 per cent of the male sample compared to 49.8 per cent of females ( $p \leq 0.001$ ).

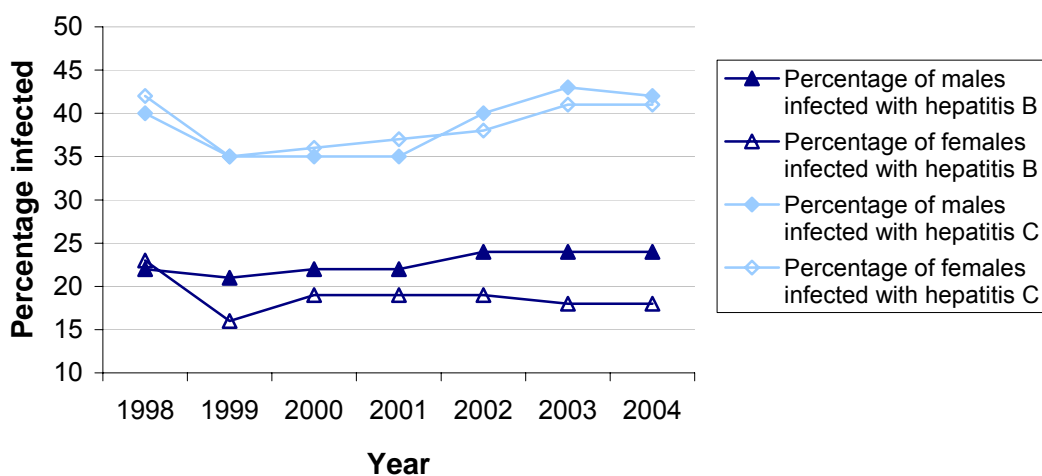
<sup>175</sup> As such, 87.1 per cent of the male sample had received income from state benefits in the last six months, compared to 94.0 per cent of the females ( $p \leq 0.001$ ).

<sup>176</sup> In a representative cross-section survey in England and Wales of 2,585 injecting drug users, only 36 or 1.4 per cent tested positive for HIV/AIDS (Health Protection Agency 2005).

<sup>177</sup> Forty-two per cent of the 2,585 tested were diagnosed with hepatitis C in England and Wales, and 22 per cent were diagnosed with hepatitis B.



Figure 16: Percentage of male and female injecting drug users diagnosed with hepatitis B and C in England and Wales, 1998-2004



Source: Health Protection Agency (2005a).

While women can have similar or even lower prevalence levels than men, female injecting drug users (IDUs) may have a higher risk of blood borne viral infections than male IDUs because they may engage in more risky behaviour. Historical data show that they are more likely to share injecting equipment: data from the Regional Drug Misuse Database show that women in England have a higher incidence of sharing injecting equipment in the last month (25% compared to 19% - out of a total of 31,815 drug users entering treatment; DH 2000). Other studies support this (Durante *et al.* 1995; Gossop 1996; Bennett *et al.* 2000) and it is thought to be because women may be more reluctant to access syringe exchange services for various reasons such as:

- injecting drug use is more stigmatised for women (McKeganey 1998; Derricott *et al.* 1999; McElrath and Jordan 2005), which may increase their reluctance to attend services (Hunter and Judd 1998; McKeganey 1998).
- perceptions that agencies target men, and that male injectors are intimidating (Derricott *et al.* 1999).
- non-child friendly agencies (Derricott *et al.* 1999).

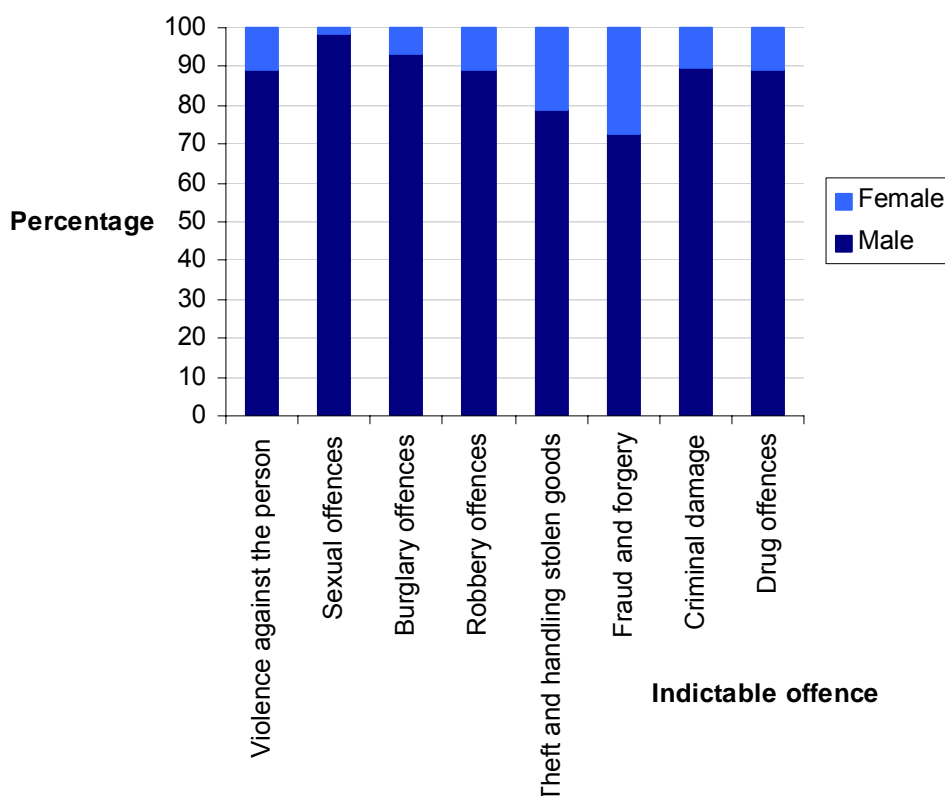
Female IDUs may also be more likely to acquire infections such as septicaemia because they are more likely to inject into a muscle or subcutaneous tissue due to poor venous access (NHS Greater Glasgow 2001).

Whilst there is little primary research regarding Anabolic Steroid (AS) use, evidence indicates that the vast majority of AS users are male (Korkia and Stimson 1993) and that most (81%) inject at least some drugs (Lenahan *et al.* 1996). There is a risk of blood borne virus transmission amongst AS injectors (Henrion *et al.* 1992); however, the UK Unlinked Anonymous HIV Prevalence Monitoring Survey found that only two per cent of a sample of 149 AS injectors had hepatitis B core antibodies and none had HIV antibodies suggesting the risk of blood borne virus transmission amongst these injectors is low (Crampin *et al.* 1998). However, despite this, the risk of contracting injection-related diseases or any adverse effects is still present (Yesalis 2000).

### 11.1.5 Crimes and arrests

Significantly more men commit crimes than women. In 2003 in England and Wales, just over two million defendants were proceeded against by a magistrates' court (Home Office 2004f). Of these, 82.4 per cent were male (1,648,822), 16.9 per cent were female (337,988) and 0.7 per cent were identified as "other" (14,012). This gender difference holds true when assessing the different types of indictable offence (see Figure 17) and is also apparent elsewhere in the UK. For example, in Northern Ireland, 90 per cent of those prosecuted are male (NIO Statistics and Research Branch 2002). In addition, for those proceeded against, the male:female ratio was highest for violent crimes and lowest for acquisitive crimes.

Figure 17 Defendants proceeded against by a magistrate's court for an indictable offence in England and Wales in 2003 by type of offence and gender as a percentage\*



Source: Home Office (2004f).

The NEW-ADAM research<sup>178</sup> found that, among the relatively few females who were tested for drugs, there was a higher rate of positive opiate tests in comparison to male arrestees<sup>179</sup> (Bennett and Holloway 2004). Female arrestees were also significantly more likely to test positive for methadone and cocaine (including crack), amphetamines and benzodiazepines. However, this may say as much about male and female offending patterns as it does about differences in drug use.

<sup>178</sup> The New English and Welsh Arrestee Drug Abuse Monitoring (NEW-ADAM) research programme interviews and examines voluntary urine tests to establish the prevalence of drug use among arrestees. It was suspended in 2002 – for further details please see [http://www.homeoffice.gov.uk/rds/drugs\\_new\\_adam.html](http://www.homeoffice.gov.uk/rds/drugs_new_adam.html).

<sup>179</sup> Forty-two per cent of the 407 females tested, had positive results for opiates compared to 69 per cent of the 2,684 males (Bennett and Holloway 2004).

Goulden and Sondhi's (2001) research with a small group of young offenders (aged 12 to 30 years old) suggested that male serious offenders were four times more likely to have used a Class A drug in the last month than female serious offenders.

### Prisons

The prison population is overwhelmingly male (see Table 32). However, overall the percentage of females in prison because of drug offences is higher than for males.

*Table 32: Number and percentage of prisoners under immediate custodial sentence who were convicted because of drug offences in the United Kingdom by gender and country in 2004*

Country	Females in prison			Males in prison		
	Number imprisoned because of drug offences	Total number of female prisoners	Percentage imprisoned because of drug offences	Number imprisoned because of drug offences	Total number of male prisoners	Percentage imprisoned because of drug offences
England and Wales	1,235	3,449	35.8%	9,252	54,475	17.0%
Northern Ireland	1	12	8.3%	58	782	7.4%
Scotland	73	258	28.3%	772	5,408	14.3%
<b>UNITED KINGDOM</b>	<b>1,309</b>	<b>3,719</b>	<b>35.2%</b>	<b>10,082</b>	<b>60,665</b>	<b>16.6%</b>

Scottish data present details for 2004/05. In England and Wales, these data are based on monthly figures for June 2004. In Northern Ireland and Scotland, the data are based on the average daily prison population for the specified time period.

Source: Home Office (2004g); O'Loan and Amelin (2005); Scottish Executive (2005i).

Home Office (2003b) interviews of 301 female prisoners highlighted that:

- nearly half were dependent on at least one drug;
- over a quarter said they were using heroin in prison;
- as noted in Section 11.1, an association with abuse, low self-esteem and mental health problems was apparent, emphasising the importance of psychological and pharmacological support. However Black/ mixed race women were less likely to seek help for emotional problems;
- the prevalence and frequency of pre-prison drug use by female prisoners matched or even exceeded that of male prisoners.

## 11.2 Responses

### 11.2.1 Gender specific responses on children and young people - prevention

#### *Universal prevention*

Much universal prevention for children and young people in the UK focuses on the school setting and campaigns such as FRANK, Know the Score and the National Drugs Helpline (see Chapter 3). These often lack a gender-specific approach. However, boys can have particular needs in drug education. This is seen as being due to a lack of advice in their magazines on issues such as drugs, and because boys and girls learn differently (Gurian 2001). Universal prevention strategies are employed in gendered environments in the UK, for example, through single sex schools, but as yet there has been no evaluation on their efficacy (White *et al.* 2004).

*Selective prevention in recreational settings*

Please see Section 11.2.2 for details of outreach work in the night time environment concerning the reduction of sexually transmitted infections. Such work is often holistic, targeting issues such as sexual health and drug use.

*Selective prevention among socially vulnerable groups*

The 2003 Crime and Justice Survey indicates that young people<sup>180</sup> identified as belonging to a vulnerable group<sup>181</sup> account for over half of young Class A drug users despite accounting for less than a third of the sampled population (Becker and Roe 2005). However, there are no direct comparisons of the effectiveness of specific curriculum content or teaching styles on different genders within the vulnerable groups (White *et al.* 2004). Such research would be beneficial by discovering the role of demography and background in prevention, and to investigate how effects can be sustained (White *et al.* 2004).

*Young people involved in sex work*

Studies suggest that more young women become involved in sex work than young men, at a ratio of 4:1 (Barrett 1998). Far less has been documented about sex work among young men but evidence suggests that boys tend to enter and exit sex work at a younger age (Palmer 2001). This population may also be less visible because of the additional perceived stigma of homosexuality (Palmer 2001).

Various interventions and organisations support young people involved in sex work such as specialist foster carers, structured day care programmes, Children and Adolescent Mental Health Services (CAMHS) and projects such as the Coalition for the Removal of Pimping (Home Office 2004d). However, few of these are gender specific and there has been little research examining them (Edmonds *et al.* 2005).

*Teenage pregnancy*

Strategies have been launched to help tackle teenage pregnancy in the UK, but these are not drug specific (Social Exclusion Unit 1999; DHSSPSNI 2002a; Scottish Executive 2003b).

*Early criminality*

Although the majority of young offenders are male (Home Office 2003c; O'Loan and Amelin 2005; Scottish Executive 2005i), the established responses in the UK (such as Youth Offending Teams) are not gender specific.

Edmonds *et al.* (2005) highlighted that more research is needed on whether a young offender's gender affects their experiences and behaviours.

**11.2.2 Problem drug use and harm reduction: provision of gender specific responses***Reduction of injecting*

Injecting drug use is normally associated with heroin use but there has been a significant rise in the number of AS using men accessing syringe exchange services (McVeigh *et al.* 2003). Harm reduction in this context is complex as they do not associate themselves with heroin injectors because of not injecting for psychoactive

<sup>180</sup> They surveyed 4,574 individuals aged 10 to 24 years old.

<sup>181</sup> Vulnerable groups are defined as those who have ever been homeless, truants, school excludees, and young offenders. These groups are not exclusive, and many young people will be part of multiple groups or transfer between them. Inclusion in one or more of these groups is not seen as a pre-cursor to problematic drug use. There may also be vulnerable sub-sets within these classifications.

reasons<sup>182</sup>. So basic harm reduction messages that are established in other injector groups, such as encouraging non-injecting drug administration, are not clear-cut (McVeigh *et al.* 2005).

Attempts to reduce injecting amongst women can also be problematic. Syringe exchange services rarely see women as clients (McVeigh *et al.* 2003). To encourage their attendance, Derricott *et al.* (1999) suggest that services should provide:

- women only sessions;
- female-specific services (such as smear tests, contraceptive advice);
- services, which are appropriate to carers of children;
- staff with awareness of female-specific injecting issues (such as greater difficulty in accessing superficial veins).

#### *Reduction of risk of sexual transmission of infectious diseases*

Because women and gay men both suffer disproportionately high levels of sexual ill health (Lacey *et al.* 1997; Hughes *et al.* 2000; DH 2003a), these groups are recognised as needing to be targeted with information and interventions (DH 2001b).

In the night-time environment, sexual health promotion activity often focuses on outreach work targeting gay cruising areas (seeking out gay men in places such as Blackpool and Manchester), and prostitutes (targeting women in places such as Edinburgh<sup>183</sup> and Liverpool) (Hughes and Bellis 2003). It has also been recommended that advice and screening for chlamydia<sup>184</sup> are targeted at males, who are more difficult to reach, outside traditional health settings and in places such as nightclubs (DH 2003a; House of Commons Health Committee 2003).

All pregnant women are offered tests for Sexually Transmitted Infections (such as hepatitis B, HIV and syphilis) as part of routine antenatal screening (NICE 2003).

#### *Male and female sex workers' health*

The *National Strategy for Sexual Health and HIV* specifically identifies those involved in prostitution as a target group for health promotion (DH 2001b). So, local projects offer services to help sex workers, and many follow a gendered approach. The Capital Care Project was established in 1999 in London to ensure that a Needs Assessment Worker is available for any woman arrested for street sex work. May *et al.*'s (2001) assessment of it noted several recommendations:

- Making sure the sex workers report incidents of violence to the Police.
- Referring clients to appropriate services.
- Giving more priority to reducing drug use.
- Relying on settings other than custody suites to access this population.

Services such as BASE 75 in Glasgow and Streetreach in Doncaster offer women a holistic programme, providing access to accommodation, education, training and help with benefits (Home Office 2004d). Other services, such as the Magdalene Group in Norwich, offer outreach work and a school prevention programme (Home Office 2004d). It is important that these projects provide flexible access, as crack and/or heroin use can influence their ability to keep appointments (Home Office 2004d). This is exacerbated by housing problems, working hours, fear of their pimp and/or partner's response to treatment, and a lack of confidence in services.

<sup>182</sup> Instead they inject for a variety of reasons including to enhance their sporting performance, to improve their ability to do their job (where size or strength are beneficial), or to enhance their physical appearance (by far the most common reason; Lenehan *et al.* 1996).

<sup>183</sup> See [www.scot-pep.org.uk](http://www.scot-pep.org.uk) for more details.

<sup>184</sup> Chlamydia is highlighted because of its high prevalence amongst young people.

Although the vast majority of the 80,000 people thought to be working in some form of prostitution in the UK are female (whether as adults or young girls), there is also a substantial sex market involving men and young boys (Home Office 2004d). SW5<sup>185</sup> provides a sexual health service in London for men and transgendered people who are, have been or are thinking about becoming involved in sex work. Many use drugs (including alcohol). SW5 offers somewhere to speak freely, advice, support, help with housing, information on education and training, and drug information. It also operates an outreach service.

#### *Pregnant problem drug users*

Pregnancy can be a significant point when the individual seeks to address their drug-using behaviour (DH 2002a), as drug use can impact on both the unborn baby (see Section 6.1, UK Focal Point on Drugs 2004) and the mother (see Sparey and Walkinshaw 1999 for further details; DH 2002a).

The Scottish Executive (2001a) has established principles to underpin good practice in maternity care for drug using parents:

- Maternity care should focus on the woman, who must be able to make informed decisions. Siney (1999) notes that women must be encouraged to admit drug use so that they are able to make these decisions.
- Staff should support partners throughout pregnancy and childbirth.
- Maternity services should be easily accessible.
- Women should help plan maternity services.
- A multi-disciplinary approach is essential.

Some further points are that:

- pregnant drug users should be able to access the same services as other women (Scottish Executive 2001b).
- care should be holistic, addressing social and financial needs too, as many obstetric problems are associated with alcohol, tobacco, social deprivation, poor health and nutrition (Siney 1999).

The Effective Interventions Unit (EIU 2005b) has issued guidance for those working with pregnant drug users (including alcohol and tobacco). This emphasises:

- the importance of focusing on the needs of the mother and baby;
- engaging the fathers in the care process;
- accounting for the parents' fears and hopes.
- multi-agency working, engaging for example paediatricians, midwives and drug services to provide a framework that is adaptable to local needs.

In 2004, DH (2004h) dedicated €2.4 million (£1.6 million) to tackling teenage pregnancy and drug abuse in England. Through the Young People's Development Programme, 27 pilot schemes will offer integrated training and education in areas such as journalism, environmental activity, arts and sport, mentoring, life skills and health-related training. It will run for three years.

See Section 11.2.3 for details on treatment services for pregnant drug users.

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<sup>185</sup> See <http://www.drugs.gov.uk/WorkPages/Diversity/CaseStudies/1074262168> for more information.

*Parents with small children*

The Advisory Council for the Misuse of Drugs (ACMD 2003) estimated that 43 per cent (95,000) of those accessing treatment in England and Wales had a dependent child over a five-year period<sup>186187</sup>. Of these, 69 per cent were fathers. Drug-using parents are more likely to live in poverty, have poor health and have a low socio-economic status<sup>188</sup> (Kettinger *et al.* 2000; Nair *et al.* 2003). However, not all find it difficult to care for their children (Barnard and McKeganey 2004).

Children can motivate their parents into addressing their drug use (Taylor 1993; Powis 2000); however, fear of having their children taken into care can affect this (DH 2002a; EIU 2002). So, programmes such as Sure Start<sup>189</sup> are used to encourage attendance at drug services. These do not follow a gendered approach. In addition, much of the literature and guidance concerning parents with small children does not address the mother and the father separately (Murray and Hogarth 2003), unless they are discussing pregnancy (for example, NHS Borders 2004).

*Prevention of drug-related mortality and morbidity**Mortality*

The National Treatment Agency for Substance Misuse (NTA 2002), when discussing DRDs, advises that all drug services should meet the needs of and attract vulnerable groups, which covers gender-specific issues.

*Mental health*

DH (2003b) recommends providing women-only community day services for those experiencing mental health problems.

**11.2.3 Treatment data***Availability of gender specific treatment*

In the UK, the majority of treatment services cater for both genders, adapting their services to the needs of the individuals<sup>190</sup>. NTORS shows how services can help both genders, even though they have different situations. Stewart *et al.* (2002) interviewed 753 NTORS clients (552 men and 201 women) and found that despite the gender differences of those presenting to services (see Section 11.1.3), there was no gender difference in treatment response, and both men and women made significant progress in reducing drug use<sup>191</sup>, health problems and criminal behaviour<sup>192</sup> after a year. However, differences were found for alcohol consumption: a fifth of participants began treatment drinking above recommended limits, but this was only reduced for men.

<sup>186</sup> In the Border regions, Murray and Hogarth (2003) estimate that between 10 and 50 per cent of clients accessing drug and alcohol services, are the parents of dependent children.

<sup>187</sup> These estimates are based on those attending drug treatment services, and so are likely to be conservative.

<sup>188</sup> Although Kettinger *et al.* (2000) argue that it is difficult to attribute drug use as the main cause of negative outcomes as a number of environmental factors may also be responsible.

<sup>189</sup> The Department for Education and Skill's Sure Start programme aims to give children in deprived areas the best possible start in life through a multi-agency approach involving health, childcare, early learning and family services - see <http://www.surestart.gov.uk/> for more details.

<sup>190</sup> An example of this is the Northern Ireland Community Addiction services, see [www.patient.co.uk](http://www.patient.co.uk) for further information.

<sup>191</sup> For example, frequency of heroin and benzodiazepine use were approximately halved at one year.

<sup>192</sup> Although the reduction here was less marked for women.

However, it is thought that universal drug services may not be able to meet the specific needs of individual groups, such as women (DH 2002a). As such, some female-specific services do exist<sup>193</sup><sup>194</sup>. These are mainly aimed at particular groups of women:

1. Pregnant users (the Women's Reproductive Health Service in Glasgow; Special Needs in Pregnancy Service available in parts of Scotland).
2. Victims of domestic abuse (through the low threshold and referral service Survive, in South Gloucestershire, England).
3. Sex workers (Base 75 – see EIU 2002).

The Drugs Strategy Directorate (DSD 2003) suggests that such gender-specific services can help to ensure that agencies are more informed about women's concerns. In addition, Osorio *et al.* (2002) evaluated a women-only service (30 service users participated). Overall, they found that the participants were satisfied, and that their health and social status had improved during contact with the service. However, because it relied on referrals, it did not reach those women who do not access services.

#### *Approaches relating to female role behaviour in treatment*

Because of the substantially fewer number of women compared to men in contact with treatment services, (see Section 11.1.3) it has been suggested that women are under-represented in these services (DH 2002a; EIU 2002). The EIU (2002) suggests that more women need to be encouraged to come forward, through addressing factors such as women's roles as mothers, their fear that their children might be taken into care, fear of judgement particularly if they are pregnant, and fear of the authorities if they are involved in criminal activities such as prostitution<sup>195</sup>. (See Section 11.1.1 for data regarding problematic drug users).

However, other researchers suggest that women may not be under-represented (Meier *et al.* 2000; Beynon *et al.* 2004; Best and Abdulrahim 2005). For example, Beynon *et al.* calculated that for Liverpool residents, there was a higher male to female ratio observed in the estimated total number of problem drug users, compared to that for individuals who had been recorded as accessing structured drug treatment. This suggested a higher service penetration by female drug users. The authors propose that men's reluctance to access treatment could explain their higher numbers with regards to DRDs (see Section 11.1.2). However, it is still important for drug services to address women's needs (Best and Abdulrahim 2005). It is suggested that they should co-operate with others to address issues such as physical and sexual abuse, eating disorders, self-mutilation and parenting (DH 2002a). This can mean working with mental health services, social services, women's refuges, antenatal care, childcare provision and welfare benefits advice. As such, DH (2002a) has recommended:

- services for children (for example, childcare, parental monitoring);
- healthcare (for example, antenatal, family planning, HIV prevention);
- appropriate staffing (female staff who are culturally and racially sensitive on telephone lines or as counsellors);
- shared care treatment programmes, for example for pregnant drug users.
- advocacy (for example, contact with welfare agencies);

<sup>193</sup> Information on the services available in Scotland can be accessed through [www.sdf.org.uk](http://www.sdf.org.uk). An example of a female service in Scotland is Brenda's House in Edinburgh.

<sup>194</sup> Information on the services available in England can be found through [www.drugs.gov.uk](http://www.drugs.gov.uk). An example of a female service in England is the Longreach Women's Treatment Centre.

<sup>195</sup> It should be noted that some of these issues can also be relevant for male drug users.



- access to education, training, housing, co-morbid services and aftercare;
- treatment incorporating factors connected to their drug use (for example, eating disorders);
- group/therapy counselling as Hodgins *et al.* (1997) suggest treatment outcomes are better for those women who have access to such services, especially when they are single sex groups;
- extended treatment; women are thought not to benefit as much from brief interventions (Thom and Green 1996);
- outpatient behavioural programmes; and
- accurate needs assessment for the female service users and their families.

Becker and Duffy (2002) propose that treatment services should be made more women-friendly by (Becker and Duffy 2002):

1. providing women-only spaces;
2. taking women directly to appointments or meeting travel expenses;
3. providing childcare;
4. employing staff from a range of different ethnic backgrounds;
5. performing outreach work;
6. providing a fast response or immediate access to services;
7. varying the opening times;
8. making stronger links, for example with midwives and social workers.

#### *Approaches relating to masculine role behaviour in treatment*

Whilst it is important to attract female drug users into treatment services, it is also important to attract male drug users. This is because men are more likely to use drugs, and because more men die from drug-related causes (see Section 11.1; Beynon *et al.* 2004). As such, for AS users, Derricott *et al.* (1999) recommended peer outreach in gyms, information in gyms and specific sessions at syringe exchange services. (Interventions and services for AS users going beyond syringe exchange and basic harm reduction measures are rare in the UK.)

#### 11.2.4 Gender specific responses in social (re)integration

As we have seen throughout this chapter, many interventions in the UK are holistic, and aim to provide both drug services and re-integration techniques. So, the gender-specific services such as SW5 and BASE 75 (see Section 11.2.2) not only provide access to treatment and information, but also provide training or help with housing.

#### *Family and social relationships*

Drug treatment services give advice and support, where needed, on issues such as family and social relationships (DSD 2003). Mother and Baby units have been established by local agencies (DSD 2004e). Services such as Corekids are more specialist (Drink and Drugs News 2005). It treats the drug-using parents and children alongside each other to enable children (who may have been looking after their parents) to renegotiate their position in the family. However, there is no structured gender dynamic to this service.

#### *Work and employment*

Progress2work (p2w) is the main intervention in the UK, which helps get drug users in treatment back into employment, but it does not use a gendered approach.

#### *Education and training*

Positive Futures is a national initiative in England and provides an intervention based on relationship-building to re-integrate vulnerable young people (including drug users) into education or training. It does not follow a gendered approach (aiming to

reach all those living in deprived areas) but it largely involves young men (28% of the 35,263 who had been involved up to October 2004 are female; DSD 2005b). However, some local projects cater in particular for vulnerable women (Home Office 2004d):

1. The Reclaim Life Project develops Information Technology and basic skills for excluded women in North and West Yorkshire.
2. Street Girls provides pre-employment courses for prison leavers in Lancashire on subjects such as gym instruction and literacy.

#### *Debt counselling*

DSD (2004d) suggests that drug agencies should integrate financial work into their services so that clients are less reliant on begging but this is not a gendered approach. This lack of a gendered-structure is because the drug user, whatever gender, finances their own drug habit (Taylor 1993), and so both men and women are likely to have financial issues that need addressing.

#### *Housing*

The Office of the Deputy Prime Minister (OPDM) and the Home Office (2005) have issued guidance on housing for those working with drug users. It identifies women as a group with specific needs because they often have access to fewer bed-spaces than men, and that those providing housing-related support to women must ensure that local services have clear policies on childcare and confidentiality.

### 11.2.5 The criminal justice system

#### *Responses to petty crime*

The Home Office is investing €14.1 million (£9.15 million) into reducing women's offending (DSD 2005c). Initiatives will be set up in two areas in England to tackle issues such as drug use, housing, childcare, domestic violence, and mental health problems.

Other responses to petty crime include Community Orders. The majority of those issued with an Order are male. For example, in 2002 in England and Wales, 82 per cent of those issued with a Drug Treatment and Testing Order (DTTO) were male (NAO 2004). The National Audit Office (NAO) suggest that women may be less likely to commit the types of crime that would lead to a DTTO (such as burglary).

#### *Prison responses, differences in culture of practices in men's and women's prisons*

There are a number of important differences when discussing women's offending and women's prisons that must be considered in comparison to men<sup>196</sup> and it has been acknowledged that the imprisonment of women is in need of revision (HM Inspectorate of Prisons 2001; Scottish Executive 2002a). There are calls for expansion into services in the community, and alternatives to custody. Yet the female prison population continues to rise (see Figure 6).

Most prison responses to drug use in UK prisons (such as CARATs, DIP – see Section 9.3.3) do not have a gendered approach. However, Ash (2003) has published guidance for prisons on working with female prisoners, which covers issues such as procedures for Mandatory Drug Tests and healthcare arrangements.

<sup>196</sup> More information can be found at [http://www.hmprisonservice.gov.uk/adviceandsupport/prison\\_life/femaleprisoners/](http://www.hmprisonservice.gov.uk/adviceandsupport/prison_life/femaleprisoners/).

## 12. European drug policies: extended beyond illicit drugs?

### 12.1 Official endorsement by the National Drug Strategy

The formal UK Drug Strategy documents do not generally include other addictive behaviours (UKADCU 1998; DSD 2002a); though with devolution Northern Ireland, Scotland and Wales have developed their own strategies, based upon UK strategy, but reflecting local need. In Wales, the strategy, is concerned with both drug and alcohol use (National Assembly for Wales 2000). In Northern Ireland, while there are separate strategies for drugs (NIO 1999) and alcohol (DHSSPSNI 2000), there is a Drugs and Alcohol Co-ordinator responsible for policy in both areas. The Scottish approach focuses mainly on the use of illicit drugs, but recognises that the problem is multi-faceted. Scotland's Drug Strategy identified that there are inextricable links between illegal drug use, smoking and alcohol misuse stating that 'Tobacco and alcohol use often provide a gateway into illicit drug use' (Scottish Office 1999).

Links between addictive behaviours are, however, well recognised, notably the link between drugs and alcohol and are addressed through various initiatives at local and national level.

#### 12.1.1 Northern Ireland Drug Strategy

The Northern Ireland Drugs Strategy (NIO 1999) identifies the main drug problem as use of recreational drugs in Northern Ireland. While the original strategy did not address alcohol, tobacco, solvents or doping, it did identify young people as a key target group for drug prevention work, as did the UK Drug Strategies (UKADCU 1998; DSD 2002a). As a result of this, education and prevention programmes are a prime focus of action. Such programmes, focusing on school children and young adults, include medicines, alcohol, tobacco and solvents. The Drug Strategy will be updated in the near future following a comprehensive review..

#### 12.1.2 Welsh Assembly Government

The Welsh strategy not only covers illicit drugs but also alcohol, prescription-only medicines (for example, anabolic steroids and benzodiazepines), over the counter medicines (for example, those containing codeine or ephedrine), and volatile substances (National Assembly for Wales 2000). The strategy recognises that drug use is multi-faceted, adding that the problem is complex, dynamic and far-reaching.

## 12.2 Genesis and Rational

### 12.2.1 Northern Ireland

The Northern Ireland Drug Strategy originally did not incorporate alcohol misuse (NIO 1999). However, the separate alcohol strategy by the Department for Health, Social Services and Public Safety, Northern Ireland (DHSSPSNI 2000) has been cross-referenced with the Drug Strategy through the *Northern Ireland Drugs and Alcohol Campaign* (DHSSPSNI 2001). This campaign enabled regional and local action plans to be developed, and to empower groups and individuals to progress initiatives. While meeting local needs, the model remained part of the overall purpose of the national strategy. In addition, a Regional Drug and Alcohol Strategy Coordinator was appointed in 2003, and tasked to take forward the implementation and delivery of the combined Drug and Alcohol Strategies (DHSSPSNI 2003).

### 12.2.2 Wales

The Welsh strategy has built upon the work of the previous strategy for Wales of 1996 (Welsh Office 1996), and following a review it developed a strategy aimed to increase prevention activity with a view to reduce the acceptability of taking drugs and of excessive or inappropriate drinking (Welsh Office 1996). It prioritised work on young people and emphasised the needs of children. The 2000 strategy expands on this and now encompasses non-illicit substances (National Assembly for Wales 2000). The rationale for this was that there are overlaps in responses required to deal with problems arising from drug use, and that use of different substances often result in similar physical, psychological and social problems.

### 12.3 Responsibilities and competencies (Coordination)

While it is only in Wales that there is formal endorsement of extending the Drug Strategy beyond illicit drugs, in England and Scotland, Drug Action Teams now commonly co-ordinate local action on alcohol and, accordingly, are frequently designated as Drug (and Alcohol) Action Teams (D(A)ATs).

#### 12.3.1 Volatile substance abuse

Further, the responsibility for a strategic response to addictions in other areas can lie within the competence of government departments who lead on drugs. Thus, the Substance Misuse Team at the Department of Health in England are responsible for developing a framework to tackle volatile substance abuse (VSA), working in partnership with Home Office and supported by the Department of Trade and Industry (DH 2005b). The principal aim is to ensure the number of deaths arising from VSA continue to fall.

Scotland does not have a specific strategy on VSA but they launched a campaign to raise awareness in March 2005 (see Section 3.2.3; Scottish Executive 2005a). This campaign follows the Lord Advocate's decision in February 2005 to revise prosecution policy (Scottish Executive 2005a).

#### 12.3.2 Alcohol

The Substance Misuse Team with the Department of Health also worked with the Home Office (responsible for UK Drug Strategy) to develop an Alcohol Harm Reduction Strategy for England (Prime Minister's Strategy Unit 2004). The Home Office and the Department of Health share responsibilities for delivery, but work closely with departments such as the Department for Culture, Media and Sport, the Office of the Deputy Prime Minister, and the Department for Education and Skills. The Public Health White Paper *Choosing Health: Making healthier choices easier* seeks to build on the commitments within the Alcohol Strategy through guidance and training, piloting approaches to targeted screening and brief intervention, and improving alcohol treatment services (DH 2004a).

The Scottish Executive published its *Plan for action on alcohol problems* in 2002 (Scottish Executive 2002b). This identifies binge drinkers and the need to reduce harmful drinking by children and young people as key priorities. It sets out the action required in relation to culture change, prevention and education, provision of services and protection and controls. The Executive will publish an updated Plan by the end of 2005, which will review progress to date and set out forward actions for the Executive and partner agencies for the next three years.

### 12.3.3 Doping

The use of performance enhancing drugs, while not incorporated in national strategies, may be addressed at local D(A)AT level. The UK Government supports the National Anti-Doping Policy (UK Sport 2005). UK Sport is the country's National Anti-Doping Organisation (NADO) and it receives Government funding to combat drugs in sport<sup>197</sup>. The Scottish Executive and sportscotland<sup>198</sup> are supporting the UK Government and UK Sport fully on this (Scottish Executive 2002c).

### 12.3.4 Tobacco

Tobacco is not within the competence of the UK Drug Strategy (UKADCU 1998; DSD 2002a). In England, the Department of Health has lead responsibility for the most recent Government White Paper on public health issues *Choosing Health: Making healthier choices easier* (DH 2004a). This aims to tackle tobacco health issues and reduce the number of smoking-related deaths. Government is to bring forward policies set out to regulate smoking in public places and workplaces, to tighten regulation of underage tobacco sales and to take action on tobacco smuggling. In addition it will continue maintaining a high level of tax on cigarettes.

Northern Ireland has a corresponding strategy (DHSSPSNI 2002b). It outlines Northern Ireland's approach to improve health, well-being and reducing health inequalities, and identifies the need to tackle smoking as a priority.

In Scotland, *A breath of fresh air for Scotland: tobacco control action plan* sets out a programme of action covering prevention and education, protection and controls and the expansion of cessation services (Scottish Executive 2004d). It also addresses the issue of second hand smoke and proposed consultations which led to the *Smoking, Health and Social Care (Scotland) Act 2005* being passed. As a result by 26 March 2006, the Scottish Executive (internal communication) suggests that Scotland will have one of the most comprehensive sets of restrictions on smoking in public places anywhere in the world.

### 12.3.5 Gambling

The Department for Media, Culture and Sport (DCMS 2004) believes that the UK has relatively low levels of problem gambling. Nevertheless, the Foresight project (see Section 7.3.1 for more details on Foresight) on Brain Science, Addiction and Drugs looked at the potential problems of behavioural addiction and reported that gambling is the 'best-known non-chemical addiction' (Orford 2005).

A new *Gambling Bill* became an Act of Parliament in April 2005. It introduces new regulations for commercial gambling and is intended to afford greater protection for those who have problems with gambling as all gambling operators will be required to act responsibly (DCMS 2004). Following the bill, the gambling industry established the Responsibility in Gambling Trust (RIGT)<sup>199</sup>. This will fund prevention, treatment and research into the causes of problem gambling and effective treatment.

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<sup>197</sup> Please see [http://www.culture.gov.uk/sport/drug\\_free\\_sport.htm](http://www.culture.gov.uk/sport/drug_free_sport.htm) and <http://www.uksport.gov.uk/> for more information.

<sup>198</sup> Sportscotland is the national agency for sport in Scotland. They aim to develop sport and physical recreation in Scotland. See <http://www.sportscotland.org.uk> for more details.

<sup>199</sup> For more information, please see <http://www.rigt.org.uk/about.asp>.

## 13. Developments in drug use within recreational settings

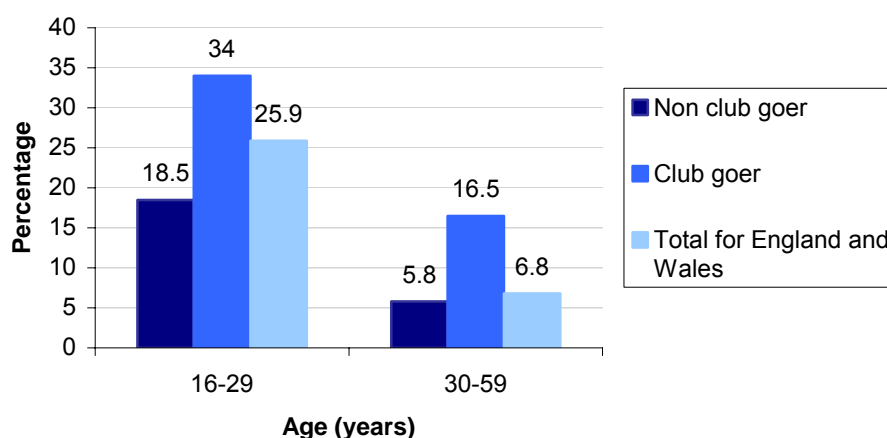
Much of the research and information available in the United Kingdom concerning recreational settings revolves around nightclubs. However, general population data indicate that people consume drugs in other recreational settings such as bars or pubs (Ramsey *et al.* 2001; Chivite-Matthews *et al.* 2005), parties, gigs, festivals etc. (Sumnall, in preparation).

### 13.1 New findings about trends in drug use, patterns of consumption and availability within recreational settings

#### 13.1.1 Research

An estimated 14.8 million people visited at least one nightclub in the UK in 2004 (Mintel 2004). Those who attend such events or venues are more likely to use drugs more frequently, in larger quantities (O'Hagan 1999; Measham *et al.* 2001; see Figure 18) and are more likely to be poly-drug users (Riley *et al.* 2001). Drug use prevalence among club goers is also likely to be higher amongst younger age groups (see Figure 18).

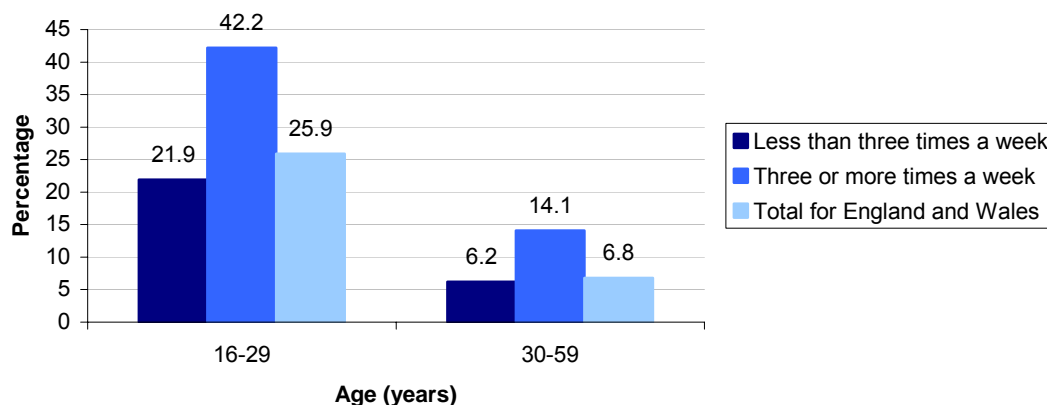
Figure 18 Percentage of individuals reporting to have used any illegal drug in the last year by frequency of visits to nightclubs or discos in the last month in England and Wales



Source: Chivite-Matthews *et al.* (2005).

Higher drug use prevalence is also associated with the frequency of attending pubs or wine bars in England and Wales, particularly amongst those in the younger age groups (see Figure 19), with similar patterns evident in Scotland (Riley *et al.* 2001).

Figure 19 Percentage of individuals reporting use of an illegal drug in the last year by frequency of visits to a pub or wine bar in the evening in the last month in England and Wales



Source: Chivite-Matthews (2005).

Deehan and Saville (2003) interviewed 760 clubbers in the South East of England. Several key points emerged:

- Seventy nine per cent had used drugs during their lifetime compared to 46.6 per cent of 16 to 24 year olds in the British Crime Survey (Chivite-Matthews *et al.* 2005).
- Ecstasy was the most common drug used, followed by cannabis and cocaine.
- A third were using both alcohol and drugs when surveyed.
- The clubbers bought their drugs from trusted dealers<sup>200</sup> to bring to the venue to minimise health risks and legal consequences. So, effective searching at the door could tackle drug use inside the venue.

### 13.1.2 Types of recreational settings where drug use is most prevalent

#### Music types

Certain music styles are thought to be associated with the use of specific drugs. Webster *et al.* (2002) state that ecstasy, amphetamines and ketamine are associated with 'techno' music whilst alcohol, cocaine and ecstasy are associated with 'garage' music. However, they do not provide a reference for this, and as music and fashion trends are transient, it must be viewed cautiously.

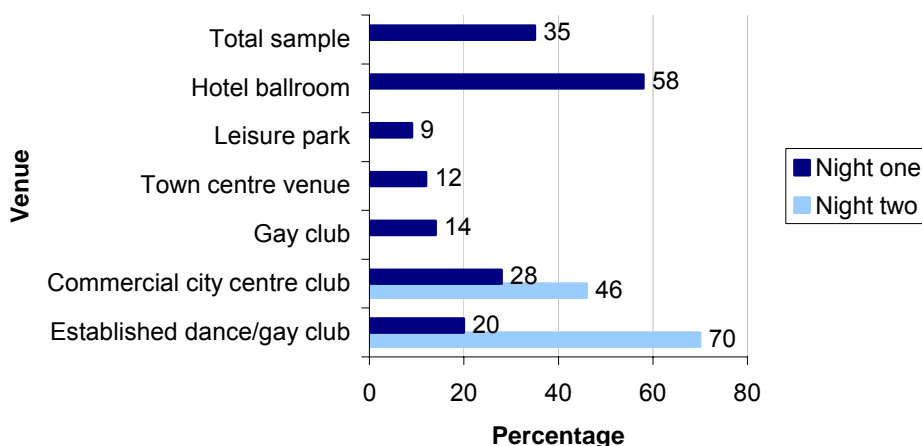
#### Venue and clientele

Levels and patterns of drug use can vary according to the venue. Deehan and Saville (2003) found that drug use<sup>201</sup> ranged from nine per cent at a leisure park to 70 per cent at an established dance/gay club (see Figure 20). Measham *et al.* (2001) also found that venue could affect drug use, as the type of venue attended was associated with the drug used.

<sup>200</sup> Riley *et al.* (2001) support this, stating that in their study drugs were more likely to be accessed through friends rather than from any other source.

<sup>201</sup> The interviewees either already had used or were intending to use an illegal drug on the evening of the interview.

Figure 20 Percentage of drug use prevalence on the night of interview among clubbers by venue in the South East of England



Source: Deehan and Saville (2003).

### Lifestyle

Those employed in casual labour abroad can show higher levels of drug use. Hughes *et al.* (2004) interviewed 92 young people from the UK working in Ibiza for the summer and found that they were more likely to use illegal drugs than holidaymakers<sup>202</sup>. For example, 43.5 per cent of workers had used amphetamines compared to 7.4 per cent of holidaymakers ( $P < 0.01$ ).

#### 13.1.3 Changes in drug use and attitudes since 2000

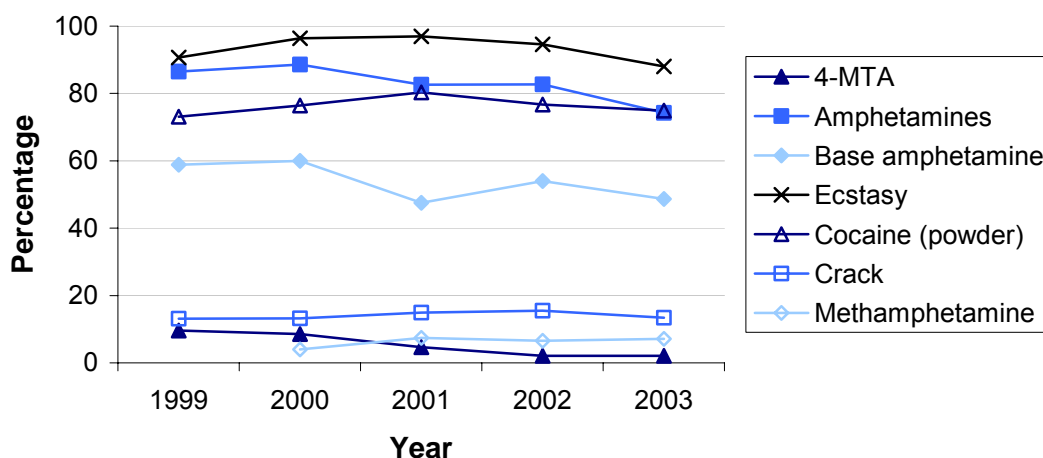
McCambridge *et al.*'s (2005) survey of Mixmag<sup>203</sup> readers shows that, since 1999, although most drugs have experienced increases and decreases in current use among dance venue attendees, overall levels of current use have remained broadly similar (see Figure 21). However, there are marked decreases in use for 4-MTA, amphetamines and base amphetamine. They found a similar pattern for lifetime prevalence.

<sup>202</sup> Who have an elevated level of drug use compared to levels of drug use in the UK – see Chapter 13.1.4.

<sup>203</sup> A UK magazine whose target audience is those interested in the dance scene.



Figure 21 Percentage prevalence of current use of specific illegal drugs in the United Kingdom among Mixmag readers, 1999-2003



(1999, n = 1,151; 2000, n = 795; 2001, n = 787; 2002, n = 335; 2003, n = 805.)

Source: McCambridge *et al.* (2005).

#### Those holidaying abroad

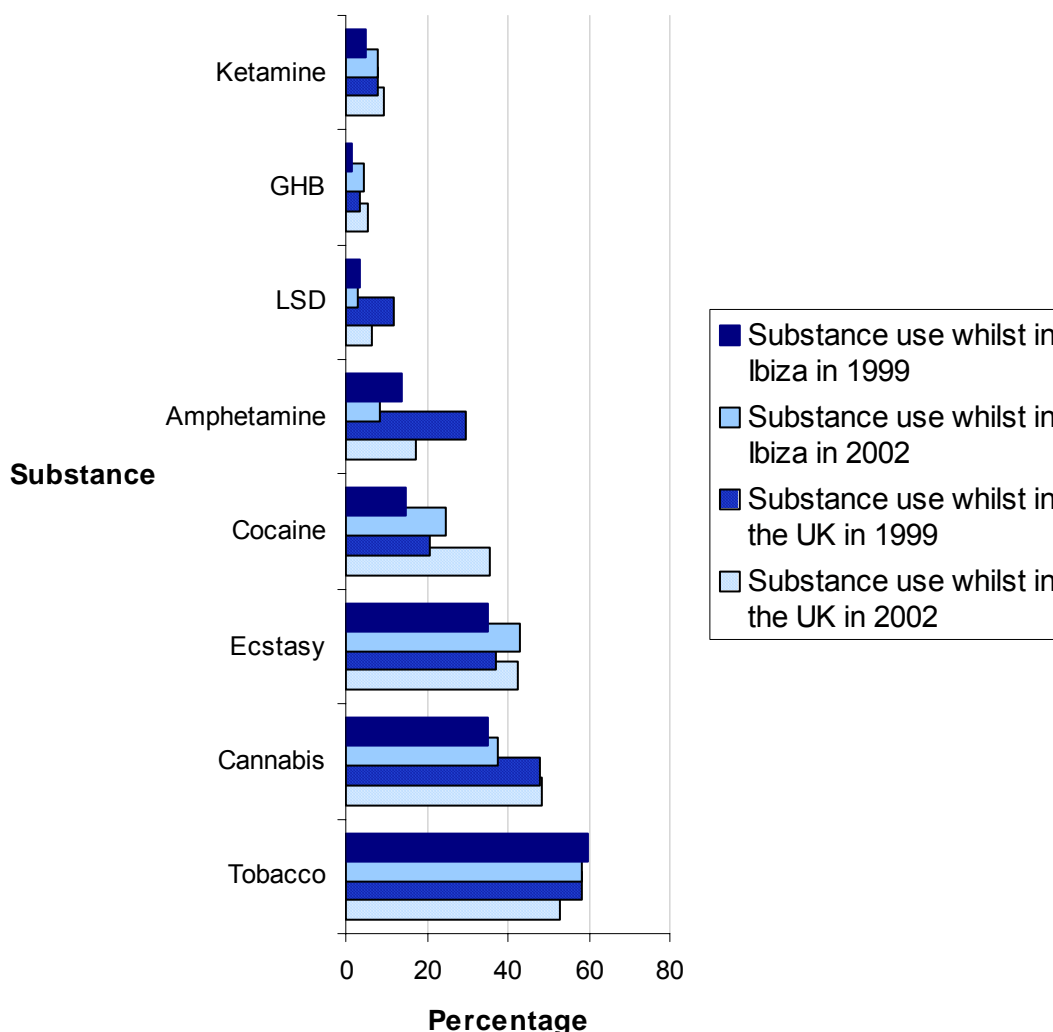
Bellis *et al.* (2003) examined the patterns of substance use amongst those holidaying<sup>204</sup> in Ibiza in 1999 and in 2002. The percentage of individuals who had ever used any illegal drugs did not change significantly over the time period either at home<sup>205</sup> or abroad<sup>206</sup>. However, cocaine, ecstasy and GHB use in both settings had risen notably by 2002, whilst tobacco, amphetamine and LSD use had reduced (see Figure 22).

<sup>204</sup> They surveyed 846 people returning to the UK from Ibiza in 1999 and 868 in 2002.

<sup>205</sup> In 1999, 56.6 per cent had ever tried an illegal drug in the UK, and in 2002, it was 57.4 per cent ( $\chi^2=0.10$ ,  $P=0.75$ ).

<sup>206</sup> In 1999, 47.7 per cent had ever tried an illegal drug whilst in Ibiza, and in 2002, it was 51.3 per cent ( $\chi^2=2.28$ ,  $P=0.13$ ).

Figure 22 Levels of drug use amongst those holidaying in Ibiza in 1999 and 2002 whilst they are in the United Kingdom and in Ibiza



Source: Bellis *et al.* (2003).

*New trends in available drugs*

*4-MTA<sup>207</sup>*

Winstock *et al.* (2002) surveyed 1,151 Mixmag readers on their awareness and use of 4-MTA or 'Flatliners'. Just over 75 per cent were aware of the drug and 10 per cent had used it.

*Ketamine*

Ketamine use has been increasing in the UK since the 1990s when it became linked to the dance scene (ACMD Technical Committee 2004). However, it appears that levels of use in clubs in some areas have stabilised<sup>208</sup>.

*Magic mushrooms*

The British Crime Survey (BCS) shows a significant increase in magic mushroom use (see Section 2.1.2). The number of shops who were selling magic mushrooms, prior

<sup>207</sup> *p*-methylthioamphetamine, 4-methylthioamphetamine.

<sup>208</sup> See <http://www.lifeline.org.uk/research/radar4.html> for more information.

to the change in legislation (see Section 13.2.2), had increased from a handful to over four hundred in the last two years<sup>209</sup>.

#### *Methamphetamine*

Reports suggest the use of crystal methamphetamine at private parties, with higher levels of usage amongst clubbers (McCambridge *et al.* 2005) although it is still unclear as to how widespread or available it is<sup>210</sup>.

#### 13.1.4 Geographical area where specified drugs/patterns of use are most prevalent

Levels of drug use are variable across the United Kingdom administrations and regions (see Chapter 2). The BCS highlights that high population areas are associated with higher levels of drug use prevalence (Chivite-Matthews *et al.* 2005). However, these findings are not related to drug use in recreational settings.

#### *Holidays*

Evidence suggests that young people holidaying abroad behave differently than when at home (Smeaton *et al.* 1998; Bellis *et al.* 2000; Bellis *et al.* 2003). This is thought to be due to time away from normal constraints, creating an atmosphere for experimentation (Sellers 1998). Bellis *et al.*'s (2003) survey found that individuals, who had never used illegal drugs in the UK, started using whilst they were on holiday in Ibiza<sup>211</sup>. For those who were already using in the UK, frequency of use was significantly higher during their stay (6.7% using ecstasy for five nights or more whilst in the UK and 36.9% in Ibiza). Participants were also more likely to use drugs if they had been on holiday in Ibiza previously.

#### 13.1.5 Correlates and consequences of specified drug/patterns of use causing concern

##### *Use of ambulance and hospital services*

Luke *et al.* (2002: 543) studied 777 'nightclub cases' attending an Accident and Emergency (A&E) department, highlighting that:

- Most of those attending had lacerations (39%) or soft tissue injuries (26%).
- Assault victims were recorded as having consumed a considerable amount of alcohol on 24 per cent of such occasions.
- Eleven per cent presented solely because of alcohol or drug consumption. The most common illegal drug causing presentation was ecstasy.

Williams *et al.* (1998) noted an association between problematic ecstasy use and weekend presentations at a large London A&E department, with young adults presenting with sympathetic overactivity, disturbed behaviour and increased temperature.

#### *Overdose*

From 1997 to 2000, there were 81 ecstasy-related deaths<sup>212</sup> in England and Wales (Schifano *et al.* 2003). Most of these occurred at the weekends, during the summer or at New Year ('party times').

<sup>209</sup> For more information, please see

<http://www.drugs.gov.uk/NationalStrategy/DrugsAct2005/MagicMushroomFAQ#1116427021>.

<sup>210</sup> See <http://www.lifeline.org.uk/research/radar4.html> for more information.

<sup>211</sup> Approximately 250,000 people under the age of 30 years old travel to Ibiza annually from the UK (Centre d'Investigació i de Tecnologies Turístiques de les Illes Balears 2002).

<sup>212</sup> Defined as a coroner's report including the words ecstasy, XTC, MDMA or MDA.

### *Other physical risks*

#### *Drug effects*

Drug effects vary depending on a range of different factors including the dose consumed, the route of administration, the setting, and the users' expectations and experiences (Jaffe 1985).

Effects of drugs such as ecstasy can be exacerbated in the night time environment by (Webster *et al.* 2002):

1. continuous dancing, raising body temperature;
2. poor ventilation, over-heated venues and over-crowding resulting in increased body temperature; and
3. insufficient water intake, preventing the body from cooling itself. Although excessive water intake can also be problematic<sup>213</sup>.

#### *Drink spiking*

Establishing the incidence drug-facilitated sexual assault (DFSA) in recreational settings<sup>214</sup> is problematic. The most comprehensive UK study reported that only 21 of the 1,014 of alleged DFSAs (2%) were attributed to involuntary drug ingestion (Scott-Ham and Burton 2005). This included three cases where the drug was ecstasy, which may have been given to reduce inhibition rather than to induce sedation. No samples tested positive for flunitrazepam (or Rohypnol), a drug often thought to be associated with such incidences. Nevertheless, such instances can happen and professionals such as door supervisors can be trained to minimise the risks (Beynon *et al.* 2005). Whilst drug detector kits are publicly available, Beynon *et al.*'s (in preparation) research suggests that their effectiveness and utility in the night-time environment has not yet been proven.

#### *Driving*

Neale *et al.* (2000) interviewed 61 dance venue attendees<sup>215</sup> in Scotland and found that 52 (85.2%) had ever driven whilst under the influence of an illegal drug. Ingram *et al.*'s (2000) study surveyed 1,008 drivers aged 18 to 39 years in Scotland, and found that nine per cent had ever driven under the influence of an illegal drug. The most common drug implicated was cannabis but ecstasy, amphetamines, cocaine and LSD were also involved (Neale *et al.* 2000).

#### *Environmental factors*

The following key risks in the night-time environment have been identified:

1. overcrowding and lack of ventilation (Bellis *et al.* 2002; Webster *et al.* 2002); although the license changes (see Section 13.2.2) may help to address this;
2. problems can arise when lighting and sound systems are used in premises that were not purpose-built (Bellis *et al.* 2002);
3. design of venues and the outside environment can contribute to alcohol and drug-related violence (Bellis *et al.* 2002).

<sup>213</sup> See <http://www.brookes.ac.uk/health/libra/ecstasy.html> or <http://www.homehealth-uk.com/index.html?f=body&fr=http://www.homehealth-uk.com/medical/ecstasy.htm|r> for more details.

<sup>214</sup> Settings such as parties, nightclubs and pubs have been associated with the risk of drink spiking (Beynon *et al.* 2005).

<sup>215</sup> These individuals had all used illegal drugs and had all driven a vehicle.

### Noise

Regular over-exposure to loud noises can damage hearing: noise levels in clubs or concerts can reach 110 decibels, 25 decibels higher than the level at which workers must be offered hearing protection<sup>216</sup> (RNID 2004). However, there is no legislation protecting nightclub customers. Employees are also affected, and Smeatham (2002) recommends that guidance should be produced to help Local Authority Inspectors enforce the existing regulations.

### Risky behaviour

Much of the literature and interventions surrounding violence in the night-time economy focus on alcohol use (Marsh and Fox-Kibby 1992; Budd 2003; Finney 2004) as there is little empirical evidence on the link with illegal drugs (Bellis *et al.* 2004). However, drugs can be involved:

- Nearly one in five violent incidents in England and Wales are drug-related (Nicholas *et al.* 2005).
- Like alcohol, drugs can hamper co-ordination and self-control, increasing the prevalence of violence and risk-taking behaviour (such as unsafe sex).
- High levels of drug use among young people in this setting (see Section 13.1.1) suggest that use of drugs are involved in night time violence.
- Like alcohol, drugs affect behaviour and can influence levels of aggression and depression (Bellis *et al.* 2002).

Violence is also associated with drug dealers. Door supervisors may be involved in drug dealing or be the victim of drug dealing-related violence (Hobbs *et al.* 2003). The new Security Industry Authority Licence will help to combat this (see Section 13.2.2).

Unsafe sexual behaviour can also be a risk in this environment (Riley *et al.* 2001). Calafat *et al.* (2003) found that those consuming substances are more likely to have more sexual partners, and are more likely to practice safe sex less frequently.

### Other psychological risks

A growing body of evidence suggests that ecstasy users may be exposing themselves to psychological risks regarding memory, cognitive abilities (Morgan 1999; Wareing *et al.* 2000; Croft *et al.* 2001) and mood regulation (Parrott *et al.* 1998; Dughiero *et al.* 2001). Long-term effects are still being investigated, although studies have shown that users who have not used the drug for at least 6 months continue to experience problems in short-term memory (Morgan *et al.* 2002) verbal working memory (Wareing *et al.* 2004), and in visuo-spatial memory (Wareing *et al.* 2005).

### Public nuisance

The BCS asked respondents about the level of disorder in their area<sup>217</sup>, and compared this against drug use prevalence (Chivite-Matthews *et al.* 2005). The survey showed that there was no significant difference in levels of drug use prevalence across the area classifications (12.3% had used any illegal drug in the last year in low disorder areas compared to 13.6% in high disorder areas). However, these findings were not related to recreational settings.

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<sup>216</sup> According to the *Noise at Work Regulations 1989*.

<sup>217</sup> This is in terms of the level of litter, the level of vandalism and the condition of the houses in their area.

## 13.2 An overview of developments in responses, national policies and legal aspects

### 13.2.1 Responses and prevention

There are various responses across the UK. They tend to follow a harm reduction or targeted prevention approach because club goers are already likely to be drug users (see Section 13.1.1), and so Webster *et al.* (2002) believe this type of message to be more effective.

#### *Guidance for those involved in dance/club events*

The proportion of clubbers who experience harm is small, but there are often specific clubs involved (Luke *et al.* 2002). These clubs typically offer cheap drinks, their staff serve intoxicated customers and ignore overcrowding. As such, guidelines exist for venue managers and promoters, Drug (and Alcohol) Action Teams (D(A)ATs), licensing officers and those providing outreach services, for example. Many of these address the safety of the venue as a physical environment through:

1. preventing overcrowding in the venue in specific areas and overall (SDF 1995; Bellis *et al.* 2002; Webster *et al.* 2002; BEDA 2005);
2. providing air conditioning and ventilation (SDF 1995; Webster *et al.* 2002; BEDA 2005);
3. providing drinking water (SDF 1995; Webster *et al.* 2002; BEDA 2005), although over-consumption can be problematic; and
4. encouraging clubbers to take a break from dancing by providing 'chill out' areas or incorporating calm time into the record mix (SDF 1995; Webster *et al.* 2002).

Such guidance also encourages staff training and first aid provision (SDF 1995; Webster *et al.* 2002; BEDA 2005).

The industry itself has also developed a Code of Practice, which members of the Bar Entertainment and Dance Association (BEDA 2005) adhere to:

1. venue managers will co-operate with the Police fully on drug-related matters;
2. every customer must submit to a search, if asked. Non-compliance will mean non-admission;
3. once inside, customers may still be required to submit to a search if there is a suspicion that they are carrying drugs;
4. if any customer possesses drugs or they are reasonably suspected, the Police will be informed;
5. any customer possessing drugs will be barred.

BEDA also emphasises the need for venues to work in partnership with for example, local authorities, the Police, and D(A)ATs. Lastly, the British Beer and Pub Association (BBPA 2005) has banned "happy hour" drink promotions in its 32,000 member pubs across the UK, and has strongly advised that the remaining 27,000 do the same to discourage binge drinking and anti-social behaviour.

#### *Advice for clubbers*

Although clubbers' safety is the responsibility of everyone involved in dance club industry<sup>218</sup>, some drugs are illegal and clubbers must take responsibility for their

<sup>218</sup> Such as club owners and promoters, those responsible for licensing and policing events, Drug (and Alcohol) Action Teams and those providing drug education or services at events.

health and safety<sup>219</sup> (Webster *et al.* 2002). As such, media campaigns aim to inform clubbers about the risks involved regarding drug use (including alcohol) and night-time risks. Leaflets (Enhance RDP and SDF 1996), press releases (Health Promotion Agency 2001, 2003; RNID 2004; Safer Swansea 2004), websites<sup>220221222</sup> and advertising (Health Promotion Agency 2001, 2003; Safer Swansea 2003; RNID 2004) detail first aid methods, the law, getting home safely and general safety tips. In addition, outreach services target clubbers and drug users at club venues. For example, D3 provides services such as:

- Free literature on safer drug using.
- Information on legal rights.
- Advice on accessing drug services.
- Information about drug quality and purity.

However, it is unlikely that information-based approaches are effective, particularly if they are used in isolation (Neale *et al.* 2000; Canning *et al.* 2004).

### 13.2.2 National policies and legal developments to address drug use

The Northern Ireland Drug Strategy (NIO 1999: 17) explicitly notes that prevention should include targeted information on issues such as “safer dancing”. The Drug Strategy for England addresses this population but under the wider term, vulnerable groups (DSD 2002a).

#### *Amendments to the Misuse of Drugs Act 1971*

In 2003, GHB<sup>223</sup> became a Class C controlled drug under the *Misuse of Drugs Act 1971*.

#### *Licensing Act 2003*

The *Licensing Act 2003* modernises licensing laws by providing more flexibility to the leisure industry<sup>224</sup> and more power to the criminal justice system to manage the night-time economy.

#### *The Drugs Act 2005*

The *Drugs Act 2005* has classified those fungi containing psilocin or psilocybin as Class A drugs (see Section 1.2.1).

#### *Security Industry Authority Licence*

Door supervisors at bars and clubs have been linked to an involvement in the problems of the night-time economy such as drug dealing and violence (Morris 1998; Luke *et al.* 2002; Hobbs *et al.* 2003). Because of this, as of April 2005, all door supervisors must have a Security Industry Authority (SIA) Licence<sup>225</sup>, under the *Private Security Act 2001*. To qualify, they must undergo a criminal background

<sup>219</sup> This ties into the recent White Paper *Choosing Health*, which seeks to provide people with the appropriate information, services and opportunities so that they can effectively take responsibility for their own health (DH 2004a).

<sup>220</sup> The Royal National Institute for Deaf People have launched a website at <http://www.dontlosethemusic.com> to give advice to clubbers on how to protect their ears.

<sup>221</sup> The Police Service of Northern Ireland have launched the Get Home Safe campaign, which is publicised through press releases and online at [http://www.psni.police.uk/index/advice\\_centre/get\\_home\\_safe.htm](http://www.psni.police.uk/index/advice_centre/get_home_safe.htm).

<sup>222</sup> The Drugs Strategy Directorate has launched Talk to FRANK, which offers advice on drugs at <http://www.talktofrank.com>.

<sup>223</sup> Gamma hydroxybutyrate.

<sup>224</sup> In terms of opening hours and new licensing formats.

<sup>225</sup> For more information, please see <http://www.the-sia.org.uk>.

check and gain specific qualifications. They must pass a course, which covers drug awareness.

*Future policy*

Because of the dangers associated with recreational ketamine use, the Advisory Council on the Misuse of Drugs Technical Committee (ACMD Technical Committee 2004) has recommended that ketamine should be controlled under the *Misuse of Drugs Act 1971* as a Class C drug.



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## Annexes

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*List of abbreviations used in the text*

4-MTA	4-methylthioamphetamine
A&E	Accident and Emergency
ACMD	Advisory Council on the Misuse of Drugs
AIDS	Acquired Immunodeficiency Syndrome
Anti-HBC	Antibodies to hepatitis B virus
Anti-HCV	Antibodies to hepatitis C virus
AS	Anabolic Steroid
ASBO	Anti-Social Behaviour Order
BBC	British Broadcasting Corporation
BBPA	British Beer and Pub Association
BCS	British Crime Survey
BCU	Basic Command Unit
BEDA	Bar and Entertainment Dance Association
BSC	Building Safer Communities
CAD	Communities Against Drugs
CAHRU	Child and Adolescent Health Research Unit
CAMHS	Children and Adolescent Mental Health Services
CARATS	Counselling, Assessment, Referral, Advice and Through-care Services
CBT	Cognitive behaviour therapy
CCTV	Closed Circuit Television
CDR Weekly	Communicable Disease Report Weekly
CDRP	Crime and Disorder Reduction Partnerships
CDSC	Communicable Disease Surveillance Centre
CI	Confidence Interval
COSMIC	Comorbidity of Substance Misuse and Mental Illness Collaborative Study
CRDHB	Centre for Drugs and Health Behaviour
D(A)AT	Drug (and Alcohol) Action Team
DAIRU	Drug and Alcohol Information and Research Unit
DARP	Drug Abuse Reporting Programme
DATOS	Drug Abuse Treatment Outcome Survey
DBS	Dried Blood Spot
DCMS	Department for Culture, Media and Sports
DEFRA	Department for Environment, Food and Rural Affairs
DENI	Department of Education Northern Ireland
DfES	Department for Education and Skills
DFSA	Drug Facilitated Sexual Assault
DfT	Department for Transport
DH	Department of Health
DHI	Drug Harm Index
DHSSPSNI	Department of Health, Social Services and Public Safety Northern Ireland
DIP	Drug Interventions Programme
DMRI	Drug Misuse Research Initiative
DOE	Department of the Environment
DORIS	Drug Outcome Research in Scotland
DPAS	Drug Prevention Advisory Service
DRD	Drug Related Deaths
DSD	Drug Strategy Directorate
DSM IV	Diagnostic and Statistical Manual – fourth edition
DTI	Department of Trade and Industry
DTLR	Department for Transport, Local Government and the Regions
DTORS	Drug Treatment Outcomes Research Study
DTTO	Drug Treatment and Testing Order
DWP	Department for Work and Pensions
EDDRA	Exchange on Drug Demand Reduction Action
EIU	Effective Interventions Unit

EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
Enhance	Enhance Recreational Drugs Project
RDP	
ESI	Education Sector Initiative
EU	European Union
FSS	Forensic Science Service
GHB	Gamma hydroxybutyrate
GMR	General Mortality Register
GO	Government Office
GP	General Practitioner
GRO	General Register Offices for England and Wales
GRONI	General Register Office for Northern Ireland
GROS	General Register Office for Scotland
HAS	Health Advisory Service
HBSC	Health Behaviour in School Aged Children
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HDA	Health Development Agency
HIV	Human Immunodeficiency Virus
HM Government	Her Majesty's Government
HM Inspectorate of Education	Her Majesty's Inspectorate of Education
HM Prison Service	Her Majesty's Prison Service for England and Wales
HM Treasury	Her Majesty's Treasury
HMIE	Her Majesty's Inspection of Education in Scotland
HPS	Health Protection Scotland
HSE	Health and Safety Executive
ICD-10	International Statistical Classification of Diseases and Related Health Problems – tenth edition
IDU	Injecting drug user
ISD	Information Services Division
KPI	Key Performance Indicator
LIT	Local Implementation Teams
LSD	Lysergic Diethylamide acid
MDA	Methylenedioxymethamphetamine
MDMA	3,4-Methylenedioxy-n-methylamphetamine
MDT	Mandatory Drug Tests
MHRA	Medicines and Health Care Products Regulation Agency
MMDU	Merseyside Middle Market Drugs Unit
MMT	Methadone Maintenance Treatment
MORI	Market and Opinion Research International
MPA	Metropolitan Police Authority
MRSA	Methicillin resistant <i>Staphylococcus aureus</i>
NACD	National Advisory Committee on Drugs
NADO	National Anti-Doping Organisation
NAO	National Audit Office
NatCen	National Centre for Social Research
NCCDP	National Collaborating Centre for Drug Prevention
NCIS	National Criminal Intelligence Service
NDEC	National Drug Evidence Centre
NEW-ADAM	New English and Welsh Arrestee Drug Abuse Monitoring
NFER	National Foundation for Educational Research
NHS	National Health Service
NHSS	National Healthy School Standard
NICE	National Institute for Clinical and Health Excellence
NICS	Northern Ireland Court Services
NICS	Northern Ireland Crime Survey
NIO	Northern Ireland Office
NIPS	Northern Ireland Prison Service
NOMS	National Offender Management Service

NPHSW	National Public Health Service Wales
np-SAD	National Programme on Substance Abuse Deaths
NTA	National Treatment Agency for Substance Misuse
NTORS	National Treatment Outcome Research Study
NWPHO	North West Public Health Observatory
ODPM	Office of the Deputy Prime Minister
Ofsted	Office for Standards in Education
ONS	Office for National Statistics
OR	Odds ratio
p2w	Progress2Work
PCT	Primary Care Trusts
PPO	Prolific and other Priority Offender
PSA	Public Service Agreement
PSHE	Personal, Social and Health Education
RCGP	Royal College of General Practitioners
RDS	Research Development and Statistics
RDS-NOMS	Research Development and Statistics-National Offender Management Service
RIGT	Responsibility in Gambling Trust
RNID	Royal National Institute for the Deaf
RoB	Restriction on Bail
SACDM	Scottish Advisory Committee on Drug Misuse
SAD	Scotland Against Drugs
SALSUS	Scottish Schools Adolescent Lifestyle and Substance Use Survey
SCIEH	Scottish Centre for Infection and Environmental Health
SCS	Scottish Crime Survey
SD	Standard deviation
SDF	Scottish Drugs Forum
SDP	Short Duration Drug Treatment Programme
SEM	Structural Equation Modelling
SIA	Security Industry Authority
SMMGP	Substance Misuse Management in General Practice
SMR	Special Mortality Register
SPS	Scottish Prison Service
STI	Sexually Transmitted Infection
TC	Therapeutic community
THC	Tetrahydrocannabinol
TOPS	Treatment Outcome Prospective Study
UAPMP	Unlinked Anonymous Prevalence Monitoring Programme
UK	United Kingdom
UKADCU	United Kingdom Anti-Drugs Coordination Unit
VDT	Voluntary Drug Testing
VSA	Volatile Substance Abuse
XTC	Methylenedioxymethamphetamine
WNHSS	Welsh National Health School Standard
YOT	Youth Offending Team
YPSMG	Young People Substance Misuse Partnership Grant

*List of websites used in the text*

Audit Commission <a href="http://www.audit-commission.gov.uk">www.audit-commission.gov.uk</a>	Department for Transport, Local Government and the Regions <a href="http://www.dlfr.gov.uk">www.dlfr.gov.uk</a>
Bank of Canada <a href="http://www.bankofcanada.ca">www.bankofcanada.ca</a>	Department for Education, Northern Ireland <a href="http://www.deni.gov.uk">www.deni.gov.uk</a>
Bar Entertainment and Dance Association <a href="http://www.beda.org.uk">www.beda.org.uk</a>	Department for Environment, Food and Rural Affairs <a href="http://www.defra.gov.uk">http://www.defra.gov.uk</a>
British Beer and Pub Association <a href="http://www.beerandpub.com">www.beerandpub.com</a>	Department of Health <a href="http://www.dh.gov.uk">www.dh.gov.uk</a>
British Broadcasting Corporation <a href="http://www.bbc.co.uk">www.bbc.co.uk</a>	Department of Health, Social Services and Public Safety, Northern Ireland <a href="http://www.dhsspsni.gov.uk">www.dhsspsni.gov.uk</a>
British Transport Police <a href="http://www.btp.police.uk/">http://www.btp.police.uk/</a>	Department of the Environment <a href="http://www.doeni.gov.uk">www.doeni.gov.uk</a>
Centre for Drug Misuse Research, University of Glasgow <a href="http://www.gla.ac.uk/centres/drugmisuse">www.gla.ac.uk/centres/drugmisuse</a>	Don't Loose the Music <a href="http://www.dontloosethemusic.com">www.dontloosethemusic.com</a>
Centre for Public Health, Liverpool John Moores University <a href="http://www.cph.org.uk">www.cph.org.uk</a>	Drink and Drug News <a href="http://www.drinkanddrugnews.net">www.drinkanddrugnews.net</a>
Centre for Research on Drugs and Health Behaviour <a href="http://www1.imperial.ac.uk/medicine/about/divisions/pcphs/pcsm/research/crdhb/">http://www1.imperial.ac.uk/medicine/about/divisions/pcphs/pcsm/research/crdhb/</a>	Drug Abuse Resistant Education <a href="http://www.dare.uk.com">www.dare.uk.com</a>
Chief Medical Officer Wales <a href="http://www.cmo.wales.gov.uk">www.cmo.wales.gov.uk</a>	Drugs Misuse Information Scotland <a href="http://www.drugmisuse.isd.scotland.org">www.drugmisuse.isd.scotland.org</a>
Child and Adolescent Health Research Unit <a href="http://www.education.ed.ac.uk/cahru">http://www.education.ed.ac.uk/cahru</a>	Drugs Strategy Directorate, Home Office <a href="http://www.drugs.gov.uk">www.drugs.gov.uk</a>
Citizens' Advice Bureau <a href="http://www.advice.org.uk">www.advice.org.uk</a>	DrugScope <a href="http://www.drugscope.org.uk">www.drugscope.org.uk</a>
Communicable Disease Surveillance Centre, Northern Ireland <a href="http://www.cdscni.org.uk">www.cdscni.org.uk</a>	European Monitoring Centre for Drugs and Drug Addiction <a href="http://www.emcdda.eu.int">www.emcdda.eu.int</a>
Criminal Reduction <a href="http://www.crimereduction.gov.uk">www.crimereduction.gov.uk</a>	European Union <a href="http://europa.eu.int/">http://europa.eu.int/</a>
Daily Telegraph <a href="http://www.telegraph.co.uk">www.telegraph.co.uk</a>	Exchange on Drug Demand Action Reduction <a href="http://eddra.emcdda.eu.int/">http://eddra.emcdda.eu.int/</a>
Department for Culture, Media and Sports <a href="http://www.culture.gov.uk">www.culture.gov.uk</a>	Exchange Supplies <a href="http://www.exchangesupplies.org">www.exchangesupplies.org</a>
Department for Education and Skills <a href="http://www.dfes.gov.uk">www.dfes.gov.uk</a>	Evening Times <a href="http://www.eveningtimes.co.uk">www.eveningtimes.co.uk</a>
Department for Transport <a href="http://www.dft.gov.uk">www.dft.gov.uk</a>	Every Child Matters <a href="http://www.everychildmatters.gov.uk">www.everychildmatters.gov.uk</a>

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[www.forensic.gov.uk](http://www.forensic.gov.uk)

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[www.talktofrank.com](http://www.talktofrank.com)

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[www.gro.gov.uk](http://www.gro.gov.uk)

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[www.gro-scotland.gov](http://www.gro-scotland.gov)

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 Scotland  
[www.hmie.gov.uk](http://www.hmie.gov.uk)

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 Wales  
[www.hmprison.gov.uk](http://www.hmprison.gov.uk)

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Middlesex University  
[www.mdx.ac.uk](http://www.mdx.ac.uk)

Mintel  
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National Audit Office  
[www.nao.org.uk](http://www.nao.org.uk)

National Centre for Social Research  
[www.natcen.ac.uk](http://www.natcen.ac.uk)

National Children's Bureau  
[www.ncb.org.uk](http://www.ncb.org.uk)

National Collaborating Centre for Drug  
 Prevention  
[www.cph.org.uk/nccdp](http://www.cph.org.uk/nccdp)

National Criminal Intelligence Service  
[www.ncis.co.uk](http://www.ncis.co.uk)

National Drug Evidence Centre, University of  
 Manchester  
<http://www.medicine.manchester.ac.uk/ndec/>

National Foundation for Educational  
 Research  
[www.nfer.ac.uk](http://www.nfer.ac.uk)

National Health Service <a href="http://www.nhs.uk">www.nhs.uk</a>	Royal College of General Practitioners <a href="http://www.rcgp.org.uk">www.rcgp.org.uk</a>
National Health Service hepatitis C awareness website <a href="http://www.hepc.nhs.uk">www.hepc.nhs.uk</a>	Safer Swansea <a href="http://www.safer Swansea.org.uk">www.safer Swansea.org.uk</a>
National Institute for Health and Clinical Excellence <a href="http://www.nice.org.uk">www.nice.org.uk</a>	School of Law, University of Edinburgh <a href="http://www.law.ed.ac.uk">www.law.ed.ac.uk</a>
National Treatment Agency for Substance Misuse <a href="http://www.nta.nhs.uk">www.nta.nhs.uk</a>	Scotland Against Drugs <a href="http://www.sad.org.uk">www.sad.org.uk</a>
New Opportunities Fund <a href="http://www.nof.org.uk">www.nof.org.uk</a>	Scottish Drugs Forum <a href="http://www.sdf.org.uk">www.sdf.org.uk</a>
North West Public Health Observatory <a href="http://www.nwpho.org.uk">www.nwpho.org.uk</a>	Scottish Enterprise <a href="http://www.scottish-enterprise.com">www.scottish-enterprise.com</a>
Northern Ireland Office <a href="http://www.nio.gov.uk">www.nio.gov.uk</a>	Scottish Executive <a href="http://www.scotland.gov.uk">www.scotland.gov.uk</a>
Northern Ireland Prison Service <a href="http://www.nips.gov.uk">www.nips.gov.uk</a>	Scottish Prison Service <a href="http://www.sps.gov.uk">www.sps.gov.uk</a>
Office of Public Sector Information <a href="http://www.opsi.gov.uk">www.opsi.gov.uk</a>	Scottish Prostitutes Education Project <a href="http://www.scot-pep.org.uk">www.scot-pep.org.uk</a>
Office of the Deputy Prime Minister <a href="http://www.odpm.gov.uk">www.odpm.gov.uk</a>	Scottish Road Safety Campaign <a href="http://www.srsc.org.uk">www.srsc.org.uk</a>
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Office for Standards in Education <a href="http://www.ofsted.gov.uk">www.ofsted.gov.uk</a>	Spiked <a href="http://www.spiked-online.com">www.spiked-online.com</a>
Patient UK <a href="http://www.patient.co.uk">www.patient.co.uk</a>	Sportscotland <a href="http://www.sportscotland.org.uk">www.sportscotland.org.uk</a>
Pharmaceutical Services Negotiating Committee <a href="http://www.psn.org.uk">www.psn.org.uk</a>	St George's Hospital Medical School <a href="http://www.sgul.ac.uk">www.sgul.ac.uk</a>
Police Service Northern Ireland <a href="http://www.psn.org.uk">www.psn.org.uk</a>	Standards Site <a href="http://www.standards.dfes.gov.uk">www.standards.dfes.gov.uk</a>
Pricing Prescription Authority <a href="http://www.ppa.org.uk">www.ppa.org.uk</a>	Student <a href="http://www.studentnewspaper.org">www.studentnewspaper.org</a>
Prime Minister's Strategy Unit <a href="http://www.strategy.gov.uk">www.strategy.gov.uk</a>	Substance Misuse Management in General Practice <a href="http://www.smmgp.demon.co.uk">www.smmgp.demon.co.uk</a>
Research and Statistics Division, Home Office <a href="http://www.homeoffice.gov.uk/rds">www.homeoffice.gov.uk/rds</a>	Tackling Anti-Social Behaviour <a href="http://www.together.gov.uk">www.together.gov.uk</a>
Responsibility in Gambling Trust <a href="http://www.rigt.org.uk">www.rigt.org.uk</a>	Teachernet <a href="http://www.teachernet.gov.uk">www.teachernet.gov.uk</a>
	Think <a href="http://www.drugdrive.co.uk">www.drugdrive.co.uk</a>

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Times  
[www.timesonline.co.uk](http://www.timesonline.co.uk)

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[www.turning-point.co.uk](http://www.turning-point.co.uk)

University of Dundee  
[www.dundee.ac.uk](http://www.dundee.ac.uk)

University of Glasgow  
[www.gla.ac.uk](http://www.gla.ac.uk)

University of Manchester  
[www.manchester.ac.uk](http://www.manchester.ac.uk)

United Kingdom Focal Point on Drugs  
[www.ukfocalpoint.org.uk](http://www.ukfocalpoint.org.uk)

United Kingdom Parliament  
[www.parliament.uk](http://www.parliament.uk)

United Kingdom Sport  
[www.uksport.gov.uk](http://www.uksport.gov.uk)

Welsh Assembly Government  
[www.wales.gov.uk](http://www.wales.gov.uk)

Wired for Health  
[www.wiredforhealth.gov.uk](http://www.wiredforhealth.gov.uk)

Youth Justice Board  
[www.youth-justice-board.gov.uk](http://www.youth-justice-board.gov.uk)



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Appendix 1: Percentage prevalence of illegal drugs in the United Kingdom by drug and country amongst 15 to 64 year olds

Illicit	British Crime Survey 2003/04 16 to 59 year olds	Northern Ireland Crime Survey 2003/04 16 to 59 year olds	All Ireland Drug Prevalence Survey 2002/03 15 to 64 year olds	Scottish Crime Survey 2003* 16 to 64 year olds	United Kingdom estimate* 15 to 64 year olds
<i>Lifetime prevalence</i>					
Any illicit drug	35.6	27.4	20.0	23.4	34.1
Amphetamine	12.2	8.5	4.0	8.9	11.7
Cannabis	30.8	19.9	16.8	21.0	29.6
Cocaine (including crack)	6.8	3.3**	1.6	4.6	6.5
Ecstasy	6.9	7.0	5.8	5.5	6.7
LSD	6.1	4.7	4.5	4.3	5.9
Magic mushrooms	7.1	4.4	4.3	4.3	6.8
<i>Last year prevalence</i>					
Any illicit drug	12.3	9.7	6.4	8.5	11.8
Amphetamine	1.5	0.9	0.8	1.3	1.5
Cannabis	10.8	6.4	5.4	7.4	10.3
Cocaine (including crack)	2.5	1.1**	0.5	1.4	2.3
Ecstasy	2.0	1.9	1.6	1.5	1.9
LSD	0.2	0.0	0.1	0.1	0.2
Magic mushrooms	0.8	0.2	0.2	0.2	0.8
<i>Last month prevalence</i>					
Any illicit drug	7.5	6.2	3.4	4.7	7.1
Amphetamine	0.6	0.2	0.2	0.3	0.5
Cannabis	6.5	4.0	2.9	4.2	6.2
Cocaine (including crack)	1.1	0.6**	0.1	0.4	1.0
Ecstasy	0.9	1.1	0.5	0.6	0.9
LSD	0.1	0.0	<0.05	<0.05	0.1
Magic mushrooms	0.3	0.1	<0.05	<0.05	0.2
<b>Total sample size</b>	<b>24,422</b>	<b>3,104</b>	<b>3,516</b>	<b>4,665</b>	<b>35,707</b>

\* The United Kingdom estimate is achieved by combining the data from the British Crime Survey, the Northern Ireland Drug Prevalence Survey and the Scottish Crime Survey.

\*\* These figures for the Northern Ireland Crime Survey are for cocaine only (and do not include data for crack).

Source: Chivite Mathews *et al.* (2005); Hay (2005a); McMullan and Ruddy (2005); National Advisory Committee on Drugs and Drugs and Alcohol Information Research Unit (NACD and DAIRU 2005); Northern Ireland Office (NIO 2005); Scottish Executive (2005a).

*Appendix 2: Number of deaths in the United Kingdom using the European Monitoring Centre for Drugs and Drug Addiction's drug-related deaths definition from 1996 to 2003, by country*

Country	1996	1997	1998	1999	2000	2001	2002	2003
Northern Ireland	9	15	17	22	21	9	12	4
Scotland	208	188	230	272	318	376	417	343
England and Wales	1153	1225	1393	1486	1606	1443	1385	1069
<b>Total</b>	<b>1370</b>	<b>1428</b>	<b>1640</b>	<b>1780</b>	<b>1945</b>	<b>1828</b>	<b>1814</b>	<b>1416</b>

Source: Corkery 2005.

*Appendix 3: The number of drug-related deaths in the United Kingdom from 1996 to 2003 according to the definition*

Definition	1996	1997	1998	1999	2000	2001	2002	2003
ONS 'Standard'	3221	3344	3411	3485	3517	3473	3297	2964
EMCDDA DRD	1370	1428	1640	1780	1945	1827	1815	1416
UK Drug Strategy	1531	1566	1748	1912	2011	1983	1972	1718

Source: Corkery (2005).

*Appendix 4: Number of people found guilty, cautioned or dealt with by compounding for drug offences in England, Scotland and Wales from 2000 to 2003 by offence*

Offence	2000	2001	2002	2003
Unlawful production	2,028	1,730	2,063	2,865
Unlawful supply	5,347	5,416	4,825	4,975
Possession with intent	6,545	6,479	5,980	6,442
Unlawful possession	91,479	96,360	101,791	104,336
Permitting premises to be used unlawfully	558	413	440	479
Unlawful import or export	1,292	1,797	1,743	1,173
Other offences involving drugs	362	441	426	673
<b>All drug offences</b>	<b>102,196</b>	<b>108,047</b>	<b>113,054</b>	<b>116,429</b>

Source: Mwenda (2005).

*Appendix 5: Percentage of male and female injecting drug users diagnosed with hepatitis B in England and Wales, 1998-2004*

Gender		1998	1999	2000	2001	2002	2003	2004
Men	Number tested	2,518	2,875	2,554	2,201	2,011	1,890	1,795
	Number positive	551	597	556	489	475	458	424
Women	Number tested	763	824	832	729	725	726	757
	Number positive	177	135	156	135	137	133	133

Source: Health Protection Agency (2005a).

*Appendix 6: Percentage of male and female injecting drug users diagnosed with hepatitis C in England and Wales, 1998-2004*

Gender		1998	1999	2000	2001	2002	2003	2004
Men	Number tested	2520	2875	2556	2201	2021	1894	1795
	Number positive	1016	1007	898	779	812	823	756
Women	Number tested	764	825	832	729	729	726	757
	Number positive	318	286	300	272	276	300	308

Source: Health Protection Agency (2005a).

*Appendix 7: Percentage of male and female injecting drug users diagnosed with HIV in England and Wales, 1996-2004*

Gender		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Men	Number tested	2,128	2,436	2,011	2,520	2,875	2,556	2,126	1,990	1,894	1,795
	Number positive	34	12	22	22	24	18	21	20	24	25
Women	Number tested	675	937	620	764	825	832	698	715	727	757
	Number positive	6	9	4	4	7	7	5	5	8	11

Source: Health Protection Agency (2005a).

*Appendix 8: Number of defendants proceeded against by a magistrate's court for an indictable offence in England and Wales in 2003 by type of offence and gender*

<b>Indictable offences</b>	<b>Male</b>	<b>Female</b>	<b>Total</b>
Violence against the person	71,174	8,438	79,612
Sexual offences	8,999	122	9,121
Burglary offences	38,572	2,709	41,281
Robbery offences	12,255	1,477	13,732
Theft and handling stolen goods	119,845	31,880	151,725
Fraud and forgery	17,998	6,741	24,745
Criminal damage	16,712	1,877	18,589
Drug offences	52,295	6,205	58,503

Source: Home Office (2004f).