



European Monitoring Centre
for Drugs and Drug Addiction



UK Focal Point
On Drugs

**2008 NATIONAL REPORT (2007 data)
TO THE EMCDDA
by the Reitox National Focal Point**

UNITED KINGDOM
**New Developments, Trends and In-depth
Information on Selected Issues**

REITOX

United Kingdom drug situation: annual report to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2008

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The United Kingdom Focal Point on Drugs

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

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

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

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

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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 one further chapter gives in-depth information on a selected issue, which changes 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 United Kingdom. This may include information about the main legislative and organisational frameworks, sources of data and definitions used, the broad picture shown by the data and recent trends.

The remainder of each chapter is concerned with **New Developments and Trends** that have not been included in previous annual reports. Generally, this covers developments that have occurred in the second half of 2007 or the first half of 2008. Relevant data that have become available during this period will also be discussed although these will often refer to earlier time periods.

This report, and the reports from the other European countries, will be used in the compilation of the EMCDDA's annual report of the drug situation in the European Union and Norway to be published in 2009.

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Table of contents

Summary	1
PART A: New developments and trends	
1. National policy and context	21
1.1 Overview	21
1.2 Legal Framework	22
1.3 Institutional framework, strategies and policies	23
1.4 Budget and public expenditure	29
1.5 Social and cultural context	31
2. Drug use in the population	34
2.1 Overview	34
2.2 Drug use in the general population	35
2.3 Drug use amongst young adults	38
2.4 Drug use in the school and youth population	44
2.5 Drug use among specific groups	48
2.6 Attitudes to and reasons for drug use	50
2.7 Relationship with other indicators and trends in a wider context	50
3. Prevention	51
3.1 Overview	51
3.2 Prevention Strategy	52
3.3 Universal prevention	52
3.4 Selective prevention	57
3.5 Indicated prevention	58
4. Problem drug use	59
4.1 Overview	59
4.2 Prevalence and incidence estimates of PDU	59
4.3 Treatment Demand Indicator	63
4.4 PDUs from non-treatment sources	69
4.5 Intensive or frequent patterns of use	70
4.6 Relationship of PDU estimates, TDI data and General Population Survey	70
4.7 Treatment engagement	70
5. Drug-Related Treatment	74
5.1 Overview	74
5.2 Treatment System	74
5.3 Pharmacologically assisted treatment	86
6. Health correlates and consequences	88
6.1 Overview	88
6.2 Drug-related deaths and mortality of drug users	89
6.3 Drug-related infectious diseases	97
6.4 Psychiatric co-morbidity (dual diagnosis)	101
6.5 Other drug-related health correlates and consequences	104
7. Responses to health correlates and consequences	108
7.1 Overview	108
7.2 Prevention of drug-related deaths	108
7.3 Prevention and treatment of drug-related infectious diseases	111

7.4 Intervention related to psychiatric co-morbidity.....	118
7.5 Interventions related to other health correlates and consequences.....	119
7.6 Interventions concerning pregnancies and children born to drug users.....	120
7.7 Drug driving.....	120
8. Social correlates and consequences	122
8.1 Overview	122
8.2 Social exclusion	123
8.3 Drug-related crime	125
8.4 Drug use and prison.....	129
8.5 Drug use in the workplace.....	131
8.6 Social costs	131
9. Responses to social correlates and consequences	132
9.1 Overview	132
9.2 Social reintegration	132
9.3 Prevention of drug related crime	139
9.4 Drug driving.....	149
9.5 Drug testing in the workplace.....	149
10. Drug markets	151
10.1 Overview	151
10.2 Availability and supply.....	152
10.3 Seizures	156
10.4 Price/purity	157
PART B: Selected issue	
11. Sentencing statistics	165
11.1 Options available.....	165
11.2 Data Collection Systems	168
11.3 Results available.....	172
PART C: Bibliography and Annexes	
Bibliography	183
List of tables used in text	207
List of figures used in text	211
List of abbreviations used in the text.....	212
List of abbreviations used in the text.....	212
Appendix A: United Kingdom prevalence estimates	215

Summary

1. National policy and context

Drug strategies

Three new drug strategies were published in the United Kingdom in 2008, each accompanied by an action or implementation plan. In the 2008 United Kingdom Drug Strategy, *Drugs: protecting families and communities*, policies concerning health, education, housing and social care are confined to England; those relating to policing and the criminal justice system cover England and Wales. The Scottish Government launched, *The Road to Recovery. A New Approach to Tackling Scotland's Drug Problem*. The Welsh Assembly Government launched *Working Together to Reduce Harm – the Substance Misuse Strategy for Wales 2008-2018*, a combined approach to the misuse of drugs, alcohol and other substances.

All aim to make further progress on reducing harm but look to a greater focus on recovery, the latter seen as requiring a change in the culture of service providers to effect it and greater co-ordination between a wide range of wraparound services. A further aim is that service provision should be more focused on the particular needs of the individual, as well as on new approaches to drug treatment and social re-integration. In all strategies, a stronger emphasis is placed on preventing harm to children and young people and to provision of support to families affected by drug misuse.

All recent drug strategies have undergone a process of public consultation or debate.

Drug classification

ACMD recommend that gamma-butyrolactone (GBL) and 1,4 butanediol (1,4-BD), precursors for GHB, and 24 steroids and 2 non-steroid agents, come under the control of the *Misuse of Drugs Act 1971* as Class C drugs. Cannabis is to be reclassified as a Class B drug although the Advisory Council on the Misuse of Drugs (ACMD) recommended it remain as Class C.

Implementation of strategies

In England, and across the United Kingdom where powers are not devolved, 30 new Public Service Agreements (PSAs) set out the key priorities for Government, each underpinned by a Delivery Agreement. One such agreement is to reduce the harm caused by alcohol and drugs. A new National Performance Framework supports delivery in Scotland, one indicator is “reducing the estimated number of problem drug users in Scotland by 2011”. In Wales, a new National Substance Misuse Strategy Implementation Board will oversee delivery of the strategy.

The Drug Harm Index

The final report on the Drug Harm Index, developed to measure a previous PSA target to reduce the harm caused by illegal drugs, shows a fall from 89.1 points in 2004 to 83.8 points in 2005.

Public expenditure

Annual public expenditure on drugs in the United Kingdom is estimated to be around €1,418 million (£970m).

Public perception of drug misuse

In the United Kingdom, amongst the population, drug misuse is seen as both a consequence and cause of many social problems, such as family breakdown and poverty, and is one of the two factors most commonly identified as the main causes of crime (lack of parental discipline was the second factor).

Initiatives in civil society

The independent United Kingdom Drug Policy Commission is seeking to develop a consensus statement on the meaning of the term recovery.

2. Drug use in the population

Population surveys

Latest survey data for England and Wales, from the 2007/08 British Crime Survey (BCS), show that prevalence of drug use amongst the general population continues to fall, largely due to a decrease in cannabis use. Recent increases in cocaine use have stabilised while reported use of crack cocaine remains low (0.1%). Recent use of ecstasy and magic mushrooms is at its lowest level since the BCS started asking drug use questions. Similar trends can be seen among young adults.

Two surveys in Northern Ireland, the Northern Ireland Crime Survey for 2006/07 and the 2006/07 Drug Prevalence Survey, while reporting similar prevalence indicate conflicting trends. The former survey, similar in methodology to the BCS, shows a decrease in recent and current drug use, with stability in lifetime use. The latter suggests an increase in both lifetime and recent use since the previous survey in 2002/03, but a decrease in current use. However, there have been changes in methodology that could affect trends. In both surveys, similar trends seen for all adults can be seen among young adults.

Drug use amongst school children

Two school surveys have been published this year, the 2007 school survey in England and the 2007 Young Person's Behaviour and Attitudes Survey in Northern Ireland. In England, recent and current drug use has fluctuated in recent years but the overall trend since 2001 is downwards. As in previous surveys, recent drug use sees the greatest increase between the age of 13 and 14 and continues to increase at age 15. Also, as with the adult population, recent use of cannabis continues to fall driving the overall reduction in drug use since 2003. In Northern Ireland, prevalence of any drug use is lower than in England, largely due to lower levels of cannabis and volatile substance use.

Other groups

Amongst the Armed Forces, around 85 per cent of service men and women are tested for drugs annually. Positive tests are extremely low, but increasing; 0.62 per cent in 2003 to 0.98 per cent in 2007. The Army accounts for 92.6 per cent of positive tests. There has been a decrease in the proportion of positive tests involving cannabis (from 50% in 2006 to 31% in 2007) and a large increase in those involving cocaine (from 22% to 47%).

Amongst truants and school excludees there has been a decrease in the proportion reporting regular drug use from 21 per cent in 2003 to 14 per cent in 2007.

A survey of lesbian and bisexual women's health found them to be five times more likely to report recent drug use than women in general.

Data show that, in 2007, 5.4 per cent of young people in care have a substance misuse problem. This is a slight increase from 5.1 per cent in 2006.

3. Prevention

Drug strategies

Prevention continues to be a prime focus in all the new drug strategies in the United Kingdom.

Drugs: protecting families and communities states that its communications will highlight the consequences and damage that can result from substance use, with the message that drug use is “unacceptable”.

In England the Government campaign FRANK produced a series of information materials for mentors and befrienders.

A key aim of the Scottish Government strategy is that no one should be ignorant of the consequences of drug use.

Drug education in schools

All strategies are committed to strengthening the role of drugs education in schools. A review of drugs education is in progress in England, and in Scotland a programme of reform of the curriculum, which includes drugs education, is on-going.

In Wales, an evaluation of the All Wales Schools Core Liaison Programme, delivered by teachers in partnership with the police, found that pupils’ knowledge and understanding of drugs issues had increased and that in general they enjoyed the lessons.

Selective prevention

In England, integrated drug prevention initiatives with vulnerable young people through targeted youth support activities such as Positive Futures are to continue. €19 million (£13m) in funding will help deliver early interventions to stop potential future offenders at the first sign of problems such as truancy, bad behaviour in school or contact with the police.

The Scottish Government has proposed that monies from the *Proceeds of Crime Act 2002* are used to fund positive opportunities for young people in communities with high levels of crime.

Indicated prevention

All strategies look towards a whole family approach to drug prevention with early identification of children at risk and families and interventions providing a more focused approach to meeting their needs.

The National Institute for Health and Clinical Excellence (NICE) is developing clinical practice guidelines for pharmacological and psychological interventions in children, young people and adults affected by attention deficit hyperactivity disorder.

4. Problem drug use

Estimate of problem drug users

The second of a three year sweep of estimates of problem drug users aged 15 to 64 in England suggests that, in 2005/06, there were:

- 332,090 problem drug users (PDUs), using opiates and/or crack, a rate of 9.97 per thousand population;
- 286,566 opiate users, a rate of 8.60 per thousand population;
- 197,568 crack cocaine users, a rate of 5.93 per thousand population; and
- 129,977 injectors who use opiates and/or crack cocaine, a rate of 3.90 per thousand population.

These estimates suggest that problem drug use has remained stable across the two sweeps. However, there was a statistically significant reduction in injectors; the rate per thousand falling from 4.16 to 3.90.

The male to female ratio of problem drug users has not changed; 3.3:1. Highest prevalence of problem drug use was amongst those aged 25 to 34.

Based on the latest research (Northern Ireland for 2004, Scotland 2003, England 2005/06, and an estimate for Wales extrapolated from England) it is estimated that in the United Kingdom there are:

- 403,547 problem drug users; and
- 156,398 injecting drug users (primarily of opiates or crack cocaine).

The Treatment Demand Indicator

Numbers presenting for treatment as measured through the Treatment Demand Indicator (TDI), having increased substantially over the previous few years, appear to have stabilised in 2006/07, with 128,208 new presentations for treatment (128,446 in 2005/06). The vast majority of treatments are reported through outpatient services (94%). Forty-four per cent (47,165) concerned drug users who sought treatment for the first time ever, a slight reduction from 2005/06 (49,625).

Forty-one per cent of treatment presentations were for those aged between 25 and 34.

Opiates, mostly heroin, were the main primary drug reported (64%). Cannabis was the second most reported primary drug (16%), and crack cocaine and cocaine powder accounted for seven per cent and six per cent respectively. However, when any use of crack cocaine use is considered, not only as primary drug, there has been a much steeper rise in presentations, with 24 per cent of new presentations reporting use. Similarly, with cocaine powder, there has been continued rise in presentations with 13 per cent reporting any use of it in 2006/07.

The actual number of presentations for opiates as primary drug stabilised in 2006/07, having increased in the previous year. The same trend can be seen in presentations for crack cocaine as primary drug of use. Presentations for cannabis have increased over time, and continue to do so, now representing nearly a quarter of first ever presentations (24%); over half of those presenting with cannabis as primary drug were under 20 years of age and three quarters under 35.

Current injecting was reported by 25 per cent; 50 per cent report having never injected.

Treatment penetration

Information on those in treatment is available for England only. The National Drug Treatment Monitoring System data show that, of those in treatment in 2006/07:

- 148,866 were problem opiate and/or crack cocaine users (either using these as primary drug or as a secondary or tertiary drug); that is 45 per cent of the PDU estimate, this compares with 42 per cent in 2005/06;
- there were 140,357 opiate users, 49 per cent of the PDU estimate (46% in 2005/06); and
- there were 46,415 crack cocaine users in treatment, 24 per cent of the PDU estimates (21% in 2005/06).

Problem users identified outside treatment services

The Arrestees Survey provides information on drug use by those arrested. The third annual sweep (2005/06) found that 26 per cent of arrestees had taken heroin, crack cocaine and/or cocaine powder in the month prior to arrest; 13 per cent having used heroin; 13 per cent cocaine powder; and 11 per cent crack cocaine.

'Topping up'

In surveys of drug users in treatment over two-thirds reported using on top of substitute drugs.

5. Drug-Related Treatment

Drug strategies

All new drug strategies continue to focus on providing better access to treatment and encouraging retention in treatment, particularly for vulnerable and excluded groups. However, there are some important changes in emphasis; throughout the United Kingdom it is expected that there will be a shift in treatment services towards a greater emphasis on recovery and on more personalised treatment.

Numbers in treatment: England

Only England provides information on the overall numbers in treatment. In 2007/08 202,666 individuals were in contact with structured drug treatment services, a much smaller increase in numbers (4%) than seen in previous years. Eighty-three per cent (168,464) either completed treatment or were retained in treatment at the end of the year. New presentations also increased by four per cent from 104,062 in 2006/07 to 107,812 in 2007/08.

Quality

An improvement review of drug services in England led by the Healthcare Commission suggested that improvements could be made across all areas of community prescribing services, care planning and care coordination. Following on from *Drug Misuse and Dependence: UK Guidelines on Clinical Management*, guidelines on ethical prescribing have since been issued. These state that it is inappropriate for medications to be used as a reward or sanction. In addition, a briefing on naltrexone implants has been prepared, suggesting that there is no sound evidence for this treatment. A consultation on guidance on clinical governance in drug treatment is underway in England.

New National Quality Standards for Substance Misuse Services in Scotland were published in 2008.

Pilot projects to consider whether contingency management works are on-going in England.

In England, the Treatment Outcome Profile (TOP), developed for use at the start of treatment and in care plan reviews, and reported through the National Drug Treatment Monitoring System, is now operational. The new Scottish Drug Misuse Database Follow-up Reporting System has been introduced, providing outcome information to enable assessment of treatment effectiveness.

6. Health correlates and consequences

Drug-related deaths

Based on the EMCDDA definition latest data on drug-related deaths across the United Kingdom are for 2006, when there were 1,785 deaths, a fall from the previous year (1,812). The rate per 100,000 population was 2.95. However, in Scotland drug-related deaths increased from the previous year, from 352 to 416, a rate of 8.13 per 100,000 population.

Males continue to be more likely to die than females, by a ratio of over 4:1, with the difference reducing over the last decade. The average age of death continues to rise; in 2006 it was 36.5 years.

Data based on the United Kingdom 'Drug Strategy' definition are available for 2006 and 2007. Based on this definition, deaths in the United Kingdom rose slightly (by 2%) in 2007, from 2,025 to 2,069, this rise being seen in England and Wales (from 1,573 to 1,604) and in Scotland (from 421 to 455), but there was a fall in deaths in Northern Ireland, from 31 to 10.

Mentions of heroin/morphine on death certificates increased by 14 per cent in 2007 (1,119), having fallen by seven per cent in 2006 (978). There was also an increase in mentions of cocaine in both years (by 2% to 225 in 2006, and 8% to 243 in 2007). Mentions of methadone also increased substantially (by 15% in 2006 to 338, and 30% in 2007 to 440).

Data from the Special Mortality Register (np-SAD) database are broadly consistent with those from the General Mortality Registers. In 2007 there was a 13 per cent increase in recorded deaths from 1,366 in 2006 to 1,539 in 2007. Opioids alone, or in combination with other drugs, accounted for the majority (71%) of deaths. The proportion of cases involving cocaine increased from 11 per cent (174) in 2006 to 16 per cent (239) in 2007.

There were six cases in both 2006 and 2007 where methamphetamine was found and 12 deaths up to the end of 2007 where piperazines have been found. The first death in the United Kingdom from cocaine powder toxicity was reported in 2007.

Forty-nine deaths associated with the abuse of volatile substances were recorded in 2006 (45 in 2005). This compares with the all-time peak of 152 in 1990.

There were 51 deaths of injecting drug users (IDUs) (including IDUs who have sex between men) with AIDS in 2006, a fall from the previous year (79).

Forty-nine deaths associated with the abuse of volatile substances were recorded in 2006 (45 in 2005). This compares with the all-time peak of 152 in 1990.

Drug-related infectious disease

Data for 2007 suggests that prevalence of infectious disease amongst injecting drug users remains stable. However, HIV prevalence remains higher than it was in 2000, at around one per cent, although in London it is higher, at or near, four per cent. There is emerging evidence suggesting a possible increase in transmission in recent years.

Prevalence of hepatitis C (HCV) is much higher than that for HIV, at around 40 per cent of IDUs.

Outbreaks of other infections among IDUs have been identified following reported increases in injecting risk behaviour.

Comorbidity

Prevalence and attribution of co-morbidity remain difficult to estimate. Latest research suggests prevalence differs between treatment settings.

Drug use and the neonate

Hospital Episode Statistics show that in England and Wales during 2006/07, there were 178 episodes of "foetus and newborn affected by maternal drugs of addiction" and 1,326 episodes of babies with "neonatal withdrawal symptoms from maternal use of drugs of addiction". In Northern Ireland there were fewer than five inpatient episodes in 2006/07 with a diagnosis of foetus and newborn affected by maternal use of drugs of addiction. There are no new data for Scotland.

7. Responses to health correlates and consequences

Drug-related death

As part of the *Action Plan on Reducing Drug-related Harm*, a campaign to reduce drug-related deaths (and infectious disease) was launched in October 2008.

In Scotland, a national database of drug-related deaths and an examination of the circumstances behind them is to be developed.

A second edition of guidance designed to promote good practice in bars and nightclubs has been published.

Drug-related infectious disease

There has been a ten-fold increase between 2002 and 2006 in the number of tests for infectious disease carried out by drug services, reportedly due to oral fluid screening. This is in addition to a high number of tests carried out by GPs at their surgeries.

While uptake of hepatitis B vaccination has increased markedly over time, rising to 66 per cent of IDUs in much of the United Kingdom in 2007, a Healthcare Commission review of harm reduction services in England found existing provision to be in need of improvement. The Commission also found weaknesses in the provision of syringe exchange services, particularly in terms of out of hours provision.

As part of the implementation of the *Action Plan on Reducing Drug-related Harm* in England, in October 2007 new data was provided to local partnerships about hepatitis C prevalence for their local area. A new national web based system to collect information from local needle exchange services in England was introduced in 2008 and a campaign to reduce infectious disease was launched.

NICE is due to publish guidance on the provision of needle exchange services in February 2009.

The ACMD Prevention Working Group on hepatitis C prevention is to consider: the epidemiology of hepatitis C; evidence on the effectiveness of interventions against hepatitis C; and effective interventions and delivery in the United Kingdom.

In Scotland, phase two of the *Hepatitis C Action Plan for Scotland*, which aims to raise awareness of the disease, reduce the number of new infections and increase numbers in treatment, is to be supported by a budget of €63 million (£43m). Standards for hepatitis C testing and the treatment, care and social support of individuals infected with hepatitis C are to be developed in Scotland, as well as a surveillance system to monitor hepatitis C testing practice.

In Scotland, a data collection system on needle exchange services is being developed.

An *Action Plan for the Prevention, Management and Control of Hepatitis C* in Northern Ireland was launched in 2007, with objectives to increase awareness and understanding and improve treatment. Actions include a review of surveillance arrangements for hepatitis C.

The Welsh Assembly Government suggests that there may be a case for using contingency management to increase the percentage of injecting drug users completing vaccination courses against hepatitis B.

A study to assess whether an uptake in hepatitis C testing among IDUs would follow on from the introduction of dried blood spot testing in drug treatment and prison settings found some preliminary evidence to support its use.

The treatment of hepatitis C is also becoming a major concern, following evidence that a large majority of those infected has not received treatment. The ACMD Prevention Working Group is to consider this issue and, as mentioned earlier, action plans in both Scotland and Northern Ireland aim to bring about improvements in treatment.

Co-morbidity

NICE have commissioned the National Collaborating Centre for Mental Health to develop clinical guidelines for the assessment and management of severe mental illness in conjunction with problematic substance misuse.

The Scottish Government has published a series of recommendations for change and improvement in the provision of services for individuals with co-occurring substance use and mental health problems including increased awareness of co-morbidity and improved support and service provision for individuals and their carers.

Drug driving

The Sentencing Guidelines Council (SGC) has published guidelines on sentencing and associated issues around death caused by dangerous driving, including while under the influence of drugs. A specification for a drug testing device is currently being developed.

8. Social correlates and consequences

Housing

New research suggests that 40 per cent of drug users seeking treatment had not been in stable accommodation in the four weeks prior to the treatment.

Unemployment

A feasibility study intended to estimate the number of problem drug users accessing state benefits estimated that 81 per cent (266,798) of problem drug users in England were in receipt of benefit, representing 6.6 per cent of all those receiving benefit.

Education

New research suggests that 38 per cent of clients seeking drug treatment had left school before the statutory minimum age of 16.

Prostitution

Research evidence from the Drug Treatment Outcomes Research Study (DTORS) found that ten per cent of female clients seeking drug treatment and one per cent of males reported being engaged in prostitution in the four weeks prior to treatment; all used heroin and/or crack.

Children of drug using parents

Research suggests that nearly half of those seeking treatment have children under the age of 16, although in three-quarters of cases these children lived apart from them; half were living with the other parent, 20 per cent living with other family members, eight per cent were in care; the rest (5%) lived elsewhere.

Drug offences

In England and Wales in 2006/07, 89,200 persons were arrested for drug offences, an increase of less than one per cent from 2005/06. In Northern Ireland in 2007/08 1,896 persons were arrested for drug offences, an increase of 9.8 per cent from the previous year. In England and Wales arrests for possession have reduced

considerably since 2004 with the introduction of a 'cannabis warning', rather than an arrest for possession of cannabis for personal use. In 2006/07 there were 22,900 cannabis warnings, an increase of 28 per cent from 2005/06.

Data presented to the EMCDDA over the last few years has been for persons found guilty, cautioned or dealt with by compounding for drug offences, which is recorded in such a way as to be able to be broken down by drug. Latest data is on an all offence basis rather than a principal offence basis; data provided in previous Focal Point reports was based on principal drug offence. New information reported this year for the United Kingdom as a whole is for both 2005 and 2006. There were 118,706 offences in 2005 increasing by 4.5 per cent to 124,344 in 2006. There were 55,984 convictions for cannabis-related offences in 2006, an increase of 2.1 per cent since 2005 (54,813). There were 15,471 convictions for heroin offences, a marginal increase since 2005 (15,629). There were 7,422 offences concerning amphetamines in 2006, an increase of 8.1 per cent since 2005 (6,864); 6,233 offences concerned ecstasy in 2006, a small decrease of 1.6 per cent since the previous year (6,337). The largest increase was for cocaine powder, there were 12,028 offences in 2005, increasing by 28.6 per cent to 15,470 in 2006.

Acquisitive crime

New research supports the already well documented evidence that problem drug users, particularly those using opiates and crack cocaine, commit a considerable amount of acquisitive crime to support their drug use.

Drug use in custody

Drug testing in prison suggests that 9.1 per cent of the prison population use drugs while in custody in England and Wales. However, survey data suggests the proportion in Scottish prisons to be 51 per cent in 2007.

Economic and social costs

Based on research into the social and economic costs of problem drug use in England, estimated costs in Scotland are in the region of €3.9 billion (£2.6bn) and in Wales around €1,140 million (£780m).

9. Responses to social correlates and consequences

Drug strategies

All new drug strategies in the United Kingdom are concerned with recovery, and seek to align strategies on social exclusion and poverty, housing, education and training.

Review of unemployment benefit for drug misusers

A major initiative in 2008 is a Government Green Paper (consultation document) on the welfare system, *No one written off: reforming welfare to reward responsibility*, which proposes that problem drug users in receipt of benefits should take action to stabilise their habit and to take steps towards employment in return for receiving benefits.

Initiatives for children of drug using parents

In both Scotland and Wales the impact of parental substance misuse upon children has been of major concern in previous strategies, and now *Drugs: protecting families and communities* also places an increased priority on children and families affected by substance misuse. Drug Courts, focused on drug using parents, already available in Scotland, are to be established in England following a process evaluation of two pilot courts.

Prisons

There has been increased concern about the ability of prisons to cope with the health care needs of a rising prison population. In England and Wales a review of the prison system suggested that as well as an expansion of prison capacity, changes are needed in existing sentencing legislation to modify the use of custody for certain types of low risk offenders and offences, reserving custody for the most serious and dangerous offenders. Following this review, the Ministry of Justice suggests that community sentences, including drug rehabilitation programmes, can be a more effective punishment than short prison sentences for drug using offenders. To this end the probation service in England and Wales is to receive an additional €58.8 million (£40m) to pilot intensive alternatives to custody (see the Drugs Interventions Programme referred to below).

In Scotland, the Scottish Prison Service is to publish a new Substance Misuse Strategy, which will complement the Scottish Government's drugs strategy.

Reviews of measures to disrupt the supply of drugs into prison in England and Wales, and in Northern Ireland, recommend the further introduction of mobile phone blocking technology. In England and Wales it is recommended that body orifice security scanners (BOSS) also be introduced, and in Northern Ireland that the introduction of mandatory drug tests, currently only undertaken in England and Wales, be considered.

In 2008, the Scottish Prison Service implemented the provision of harm reduction packs for prisoners engaged in injecting behaviour. The packs consist of water ampoules, citric acid, Sterispoons, swabs, filter and foil. Plans for a syringe exchange pilot in prisons in Scotland reported in the previous Focal Point report are yet to be finalised. Disinfectant tablets are now provided in all adult prisons in England and Wales.

A review of prison-based drug treatment funding in England suggests the need for a more strategic and evidence-based approach to service delivery. Following this, a Prison Drug Treatment Review Group has been established to foster the development of prison drug treatment. As of April 2008, 29 prisons had received funding to introduce an Integrated Drug Treatment System (IDTS), which aims to integrate clinical and psychological treatment in prison into one system. To allow for the full introduction of IDTS in all adult prisons in England by 2011, funding for clinical treatment in prisons is planned to increase from €18.57 (£12.7m) in 2007/08 to €62.9 (£43m) by 2010/11.

The Scottish Government is to review the feasibility of the transfer of primary health care in prison to the National Health Service; this has already occurred in England and Wales.

In Scotland, there is to be a review of a pilot project to improve the integration of medical treatment with wider 'wraparound' therapeutic support.

A new package of measures aimed at helping prisoners in England and Wales become drug free and access employment on release has been announced, including a drive to involve more employers in training offenders and offering them employment, and the drawing up of contracts with prisoners in return for opportunities to learn new skills.

Criminal justice interventions

The Drug Interventions Programme (DIP) continues to be the main focus of action in England and Wales to reduce drug-related crime, with continued work to engage those identified through the criminal justice system in treatment. Major interventions continue to be drug testing on arrest or charge, required assessment and restriction on bail, while conditional cautions have now been introduced. The new United Kingdom Drug Strategy seeks to increase the number of conditional cautions with a DIP condition to 2,000 by March 2009, which means doubling current usage. Drug Rehabilitation Requirements (DRRs) are also to be extended with plans for 1,000 such orders by 2009. As mentioned previously, to this end the probation service is to receive additional funding to pilot intensive alternatives to custody.

Drug Treatment and Testing Orders continue to be the main community sentence imposed on drug using offenders in Scotland although, until recently, they were used only with high tariff offenders. In June 2008, two pilots extending them to lower tariff offenders began. Also, in Scotland, following an evaluation, there are plans to extend the Structured Deferred Sentence which has been piloted in five courts. This is a low-tariff intervention providing structured social work for offenders post-conviction, but prior to final sentencing, primarily aimed at offenders with underlying substance misuse problems, mental health or learning difficulties. The purpose is to match, more effectively, intensity of intervention/supervision, as well as building offender motivation for positive change.

Research suggests that 22 per cent of employers test employees for drug and alcohol use, with manufacturing and production organisations more likely to do so, and safety-critical organisations the most likely (53%). Testing is most commonly carried out on suspicion of misuse; the next most common reasons are post-incident testing and pre-employment testing.

10. Drug markets

Availability

Cannabis continues to be imported into the United Kingdom in significant quantities but domestic cultivation is rising, particularly of sinsemilla (skunk). In late 2007 it was reported that 1,564 farms/factories had been found in England and Wales and in Scotland in 2006/07, 70. Many are run by Vietnamese and are located in residential properties. The market share of sinsemilla has increased markedly over recent years from 15 per cent in 2002 to 81 per cent in 2008.

Seizures

There were 209,566 seizures of drugs in the United Kingdom in 2006/07, an 11 per cent increase from 2005. Increases are reported for herbal cannabis (44%) and cannabis plants (36%) but numbers of cannabis resin seizures have fallen by 27 per cent. The quantity of cannabis plants seized increased substantially (72%). Cocaine powder seizures continue to increase, a 36 per cent rise from 2005 although the quantity of cocaine seized has decreased by 14 per cent. The quantity of heroin seized has fallen by 44 per cent but the number of seizures has remained stable. Crack cocaine and ecstasy seizures have increased both in number and quantity.

Price

The price of heroin and cocaine powder at street level has again fallen. Prices for other drugs remain stable while an apparent rise in cannabis prices can be explained by a change in methodology.

Purity

Heroin purity has continued to increase since 2003 although there have been reports in 2008 of a lack of 'good' quality heroin at street level. The mean MDMA tablet content of ecstasy seized in 2007 was slightly higher than in 2006. Purity of amphetamines has remained stable since 2003. The average purity of cocaine powder seized by Revenue and Customs has remained stable, but that seized by the police continues to fall suggesting increased adulteration within the United Kingdom. There has also been a fall in the purity of crack cocaine. The potency of traditional imported herbal cannabis and cannabis resin has fallen since the late 1990s with potency of sinsemilla increasing.

Selected Issue

11. Sentencing statistics

Options available to law enforcement agencies

Law enforcement agencies have a number of measures available to them when dealing with drug offenders. These include out-of-court disposals such as cautions in England, Wales and Northern Ireland and fiscal fines in Scotland. In addition, there are a wide range of measures that can be used after a finding of guilt by a court including custodial sentence, community sentence, fine, and confiscation order.

Data collection systems

Police forces and courts are required to submit data centrally for the collection of criminal justice data. Different legal and data collection systems in England and Wales, in Scotland, and in Northern Ireland mean that it is not possible to provide data on the outcome of drug offences on a United Kingdom basis.

England and Wales

In England and Wales in 2006 there were 200,270 drug possession offences recorded by police and 37,913 drug trafficking offences. There were a total of 90,926 arrests for drug offences. Forty-two per cent of all stop and searches carried out were under suspicion of drug offences. Of these, eight per cent resulted in an arrest for Class A drugs.

Drug possession offences

In 2006, just over half of drug possession offences were for cannabis (this does not include cannabis warnings). For drug possession offences (excluding cannabis warnings) the most common disposal was a caution (57%) followed by a fine (19%) with only two per cent receiving immediate custody. Offences involving heroin and crack cocaine were more likely to receive immediate custody or a community sentence and less likely to be cautioned than offences involving other drugs. Cocaine powder offenders were more likely to receive a caution or fine and less likely to receive a community sentence or immediate custody than crack cocaine offenders.

Drug trafficking offences

A third of offenders found guilty at court or cautioned for drug trafficking were found guilty of cannabis offences with a fifth guilty of heroin trafficking offences. The most common disposal was immediate custody (44%) followed by a caution (21%) and community sentence (18%). Around 70 per cent of heroin, crack cocaine and cocaine powder trafficking offenders received a custodial sentence. Cannabis and LSD trafficking offences were the only offences where a custodial sentence was not the most common disposal.

Average sentence length

Average sentence length was less than a year for possession and around three years for trafficking. Cannabis offences received the shortest sentence.

Scotland

2006 data for Scotland are for court outcomes only. Three-quarters of those found guilty at court of drug possession offences received a fine with four per cent receiving immediate custody. Almost half of those found guilty of drug trafficking offences received immediate custody, a further 19 per cent received a community sentence, and 16 per cent a fine.

Northern Ireland

In Northern Ireland, 58 per cent of all drug possession offences were dealt with by a caution and only one per cent by immediate custody. Forty-five per cent of drug trafficking offences received immediate custody. Penalties were proportionally higher for drugs in higher classes.

Most relevant developments and trends

New drugs strategies

In 2008 three new drug strategies were launched in the United Kingdom, accompanied by an action or implementation plan. All aim to make further progress on reducing the harms associated with drug use, to have a greater focus on personalised treatment and to promote recovery, and all give priority to the needs of the children of drug using parents.

Reclassification of cannabis

The independent Advisory Council on the Misuse of Drugs (ACMD) undertook an extensive review of cannabis and recommended that it remain a Class C drug. However, Government has decided that cannabis should be reclassified as a Class B drug, ACMD has recommended that gamma-butyrolactone (GBL) and 1,4 butanediol (1,4-BD), precursors for GHB, and 24 steroids and 2 non-steroid agents come under the control of the *Misuse of Drugs Act 1971* as Class C drugs.

Continued decline in drug use in the population

Prevalence of drug use in the general population continues to decline and the trend amongst school children also continues to be downwards. These trends continue to be associated with falls in cannabis use. The increase in use of cocaine powder, seen amongst both school children and adults over recent years, appears to be stabilising in England and Wales.

Early intervention projects

Momentum is gaining on establishing early intervention projects and parenting programmes.

Stability of problem prevalence

Problem prevalence in England appears to be stable, with the latest estimates for 2005/06 showing no significant change, however there is a decrease in injecting.

Stability in presentations to treatment services

Presentations to treatment services appear to be reaching a plateau. This is seen amongst both all new presentations and first ever presentations in 2006/07. It is also of note that numbers in treatment in England (such information is not available elsewhere) increased by four per cent in 2007/08, a smaller increase than in previous years.

Interventions for the prevention and treatment of hepatitis C

There has been a continued focus on the prevention of drug-related infectious disease over the last year, with further action around prevention and surveillance, syringe exchange monitoring, vaccination and counselling and testing. Also, there is

renewed focus on providing treatment for hepatitis C across much of the United Kingdom.

New proposals for problem drug users receiving benefits

The Department of Work and Pensions, with a remit across the United Kingdom, proposes new legislation requiring problem drug users in receipt of out-of-work benefits to take action to stabilise their drug habit and to take steps towards employment in return for benefits.

Rise in cultivation of cannabis in the United Kingdom

Domestic cultivation of cannabis within the United Kingdom is rising, particularly sinsemilla (skunk).

Consistency between indicators

Opiates

Opiate use, difficult to estimate by population based surveys, remains very low, reported by less than 0.1 per cent. However, it is estimated that there were 286,566 problem opiate users in England alone in 2005/06, a rate of 8.60 per thousand population aged 15 to 64. This latest estimate is not a significant increase since the previous estimate for 2004/05. Opiates also remain the most reported primary drug amongst those presenting to treatment (63.7%) and, although as a proportion of all presentations this has steadily reduced over time, the number actually reporting opiates as main drug has remained stable over the last two reporting periods (77,580 in 2005/06 and 77,849 in 2006/07), having previously increased. For first ever presentations to treatment there was a slight decrease in numbers in 2006/07 (21,561) compared to 2005/06 (23,021), having previously steadily increased. Opiates continue to be associated with injecting drug use, and the spread of infectious disease, though there is no real change in the prevalence of HIV or hepatitis C in the United Kingdom. Opiates continue to account for the most mentions on death certificates. There were around 1,000 heroin/morphine mentions per year over the last four years, with 1,119 in 2007. In 2006 there was a very small increase in drug law offences concerning heroin (from 15,629 to 15,741) and a similar marginal increase in the number of heroin seizures (from 16,402 to 16,553), although the quantity of seized heroin decreased. It has been reported that there has been a significant increase in the quantity of opium seized entering the United Kingdom with more than 500kg of opium seized since the beginning of 2006/07 and three seizures each in excess of 150kg. The price of heroin at street level has continued to fall, but purity has continued to increase although there have been reports in 2008 of a lack of 'good' quality heroin at street level.

Crack cocaine

There is no indication of increased use of crack cocaine in general population surveys, reported use remaining at less than one per cent. However, problem drug use estimates for England suggest that, in 2005/06, there were 197,568 problem crack cocaine users aged 15 to 64, 5.9 per thousand population; this is not a significant increase since the previous estimate for 2004/05. The proportion of presentations to treatment for crack cocaine as primary drug has hardly changed over the last four reporting periods (from 5.4% to 5.8%), although the numbers presenting have steadily increased from 4,980 to 7,096. First ever presentations for crack cocaine as primary drug, accounting for six per cent of presentations in 2006/07, showed a slight decrease from the previous year in actual numbers presenting (from 3,116 to 2,900), having increased over the previous three reporting periods from 1,722 to 3,116. However, when any use of crack cocaine is considered (not only as primary drug) there has been a much steeper rise in presentations and

the total number reporting such use is four times those reporting crack cocaine as primary drug, with 29,086 presentations (24% of the total) reporting use in 2006/07 compared to 17,110 (18.5%) in 2003/04. Convictions for drug law offences involving crack cocaine continue to rise, rising over the last year by nine per cent (from 3,734 in 2006 to 4,076 in 2006). Seizures increased by five per cent in 2006/07 with the quantity of seized crack cocaine increasing by 16 per cent. Price has remained stable, however, purity has fallen, reflecting the trend in cocaine powder.

Cocaine powder

There has been increased use of cocaine powder reported within the general population in the United Kingdom over the previous few years. However, the most recent survey data, for England and Wales in 2007/08, show a decrease in last year use amongst 16 to 59 year olds from 2.6 to 2.3 per cent, and amongst young adults aged 16 to 24 the fall was from 6.0 per cent to 5.0 per cent. Amongst school children, last year use was 1.6 per cent in 2006 and 1.8 per cent in 2007. Treatment presentations for primary cocaine powder use have risen steadily over the previous four reporting periods, from 3,739 in 2003/04 to 8,372, with a 22 per cent rise from the previous year's figure (6,890). First ever presentations for cocaine powder have also increased over the last four years, the actual number of presentations increasing from 1,683 in 2003/04 (5.8% of all presentations) to 4,951 in 2006/07 (10.5% of all presentations). Thirteen per cent (8,372) of those presenting to treatment in 2006/07 reported use of cocaine powder as either primary or other drug used, a number steadily increasing over time. Deaths associated with cocaine have also increased steadily over time, with 158 in 2003 and 243 in 2007. However, without being able to distinguish between crack cocaine and cocaine powder in autopsies, deaths could involve the former. The largest increase in convictions for drug offences in 2006 was for cocaine with 15,470 convictions, an increase of 28.6 per cent from 12,028 in 2005. Seizures increased by 36 per cent in 2006/07 although the quantity seized fell by 14 per cent. The price of cocaine powder at street level continues to fall, as does purity.

Cannabis

Cannabis remains the most widely used drug across all age groups, but there has been a downward trend in use over the last five reporting years. Latest survey data for England and Wales show that, in 2007/08, 30 per cent of adults aged 16 to 59 had used cannabis in their lifetime, 7.4 per cent had used recently and 4.2 per cent were current users. Amongst young adults aged 16 to 34, a downward trend has been seen since 2002/03. Amongst younger people (16 to 24), the downward trend in recent use has been apparent over the last decade. Amongst school children in England there has also been a downward trend in use of cannabis since 2004. Cannabis use is not included in problem drug use estimates, but it is the second most common drug for which treatment is sought, representing 15.6 per cent of treatment demands in 2006/07. This proportion has increased over recent years, although no increase was seen in 2006/07. Numbers presenting have also increased; doubling from 9,847 in 2003/04 to 19,108 in 2006/07. First ever treatment presentations for cannabis accounted for 42 per cent of all such presentations in 2006/07, not a significant change from the previous year, but again numbers have doubled over the four years of reporting, from 5,289 to 11,325. Cannabis offences continued to account for the majority of offences in 2006 (55,984), an increase of 2.1 per cent from 2005. Cannabis also accounted for the majority of seizures with herbal cannabis seizures and cannabis plants seizures increasing in both number and quantity in 2006/07. Cannabis resin seizures fell, however, as did the quantity seized. The price of cannabis has remained stable. The potency of traditional imported herbal cannabis and cannabis resin has fallen since the late 1990s with potency of sinsemilla increasing.

Amphetamines

Recent and current amphetamine use in the general population remains very low and continues to fall, recent use reported by one per cent in 2007/08 in England and Wales and current use by 0.4 per cent. Amongst school children recent use has remained steady at around one per cent over the last seven years. The proportion of treatment presentations has also remained stable at between 3.5 per cent and 3.8 per cent over the last four reporting periods, although actual numbers of demands have increased from 3,474 in 2003/04 to 4,622 in 2006/07. First ever treatments accounted for 4.3 per cent of all such presentations in 2006/07; while this is an increase since the previous year (3.9%), the overall trend appears to be downward. However, there were 7,422 offences concerning amphetamines in 2006, an increase of 8.1 per cent from 2005. There was also a seven per cent increase in the number of amphetamines seizures in 2006/07 although the quantity seized decreased by 29 per cent. Price has remained stable, as has purity.

Ecstasy

Ecstasy is the third most commonly used drug after cannabis and cocaine powder for recent and current use. In 2007/08, recent use in England and Wales was reported by 1.5 per cent, the lowest level since the British Crime Survey began measurement of self-reported drug use. Prevalence of recent use by young adults aged 16 to 34 was 3.1 per cent and for those aged between 16 and 24, 3.9 per cent. Recent use of ecstasy amongst school children in England and Wales has remained stable over the last seven years at around 1.5 per cent although the figure for 2007 (1.3%) is lower than in any year since 2001. Treatment demands are extremely low. There were 6,233 offences concerning ecstasy in 2006, a small decrease of 1.6 per cent since the previous year (6,337). However, in 2006/07, there was a 28 per cent increase in ecstasy seizures and the quantity of tablets seized more than doubled. The price of ecstasy has decreased since 2003 and the mean MDMA content has also decreased.

Magic mushrooms

In 2007/08 recent use of magic mushrooms in England and Wales was at its lowest level for 10 years at 0.5 per cent. Recent use of magic mushrooms by young adults aged 16 to 34 had increased to 2.2 per cent in 2004/05 but then fell steadily to 1.0 per cent in 2007/08. Recent use by those aged 16 to 24 was 1.2 per cent, again having decreased in recent years. Amongst school children in England there has been a steady decline in recent use from 2.1 per cent in 2001 to 1.2 per cent in 2007. There is no information on treatment demands or on price.

LSD

Within the general population, recent and current use of LSD is low, 0.3 per cent and 0.1 per cent respectively and, for last year use among young adults aged 16 to 34, 0.6 per cent and those aged 16 to 24, 0.7 per cent. LSD use amongst school children has remained at between 0.6 per cent and 0.7 per cent since 2001. There is no information on treatment demands. The number and quantity of LSD seizures decreased in 2006/07. Prices appear to be remaining stable.

The United Kingdom and its constituent countries



The United Kingdom population was estimated to be 61 million in the middle of 2007. 83.8 per cent (51.1 million) live in England, 8.4 per cent (5.1 million) in Scotland, 4.9 per cent (3.0 million) in Wales and 2.9 per cent (1.8 million) in Northern Ireland.

PART A

New developments and trends

1. National policy and context

1.1 Overview

The United Kingdom comprises four countries, England, Wales, Scotland and Northern Ireland. England is the largest country with 84 per cent of the population.¹ A number of powers have been devolved from the United Kingdom Parliament to Wales, Scotland and Northern Ireland, but there are different levels of devolved responsibilities in each country.

The Misuse of Drugs Act 1971 is the principal legislation in the United Kingdom with respect to the control and supply of drugs that are considered dangerous or otherwise harmful when misused. This Act divides such drugs into three classes (A, B and C) to reflect their relative harms and sets maximum criminal penalties for possession, supply and production in relation to each class. Drugs in Class A include cocaine based drugs, ecstasy, LSD, magic mushrooms, heroin, methadone and injectable amphetamines. In addition, methamphetamine was reclassified from Class B to Class A in January 2007. Class B drugs include amphetamines. Class C drugs include anabolic steroids and tranquillisers, and since January 2006, ketamine. Cannabis was reclassified from Class B to Class C in 2004, but the Home Secretary has asked Parliament to consider reclassifying the drug back to Class B. *The Drugs Act 2005* amended sections of *The Misuse of Drugs Act 1971* and *The Police and Criminal Evidence Act 1984*, strengthening police powers in relation to the supply of drugs.

In 1998 the first United Kingdom drug strategy was launched, setting four principal aims: prevention of drug use amongst young people, safeguarding communities, providing expanded treatment and reducing availability (UKADCU 1998). Following devolution, each administration produced its own strategy, reflecting the United Kingdom drug strategy but tailored to its individual circumstances and deciding upon policy in areas where responsibility is devolved (NIO 1999; Scottish Office 1999; National Assembly for Wales 2000). Northern Ireland updated its strategy in 2006, combining drug misuse with alcohol (DHSSPSNI 2006).

The United Kingdom Government is responsible for setting the overall strategy and for its delivery in the devolved administrations only in the areas where it has reserved power. A new United Kingdom Drug Strategy was launched in February 2008; within it, policies concerning health, education, housing and social care are confined to England; policing and the criminal justice system, cover England and Wales. The Scottish Government and the Welsh Assembly Government also launched new strategies in 2008, the latter combining drugs, alcohol and prescription drugs. All aim to make further progress on reducing the harms and each looks towards a greater focus on recovery. All three strategy documents are accompanied by an action or implementation plan.

Annual public expenditure on drugs in the United Kingdom is estimated to be around €1,418 million (£970m²).

¹ For more information see: <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15106>

² The conversion rate used throughout is the December 2007 monthly average spot exchange rate quoted by the Bank of England unless stated otherwise.

1.2 Legal Framework

1.2.1 Laws, regulations, directives or guidelines

Classification of cannabis

In July 2007, the Home Secretary asked the Advisory Council on the Misuse of Drugs (ACMD) to review the classification of cannabis. The ACMD reported back in May 2008, advising that after scrutiny of the available evidence, it considered that, based on its harmfulness to individuals and society, cannabis should remain a Class C substance (ACMD 2008a). It was, however, acknowledged that use of cannabis is a significant public health issue, that it can unquestionably cause harm to individuals and society and that there is clear evidence that its use may worsen the symptoms of schizophrenia and lead to relapse. Whilst it concluded that, in the population as a whole, cannabis most likely plays a modest role in the development of psychotic illness, it also accepted that the possibility that the greater use of higher potency cannabis may increase the harmfulness to mental health, more so if young people start to use at an early age or “binge smoke”.

The Council made a total of 21 recommendations, including that given the widespread use of cannabis, a concerted public health response is needed to drastically reduce its use and that special emphasis should be placed on developing effective primary prevention programmes, directed at young people. It also suggested that the scale and public health significance of cannabis use in the United Kingdom requires further research; with the British Crime Survey extended to include young people under the age of 16. Publication of the ACMD report was accompanied by a report on the potency of cannabis (Hardwick and King 2008) (See Chapter 10).

The United Kingdom Government has accepted all the ACMD recommendations except that relating to classification. The Government published its response to the ACMD report.³ in October 2008. The Home Secretary has asked Parliament to reclassify the drug back to Class B as a precautionary measure in response to both the known risks to health as well as the potential long term impacts on health where the evidence is not conclusive at this time, particularly around the availability and use of higher potency cannabis - sinsemilla (skunk). (Home Office 2008). With Parliamentary agreement, reclassification to Class B will come into effect on 26 January 2009. The Association of Chief Police Officers (ACPO) has proposed a stronger enforcement approach for repeat offenders for cannabis possession through a robust escalation process, which includes a Penalty Notice for Disorder for a second offence (internal communication from the Home Office).

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

Reporting on the risk of Gamma-butyrolactone (GBL) and 1,4-butanediol (1,4-BD), which are precursor chemicals that are rapidly converted to intoxicant gamma-hydroxybutyrate (GHB), ACMD provisionally recommends they be brought under control of the *Misuse of Drugs Act 1971* and licensing arrangements be made for their legitimate industrial use as solvents (ACMD 2008b).

ACMD advice on steroids

Following advice from the ACMD (2008c) Government announced, in August 2008, its intention to include 24 steroids and 2 non-steroidal agents (beta-2-agonists and growth hormones) under the *Misuse of Drugs Act 1971* in Class C. ACMD

³ See:

<http://drugs.homeoffice.gov.uk/publication-search/cannabis/acmd-cannabisreclassification>

recommend inclusion as Schedule 4 (IV) substances under the *Misuse of Drugs Regulations*, so as not to preclude their legitimate use on prescription.⁴

Restriction on prescribing of methamphetamine precursors

Following public consultation and recommendation by the Commission on Human Medicines, the Medicines and Healthcare Products Regulatory Agency (MHRA) implemented tighter controls for pseudoephedrine and ephedrine, precursors used in the manufacture of methamphetamine, contained in nasal decongestants in cold and flu remedies. Reporting structures developed by the Royal Pharmaceutical Society of Great Britain for pharmacists have been put in place together with controls for United Kingdom internet pharmacies. Large packs of these decongestants have been replaced by smaller ones and sales limited to one pack per customer in retail pharmacies.⁵

1.3 Institutional framework, strategies and policies

1.3.1 Co-ordination arrangements

The Home Office continues to be responsible for overall delivery of the Drug Strategy and is the lead department for a new Public Service Agreement (PSA 25) on reducing the harm caused by alcohol and drugs (see section 1.3.3). It also has responsibility for a number of the key actions within the drug strategy's three-year action plan, including actions on enforcement and overarching actions on communications and information campaigns, diversity and the evidence base.

National Community Safety Plan 2008-11

In July 2007 the Government published *Cutting Crime: A New Partnership 2008-11* (Home Office 2007a), which sets out a new strategic framework for community safety. The *National Community Safety Plan* (HM Government 2007) covers the same period and has been revised to ensure it is in line with the new Crime Strategy and new Public Service Agreements (PSAs) (see 1.3.3). It seeks a stronger focus on more serious violence, greater flexibility for local partners to deliver local priorities and specific outcomes to increase community confidence.

1.3.2 National plan and/or strategies

Three new drug strategies have been published in the reporting period, each accompanied by an action or implementation plan. The United Kingdom strategy, *Drugs: protecting families and communities*. The 2008 drug strategy reflects the devolution of powers to Northern Ireland, Scotland and Wales (HM Government 2008a). The Scottish Government also published its strategy, *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem* (Scottish Government 2008a). The Welsh Assembly Government's substance misuse strategy, *Working Together to Reduce Harm – the Substance Misuse Strategy for Wales 2008-2018*, deals with drugs, alcohol and other substances including prescription drugs (Welsh Assembly Government 2008a).

All new strategies aim to make further progress on reducing the harms associated with drug use and each looks towards a greater focus on recovery, which is seen as requiring a change in the culture of service providers to affect it and even greater co-ordination between services. In both the United Kingdom strategy, as it relates to England, and in the Scottish strategy, there are concerns that service provision should be more focused on the particular needs of the individual.

⁴ See: <http://press.homeoffice.gov.uk/press-releases/crackdown-on-steriods>

⁵ See: <http://www.mhra.gov.uk/NewsCentre/Pressreleases/CON2033608>

United Kingdom Drug Strategy 2008 to 2018

The United Kingdom Government's new ten-year drug strategy (2008-2018) was launched in February 2008, following a 12-week consultation between July and October 2007. This strategy, *Drugs: protecting families and communities. The 2008 drug strategy* (HM Government 2008a) is accompanied by a three year action plan (HM Government 2008b). The aim is to restrict the supply of illegal drugs and reduce the demand for them; it also focuses on protecting families and strengthening communities. The four strands of work within the strategy are:

- protecting communities through tackling drug supply, drug-related crime and anti-social behaviour;
- preventing harm to children, young people and families affected by drug misuse;
- delivering new approaches to drug treatment and social re-integration; and
- public information campaigns, communications and community engagement.

Policies include:

- embedding action to tackle drugs within the neighbourhood policing approach, to gather community intelligence and to increase community confidence;
- targeting the drug-misusing offenders causing the highest level of crime, improving prison treatment programmes and increasing the use of community sentences with a drug rehabilitation requirement (DRR);
- strengthening and extending international agreements to intercept drugs being trafficked to the United Kingdom;
- extending powers to seize the cash and assets of drug dealers, to demonstrate that dealing does not pay;
- focusing on the families where parents misuse drugs, intervening early to prevent harm to children, prioritising parents' access to treatment where children are at risk, providing intensive parenting guidance and supporting family members, such as grandparents, who take on caring responsibilities;
- developing a package of support to help people in drug treatment to complete it and to re-establish their lives, including ensuring local arrangements are in place to refer people from Jobcentres to sources of housing advice and advocacy and appropriate treatment;
- using opportunities presented by the benefits system to support people in re-integrating into society and gaining employment, with a commitment to examine further how claimants can be incentivised to engage with treatment and other services; and
- piloting new approaches which allow a more flexible and effective use of resources, including individual budgets to meet treatment and wider support needs.

For more detailed information see Chapters 3, 5, 7 and 9 in this report.

Scotland's drug strategy

A key priority of *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem* is to reinforce the message that, more than just reducing the risk and harm associated with drug use, services should support people to move on, towards a drug-free life, as active and contributing members of society (Scottish Government 2008a). Problem drug use is seen as symptomatic of the failure of other policies to bring about a wealthier and fairer society. There is, therefore, a belief that tackling the problem can only be achieved through effective policies on the economy, tackling poverty and on supporting families and children, in particular the children of drug using parents (see Chapter 9). Therefore, the strategy is complemented by wider social policies including a new economic strategy (Scottish Government 2008b) and early years and early intervention policy (Scottish Government and COSLA 2008), as

well as increasing investment in drug services (see Chapters 5 and 9). There is also to be a fresh approach to drugs education and prevention (see Chapter 3) and a stronger focus on law enforcement and drug-related crime (see Chapters 9 and 10). An action plan details key activities to be undertaken to achieve the aims and objectives of the strategy.

Key priorities are:

- better prevention of drug problems, with improved life chances for children and young people, especially those at particular risk of developing a drug problem, allowing them to realise their full potential in all areas of life;
- to see more people recover from problem drug use so that they can live longer, healthier lives, realising their potential and making a positive contribution to society and the economy;
- having communities that are safer and stronger places to live and work because crime, disorder and danger related to drug use have been reduced;
- ensuring that children affected by a parental drug problem are safer and more able to achieve their potential; and
- improving the effectiveness of delivery at a national and local level.

Actions include:

- the setting up of a Drug Recovery Network to promote and support the concept of recovery among local partners, service providers and people with problem drug use;
- developing an outcomes based framework for assessing and managing performance at a local level focused clearly on recovery;
- setting up a national support function to take forward the development and implementation of the recovery model in drugs services;
- establishing a National Drugs Evidence Group to develop a co-ordinated approach to identify gaps in research and encourage innovation;
- establishing of a Steering Group to develop more effective substance misuse education in schools; and
- provision of ongoing multi-agency training to help identify children at risk at an early stage, to know when to seek support from specialist areas, and when to share information.

For more detailed information see Chapters 3, 5, 7 and 9 in this report.

Substance Misuse Strategy for Wales 2008 to 2018

The substance misuse strategy for Wales, *Working Together to Reduce Harm – the Substance Misuse Strategy for Wales 2008-2018*, was launched in 2008 (Welsh Assembly Government 2008a). The strategy has four aims:

- reducing the harm to individuals (particularly young people) their families and wider communities from the misuse of drugs and alcohol, whilst not stigmatising substance misuse;
- improving the availability and quality of education, prevention and treatment services and related support, with a greater priority given than under the previous strategy to those related to alcohol; and
- making better use of resources – supporting evidence based decision making, improving treatment outcomes, developing the skills base of partners and service providers by giving a greater focus to workforce development and joining up agencies and services more effectively in line with *Making the Connection*.⁶

⁶ See: <http://new.wales.gov.uk/about/strategy/makingtheconnections/?lang=en>

- Embedding the core Welsh Assembly Government values of sustainability, equality and diversity, support for the Welsh Language and developing user focused services and a rights base for children and young people in both the development and delivery of the strategy.

The strategy is accompanied by a three-year implementation plan (Welsh Assembly Government 2008b). Key areas for actions are:

- preventing harm – helping children, young people and adults resist, reduce or delay substance misuse by educating them about the damage that substance misuse can cause to their health, their families and the wider community;
- support for substance misusers - to improve their health and aid and maintain recovery thereby reducing the harm they cause themselves, their families and their communities;
- supporting families – to reduce the risk of harm to children and adults as a consequence of substance misusing behaviour of a family member; and
- tackling availability and protecting individuals and communities - reducing the harm caused by substance misuse related crime and anti-social behaviour, by tackling the availability of illicit drugs and the inappropriate availability of alcohol and other substances.

For more detailed information on the strategy see Chapters 3, 5, 7 and 9 in this report.

Responses to the strategies

There has been a lot of media attention and comment on *Drugs: protecting families and communities* (HM Government 2008a), particularly at the consultation stage. These include responses from the ACMD⁷, the Royal Society for the Encouragement of Arts, Manufactures and Commerce (RSA)⁸ and the United Kingdom Drug Policy Commission (UKDPC).⁹ A major concern about the draft of this strategy was the lack of an accompanying statement of the evidence base, which was rectified in the final document. The strategy received praise for its focus on helping users to reintegrate into society. The UKDPC, in its response to the Welsh strategy during the consultation, has welcomed the fact that it seeks to address all substance misuse, its focus on reducing harm and the emphasis on support for substance misusers, but expressed some concern about the evidence for drug education in the strategy (see Chapter 3.2). A major response from UKDPC concerns the concept of recovery (see section 1.5.2) (UKDPC 2008a).

1.3.3 Implementation of policies and strategies

In England, Public Service Agreements (PSAs) set out the key priority outcomes the Government wants to achieve. The 2007 Comprehensive Spending Review (CSR)¹⁰

⁷ See: <http://drugs.homeoffice.gov.uk/publication-search/acmd/acmdconsultresponse.pdf>

⁸ The RSA Drugs Commission is an independent body with members drawn from various fields and disciplines concerned with drug misuse. The Drugs Commission was set up in January 2005 to examine the efficacy of current drugs policy and consider alternatives. For more information see: <http://www.rsadrugscommission.org/>

⁹ The UK Drug Policy Commission an independent body established to provide objective analysis of UK drug policy and to improve political, media and public understanding of drug policy issues and the options for achieving a rational and effective (evidence-led) response to the problems caused by illegal drugs. For more information see: <http://www.ukdpc.org.uk/>

¹⁰ Spending Reviews set firm and fixed three-year Departmental Expenditure Limits and, through Public Service Agreements (PSA), define the key improvements that the public can expect from these resources. The 2007 Comprehensive Spending Review set spending plans for 2008-11. For more information see:

announced spending by Government over three years, 2008 to 2011, setting 30 new PSAs (HM Treasury 2007a). Each PSA is underpinned by a single Delivery Agreement shared across all contributing government departments and taking effect from April 2008. PSA Delivery Agreement 25 is to reduce the harm caused by alcohol and drugs. Progress will be measured by a number of indicators including:

- the number of drug users recorded as being in effective treatment;
- the rate of drug-related offending; and
- the percentage of the public who perceive drug use or dealing as a problem in their area.

At the local level, Local Authorities and their Strategic Partnerships, responsible for a wide range of services, and Primary Care Trusts (PCTs), responsible for health services, are measured by a set of 198 National Indicators (NI) which relate to specific PSAs (CLG 2007). In each area, targets against the set of national indicators are negotiated through new Local Area Agreements (LAAs). Each Agreement is expected to include up to 35 targets from among the national indicators. The national indicator set includes the three PSA indicators listed above.

It is of note that the previous PSA, “to reduce the use of Class A drugs and the frequent use of any illicit drug among all young people under the age of 25, especially by the most vulnerable young people”, is no longer valid.¹¹ A new PSA (14) directly relates to young people’s substance misuse and is to “increase the number of children and young people on the path to success”. This PSA is the responsibility of the Department for Children, Schools and Families (DCFS) and has an associated local indicator specifically on substance misuse by young people – the proportion of young people frequently using illicit drugs, alcohol or volatile substances (NI 115).

In Scotland a National Performance Framework supports the delivery of the Scottish Government’s purpose:

“To focus the Government and public services on creating a more successful country, with opportunities for all Scotland to flourish, through increasing sustainable economic growth”.

The National Performance Framework contains 15 outcomes and 45 indicators. Progress on the outcomes is measured through these indicators. Included in the set of national indicators is “reducing the estimated number of problem drug users in Scotland by 2011”.

This National Performance Framework also underpins a new relationship between Government and local government through a Concordat agreed in November 2007 (Scottish Government 2007). Measures contained within the Concordat include the introduction of Single Outcome Agreements (SOAs). Under the Concordat an SOA will be developed between central government and the local authority or Community Planning Partnership (CPP) in each area of Scotland. From 2009 the SOA will be

http://www.hm-treasury.gov.uk/spending_review/spend_index.cfm

¹¹ Other previous PSAs were to: reduce the harm caused by illegal drugs including substantially increasing the number of drug misusing offenders entering treatment through the criminal justice system, and to increase the participation of problem drug users in drug treatment programmes by 100% by 2008 and increase year on year the proportion of users successfully sustaining or completing treatment programmes. See: <http://drugs.homeoffice.gov.uk/publication-search/drug-strategy/technical-notes-290704?view=Binary>

between central government and the CPP. The SOAs, therefore will help identify the contribution tackling drug use makes to the achievement of local outcomes. SOAs for 2008/09 have been agreed and those for 2009/10 are currently in the process of being developed (Scottish Government 2008a; internal communication from the Scottish Government).

The Scottish Government is also setting up a Drug Recovery Network to promote and support the concept of recovery among local partners, service providers and people with problem drug use and to effect cultural change among those working with, or affected by problem drug use. Also, it will set up a national support function to take forward the development and implementation of the recovery approach in drugs services. The specific functions and priorities which the national support function will provide are being considered by a Delivery Reform Group jointly supported by the Scottish Advisory Committee on Drug Misuse (SACDM) and the Scottish Ministerial Advisory Committee on Alcohol Problems (SMACAP), which has been set up to look at the future of alcohol and drug delivery arrangements. The group will also develop and propose an outcomes-based framework for assessing and managing performance at a local level, focused clearly on recovery. It will also develop and propose a clear statement of the strategic functions needed to implement the national strategy locally. Finally, it will propose accountability arrangements between central government and partner organisations to ensure that resources are used efficiently and effectively and local partners can demonstrate to Government that this is the case. The Scottish Government will publish and respond to the conclusions of the group in time to allow its work to inform accountability arrangements from April 2009.

In Wales, the national strategy is accompanied by an implementation plan (Welsh Assembly Government 2008b) and a National Substance Misuse Strategy Implementation Board is to be established to oversee the delivery of the Strategy. This will have representation from key Welsh Assembly policy divisions, the Advisory Panel on Substance Misuse, non-devolved bodies and stakeholders. The Board will also measure the impact of the strategy against the key performance indicators (published in the previous United Kingdom Focal Point report). The lead responsibility for delivering this strategy at a local level will continue to rest with the 22 Community Safety Partnerships in Wales. Links with other relevant partnerships, particularly local Children and Young People's Partnerships are to be strengthened. Co-ordination arrangements are also to be strengthened at regional level.¹²

Within the Northern Ireland Executive's, *Programme for Government 2008-2011*, under PSA 8: Promoting health and addressing health inequalities, there are a range of targets related to drug misuse, particularly among young people and vulnerable groups (Northern Ireland Executive 2007). A report updating progress against the Northern Ireland alcohol and drug strategy, *New Strategic Direction for Alcohol and Drugs* (DHSSPSNI 2006), including its outcomes and indicators, is due to be published in late 2008.

1.3.4 Evaluation of policies and strategies

The Drug Harm Index

The Drug Harm Index (DHI) was developed by the Home Office as the overarching measure for a previous Public Service Agreement target to: "Reduce the harm caused by illegal drugs (as measured by the Drug Harm Index encompassing measures of the availability of Class A drugs and drug-related crime)" and included

¹² Regions are coterminous with the four police force areas in Wales.

“substantially increasing the number of drug misusing offenders entering treatment through the criminal justice system.”¹³ The specific target to increase the number of drug-misusing offenders entering treatment through the criminal justice system to 1,000 a week by the end of March 2008 (from a baseline of 438 entering treatment in March 2004), was met two months early, in January 2008. The latest report on the Drug Harm Index¹⁴ shows a fall from 89.1 points in 2004 to 83.8 points in 2005. This is a drop of 5.3 points or 5.9 per cent (Goodwin 2007). This compares to a decrease of 18.2 per cent between 2003 and 2004. The index has now fallen year-on-year since 2001. It is suggested that the fall between 2004 and 2005 is largely due to further reductions in drug-related crime (most notably domestic and commercial burglaries, theft from a domestic vehicle, shoplifting and other thefts). In terms of the health-related indicators, drug-related hepatitis C cases had a noticeable downward impact on the DHI, but this was more than offset by an increase in drug-related deaths from 1,495 in 2004 to 1,608 in 2005. The only other variable with a large upward impact on the DHI was robbery. The DHI will not be continued in future.

1.4 Budget and public expenditure

1.4.1 In law enforcement, social and health care, research, international actions, coordination, national strategies

England

Table 1.1 shows labelled public expenditure for England by the United Nations Classifications of Functions of Government (COFOG).

Table 1.1: Public expenditure by COFOG in England, 2006/07 and 2007/08

COFOG category	2006/07 €m (£m)	2007/08 €m (£m)
01 – General public services	67.4 (46.1)	50.4 (34.5)
03 – Public order and safety	394.3 (269.7)	358.9 (245.5)
07 – Health	962.6 (658.1)	958.2 (655.4)
09 – Education	21.1 (14.4)	15.2 (10.4)
10 – Social protection	10.4 (7.1)	10.5 (7.2)
<i>Total*</i>	<i>1462.8 (1000.0)</i>	<i>1399.2 (957.3)</i>

*Includes Prospect Programme (€6.7m (£4.6m) in 2006/07 and €6.3m (£4.3m) in 2007/08)

Source: Home Office

Northern Ireland

Approximately €10.2 million (£7m) per year is allocated to the implementation of the Northern Ireland alcohol and drug strategy, *New Strategic Directions* (DHSSPSNI 2006). This funding does not include the amount allocated to statutory addiction services, or any additional funding being allocated at a local level to tackle inequalities related to alcohol or drug issues.

¹³ A technical account of the DHI was published in March 2005 with data up to and including 2003, along with a full description of data sources and methodology. This report is available at www.homeoffice.gov.uk/rds/pdfs05/rdsolr2405.pdf. An update was published in March 2006 to incorporate some minor improvements to the methodology and data for 2004; see <http://www.homeoffice.gov.uk/rds/pdfs06/rdsolr0806.pdf>

¹⁴ The previous DHI update included some minor methodological improvements. Whilst the latest version of the DHI retains these changes, there have not been any further changes to the methodology. However, certain data providers have retrospectively updated some of the historical data used to construct the DHI. Incorporating these data revisions has led to a slight increase in the value of the DHI between 1999 and 2004 compared to the previously published figures. These changes have made little difference to the trend over time.

Table 1.2: Public expenditure in Northern Ireland, 2007/08

	€m (£m)
Allocation to Drug and Alcohol Coordination Teams (DACTs)	0.10 (0.07)
Allocation to implement the national strategy across DACTs	7.01 (4.8)
Substitute prescribing allocation to Health Boards	1.46 (1.0)
Policy development/research	0.29 (0.2)
Public information campaigns	0.44 (0.3)
Needle and Syringe Exchange Scheme	0.15 (0.1)
4 Regional Posts (Service User; Harm Reduction; Workplace Development and Workplace Policy)	0.15 (0.1)
Other Expenditure	0.73 (0.5)
Total	10.34 (7.07)

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

Scotland

In Scotland, a total of €96.3 million (£65.9m) was allocated to tackling drug misuse in 2007/08 under the Justice portfolio. This consisted of €34.6 million (£23.7m) for drug treatment and rehabilitation services, €33.8 million (£23.1m) to the Scottish Crime and Drug Enforcement Agency (SCDEA), €20.6 million (£14.1m) for criminal justice interventions (including Drug Testing and Treatment Orders), and €7.3 million (£5m) to support the work of Drug Action Teams and centrally managed projects.¹⁵ Significant resources outside the Justice portfolio budget are also applied to tackling drug misuse. In the past this has included expenditure by local authorities on services for those affected by drugs and/or alcohol misuse, €61.8 million (£42.3m) in 2006/07 and additional expenditure by Health Boards on treatment services from their unified budgets.

Future funding proposals are tied to the key priorities of the new national drugs strategy. Allocations to Health Boards to fund drug treatment and rehabilitation services and for centrally managed initiatives are to increase by 14 per cent over the period 2008 to 2011. Expenditure on criminal justice interventions and the SCDEA is to increase slightly with a further €62.9 million (£43m) being made available over the next three years to implement the *Hepatitis C Action Plan Phase II*. The Scottish Government is also investing €137.4 million (£94m) over the next three years to deliver a more visible policing presence by recruiting 1,000 more police officers, many of whom will be dealing with drug misuse.

Audit Scotland is undertaking an exercise to identify the scale and effectiveness of public expenditure on measures to tackle drug misuse; it intends to report no later than Spring 2009. This work will inform future spending priorities.

Wales

Funding for the Welsh substance misuse strategy will come from the investment of an extra €14 million (£9.6m) into the *Substance Misuse Action Fund* over the next three years, taking the total funding to over €39.5 million (£27m) per annum by 2010-11. Also, there will be an additional €4.39 million (£3m) over the next 3 years from the *Health Inequalities Fund* to take forward the alcohol actions within the implementation plan and nearly €16.1 million (£11m) a year ring-fenced funding provided to local Health Boards for tackling substance misuse.¹⁶

¹⁵ <http://www.scottish.parliament.uk/business/pqa/wa-08/wa0617.htm>

¹⁶ For more information see:

<http://new.wales.gov.uk/news/presreleasearchive/030308comm/?lang=en>

1.4.2 Funding arrangements

England

Treatment

There have been changes to the way funding for drug treatment has been allocated to local drug action teams. Funding received by partnerships will now largely depend upon the number of individuals in the area in effective treatment in that year i.e. those who complete or are retained in treatment for 12 weeks or more. Additional factors will be taken into consideration, including: the number of crack cocaine and/or opiate users being treated; the complexity of local caseloads; and the varying costs involved in providing treatment in different areas of the country. These changes mean that, over the coming years, the variations in spending per person in treatment will continue to narrow with funding redirected from partnerships which have historically received a higher than average share per person in treatment of the national treatment budget, towards those who have received a lower than average allocation.¹⁷

1.5 Social and cultural context

1.5.1 Public opinions of drug issues

In a public consultation¹⁸ by the Joseph Rowntree Foundation exploring the 'social evils' facing Britain today, amongst a number of concerns raised were drugs and alcohol, which were viewed as the consequence and cause of many other social problems, such as family breakdown and poverty (Joseph Rowntree Foundation 2008).

Results from the 2007/08 British Crime Survey (BCS) show that drugs were one of the two factors most commonly identified by people as the main causes of crime in Britain today (lack of discipline from parents was the second factor), mentioned by 71 per cent of respondents. The 2007/08 BCS shows a statistically significant decrease in overall perceptions of antisocial behaviour from 18 per cent in 2006/07 to 16 per cent in 2007/08, including a statistically significant decrease in the respondents reporting that people using or dealing drugs was a "very/fairly big problem in their area", from 28 per cent to 26 per cent (Kershaw *et al.* 2008).

1.5.2 Initiatives in parliament and civil society

Consultation on drug strategies

All recent drug strategies have undergone a process of public consultation.¹⁹

¹⁷ See: http://www.nta.nhs.uk/news_events/newsarticle.aspx?NewsarticleID=7

¹⁸ A web-based consultation was held from July to September 2007. Anyone could contribute to this by visiting the website and listing their top three social evils. Approximately 3,500 people took part and a further 100 responses by post. However, this group was not representative of the British population generally; for example, black and minority ethnic groups and younger people were under-represented. The results of this consultation can be found at: <http://www.sociale evils.org.uk/>. In addition, The National Centre for Social Research was commissioned to ensure that the potentially excluded groups be included. In total, 60 people took part in eight discussion groups held across England and Scotland in 2007 with participants recruited through a number of charitable organisations working with potential excluded groups, including people with learning difficulties, ex-offenders, people with experience of homelessness, unemployed people, care leavers and carers. The results of this consultation can be found at: <http://www.sociale evils.org.uk/>

¹⁹ See, for example:

Scotland's Futures Forum

Scotland's Futures Forum²⁰ was established by the Scottish Parliament in 2007 to look beyond immediate horizons to some of the challenges and opportunities to be faced in the future. In 2007 it was asked to consider the question, "How can Scotland reduce the damage caused to its population through alcohol and drugs by half by 2025?" It has published a report based on evidence gathered from some of the world's leading experts in tackling drug and alcohol misuse, adopting a systems mapping approach to addressing the key issues (Scotland's Futures Forum 2008a). A report containing the views of those consulted is also available (Scotland's Futures Forum 2008b).

Key findings were that:

- transparent evidence based research should underpin all policy and practice, and this should be scrutinised in the public domain;
- research shows a high association between drug problems and inequality;
- a population-based approach is required to improve public health;
- treatment and recovery networks make one of the most significant contributions to reducing drug harm and should be strengthened;
- there are substantive questions to be answered about the effectiveness of the current heavy bias of resources towards enforcement and there needs to be a counterbalancing of resources on prevention and social well-being;
- further discussion is needed to rebalance the regulation and prohibition for each substance; and
- people will use a range of psychoactive drugs, balancing benefits and harm, for the foreseeable future.

Consensus statement on recovery

The UKDPC is seeking to develop a consensus statement defining recovery, following what it sees as increasing polarisation of opinion amongst professionals, academics and the media between the concepts of harm reduction and abstinence. The aim is to identify common ground and develop a description of the process of recovery from substance use problems which would encompass the wide range of individual experiences of recovery and the differing contributions that treatment and support services make to assisting those in recovery. The statement, at the time of writing, is that:

"The process of recovery from problematic drug use is characterised by voluntary sustained control over substance use which maximises health and well-being and participation in the rights, roles and responsibilities of society." (UKDPC 2008a)

It is suggested that:

"Recovery is about building a satisfying and meaningful life, as defined by the person themselves, and involves participation in the rights, roles and responsibilities of society. The word 'rights' is included here in recognition of the stigma that is often associated with problematic drug use and the discrimination users may experience and which may inhibit recovery. Recovery embraces inclusion, or a re-entry into society, and the improved self-identity that comes with a productive and meaningful role. For many people this is likely to be able to

<http://new.wales.gov.uk/consultations/currentconsultation/housandcomm/workingtogether/?lang=en>, and: <http://drugs.homeoffice.gov.uk/publication-search/drug-strategy/drug-strategy-consultation.pdf>

²⁰ For more information about the Futures Forum see: <http://www.scotlandfutureforum.org/>

include being able to participate fully in family life and undertake work in a paid or voluntary capacity.” (UKDPC 2008a)

“Recovery is a process, not a single event, and may take time to achieve and effort to maintain. The process and the time required will vary between individuals.” (UKDPC 2008a)

The place of substitute medication within the process is seen as important:

“Recovery requires control over substance use (although it is not sufficient on its own). This means a comfortable and sustained freedom from compulsion to use. For many people this will require abstinence from the problem substance or all substances, but for others it may mean abstinence supported by prescribed medication or consistently moderate use of some substances.” (UKDPC 2008a)

The legalisation of illegal drugs

Amongst a number of concerns over the past year has been the question of the legalisation of illegal drugs which was a topic for discussion in the British Medical Journal in 2007, with a number of contributors on the subject, some seeking it on the grounds that prohibition breeds crime and exacerbates drug problems, others arguing it will send out the wrong message.²¹ There has also been some debate about how dangerous ecstasy²² is, and there has been a major debate, led by the ACMD, on whether cannabis should be reclassified (see section 1.2.1). As part of this review, the ACMD invited members of the public to a meeting in February 2008.²³

Beckley Foundation report

A report from the Beckley Foundation (Barrett *et al.* 2008)²⁴ suggests that prohibitionist policies are dominant in most countries and marginalise and stigmatise the most vulnerable sectors of society, subjecting them to human rights violations. It is suggested that a number of reforms within the United Nations are essential if a human rights-based approach to drug control is to be achieved.

1.5.3 Mass Media Campaigns

The first National Tackling Drugs Week, run between the 19th and 23rd of May 2008, allowed local agencies, involved in delivery of the Drug Strategy, an opportunity to publicise the work that they carry out to tackle drugs issues in the community.²⁵

In Scotland, Know the Score launched its *Informing Parents* campaign in March 2008 which aimed to provide parents with information, advice and resources on drugs to help them become properly equipped to approach their children about this issue.²⁶ A direct mailing to households with children under 16 years, grandparents and other family members was undertaken in June 2008. Further targeted work, in partnerships with the education, youthwork, health and prison sectors is being developed (see also Chapter 3.3.1).

²¹ See: <http://www.nelm.nhs.uk/Record%20Viewing/vR.aspx?id=587105>

²² See: <http://www.timesonline.co.uk/tol/news/uk/article3119399.ece>

²³ See: <http://drugs.homeoffice.gov.uk/news-events/events/ACMD-open-meeting-feb-2008>

²⁴ The Beckley Foundation Drug Policy Programme (BFDPP,) is a non-governmental initiative dedicated to providing a rigorous independent review of the effectiveness of national and international drug policies. For more information see: www.internationaldrugpolicy.net

²⁵ See:

<http://drugs.homeoffice.gov.uk/communications-and-campaigns/tackling-drugs/NationalTacklingDrugsWeek/>

²⁶ See: <http://www.knowthescore.info/kts/898.html>

2. Drug use in the population

2.1 Overview

Estimates of the prevalence of drug use in the general population in England and Wales are provided by the British Crime Survey.²⁷ Similar surveys are undertaken in Scotland²⁸ and Northern Ireland.²⁹ Combining data from surveys undertaken in 2006/07, it was estimated that just over a third of the adult population in the United Kingdom aged between 16 and 59 had used an illicit drug in their lifetime. In England and Wales, for which the most complete time series data are available, prevalence of recent (last year) use had been fairly stable at around 11 per cent from 1996 to 2003/04 but has subsequently fallen annually to just over nine per cent in 2007/08.

Young adults under 35 are much more likely to use drugs, and amongst those who are under 25 years old, recent and current (last month) prevalence is higher still. In England and Wales, amongst these young adults, there has nevertheless been a steady decline in the recent use of any drug since 1996 with a decrease from 24 per cent to 21 per cent between 2006/07 and 2007/08.

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

Amongst the school age population, surveys of drug use prevalence have been undertaken in each of the four administrations of the United Kingdom.³⁰ In England, for which the longest time series are available, drug use increased between 1998 and 2003, but has fallen since then.

Cannabis continues to be the most commonly used drug across all age groups, with prevalence rates close to those for use of any drug. Use of other drugs is considerably lower. Since the mid 1990s the British Crime Survey shows that use of cocaine powder increased substantially (with the greatest change before 2001/02)

²⁷ The British Crime Survey (BCS) is a victimisation survey which gathers information about experience of crime in England and Wales, and is designed to provide a complementary measure of crime to police recorded crime statistics. It also asks respondents about their use of illicit drugs in a self-completion module. In 2001/02 it became a continuous survey.

²⁸ The Scottish Crime and Victimisation Survey (SCVS, previously the Scottish Crime Survey) is similar in scope and aims to the BCS. Surveys were carried out, as part of the British Crime Survey (BCS) in 1982 and 1988, as the independent Scottish Crime Survey in 1993, 1996, 2000, 2003 and as the SCVS in 2004 and 2006.

²⁹ The Northern Ireland Crime Survey is also similar to the BCS. Surveys were carried out in 1994/95, 1998, 2001 and 2003/4 and the survey has been continuous since January 2005. The latest published results are for 2006/07. In addition, a Drug Prevalence Survey, based on the EMCDDA model questionnaire, was carried out in Northern Ireland in 2002/03 and 2006/07.

³⁰ Amongst the school age population, the main sources of information on drug use prevalence are surveys undertaken in schools. In England, a survey of the prevalence of drug use, smoking and drinking amongst young people (11 to 15 year old school children), has been undertaken annually since 1998. The *Young Person's Behaviour and Attitudes Survey* was undertaken in Northern Ireland in 2000 for the first time, and repeated in 2003 and 2007. In Scotland, the *Scottish Schools Adolescent Lifestyle and Substance Use Survey* (SALSUS) is undertaken every two years. Results from the 2006 survey were reported in the UK Focal Point Annual Report 2007. The *Health Behaviour in School Age Children Survey* (HBSC) provides data from Wales and is undertaken every four years with a two-year interim survey. The most recent survey, was conducted in 2006.

and it is now the second most used drug amongst adults. However, there has been a corresponding decline in the use of amphetamines, previously the second most used drug.

2.2 Drug use in the general population

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

2.2.1 Drug use in the United Kingdom

By combining data from the 2006/07 BCS (Murphy and Roe 2007), the 2006 Scottish Crime and Victimization Survey (SCVS) (Brown and Bolling 2007) and the 2006/07 Drug Prevalence Survey in Northern Ireland (NACD and PHIRB 2008a)^{31,32}, an estimate has been produced for 16 to 59 year olds in the United Kingdom (Table A.1, Appendix A) showing that:

- 35.4 per cent have used drugs in their lifetime (ever);
- 10.2 per cent have used drugs in the last year (recent use); and
- 6.0 per cent have used drugs in the last month (current use).

Since the last United Kingdom estimate was produced in 2005, based on data from surveys undertaken around 2003, lifetime drug use has increased from 34.1 per cent. However, recent use has declined from 11.8 per cent and current use has declined from 7.1 per cent.

Drug use prevalence is highest in Scotland across all recall periods and for each individual drug. This contrasts with the United Kingdom estimate in the Focal Point's 2005 Report where drug use was lowest in Scotland. However, the change is largely attributable to a change of methodology for the SCVS rather than to a large increase or decrease in individual countries within the United Kingdom.³³ Reported drug use remains lowest in Northern Ireland.

2.2.2 England and Wales: the British Crime Survey

The latest findings from the 2007/08 British Crime Survey show that 9.3 per cent of 16 to 59 year olds have used drugs in the last year and 5.3 per cent have used drugs in the last month (Table 2.1). Cannabis was the most commonly used drug across all recall periods followed by cocaine for recent and current use. Males were much more likely to report drug use than females across all recall periods but especially recent and current drug use.

³¹ The Public Health Information and Research Branch (PHIRB), formerly the Drug and Alcohol Information and Research Unit (DAIRU).

³² The 2006/07 All Ireland Drug Prevalence Survey is a survey of drug use in Ireland and Northern Ireland amongst 15-64 year olds carried out between October 2006 and May 2007 using CAPI. The overall sample for the survey was 6,969, with a sample size of 2,002 in Northern Ireland (62 per cent response rate). The sample in Northern Ireland was stratified by Health and Social Services Board (HSSB) area and then random sampling was employed within the strata. Results have been weighted by age gender and HSSB area.

³³ In 2006, the SCVS changed from paper completion to Computer Assisted Personal Interviewing (CAPI), which appears to have had an impact on reported drug use. This change in methodology means it is now similar to the BCS methodology.

Table 2.1: Percentage of 16-59 year olds reporting having used individual drugs in lifetime, last year and last month in England and Wales, 2007/08

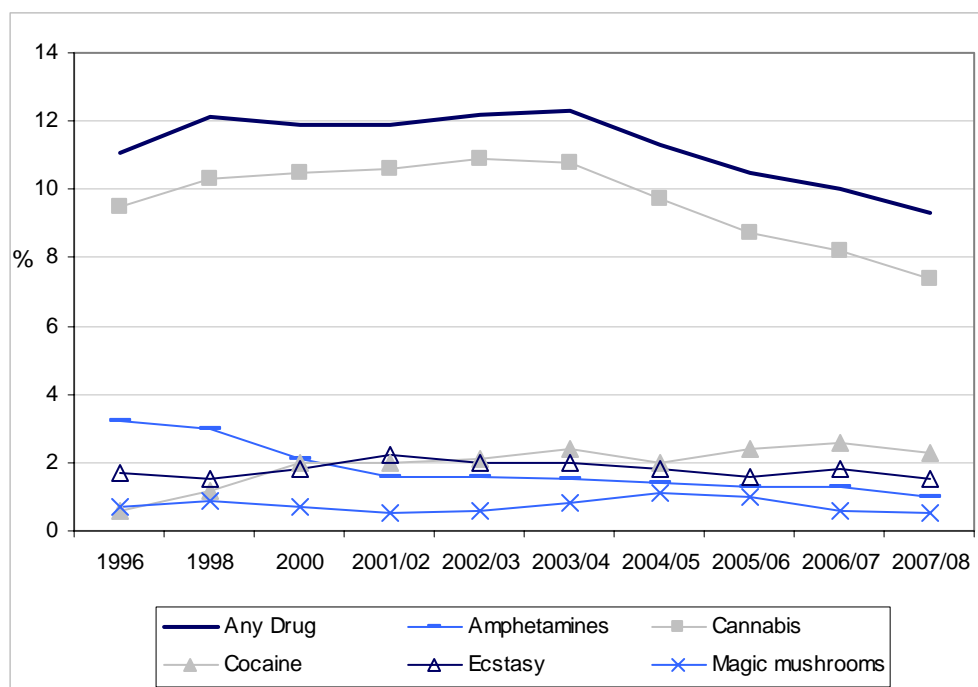
	Lifetime use			Last Year use			Last Month use		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug	41.8	29.9	35.8	12.6	6.2	9.3	7.5	3.2	5.3
Amphetamines	14.4	9.0	11.7	1.3	0.7	1.0	0.5	0.2	0.4
Cannabis	35.9	24.4	30.0	10.1	4.8	7.4	6.0	2.4	4.2
Cocaine	10.3	5.1	7.6	3.3	1.3	2.3	1.5	0.6	1.0
Ecstasy	9.7	5.3	7.5	2.1	0.8	1.5	0.8	0.3	0.5
LSD	7.4	3.0	5.2	0.4	0.1	0.3	0.1	0.1	0.1
Magic mushrooms	9.7	4.1	6.9	0.8	0.2	0.5	0.1	0.1	0.1
Opiates	1.2	0.5	0.8	0.3	0.1	0.2	0.2	0.1	0.1
Base	13,209	15,291	28,500	13,120	15,211	28,331	13,103	15,202	28,305

Source: Standard Table prepared for the United Kingdom Focal Point

Trends in drug use

Changes in recent use since 1996 are shown in Figure 2.1. This shows a decline in overall drug use since 2003/04 from 12.3 per cent to 9.3 per cent and a corresponding decline in cannabis use from 10.8 per cent in 2003/04 to 7.4 per cent in 2007/08. The increase in cocaine powder use and decrease in use of amphetamines since 1996 are also shown, with the greatest change occurring before 2001/02. However, while the use of amphetamines continues to fall, the recent increase in cocaine powder use appears to be stabilising with last year use falling slightly from 2.6 per cent in 2006/07, to 2.3 per cent in 2007/08. In 2007/08 recent use of ecstasy and magic mushrooms was similar to the levels reported when the BCS started collecting drug use data, 1.5 per cent and 0.5 per cent respectively.

Figure 2.1: Percentage of 16 to 59 year olds reporting having used drugs in the last year in England and Wales, 1996 to 2007/08



Note that the first three time intervals in this graph are greater than a year

Source: Kershaw et al. 2008

2.2.3 Drug Prevalence Survey 2006/07 in Northern Ireland

The first results from the 2006/07 Drug Prevalence Survey were published in 2008 (NACD and PHIRB 2008a).³⁴ They show that:

- 28.0 per cent of adults aged 15 to 64 have ever used drugs;
- 9.4 per cent have used drugs recently; and
- 3.6 per cent are current drug users.

As with other parts of the United Kingdom, cannabis was the most widely used drug: a quarter of adults (24.7%) reported lifetime use, 7.2 per cent recent use, and 2.6 per cent current use. For recent use, cocaine (1.9%) and ecstasy (1.8%) were the next most commonly used drugs but current cocaine use (0.3%) was less common than current ecstasy use (0.8%) (Table 2.2).

Gender

A higher proportion of males than females reported recent use of any drug, 13.7 per cent compared to 5.2 per cent.

Table 2.2: Percentage of 15-64 year olds reporting having used individual drugs in lifetime, last year and last month in Northern Ireland, 2006/07 (DPS)

	Lifetime use			Last Year use			Last Month use		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug*	33.9	22.1	28.0	13.7	5.2	9.4	4.9	2.4	3.6
Amphetamines	7.3	4.4	5.8	1.1	0.9	1.0	0.4	0.2	0.3
Cannabis	30.1	19.3	24.7	10.3	4.1	7.2	3.7	1.6	2.6
Cocaine	7.4	2.9	5.2	2.8	0.9	1.9	0.7	0.0	0.3
Ecstasy	9.9	5.5	7.7	2.4	1.2	1.8	0.8	0.7	0.8
LSD	9.7	3.5	6.6	0.2	0.2	0.2	0.0	0.1	0.0
Magic mushrooms	11.2	2.4	6.7	0.1	0.3	0.2	0.1	0.0	0.0
Opiates	0.7	0.4	0.5	0.0	0.1	0.1	0.0	0.1	0.1
Base	893	1109	2,002	893	1109	2,002	893	1109	2,002

*amphetamines, cannabis, cocaine, ecstasy, heroin, LSD, magic mushrooms, methadone, poppers and solvents

Source: Standard Table prepared for United Kingdom Focal Point from Drug Prevalence Survey in Northern Ireland

Trends in drug use

Lifetime use of drugs increased from 20 per cent in the 2002/03 Drug Prevalence Survey to 28 per cent in 2006/07, recent drug use increased from 6.4 per cent to 9.4 per cent but there was no significant change in current drug use. The increase in lifetime and recent drug use may show that there is more experimentation in recreational drugs. However, there have been changes in methodology³⁵ which may have had an impact on reported drug use and results from NICS suggest that drug use is stable in Northern Ireland (see 2.2.4 below).

2.2.4 Northern Ireland Crime Survey 2006/07

Results from the Northern Ireland Crime Survey (NICS) 2006/07³⁶ have been published (Ruddy and Brown 2007). In 2006/07, amongst adults aged 16 to 59³⁷:

³⁴ The 2006/07 All Ireland Drug Prevalence Survey is a survey of drug use in Ireland and Northern Ireland amongst 15-64 year olds carried out between October 2006 and May 2007 using CAPI. The overall sample for the survey was 6,969, with a sample size of 2,002 in Northern Ireland (62 per cent response rate). The sample in Northern Ireland was stratified by Health and Social Services Board (HSSB) area and then random sampling was employed within the strata. Results have been weighted by age gender and HSSB area.

³⁵ In 2006/07 the DPS in Northern Ireland changed from paper completion to CAPI.

³⁶ The fieldwork was carried out between April 2006 and March 2007. The sample size was 2,390 giving a 91% eligible response rate.

- 27.3 per cent reported lifetime use of an illegal drug;
- 8.4 per cent reported recent drug use; and
- 4.3 per cent reported current drug use.

Cannabis was again the most commonly used drug; lifetime use was reported by 20.1 per cent of respondents, recent use by 6.3 per cent and current use by 3.0 per cent. Cocaine and ecstasy were the next most commonly reported drugs for recent use. There was once again a large gender difference in recent drug use with 10.6 per cent of males reporting recent drug use compared to 6.4 per cent of females.

The difference in prevalence between the two surveys in Northern Ireland is less than in previous sweeps. However, it is difficult to compare the prevalence rates in the two surveys due to differences in the sampling and survey methodologies.

Trends in drug use

Lifetime use of any drug has remained stable since 2003/04 at around 27 per cent (Table 2.3). However, there has been a decrease in recent and current drug use for 16-59 year olds between 2003/04 and 2006/07.³⁸ This trend exists for both males and females.

Table 2.3: Percentage of 16 to 59 year olds reporting lifetime, last year and last month use of any drug in Northern Ireland, 2003/04 to 2006/07(NICS)

	Lifetime use			Last Year use			Last Month use		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
2003/04	31.6	23.7	27.4	11.5	8.1	9.7	7.4	5.1	6.2
2005	32.0	21.0	26.2	12.4	4.5	8.2	7.5	2.5	4.9
2006/07	31.5	23.4	27.3	10.6	6.4	8.4	5.4	3.3	4.3

Source: Ruddy and Brown 2007

Unlike in England and Wales where the fall in recent drug use is largely attributable to a fall in cannabis use, recent cannabis use in Northern Ireland has remained stable (6.4% in 2003/04 and 6.3% in 2006/07). Recent cocaine use has also remained stable at around one per cent with decreases in reported ecstasy use (1.9% in 2003/04 to 0.9% in 2006/07) and amphetamines use (0.9% to 0.5%).

2.3 Drug use amongst young adults

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

2.3.1 Estimates for the United Kingdom (2008)

By combining data from surveys as described in section 2.2.1, estimates of prevalence of drug use amongst 16 to 34 year olds show that:

- 46.9 per cent have ever used drugs;
- 19.0 per cent have used drugs recently; and
- 11.3 per cent are current drug users (Table A.2, Appendix A).

Lifetime use of any drug is the same as the estimate in the 2005 Focal Point annual report but recent and current use has declined from 21.4 per cent and 13.1 per cent

³⁷ Results differ slightly from standard table (ST)01 as it was provided on an EMCDDA basis and refers to 16 to 64 year olds not 16 to 59 year olds. For comparison with results from previous surveys, 16 to 59 year olds have been used here.

³⁸ The total sample size for NICS 2003/04 was 2,121 and for NICS 2005, 2,381.

respectively. As with the adult population, the decrease in recent and current drug use is largely attributable to a fall in cannabis use.

Amongst 16 to 24 year olds the use of illicit drugs is higher still. In the United Kingdom it is estimated that:

- 45.2 per cent have ever used drugs;
- 24.5 per cent have used drugs recently; and
- 14.6 per cent are current drug users (Table A.3, Appendix A).

Recent and current use are lower than in the 2005 estimate.

2.3.2 England and Wales: the British Crime Survey

Findings from the 2007/08 British Crime Survey show that 17 per cent of 16 to 34 year olds have used drugs in the last year. The most commonly reported drug was cannabis followed by cocaine and ecstasy (Table 2.4). Males (22.5%) were almost twice as likely to be recent drug users as females (11.6%) and the difference increased amongst 25 to 34 year olds; 7.7 per cent of females aged 25 to 34 reported any drug use compared to 19.2 per cent of males.³⁹ Amongst 16 to 24 year olds, drug use is higher, 21.3 per cent reported recent drug use with cannabis again the most commonly used drug.

Table 2.4: Percentage of 16-24 year olds and 16-34 year olds reporting last year use of individual drugs in England and Wales, 2007/08 by gender

	16-24 year olds			16-34 year olds		
	Male	Female	Total	Male	Female	Total
Any drug	26.3	16.4	21.3	22.5	11.6	17.0
Amphetamines	2.6	2.1	2.4	2.2	1.5	1.8
Cannabis	22.5	13.3	17.9	18.6	9.2	13.8
Cocaine	6.8	3.3	5.0	6.3	2.9	4.5
Ecstasy	5.2	2.6	3.9	4.3	1.9	3.1
LSD	0.9	0.4	0.7	0.8	0.3	0.6
Magic mushrooms	2.0	0.5	1.2	1.5	0.5	1.0
Base	2,711	3,056	5,767	4,446	5,385	9,831

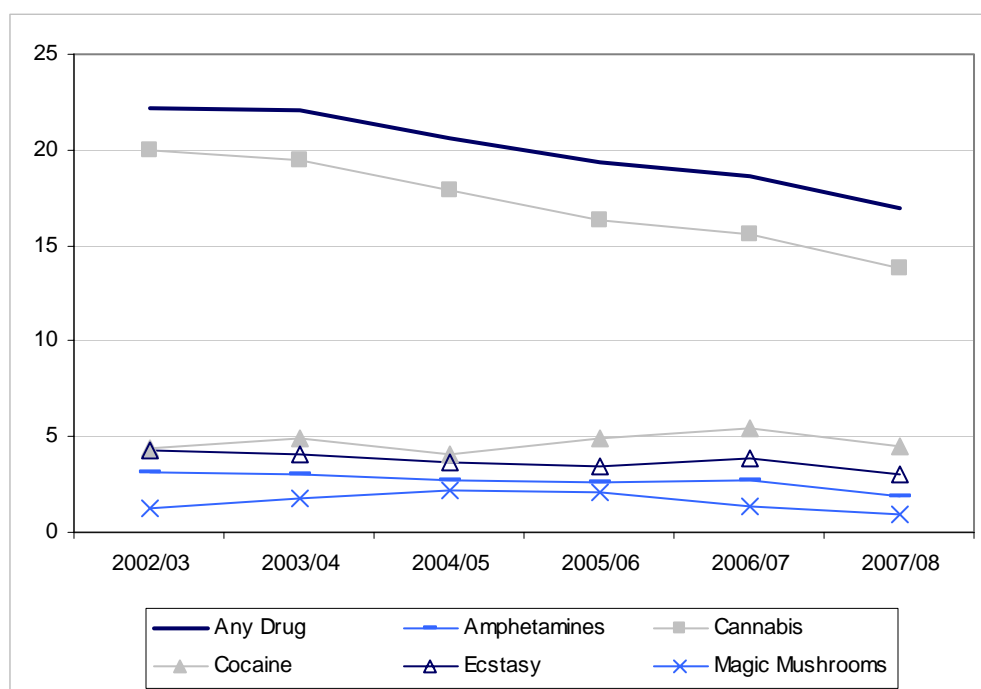
Source: Standard Table prepared for the United Kingdom Focal Point

Trends in drug use

Recent use of any drug amongst 16 to 34 year olds decreased from 22.2 per cent in 2002/03 to 17.0 per cent in 2007/08 (Figure 2.2). Over the same period cannabis use has fallen from 20.0 per cent to 13.8 per cent. Recent use of magic mushrooms increased to 2.2 per cent in 2004/05 falling steadily to 1.0 per cent in 2007/08. Any cocaine use increased from 4.3 per cent to 5.4 per cent in 2006/07 but fell to 4.5 per cent in 2007/08.

³⁹ See Standard Table 01 for England and Wales

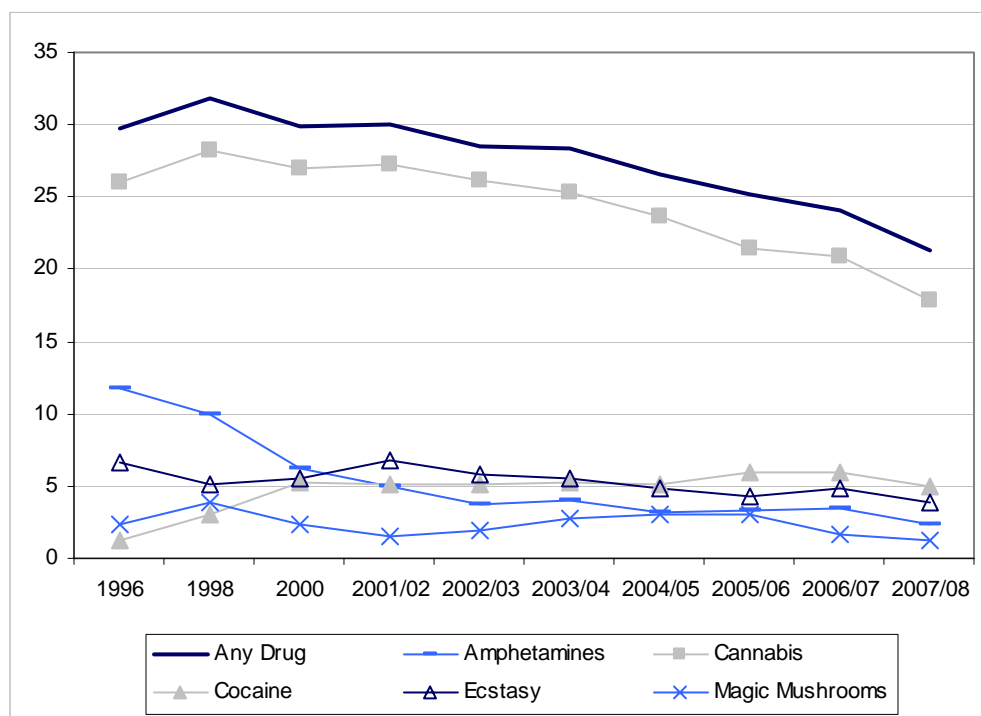
Figure 2.2: Percentage of 16 to 34 year olds reporting having used drugs in the last year in England and Wales, 2002/03 to 2007/08



Source: Standard Tables prepared for the United Kingdom Focal Point

Amongst 16 to 24 year olds, the decreases seen since 2001/02 have continued in 2007/08 (Figure 2.3). Overall the proportion of 16 to 24 year olds reporting use of any drugs in 2007/08 is 21.3 per cent compared with 29.7 per cent in 1996 and 31.8 per cent in 1998. Since 1996 use of cannabis, amphetamines, magic mushrooms, ecstasy and LSD has decreased significantly while cocaine use has increased and all other drug use has remained broadly stable. Between 2006/07 and 2007/08 there were significant decreases in the use of cannabis, ecstasy and amphetamines while increases in cocaine use over the last two years have not continued, with recent cocaine use remaining stable between 2006/07 and 2007/08.

Figure 2.3: Percentage of 16 to 24 year olds reporting having used drugs in the last year in England and Wales, 1996 to 2007/08



Source: Kershaw *et al.* 2008

Frequency of Use

Questions on frequency of use in the BCS have been completed by 16 to 24 year olds only since 2002/03. Frequent use (defined as use of any drug more than once a month in the past year) among 16 to 24 year olds has decreased significantly since 2003/04 (Table 2.5).

Table 2.5: Frequent use: percentage of 16 to 24 year olds (all respondents) who have used any drug more than once a month in the past year in England and Wales, 2002/03 to 2007/08

	Year					
	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
Frequent use (%)	11.6	12.4	10.3	9.5	8.3	7.3*
Base	3,311	5,234	6,070	5,768	5,577	5,630

*Statistically significant change 2002/03 to 2007/08

Source: Hoare and Flatley 2008

Frequency of use differs with individual drug, 37 per cent of recent cannabis users reported frequent drug use compared to 23 per cent of recent cocaine powder users and 13 per cent of recent ecstasy users. Hallucinogens were least likely to be used frequently, three per cent reported frequent use.

Lifestyle and drug use amongst 16 to 24 year olds

Regular nightclub goers (four or more time in the last month) were more than twice as likely to be recent drug users as those who had not visited a club in the last month, 33 per cent compared to 16 per cent. The BCS also found that any drug use in the last year increases as the frequency of pub visits increases or the frequency of drinking alcohol increases. Similar results were found for frequent drug use.

2.3.3 Drug Prevalence Survey in Northern Ireland 2006/07

Nineteen per cent of 15 to 24 year olds reported recent use of any drug. Cannabis was the most commonly reported drug (13.7%) followed by ecstasy (3.7%) and

cocaine (2.3%) (Table 2.6). Unlike the rest of the United Kingdom where recent and current use of cocaine amongst 16 to 24 year olds is higher than ecstasy use (Table A.3, Appendix A), in Northern Ireland ecstasy use is more commonly reported.

However, amongst young adults aged 15 to 34, recent cocaine use is similar to ecstasy use (3.5% compared to 3.4%). This reflects the higher use of cocaine by 25 to 34 year olds who are twice as likely to report recent cocaine use as 15 to 24 year olds (5.0% compared to 2.3%). The higher prevalence amongst 25 to 34 year olds is due to much higher use amongst males in this age group; 8.6 per cent of 25 to 34 year old males report recent use compared to 1.8 per cent of 15 to 24 year old males. Amongst females, 2.8 per cent of 15 to 24 year old females reported recent cocaine use compared to 1.4 per cent of 25 to 34 year old females. An analysis of cocaine results from the 2006/07 survey showed that the median age of first cocaine powder use was 24 amongst males and 22 amongst females (NACD and PHIRB 2008b). These findings are indicative rather than definitive owing to the small numbers involved (see Standard Table 01).

Table 2.6: Percentage of 15-24 year olds and 15-34 year olds reporting last year use of individual drugs in Northern Ireland, 2006/07 by gender (DPS)

	15-24 year olds			15-34 year olds		
	Male	Female	Total	Male	Female	Total
Any drug	25.5	12.2	19.0	24.1	10.4	17.3
Amphetamines	2.2	1.6	1.9	1.8	1.7	1.7
Cannabis	17.3	10.0	13.7	16.6	8.1	12.4
Cocaine	1.8	2.8	2.3	5.0	2.1	3.5
Ecstasy	4.2	3.1	3.7	4.2	2.6	3.4
LSD	0.0	0.0	0.0	0.0	0.0	0.0
Magic mushrooms	0.0	1.2	0.6	0.3	0.6	0.5
Base	136	163	299	308	406	714

Source: Standard Table prepared for United Kingdom Focal Point

2.3.4 Northern Ireland Crime Survey 2006/07

Findings from the 2006/07 NICS show that:

- 38.7 per cent of 16 to 24 year olds reported lifetime drug use;
- 22.0 per cent reported recent drug use; and
- 9.5 per cent reported current use.

Prevalence of recent and current drug use is greater than that reported in the Drug Prevalence Survey in Northern Ireland⁴⁰ although the pattern of drug use is similar. Cannabis is the most commonly reported drug, 17.8 per cent reported recent use, followed by ecstasy (3.0%) and cocaine (2.0%). For current use, however, cocaine (1.2%) is the second most reported drug followed by ecstasy and amphetamines (each 0.8%).

As in the Drug Prevalence Survey in Northern Ireland, males aged 25 to 34 are more likely to be recent cocaine users than those aged 16 to 24, 4.1 per cent compared to 2.7 per cent. However, overall drug use is lower for 16 to 34 year olds than 16 to 24 year olds mainly due to lower use of cannabis (Table 2.7).

⁴⁰ It should be noted that the Drug Prevalence Survey in Northern Ireland includes 15 year olds, which may lower overall drug prevalence rates.

Table 2.7: Percentage of 16-24 year olds and 16-34 year olds reporting last year use of individual drugs in Northern Ireland, 2006/07 by gender (NICS)

	16-24 year olds			16-34 year olds		
	Male	Female	Total	Male	Female	Total
Any drug	25.0	18.8	22.0	20.2	12.1	16.0
Amphetamines	2.0	0.8	1.4	1.8	0.4	1.1
Cannabis	19.1	16.0	17.8	15.9	10.2	13.0
Cocaine	2.7	1.3	2.0	3.6	0.8	2.1
Ecstasy	3.5	2.5	3.0	3.0	1.1	2.0
LSD	0.0	0.4	0.2	0.2	0.2	0.2
Magic mushrooms	1.6	0.0	0.8	0.8	0.0	0.4
Base	176	166	342	444	476	920

Source: Standard Table prepared for the UK Focal Point

Trends in drug use

Trends amongst young adults are similar to the general adult population. Unlike in England and Wales, cannabis use has not decreased much, making overall drug prevalence rates more stable. Recent ecstasy use has fallen from 4.5 per cent in 2003/04 to 2.0 per cent in 2006/07, while the use of amphetamines and cocaine has also fallen.

2.3.5 Drug use over the youth-adult transition

A study carried out among a cohort in the West of Scotland⁴¹ found that lifetime drug use rose from 8.9 per cent at age 15, to 31.8 per cent at age 18, and to 57.7 per cent at age 23, rising little thereafter (Sweeting and West 2008). At age 15 respondents mostly reported use of cannabis, volatile substances and magic mushrooms but by age 18, experience of drugs had widened. While the greatest increase in lifetime use of cannabis occurred between the age of 15 and 18, use of other drugs increased most between the age of 18 and 23 and remained stable thereafter. The use of 'hard'⁴² drugs continued to increase to age 30, largely due to a near doubling of lifetime cocaine powder use from 7.2 per cent to 13.4 per cent.

Last year drug use peaked at age 23 (35%) and was similar at age 18 and 30 at around 23 per cent. However, recent use of heroin, methadone and tranquilisers increased at age 30 and cocaine powder use almost doubled from 3.2 per cent at age 23 to 5.8 per cent at age 30.

The authors conclude that there is considerable transitory use, particularly amongst cannabis only users and those initiating later. They also found that cannabis only or other drug use was not higher among those from a lower social class background but there was a 'student effect'; those from a non-manual background in full-time education at age 18 were most likely to report cannabis only initiation between age 18 and 23.

⁴¹ Data were taken from the youngest cohort of the West of Scotland Twenty-07 Study located in a predominantly urban area in and around Glasgow. The study began in 1987 when the cohort were 15, with interviews repeated at age 18 (90% of wave 1 participants), age 23 (67%), and age 30 (57%). A total of 499 completed every interview.

⁴² 'Hard' drugs defined in the study as barbiturates, tranquilisers, heroin, methadone, Temgesic, cocaine, crack, morphine, opium and PCP.

2.4 Drug use in the school and youth population

2.4.1 England

The latest survey of drug use, smoking and drinking in England was undertaken in 2007 (Fuller 2008). Key findings are that:

- 17.3 per cent of 11 to 15 year olds had taken drugs recently and 9.5 per cent were current drug users;
- recent drug use increased with age from 6.1 per cent of 11 year olds to 31.1 per cent of 15 year olds; and
- the prevalence of recent and current drug use was similar for boys and girls but boys were twice as likely to report drug use at the youngest age (age 11).

Table 2.8 shows prevalence figures by drug. Cannabis was the most commonly reported drug for recent and current use although pupils were more likely to report lifetime use of volatile substances. Boys were more likely than girls to have ever used cannabis although the difference is less pronounced with recent and current use. Girls were more likely to report use of stimulants, 7.4 per cent of girls reported recent use compared to 6.4 per cent of boys. Use of cocaine powder, amphetamines, ecstasy and volatile substances was higher for girls across all recall periods.

It should be noted that amyl nitrate ('poppers'), while not reported in EMCDDA standard tables, is included in the 'any drug' figure shown and is the third most used drug (4.9% reporting recent use).

Table 2.8: Percentage of pupils reporting use of individual drugs in the last month, in the last year and in lifetime, by gender in England, 2007

	Lifetime use			Last Year use			Last Month use		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug	26.0	24.3	25.2	17.6	17.0	17.3	9.7	9.3	9.5
Amphetamines	1.1	1.6	1.3	0.9	1.2	1.0	0.5	0.5	0.5
Cannabis	12.1	10.9	11.5	9.6	9.2	9.4	5.4	5.0	5.2
Cocaine powder	2.0	2.6	2.3	1.6	2.1	1.8	0.8	1.1	0.9
Crack cocaine	1.3	1.6	1.4	1.0	1.0	1.0	0.4	0.4	0.4
Ecstasy	1.7	1.9	1.8	1.0	1.6	1.3	0.5	0.8	0.6
LSD	0.9	0.8	0.9	0.7	0.6	0.6	0.2	0.2	0.2
Magic mushrooms	2.1	1.6	1.9	1.2	1.1	1.2	0.4	0.4	0.4
Opiates	0.8	1.0	0.9	0.5	0.9	0.7	0.2	0.5	0.4
Volatile substances*	12.7	14.2	13.5	5.6	6.8	6.2	2.4	2.8	2.6
Base	4,064	3,749	7,813	4,064	3,749	7,813	4,064	3,749	7,813

*includes glues, gas, aerosols and solvents

Source: Fuller 2008

Age

Recent drug use sees the greatest increase between the age of 13 and 14 and continues to increase at age 15 (Table 2.9).

Table 2.9: Percentage of pupils reporting use of individual drugs in the last year, by age in England, 2007

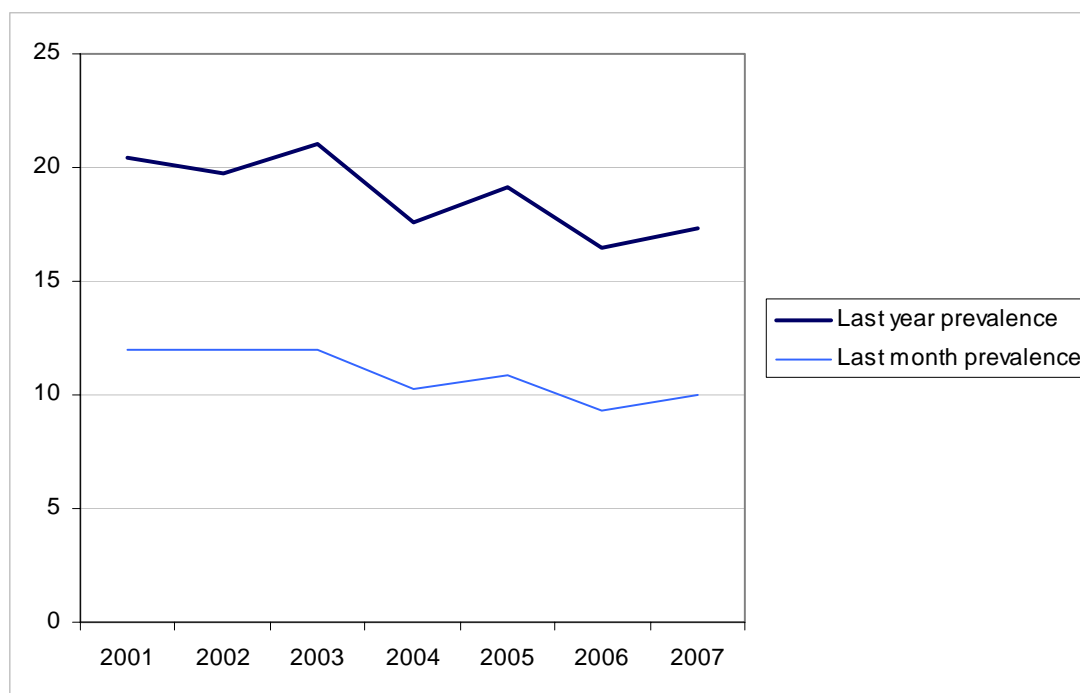
	11 yrs	12 yrs	13yrs	14yrs	15yrs	Total
Boys	7.8	8.2	11.1	24.5	31.9	17.6
Girls	4.4	7.1	13.8	23.9	30.3	17.0
Total	6.1	7.7	12.4	24.2	31.1	17.3
Base (boys)	615	881	829	807	932	4,064
Base (girls)	596	747	798	715	893	3,749
Base (total)	1,211	1,628	1,627	1,522	1,825	7,813

Source: Fuller 2008

Trends in drug use

Recent and current drug use has fluctuated in recent years but the overall trend since 2001 is downwards (Figure 2.4).

Figure 2.4: Drug use amongst school children in England, 2001 to 2007



Source: Fuller 2008; Standard Tables prepared for United Kingdom Focal Point

The recent use of cannabis continues to fall, driving the overall reduction in recent drug use since 2003 (Table 2.10). The use of ecstasy and amphetamines fell slightly in 2007, both drugs to below 2001 levels, but cocaine powder use has increased. The use of magic mushrooms has continued to fall while LSD use has remained relatively stable. The increase in drug use in 2007 seems to be largely attributable to an increase in volatile substance use in 2007; the use of any drug excluding volatile substances remained stable at 13.4 per cent in 2006 and 13.3 per cent in 2007.

Table 2.10: Percentage of pupils reporting last year use of individual drugs in England, 2001 to 2007

	2001	2002	2003	2004	2005	2006	2007
Any Drug	20.4	19.7	21.0	17.6	19.1	16.5	17.3
Amphetamines	1.1	1.2	1.2	1.3	1.2	1.2	1.0
Cannabis	13.4	13.2	13.3	11.3	11.7	10.1	9.4
Cocaine powder	1.2	1.3	1.3	1.4	1.9	1.6	1.8
Crack cocaine	1.1	1.0	1.2	1.1	1.0	0.8	1.0
Ecstasy	1.6	1.5	1.4	1.4	1.5	1.6	1.3
LSD	0.7	0.7	0.6	0.7	0.6	0.7	0.6
Magic Mushrooms	2.1	1.5	2.1	2.0	1.8	1.4	1.2
Opiates	0.8	0.8	0.9	0.7	0.9	0.7	0.7
Volatile substances*	7.1	6.3	7.6	5.6	6.7	5.1	6.2
Base	9,357	9,830	10,371	9,666	9,174	8,132	7,813

*includes glues, gas, aerosols and solvents

Source: Fuller 2008

Frequency of use

The proportion of pupils who usually take drugs as least once a month was five per cent in 2007, compared with four per cent in 2006, but a decrease from seven per cent in 2003. Of those pupils who had taken drugs in the last year, 34 per cent

reported use at least once a month with girls slightly more likely to report frequent use than boys (35% compared to 33%). The proportion of pupils reporting use of drugs on only one occasion was 29 per cent with younger pupils twice as likely to report use only once compared with older pupils (46% of 11 to 12 year olds who had taken drugs in the last year compared to 22% of 15 year olds)

TellUs2 Survey

The TellUs2 Survey⁴³ carried out in Spring 2007 asked Year 8 (aged 12 to 13) and Year 10 pupils (aged 14 to 15) in England about their drug use (Ofsted 2007). Results show that:

- 80 per cent had never used drugs
- nine per cent reported current use of cannabis; and
- three per cent reported current use of other drugs (excluding solvents)

Current cannabis use was more prevalent amongst Year 10 pupils with 13 per cent reporting current use compared to four per cent of Year 8 pupils. This is higher than in Fuller (2008).

2.4.2 Northern Ireland

The latest Young Person's Behaviour and Attitudes Survey (YPBAS) was carried out in 2007 amongst 12 to 16 year olds. Headline figures were published in a Bulletin in 2008 (NISRA 2008a). Key findings are that:

- 19.3 per cent of pupils had ever used drugs;
- 13.7 per cent had used drugs recently; and
- 7.7 per cent reported current drug use.

The most commonly reported drug across all recall periods was cannabis followed by solvents, and cocaine (Table 2.11). Prevalence of any drug use is lower than in England largely due to lower levels of cannabis and volatile substance use. However, use of stimulants such as cocaine, amphetamines and ecstasy are similar or higher. It must be noted that the survey in England includes 11 year olds, which may affect comparability.

Gender

There were no significant differences between males and females in the various drug prevalence rates across all recall periods.

⁴³ The TellUs2 survey was a survey of children and young people across England, asking about their views about their local area and including questions covering the five Every Child Matters outcomes. 111,325 responses were received from children in Year 6, 8 and 10. Only those in Year 8 and Year 10 answered questions on drug use.

Table 2.11: Percentage of pupils reporting use of individual drugs in the last month, in the last year and in lifetime, by gender in Northern Ireland, 2007

	Lifetime use			Last Year use			Last Month use		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug	19.4	19.3	19.3	13.7	13.8	13.7	8.0	7.4	7.7
Amphetamines	1.6	2.0	1.8	1.0	1.1	1.0	0.4	0.4	0.4
Cannabis	10.0	8.7	9.3	7.3	6.6	6.9	4.3	3.4	3.9
Cocaine	3.2	4.2	3.7	2.6	2.9	2.7	1.4	1.2	1.3
Cocaine powder	2.1	3.2	2.6	1.6	2.2	1.9	1.0	0.8	0.9
Crack cocaine	1.3	1.9	1.6	1.1	1.2	1.1	0.6	0.6	0.6
Ecstasy	2.8	3.0	2.9	2.2	2.4	2.3	1.1	1.3	1.2
LSD	1.3	2.0	1.6	0.8	1.1	1.0	0.4	0.5	0.4
Magic mushrooms	1.6	1.0	1.3	0.9	0.6	0.7	0.4	0.3	0.3
Opiates	0.9	1.3	1.1	0.7	0.6	0.6	0.4	0.3	0.4
Solvents	8.5	8.6	8.5	4.6	4.6	4.6	2.4	2.1	2.3
Base	1,664	1,558	3,225	1,664	1,558	3,225	1,664	1,558	3,225

Source: Standard Table prepared for United Kingdom Focal Point

Age of first use

Fifty-six per cent of those who had ever used cannabis started at age 13 or 14 with 14 per cent first using cannabis at age 12 and less than ten per cent reporting cannabis use at a younger age (NISRA 2008b). Almost a third (32%) of pupils first tried solvents before the age of 12 while the majority of cocaine powder users (70%) first used the drug at age 14 or older.

Frequency of cannabis use

Forty-one per cent of pupils who reported lifetime use of cannabis do not use any more, 24 per cent do so rarely and nine per cent used cannabis a few times a year. Twenty-six per cent used cannabis at least a few times a month with five per cent reporting daily cannabis use.

2.4.3 Scotland

Health Behaviour in School-aged Children Survey – cannabis use

Results from the 2006 Health Behaviour in School-aged Children (HBSC) Survey have been published (Currie *et al.* 2008).⁴⁴ Twenty-eight per cent of 15 year olds and seven per cent of 13 year olds reported lifetime use of cannabis. Twenty-two per cent of 15 year olds and five per cent of 13 year olds reported recent cannabis use with 13 per cent and three per cent reporting current use respectively.

Frequency of use

Fifteen year old pupils were asked about the frequency of cannabis use. The survey found that:

- eight per cent can be classified as 'experimental'⁴⁵ users;
- 10 per cent can be classified as 'regular' users; and
- three per cent can be classified as 'heavy' users.

Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)

Results from the 2006 SALSUS were reported in the 2007 Focal Point Report. Information Services Division (ISD) Scotland is currently commissioning for the 2008 and 2010 surveys. The 2010 survey will have a considerably larger sample than

⁴⁴ The school based survey is administered to a nationally representative sample of 1,500 pupils in each age group; 11 years, 13 years and 15 years. Questions on drug use are asked of 13 year olds and 15 year olds only.

⁴⁵ 'Experimental users' were those who had used cannabis once or twice in the last year; 'regular users' were those who had used cannabis three to 39 times in the last year and 'heavy users' were those who had used cannabis more than 40 times in the last year.

previously (30,000+ compared to 9,000 in 2008) which will be drawn from all schools in Scotland. This will provide estimates at a local level.

2.4.4 Wales

The 2006 HBSC Survey report shows that 32 per cent of girls aged 11 to 16 and 30 per cent of boys aged 11 to 16 reported lifetime cannabis use (WHO 2008). This is higher than in both Scotland and England.

Case and Haines (2008) carried out analysis on the 2003 HBSC Survey in Wales.⁴⁶ Forty-three per cent of pupils aged 11 to 16 years old reported lifetime drug use with 22 per cent reporting recent use. Lifetime drug use was much higher than in the 2003 English school survey but recent use was similar.

2.4.5 Knowledge of drugs amongst young school children

A survey carried out amongst children aged nine to 11 in England and Northern Ireland⁴⁷ found that more than half the children surveyed (56%) could name four or more drugs and this increased with age. Cocaine was the most widely known drug with 71 per cent naming it, 64 per cent naming cannabis and 58 per cent naming heroin. Less than six per cent named speed, solvents and glue and eight per cent named magic mushrooms (Life Education Centres 2008).

2.5 Drug use among specific groups

2.5.1 Armed Forces

Compulsory drug testing in the Armed Forces was introduced by the *Armed Forces Act 1996*.⁴⁸ Around 85 per cent of servicemen and women are tested annually (House of Commons Written Answers, 10th May 2006). The proportion of individuals testing positive for drugs has increased from 0.62 per cent in 2003 to 0.98 per cent in 2007 (Table 2.12), with the Army accounting for the vast majority of positive tests (92.6 per cent). Over the same period, in the British Army there has been a decrease in the proportion of positive tests involving cannabis and a large increase in those involving cocaine; in 2003, 50 per cent of positive tests were for cannabis only and 22 per cent for cocaine only while in 2006, the figures were 31 per cent and 47 per cent respectively. This trend continued in the first half of 2007, with 25 per cent of positive tests for cannabis alone and 49 per cent for cocaine alone (Bird 2007). The proportion of positive tests that are for ecstasy alone has decreased from 20 per cent in 2003 to 12 per cent in the first half of 2007.

⁴⁶ An opportunity sample of 3,088 pupils aged 11 to 16 was drawn from a random sample of 22 secondary schools (10% of all schools in Wales) between September and December 2003.

⁴⁷ The survey was carried out with 1,491 children aged 9 to 11 in England and Northern Ireland in April and May 2008. Thirty schools were originally identified through local contacts and mapped against indices of deprivation to ensure a reasonable spread. Twenty-five returned questionnaires.

⁴⁸ EMCDDA reporting guidelines ask for information on conscripts. There is, however, no conscription (compulsory military service) in the United Kingdom.

Table 2.12: Drug tests and percentage positive in the British Armed Forces, 2000 to 2007

Year	No. tested	No. Positive	% Positive
2000	107,142	760	0.71
2001	96,504	705	0.73
2002	89,585	567	0.63
2003	95,376	594	0.62
2004	88,747	705	0.79
2005	91,711	863	0.94
2006	92,275	844	0.91
2007	74,522	731	0.98

Source: MOD 2006; House of Commons Written Answers, Tuesday 25th March 2008

2.5.2 Ethnic Minorities

Findings from the 2007/08 BCS in England and Wales show that people who described themselves as non-White were significantly less likely to be recent drug users than those who described themselves as White; five per cent compared to 10 per cent. Amongst 16 to 24 year olds the difference is much larger, eight per cent of non-White respondents were recent drug users compared to 23 per cent of White respondents (Hoare and Flatley 2008).

2.5.3 Truants and Excludees

Pupils in England who had ever truanted or been excluded are much more likely to be regular drug users, 14 per cent of truants and excludees reported drug use at least once a month compared to two per cent of other pupils. There has, however, been a decrease in the proportion reporting regular drug use from 21 per cent in 2003 (Fuller 2008).

2.5.4 Health care professionals

Raistrick *et al.* (2008) report on a survey of substance use amongst NHS staff in one NHS Region in England.⁴⁹ Eleven per cent reported recent use of any drug, with use highest amongst nurses (11.6%) and lowest amongst health care assistants (8.8%). Cannabis was the most commonly used drug (8.6%) followed by ecstasy/amphetamines (2.5%) and tranquilisers (1.9%). Opiate use was reported by 0.9 per cent of respondents. The authors report that drug use amongst health care professionals is similar to drug use in the general population.

2.5.5 Lesbians, Gay Men and Bisexuals

A survey of lesbian and bisexual women's health⁵⁰ found that lesbian and bisexual women were five times more likely to report recent drug use than women in general, 30 per cent reported recent use compared to seven per cent in the BCS 2006/07 (Stonewall 2008).

⁴⁹ A cross-sectional survey of health care professionals in Yorkshire Region in England was undertaken. The target sample consisted of qualified nurses and midwives, health care assistants and medical staff working in secondary care services where contact with substance misuse patients is particularly likely. Fifteen wards or departments were randomly selected from the six health authorities and all staff asked to complete a questionnaire. A total of 2,716 staff were targeted, 1,141 (42%) responded and 1,116 included their profession.

⁵⁰ In the summer of 2007, 6,178 lesbian and bi-sexual women in England, Scotland and Wales responded to an online and paper survey on their health needs and experiences. The age range of respondents was 14 to 84.

Questions on drug use are included every two years in the Gay Men's Survey. Results from the 2005 survey were published in the Focal Point's 2007 Annual Report. A survey was carried out in 2007 and will be published in Spring 2009.

2.5.6 Looked after children

In 2006, the Department for Children, Schools and Families (DCFS) (formerly the Department for Education and Skills) started collecting information on the number of looked after children identified as having a substance misuse problem. Of the 44,200 children looked after for at least 12 months in the year ending 30th September 2007, 2,400 (5.4%) were identified as having a substance misuse problem (DCSF 2007). This is a slight increase from 5.1 per cent in 2006.

2.6 Attitudes to and reasons for drug use

The 2007 school survey in England found that 10 per cent of pupils think it is "okay to try cannabis to see what it's like" with six per cent believing it's okay to use cannabis once a week (Fuller 2008). Older pupils were more likely to think cannabis use was okay, 23 per cent of 15 year olds thought it was okay to try, and 13 per cent to use weekly. Only three per cent thought trying cocaine was okay compared to four per cent in 2003 despite an increase in use over the same period.

Fifty-five per cent of pupils who had ever taken drugs said they did so on the first occasion to see what it was like, 18 per cent said they wanted to get high or feel good and 17 per cent said because their friends did. Of those who had used drugs recently and on more than one occasion, 43 per cent said they did so because they wanted to get high or feel good, with 29 per cent saying they wanted to see what it was like and 21 per cent saying they had nothing better to do.

2.7 Relationship with other indicators and trends in a wider context

Consistency between indicators is discussed in the introductory section of this report and the relationship between general prevalence data, treatment demand data and problem drug use estimates is discussed in Section 4.6.

3. Prevention

3.1 Overview

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

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

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

Communities are provided with assistance to build the capacity to resist drugs, through a range of initiatives which are delivered by local partnerships. There are specific interventions targeting young people in deprived communities, for example, Positive Futures. In Scotland, a number of projects receive time limited funding from the Scottish Government in partnership with Lloyds TSB Partnership Drugs Initiative (PDI)⁵¹, targeting children with, or at risk of, problem drug misuse, as well as those affected by familial drug use.

Increasingly, family interventions are being set up, more specifically for problem drug users, to help support parenting, and therefore reduce the risk of drug use amongst their children, but also with wider objectives (see Chapter 9).

⁵¹ See: <http://www.ltsbfoundationforscotland.org.uk/index.asp?tm=16&cookies=True>

3.2 Prevention Strategy

3.2.1 New drug strategies

Drugs: Protecting Families and Communities continues its commitment to prevention of drug use, particularly amongst the young (HM Government 2008a). A key aim is to reduce the numbers of young people that start using drugs, with a commitment to expand drug prevention work to encompass younger people and families before they have problems. Prevention will also focus on legal substances such as alcohol as well as volatile substance abuse. The Government has pledged to strengthen the evidence base regarding the risk factors associated with substance misuse and the most effective interventions (HM Government 2008b).

The Scottish Government's drug strategy, *The Road to Recovery: a New Approach to Tackling Scotland's Drug Problem* is based on the premise that prevention of drug use is preferable to the treatment of problem drug use at a later stage. Provision of drugs information and effective communication, with the general public and young people in particular, is seen as a vital component. Importance is also placed on early interventions and the Scottish Government is to develop an *Early Years Framework* in order to help the development of children and provide integrated support services. It also suggests that wider policies, currently under development, such as a new Economic Strategy are also necessary in order to have an impact on prevention (Scottish Government 2008a).

The Welsh substance misuse strategy, *Working Together to Reduce Harm: the Substance Misuse Strategy for Wales 2008-2018*, also identifies prevention as a key area with a continued focus on education, and early interventions for the most at-risk children (Welsh Assembly Government 2008a).

3.3 Universal prevention

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

3.3.1 Universal prevention campaigns

Drugs: Protecting families and communities states that its communications will highlight the consequences and damage that can result from substance use and that it will send out the message that drug use is "unacceptable". It aims to develop communication and education campaigns that involve the community, young people and families (HM Government 2008a).

FRANK

The FRANK campaign has now been running for five years and the Government has stated its continued commitment to it (HM Government 2008a). Following on from last year's 'Brain Warehouse' cannabis campaign⁵², which was reported to have reached 67 per cent of young people and 56 per cent of adults through its television adverts (Home Office 2007b)⁵³, it has recently launched a €1.5 million (£1m) multi-

⁵² The 'Brain Warehouse' advert was launched in October 2006. The 'Brain Warehouse' theme was carried through online and with advertising on bus shelters and in buses. The TV advert accompanied several radio adverts that carried a mix of cannabis related messages. See: <http://www.brainwarehouse.tv/>

⁵³ During February and March 2007 a total of 1607 face-to-face interviews were conducted with 471 parents of 11 to 18 year olds and 1226 young people aged between 11 and 24.

media campaign aimed at tackling cocaine powder use.⁵⁴ This includes the publication of an information leaflet aimed at 15 to 18 year olds to raise awareness of the health and ethical issues surrounding cocaine powder use. It forms part of a wider government initiative specifically focusing on the drug and is part of the *Shared Responsibility*⁵⁵ campaign involving the Colombian government. In addition to highlighting the personal and social consequences of cocaine powder consumption, the campaign also has an ethical component, focusing on the effects cocaine production has on the environment, such as the clearing of rainforests and pollution, as well as the human rights issues that it raises.

FRANK has also produced a series of information materials in partnership with the Mentoring and Befriending Foundation including a pocket sized card entitled *Safety First: Advice Card* for mentors and befrienders⁵⁶, containing advice on what to do in an emergency, such as how to place someone in the recovery position. There are also information materials aimed at professionals who are involved in mentoring and befriending projects with young people.

In Northern Ireland, the Health Promotion Agency⁵⁷ has re-published a series of drug awareness leaflets and booklets originally released in 2006. The campaign includes a booklet entitled 'Your body, your life, your choice' aimed at 14 to 17 year olds. It provides information on different types of drugs and their effects, health risks, the law and contact details for the national drugs helpline. A leaflet aimed at 11 to 13 year olds has also been re-issued. Other communication materials recently re-released include a safer clubbing leaflet and leaflets aimed at parents containing drugs and solvents information.

In its new drug strategy, the Scottish Government has stated its continued commitment to fund and further develop the Know The Score communication campaign. A key aim of the strategy is that no-one should be ignorant of the consequences of drugs and that the necessary, factual information regarding drugs should be available so that individuals can make informed choices. It goes on to say that this information should also be readily available for family members such as parents and grandparents so that they can engage in well-informed dialogues about drugs with younger members of the family (Scottish Government 2008a).

In Wales, the Welsh Assembly Government continues to fund its own bilingual (Welsh and English) Drug and Alcohol Helpline, DAN 24/7, which is formally hosted by the North Wales Mental Health Trust, through its call centre facility. The helpline is structured to provide a range of advice, guidance and information relevant to the context of the caller's needs. The past 12 months has seen a 50 per cent growth in calls with a growing trend linked to families and partners seeking advice.

As part of the Welsh Assembly Government's new strategy, campaigns linked to the promotion of the Helpline are to be introduced throughout the year with an emphasis on young people, advice associated with festivals, prisoners and their families, and how best to access treatment. A target figure has been set to double the call volume for 2008/09. These campaigns, allied with a range of leaflets and posters will also use web-based technology, texting and news-media to promote the helpline and its purpose. The underlying ethos of the helpline is to make access to information easy,

⁵⁴ See: <http://drugs.homeoffice.gov.uk/publication-search/frank/cocaine?view=Binary>

⁵⁵ See: <http://www.sharedresponsibility.gov.co/>

⁵⁶ See: <http://drugs.homeoffice.gov.uk/publication-search/frank/safetyfirst?view=Standard&pubID=546481>

⁵⁷ See: <http://www.healthpromotionagency.org.uk/work/Drugs/publications.htm>

simple and clear. In partnership with the service provider, the Welsh Assembly Government will be enhancing the skills of the call centre staff in order to equip them with the capacity to offer direct advice associated with safe drug and alcohol use and how best to get help when problems begin to arise (internal communication from the Welsh Assembly Government).

3.3.2 School

Review of drugs education in England

A Department for Children, Schools and Families (DCSF) review of drugs education in England is currently in progress and once it is complete it is anticipated that the FRANK campaign will be developed to complement any changes made to drugs education in schools (HM Government 2008a).

Blueprint Drug Education Research Programme

A research report into the delivery of the Blueprint Drug Education Research Programme was published in November 2007. In the report, the programme was assessed to establish if the different Blueprint components (namely: schools; parents; media; health policy; and community) were delivered as originally intended and to identify the factors that had a positive or negative influence on delivery. It was found that delivery against the planned programme varied across the components. Delivery of the parent component was not as originally intended and only partially met the aim; the coverage from the media component reached between a fifth and a quarter of young people and parents respectively. However, the majority of the school based lessons were delivered according to the original content and methods (Stead *et. al* 2007). A further report aimed at practitioners and teachers has been published (Stradling *et. al* 2007). An impact report is expected in late 2008.

Drug, alcohol and tobacco education in schools in Scotland

Scotland is currently undertaking a programme of education reform as part of the *Curriculum for Excellence* programme. Guidance on teaching and learning around substance misuse forms part of the *Health and Wellbeing* learning outcomes and experiences, released in draft in May 2008 as part of Curriculum for Excellence.⁵⁸

Substance Misuse Education Steering Group

The Welsh Assembly Government will establish a national substance misuse education steering group of experts and key stakeholders to monitor the delivery of this element of the new substance misuse strategy. The group will oversee the further development of substance misuse education, prevention and advice provision in schools and other educational settings (Welsh Assembly Government 2008a).

All Wales School Liaison Core Programme

The *All Wales School Liaison Core Programme* is delivered in partnership between the police and schools to mainstream pupils in education. It became fully operational in 2004. A second external evaluation of the programme was undertaken in 2007 (Markit Training and Consultancy Ltd. 2007). It assessed pupils on eight specific criteria using a model adapted from police training programmes, called KUSAB (considering pupils' knowledge, understanding, skills, attitudes, behaviour, continuity and progression, coherence, and enjoyment of the substance use related education delivered within the programme) to give an indication of the knowledge and understanding gained as they experience it. The results found that pupils' knowledge and understanding of the subject matter had increased and that in general they

⁵⁸ For more information see Learning and Teaching Scotland, which is funded by the Scottish Government and is the main organisation for the development of the Scottish curriculum, including Curriculum for Excellence: <http://www.ltscotland.org.uk/aboutLTS/>

enjoyed the lessons. Teachers were also generally positive about the programme. However, the evaluation was unable to quantify the programme in terms of its impact on pupils' attitude and any future behaviour change.

To achieve greater effectiveness, the programme has been extended in order to develop positive relationships with pupils that have the potential for disengagement, whilst maintaining the commitment to mainstream pupils. The Disengaged Element of the Programme was successfully piloted in five youth crime 'hot spot' areas and will now be introduced out across Wales. The client groups are from Pupil Referral Units or from units within mainstream schools, at each key stage, for children with educational and social behavioural difficulties, although some groups include pupils with special educational needs.

It is of note that the United Kingdom Drug Policy Commission argues that generally, the evidence for drug education as a strategy for reducing drug use is weak, which makes evaluation of outcomes (including unintended consequences) from schemes especially important. It suggests that the final impact report from the Home Office's Blueprint drug education pilot, together with the long-term evaluation of outcomes of the *All Wales School Liaison Core Programme* will help the further development of secondary school programmes (UKDPC 2008b).

Attitudes towards drugs education in schools

The English school survey

Nearly two thirds (61%) of secondary pupils in England aged 11 to 15 surveyed in 2007 (see Chapter 2 for more details) recalled having received lessons about drugs in the last year, a similar figure to previous years (Fuller 2008). Older pupils were more likely to recall having had such education (72% of Year 10 pupils compared to 46% of Year 7 pupils). Most pupils who remembered the lessons reported that they had helped them: think about the risks associated with drugs (95%); find out more about drugs (90%); learn that drugs are illegal (84%); and avoid drugs (80%) or think what to do if they were offered them (77%). Just over a third (39%) of pupils thought that the lessons showed them that less young people than they thought took drugs and it is reported that most pupils had a quite accurate knowledge of how many people of their age actually take drugs.

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

Northern Ireland Young Persons' Behaviour and Attitudes Survey

In Northern Ireland the 2007 Young Persons' Behaviour and Attitudes Survey (NISRA 2008a) (See Chapter 2 for more details) included questions regarding the type of drugs education (for example, talks/lessons, packs, leaflets, drama workshops, television advertisements) they have received in the past twelve months and where they received it. School was the most popular response with 76 per cent of pupils responding that they received it there, a fifth had received it at a youth facility (such as a youth club or community centre), 17 per cent said 'somewhere else' and 15 per cent had not received it in any of these locations. Pupils were also asked whether the education that they had received made them less inclined to take drugs. Of those who responded, 91 per cent said 'yes'.

3.3.3 Family

The new United Kingdom Drug Strategy proposes to take a whole family approach to drug prevention. It aims to ensure assessments for treatment take the needs of the family into account and that additional parenting support will be provided alongside drug treatment, including the targeting of drug misusers who have children (and their partners) by 'Family Intervention Projects'⁵⁹ which will be developed with parenting experts. The Government has placed the early identification of at-risk children and families and the provision of suitable interventions as a priority and aims to provide a more focussed approach to the needs of the family as a whole and a tailored support service. A package of interventions is proposed including parenting skills; drugs education for children; family support to help them stay together; addressing other problems; support for kinship carers and in some cases, intensive interventions (HM Government 2008a).

Early intervention and therefore prevention of more serious problems, is also an aim of drug courts (see Chapter 9.2.5).

3.3.4 Community

In Scotland the Government proposes to fund sporting, cultural and arts based activities, aimed at young people from communities affected by crime, with money recovered through the *Proceeds of Crime Act 2002* (Scottish Government 2008a). Funding will be targeted at areas with high crime and anti-social behaviour although the activities will be open to all children and young people. The aim is to engage young people to engage in participatory and diversionary activities in order to increase their chances of gaining positive long-term outcomes. Around 30,000 young people across Scotland will be offered free football coaching and playing opportunities, as part of the '*CashBack for Communities*' programme funded from the proceeds of crime.⁶⁰

Muslim Youth Involvement Project

Mentor UK has commissioned the Right Start International Foundation to run the Muslim Youth Involvement Project⁶¹ in England, which will seek the views of young Muslims aged between 12 to 18 years old living in Birmingham and Tower Hamlets, London. The aim of the project is to produce a drug prevention toolkit that can be used by agencies who are seeking to involve young Muslims. The project aims to develop the skills, confidence, well-being and self esteem of young Muslims by engaging with them, gathering their views and providing them with training in areas such as group work and communication; drugs prevention; health promotion and community participation. The project will also include activities, such as treasure hunts, sports and visits to the Houses of Parliament, which relate to the training and will allow participants to enhance their skills and put theory into practice.

Mentor UK Youth Involvement Project

The Youth Involvement Project⁶² has been running since 2005 engaging with young people aged 12 to 20 from England and Wales regarding their opinions on drugs. In previous years they have provided input into drugs policy and guidance such as

⁵⁹ See:

http://www.respect.gov.uk/uploadedFiles/Members_site/Documents_and_images/Supportive_interventions/FIP_Respect_Projects_0026.pdf

⁶⁰ For more information see: <http://www.scotland.gov.uk/News/Releases/2008/05/14143627>

⁶¹ See: <http://drugeducationforum.wordpress.com/2008/01/31/muslim-youth-involvement-project/>
<http://drugeducationforum.wordpress.com/2008/01/31/muslim-youth-involvement-project/>

⁶² See: <http://www.mentorfoundation.org/projects.php?pg=1&id=103>

community based interventions to reduce substance misuse amongst vulnerable and disadvantaged young people (NICE 2007a).

3.4 Selective prevention

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

3.4.1 At risk groups

Targeted Youth Support and Youth Taskforce Action Plan

Key actions in Drugs: Protecting Families and Communities include the development of local, integrated drug prevention initiatives with vulnerable young people through *Targeted Youth Support*.⁶³ This will be jointly managed by the Home Office and the DCSF. A local focus will be encouraged in order to reduce the proportion of young people regularly using drugs. Activities such as Positive Futures will continue and actions from the *Aiming High for Young People*⁶⁴ strategy (HM Treasury 2007b) will be implemented in order to reduce the risk factors that are associated with drug misuse (HM Government 2008b).

The DCSF has launched its *Youth Taskforce Action Plan*⁶⁵ in England and has asked 52 local areas to bid for funding to support delivery of the plan. Around €19 million (£13m) in funding will be available to help deliver 'Challenge and Support' projects, an early intervention to stop future offenders at the first sign of problems such as truancy, bad behaviour in school or contact with the police. Whilst a key objective of the project is to stop antisocial behaviour (ASB) by way of enforcement and support, it also aims to address the causes of ASB by utilising Individual Support Orders (ISOs)⁶⁶ alongside Anti-Social Behaviour Orders (ASBOs⁶⁷). Whilst an ASBO requires the young person to refrain from acting in a certain way, an ISO also requires a young person to get help to tackle the cause of their behaviour; including drug or alcohol treatment or supervision by a Youth Offending Team worker. If they fail to take that help they face a criminal record and a fine up to €1,500 (£1,000). Also, as part of the *Youth Taskforce Action Plan*, a targeted intensive (non-negotiable) intervention will be applied to a thousand of the most 'challenging' young people, whereby they will agree to a contract and a support worker assigned to them will ensure that they get the required help to tackle their behaviour. In cases of bad behaviour related to substance misuse, drug treatment would be made available.

Evaluation toolkit

The Centre for Public Health⁶⁸ at Liverpool John Moores University has developed a toolkit for practitioners to help them self-evaluate their drug prevention services. It

⁶³ For more information see: <http://www.everychildmatters.gov.uk/resources-and-practice/IG00206/>

⁶⁴ See: http://www.hm-treasury.gov.uk/media/2/6/cyp_tenyearstrategy_260707.pdf

⁶⁵ The Youth Taskforce was established in October 2007 to take the work of the Respect programme to the next stage and put an even greater focus on the twin track approach to promote earlier intervention and more positive activities for young people.

⁶⁶ ISOs can be attached to an ASBO on a young person and contain positive obligations which are designed to tackle the underlying causes of a young person's antisocial behaviour. ISOs can last for up to six months.

⁶⁷ An ASBO is a civil order that is placed upon an individual in order to protect the public from harassment, alarm or distress. They usually contain conditions that prohibit an individual from entering a defined area and/or acting in a specified anti-social manner and are effective for at least two years. See:

<http://www.crimereduction.homeoffice.gov.uk/antisocialbehaviour/antisocialbehaviour55.pdf>

⁶⁸ See: <http://www.cph.org.uk/substanceuse/index.aspx?teamid=23>

has been designed to contain all the tools required by practitioners, managers and researchers to evaluate services that either they or others provide. The toolkit was piloted by a number of services and is currently being developed into an online version. Building on this work, a further resource aimed at academics and/or evaluators at a postgraduate level is also under development.

Inspiring Scotland

Lloyds TSB Foundation for Scotland (a partnership between Government, trusts and foundations, businesses and charities) have developed a new initiative, *Inspiring Scotland*⁶⁹ with funding and services provided for Scotland's most vulnerable people. Although it is currently managed by the Lloyds TSB Foundation it is anticipated that this initiative will in the future become a separate legal entity.

Also, in Scotland, €4.4 million (£3m) will fund additional projects supporting at-risk young people and over €2 million (£1.4m) will fund free rugby coaching and playing activities for over 30,000 young people throughout the country by 2011. An additional €877,000 (£600,000) will go to the *CashBack for Communities Arts and Business Match Fund* which will be used to support cultural activities for vulnerable youngsters. Arts and Business Scotland are encouraging Scottish businesses to match every €1.46 (£1) of government investment, in order to double the funding available and thereby releasing a minimum of €1.75 million (£1.2m) over the next two years.

High Focus Areas

An evaluation of some of the prevention initiatives working in High Focus Areas⁷⁰ has been carried out by the Centre for Public Health at Liverpool John Moores University. The final report was submitted to the Department of Health in May 2008.

3.4.2 At risk families

There are a number of generic early interventions for families and/or children, including those families where parental substance misuse is seen as placing children at risk (see Chapter 9.2.4).

3.5 Indicated prevention

These interventions are designed to prevent the onset of problem drug use in individuals who already are experiencing early signs of substance abuse and other problem behaviours, including children at risk of individually attributable risk factors such as Attention Deficit Hyperactivity Disorder (ADHD).

NICE: Clinical guideline for ADHD interventions

The National Institute for Health and Clinical Excellence (NICE) is developing clinical practice guidelines for pharmacological and psychological interventions in children, young people and adults affected by attention deficit hyperactivity disorder in England and Wales. A consultation period on the draft guideline⁷¹ closed at the end of March 2008 and the final guideline is due for publication in late 2008.

⁶⁹ See: <http://www.inspiringscotland.org.uk/>

⁷⁰ The High Focus Area (HFA) Initiative was launched in England in April 2005, as part of a joint strategy between the Home Office, the Department for Education and Skills and the Department of Health, in 30 local authority areas to support faster and sustained progress in implementation of universal, targeted and specialist services as set out in strategic guidance *Every Child Matters: Young People and Drugs*, and to learn from their experience. The areas were selected on the basis of local need and levels of current service provision, including deprived/high crime areas where drug misuse problems are prevalent.

⁷¹ See: <http://www.nice.org.uk/nicemedia/pdf/ADHDConsFullGuideline.pdf>

4. Problem drug use

4.1 Overview

Estimates of problem drug use in the United Kingdom reflect the drugs identified as problematic and the methodology used.⁷² Latest estimates for England are for 2005/06, for use of opiates and/or crack cocaine (332,090), with additional estimates for opiate use (286,566), crack cocaine use (197,568), and drug injecting by users of opiates or crack cocaine (129,977). In Northern Ireland latest estimates are for 2004 for opiate and/or cocaine (including crack cocaine) use (3,303), with, also, an estimate for opiate use (1,395). In Scotland the latest estimate is for 2003, for opiate and/or benzodiazepine use (51,582). There are no recent estimates for Wales. Based on these, it is estimated that there are 403,547 problem drug users in the United Kingdom, and 156,398 injecting drug users (primarily of opiates or crack cocaine).⁷³

The Treatment Demand Indicator (TDI)⁷⁴ measures presentations to structured drug treatment services by drug users; data are provided for those in contact with general practitioners, outpatient (community-based drug services) and inpatient services. Numbers presenting have increased substantially over the previous few years but appear to have stabilised in this latest reporting year. Latest combined data for the United Kingdom are for 2006/07 when there were 128,208 new demands for treatment, a small decrease from the previous year (128,446). Where type of drug is known (in 95% of cases), opiates, mostly heroin, were the main primary drug reported (64%, n = 77,849). Cannabis was the second most reported primary drug (16%, n = 19,108), and crack cocaine and cocaine powder accounted for seven per cent (8,372) and six per cent (7,096) respectively of primary drug reported. The actual number of presentations for opiates as main drug stabilised in 2006/07, having increased in the previous year. The same trend can be seen in presentations for primary crack cocaine, however when any use of crack cocaine is considered (not only as primary drug) there has been a much steeper rise in presentations, with 24 per cent of new presentations reporting use. Similarly with cocaine powder, where there has been a continued rise in presentations with 13 per cent reporting any use of it in 2006/07. Presentations for cannabis have increased over time, and continue to do so, now representing nearly a quarter of first ever presentations (24%, n = 11,325).⁷⁵ Current injecting was reported by 25 per cent; 50 per cent report having never injected. Forty-one per cent were aged between 25 and 34. Amongst those presenting to treatment these characteristics have changed little over recent years.

4.2 Prevalence and incidence estimates of PDU

There is no information on incidence of PDUs.

⁷² These are based on the capture-recapture method where possible, and where not, by the multiple indicator method.

⁷³ Estimates of injecting drug users are based on England estimates for opiate and/or crack injectors.

⁷⁴ The TDI is one of the five epidemiological indicators established by EMCDDA to monitor the drug situation in the European Union. Currently it provides a measure of those presenting to treatment, for the very first time, or for the first time within the year. It does not include those who are already in treatment in that year. It can therefore best be described as a measure of treatment incidence.

⁷⁵ This could, in part be attributed to improved data reporting by young person's drug services.

4.2.1 Prevalence estimates for England for 2005/06

New estimates of the prevalence of problem drug use in England for 2005/06, nationally, and regionally, are from the second yearly sweep of a three-year project (Hay *et al.* 2007). Estimates are for opiate and/or crack cocaine users, opiate users, crack cocaine users and injectors who use opiates and/or crack cocaine (Table 4.1). There were an estimated 332,090 problem drug users, a rate of 9.97 per thousand population aged 15 to 64; an estimated 286,566 opiate users, a rate of 8.60 per thousand population; an estimated 197,568 crack cocaine users, a rate of 5.93 per thousand population; an estimated 129,977 injectors who use opiates and/or crack cocaine, a rate of 3.90 per thousand population. These suggest that national prevalence estimates for problem drug use have remained stable across the two years. As in the previous sweep these latest estimates show marked variation in prevalence rates across Government Regions as well as distinct differences in prevalence by gender (Table 4.2) and age (Table 4.3).

Table 4.1: Problem drug user estimates and rates per 1,000 population aged 15 to 64 in England, 2005/06

	Estimate	95% Confidence Interval	Rate	95% Confidence Interval
Opiate and/or crack cocaine users	332,090	324,546 – 346,345	9.97	9.74 – 10.40
Opiate users	286,566	281,668 – 299,394	8.60	8.46 – 8.99
Crack cocaine users	197,568	190,786 – 208,322	5.93	5.73 – 6.25
Injecting drug users	129,977	125,786 – 137,034	3.90	3.78 – 4.11

Source: Hay *et al.* 2007

Regional differences

London had the highest prevalence of problem drug users, followed by Yorkshire and Humber and then the North West, although for opiate users and for injecting opiate and/or crack cocaine users Yorkshire and Humber was higher than London. Compared to other areas crack cocaine use was exceptionally high in London. The East of England followed by the South East had the lowest prevalence estimates for all types of drug users (Hay *et al.* 2007).

Gender

The male to female ratio of problem drug users was 3.3:1 (Table 4.2).

Table 4.2: Prevalence rate per 1,000 population of opiate and/or crack cocaine users by gender in England, 2005/06

Female			Male		
Rate	95% CI		Rate	95% CI	
4.64	4.61	4.99	15.32	14.86	15.87

Source: Hay *et al.* 2007

Age

The highest prevalence of problem drug was amongst those in the 25 to 34 age group (Table 4.3).

Table 4.3: Prevalence rate per 1,000 population of opiate and/or crack cocaine users by age group in England, 2005/06

Age								
15 to 24 years			25 to 34 years			35 to 64 years		
Rate	95%CI		Rate	95% CI		Rate	95% CI	
10.07	9.85	10.66	21.43	20.76	22.24	6.10	5.96	6.39

Source: Hay *et al.* 2007

Trends

The prevalence estimates per thousand population changed from 9.93 in 2004/05 to 9.97 per thousand in 2005/06, this is not statistically significant. There was no change in prevalence of opiate use and of crack cocaine use. However, there was a statistically significant reduction in the prevalence of injectors of opiates and/or crack cocaine; the rate per thousand falling from 4.16 in 2004/05 to 3.90 in 2005/06.

At the regional level there were no significant changes in problem drug use between 2004/05 and 2005/06 in estimated prevalence rates for all problem drug users, nor was there a significant change to the estimated prevalence of crack cocaine use (Hay *et al.* 2007). There was, however, a significant reduction in the prevalence of opiate use in the South West region and in injecting of opiates and/or crack cocaine in the North East and the West Midlands.

4.2.2 Estimates of problem drug use in the United Kingdom

Estimates of problem drug use provided by the United Kingdom Focal Point are based on the latest available research in the four countries (Hay *et al.* 2004; Hay *et al.* 2006a; Hay *et al.* 2006b; Hay *et al.* 2007). These suggest an overall prevalence of 403,547 problem drug users, a rate of 10.19 per thousand population (Table 4.4) and 156,398 injecting drug users (predominantly of opiates and crack cocaine), a rate of 3.95 per thousand population (Table 4.5).

Table 4.4: Estimates of problem drug use in the United Kingdom: number and rate per 1,000 population

Country	Estimate	95% Confidence Interval		Rate	95% Confidence Interval	
England	332,090	324,546	346,345	9.97	9.74	10.40
Northern Ireland	1,395	1,316	1,910	1.28	1.21	1.75
Scotland	51,582	51,456	56,379	15.39	15.35	16.82
Wales	18,480	18,060	19,273	9.97	9.74	10.40
<i>United Kingdom*</i>	<i>403,547</i>	<i>395,378</i>	<i>423,907</i>	<i>10.19</i>	<i>9.98</i>	<i>10.70</i>

*Based on estimates of opiates and/or crack cocaine use in England for 2005/06, opiate use in Northern Ireland for 2004, and problem drug use in Scotland, 2003. Estimates for Wales are extrapolated from England estimates.

Source: Standard Table prepared for the United Kingdom Focal Point

Table 4.5: Estimates of injecting drug use in the United Kingdom: number and rate per 1,000 population

Country	Estimate	95% Confidence Interval		Rate	95% Confidence Interval	
England	129,977	125,786	137,034	3.90	3.78	4.11
Northern Ireland ⁷⁶	451	515	748	0.41	0.47	0.69
Scotland	18,737	17,731	20,289	5.59	5.29	6.05
Wales	7,233	7,000	7,625	3.90	3.78	4.11
<i>United Kingdom*</i>	<i>156,398</i>	<i>151,032</i>	<i>165,696</i>	<i>3.95</i>	<i>3.81</i>	<i>4.18</i>

*Based on estimates of injecting of opiates and/or crack cocaine in England for 2005/06, opiate and/or problem cocaine use in Northern Ireland for 2004, and injecting drug use in Scotland, 2003. Estimates for Wales are extrapolated from England estimates. Injecting estimates for Northern Ireland assume the same proportion injecting as England.

Source: Standard Table prepared for the United Kingdom Focal Point

Trends in prevalence of problem drug use

Table 4.6 shows estimates provided over time; the dates refer to the year the estimate was produced rather than the year the estimate refers to.⁷⁷ Table 4.7 shows estimates for injecting drug use; again increases may reflect improved methodology rather than increased prevalence.

Table 4.6: Estimates of problem drug use: number and rate per 1,000 population, aged 15 to 64 in the United Kingdom

Year of estimate	Estimate	95% confidence interval		Rate	95% confidence interval	
2004*	360,811			9.34	8.99	9.79
2006**	357,160	344,263	375,615	9.26	8.92	9.73
2007***	398,845	397,033	421,012	10.15	10.11	10.72
2008****	403,547	395,378	423,907	10.19	9.98	10.70

* Based on estimates of problem drug in England for 2001 (Frischer *et al.* 2004), problem drug use in Northern Ireland for 2000 (McElrath 2002), and problem drug use in Scotland, 2000 (Hay *et al.* 2001). Estimates for Wales are extrapolated from England estimates.

** Based on estimates of problem drug in England for 2001 (Frischer *et al.* 2004), problem drug use in Northern Ireland for 2000 (McElrath 2002), and problem drug use in Scotland, 2003 (Hay *et al.* 2004). Estimates for Wales are extrapolated from England estimates.

*** Based on estimates of opiates and/or crack cocaine use in England for 2004/05 (Hay *et al.* 2006a), opiate and/or problem cocaine use in Northern Ireland for 2004 (Hay *et al.* 2006b), and problem drug use in Scotland, 2003 (Hay *et al.* 2004). Estimates for Wales are extrapolated from England estimates.

**** Based on estimates of opiates and/or crack cocaine use in England for 2005/06 (Hay *et al.* 2007), opiate and/or problem cocaine use in Northern Ireland for 2004 (Hay *et al.* 2006b), and problem drug use in Scotland, 2003 (Hay *et al.* 2004). Estimates for Wales are extrapolated from England estimates.

Source: Hay 2004; Hay 2006; Hay 2007; Hay 2008

Table 4.7: Estimates of number of injecting drug users and rate per 1,000 population, aged 15 to 64, United Kingdom

Year of estimate	Estimate	95% confidence interval		Rate	95% confidence interval	
2004	123,498			3.20	3.07	3.34
2006	117,722	116,343	120,472	3.05	3.01	3.12
2007	164,036	158,881	178,614	4.18	4.04	4.55
2008	156,398	151,032	165,696	3.95	3.81	4.18

Source: Hay 2004; Hay 2006; Hay 2007; Hay 2008

⁷⁶ This table makes the assumption that Northern Ireland shows the same proportion of injecting amongst the drug using population. This assumption may not be entirely appropriate and therefore the rate of injecting should not be used in isolation. However, it is an appropriate assumption for the United Kingdom given the size of the confidence interval.

⁷⁷ For more information on these estimates see previous United Kingdom Focal Point reports.

4.2.3 Problem drug use falling outside the EMCDDA definition

There are no estimates of problem use other than those referred to above. It is however of note that information obtained through the Drug Treatment Outcomes Study (DTORS), reported in 4.3.3 below, shows that 25 per cent of clients entering treatment in England had used unprescribed benzodiazepines in the four weeks prior to entry.

4.2.4 Problem drug use for which estimates are not available

The capture-recapture method has been used to estimate the prevalence of problem drug use within the United Kingdom. Different studies employ different case definitions, partly to satisfy the policy need for certain estimates, but primarily to reflect the availability of suitable data. A key assumption of the capture-recapture method is that it is applied to homogeneous groups of drug users. Typically, heroin users, or heroin and/or crack cocaine users show a similar pattern of contact with treatment services and their involvement with criminal justice services is also relatively similar. This is not the case for cocaine powder users, where it is difficult to differentiate (particularly in criminal justice data sources) between people who use cocaine powder problematically and those that use cocaine powder on an occasional or recreational basis. Thus, it has not been possible to include problem cocaine powder use in PDU estimates for the United Kingdom (apart from in the specific case of Northern Ireland, where the nature and extent of drug use is known to vary significantly from the rest of the United Kingdom). The prevalence estimates for England include crack cocaine use, and with the comparatively low levels of crack cocaine use found in previous studies in Scotland, it is felt that this estimate is sufficient as a proxy for the United Kingdom.

4.3 Treatment Demand Indicator

In 2006/07, 128,208 presentations to treatment services were recorded through the Treatment Demand Indicator (TDI); showing a very small decrease from the previous year (128,446). Of known cases, 44 per cent (47,165)⁷⁸ concerned drug users who sought treatment for the first time ever, a slight reduction from 2005/06 (49,625); in Northern Ireland first treatments accounted for a much greater proportion, (67%) of treatment presentations (such presentations accounted for 72% in the previous year).

4.3.1 Treatment centres

Reports to the TDI are based on structured treatment⁷⁹ only and do not include low threshold services. In the United Kingdom, type of treatment is defined by whether it is structured or not, rather than by the building or organisation providing that treatment, therefore any structured treatment offered in the community will be identified either as outpatient or GP treatment, not as being provided by so-called low threshold services.

The vast majority of treatments are reported through outpatient services (94%, n=120,226)⁸⁰ (Table 4.8). However, in Wales and Northern Ireland there is no information about treatment through either GPs or inpatient services; in both countries it is thought that GPs provide very little treatment except through shared

⁷⁸ In 20,686 cases (16%) it is not known whether this is a first treatment or whether the presenting drug user has been in treatment previously.

⁷⁹ Treatment where a care plan is provided.

⁸⁰ Most such services in the United Kingdom are specialist community based treatment services.

care arrangements with specialist drug services, in which case patients will be captured through monitoring of outpatient services.

Table 4.8: Presentations by centre type in the United Kingdom, 2003/04 to 2006/07

Centre type	2003/04		2004/05		2005/06		2006/07	
	n	%	n	%	n	%	n	%
Outpatient	91,659	91.9	111,434	94.6	121,202	94.4	120,226	93.8
GP	3,966	4.0	3,402	2.9	3,833	3.0	4,303	3.6
Inpatient	4,038	4.0	2,945	2.5	3,411	2.7	3,679	2.8
Total	99,663		117,781		128,446		128,208	

Source: Standard Tables prepared for United Kingdom Focal Point

4.3.2 Data coverage

Funding for community based treatment (outpatients) and non-hospital based residential treatment is linked to drug treatment monitoring systems and funding, and therefore data coverage is exceedingly high. Hospital based services are not linked in the same way, nor, necessarily, is treatment provided by GPs in isolation from specialist drug services, therefore it is likely that there will be some under-reporting in these areas. As noted above, low threshold interventions are not regarded as structured treatment and therefore are not monitored through the National Drug Treatment Monitoring System; all structured treatments provided by community based services are counted as outpatient treatment. Only Northern Ireland has been able to provide TDI data on prison treatment. Table 4.9 shows the number of units covered by centre type.

Table 4.9: Number of units covered by centre type in the United Kingdom, 2006/07

Treatment centre type	Units Covered	
	n	%
Outpatient	2,535	98
Inpatient	99	99
GP	235	NK

Source: Standard Tables prepared for United Kingdom Focal Point

4.3.3 Profile of clients in treatment

Drugs used

In the United Kingdom data are missing on main drug in 4.7 per cent of cases, though for England the proportion missing is less than two per cent (1.7%) in Scotland 17.4 per cent and in Wales 21.2 per cent; records are complete for Northern Ireland.

Where main drug is known, opiates (63.7%) remain the most reported primary drug amongst the TDI population and cannabis the second most reported primary drug (15.6%). Cocaine powder and crack cocaine were reported by seven and six per cent respectively (Table 4.10). These are not significantly different from previous years (Table 4.12). There are some variations between parts of the United Kingdom. In Northern Ireland primary opiate use accounts for 17.1 per cent of presentations, a significant rise from the previous year (14.6%), with primary cannabis use accounting for 44.2 per cent. Also, in Northern Ireland, 13.9 per cent of presentations were for primary benzodiazepine use, a problem previously associated with Scotland, although this is not reflected by the TDI (Table 4.10). In England, 6.8 per cent of presentations were for primary crack cocaine use, compared to one per cent or less in the rest of the United Kingdom, and these accounted for the majority of crack cocaine presentations (97%) across the United Kingdom. While England also accounts for the majority of cocaine powder presentations (89%), Northern Ireland

shows the highest proportion of primary cocaine powder users, at ten per cent, accounting for two per cent of the presentations for cocaine powder in the United Kingdom as a whole.

Table 4.10: Number and percentage of drug treatment presentations by primary drug of use in the United Kingdom, 2006/07

Drug	England		Northern Ireland		Scotland		Wales		United Kingdom	
	n	%	n	%	n	%	n	%	n	%
Amphetamines	3,603	3.5	22	1.6	238	2.2	759	9.8	4,622	3.8
Benzodiazepines	1,132	1.1	193	13.9	682	6.4	219	2.8	2,226	1.8
Cannabis	15,857	15.5	613	44.2	1,438	13.5	1,200	15.4	19,108	15.6
Cocaine powder	7,474	7.3	142	10.3	522	4.9	234	3.0	8,372	6.9
Crack cocaine	6,908	6.8	6	0.4	70	0.7	112	1.4	7,096	5.8
Opiates	65,592	64.1	237	17.1	7,151	67.0	4,869	62.7	77,849	63.7
Other	1,770	1.7	173	12.5	570	5.3	377	48.5	2,890	2.4
<i>Sub Total</i>	<i>102,336</i>		<i>1,386</i>		<i>10,671</i>		<i>7,770</i>		<i>122,163</i>	
Not Known	1,726	1.7	0	0	2,231	17.3	2,088	21.2	6,045	4.7
Total	104,062		1,386		12,902		9,858		128,208	

Source: Standard Tables prepared for United Kingdom Focal Point

The majority of all those presenting to treatment are treated within outpatient services, 62 per cent presenting with opiates as primary problem drug, and 16 per cent with cannabis. Proportionately GPs (89%), followed by inpatient services (76%) see a larger number of those presenting with opiate as primary problem drug and considerably less of other users, except crack cocaine users who represent 14 per cent of those presenting to inpatient services (Table 4.11).

Table 4.11: Primary drug by centre type in the United Kingdom, 2006/07

Drug	Outpatients		Inpatients*		GP*		Total	
	n	%	n	%	n	%	n	%
Amphetamines	4,499	3.9	74	2.0	49	1.2	4,622	3.9
Benzodiazepines	2,085	1.8	48	1.3	93	2.3	2,226	1.8
Cannabis	18,865	16.5	99	2.7	144	3.6	19,108	16.1
Cocaine powder	8,147	7.1	140	3.8	85	2.1	8,372	7.0
Crack cocaine	6,555	5.7	478	13.1	63	1.6	7,096	6.0
Opiates	71,450	62.4	2,784	76.2	3,615	89.0	77,849	62.9
Other	2,849	2.5	29	0.8	12	0.3	2,890	2.4
<i>Sub Total</i>	<i>114,450</i>		<i>3,652</i>		<i>4,061</i>		<i>122,163</i>	
Not Known	5,776		27		242		6,045	4.7
Total	120,226	93.8	3,679	3.6	4,303	2.9	128,208	

* Data only for England and Scotland

Source: Standard Tables prepared for United Kingdom Focal Point

First treatment demands show a slightly different pattern (Table 4.12) with primary opiate use accounting for just less than half (48%) of first treatment demands, although they account for 57 per cent in Scotland but only eight per cent in Northern Ireland.

Presentations with cannabis as primary drug accounted for a quarter of all first presentations in the United Kingdom, and in Northern Ireland for 50 per cent. The third highest number of first demands were for primary cocaine powder problems, although accounting for a much lower proportion (11%) than primary opiate or cannabis use; first treatment presentations for primary cocaine powder problems accounted for nine per cent all such presentations in the previous year.

Table 4.12: Number and percentage of first drug treatment demands by primary drug of use in the United Kingdom, 2006/07

Drug	England		Northern Ireland		Scotland		Wales		UK	
	n	%	n	%	n	%	n	%	n	%
Amphetamines	1,746	4.5	10	1.1	129	3.4	160	11.1	2,045	4.5
Benzodiazepine	462	1.2	156	16.7	242	6.4	56	3.9	916	2.0
Cannabis	9,803	25.1	470	50.3	760	20.2	292	20.3	11,325	25.1
Cocaine powder	4,450	11.4	100	10.7	314	3.4	87	6.1	4,951	11.0
Crack cocaine	2,849	7.3	1	0.1	19	0.5	31	2.2	2,900	6.4
Opiates	18,670	47.8	78	8.4	2,130	56.7	-	47.6	21,561	47.7
Other	1,061	2.7	119	12.7	161	4.3	127	8.8	1,468	3.3
<i>Sub Total</i>	<i>39,041</i>		<i>934</i>		<i>3,755</i>		<i>1,436</i>		<i>45,166</i>	
Not Known	858	2.2	0	0	808	17.7	333	18.8	1,999	4.2
Total	39,899		934		4,563		1,769		47,165	
	84.63%		1.98%		9.67%		3.75%			

Source: Standard Tables prepared for United Kingdom Focal Point

The majority of all those presenting to treatment for the first time are treated within outpatient services (95%), with a lower proportion presenting with opiates as primary problem drug (46%) than present to GPs (82%). Twenty-six per cent of new treatments in outpatients were for cannabis (Table 4.13).

Table 4.13: Primary drug by centre type, first drug treatment, 2006/07

Drug	Outpatients		Inpatients*		GP*		Total	
	n	%	n	%	n	%	n	%
Amphetamines	1,995	4.7	29	2.4	21	2.0	2,045	4.3
Benzodiazepines	858	2.0	13	1.1	45	4.3	916	1.9
Cannabis	11,236	26.2	32	2.7	57	5.4	11,325	24.0
Cocaine powder	4,857	11.3	51	4.2	43	4.1	4,951	10.5
Crack cocaine	2,728	6.4	153	12.7	19	1.8	2,900	6.1
Opiates	19,774	46.1	922	76.4	865	82.2	21,561	45.7
Other	1,458	3.4	7	0.6	3	0.3	1,468	3.1
<i>Sub Total</i>	<i>42,906</i>		<i>1,207</i>		<i>1,053</i>		<i>45,166</i>	
Not Known	1,915		7		43		1,965	
Total	44,821	95.0	1,214	2.57	1,130	2.47	47,165	

* Data only for England and Scotland

Source: Standard Tables prepared for United Kingdom Focal Point

Age

Forty-one per cent of all treatment presentations were for those aged between 25 and 34, this compares with 42 per cent in the previous year. Twenty-seven per cent were under 25 (29% in the previous year). As expected, those presenting to treatment for the first time ever were considerably younger, with 37 per cent under the age of 24 years (38% in the previous year) (Table 4.14).

Table 4.14: Age of drug users identified through TDI in the United Kingdom, 2006/07

	Age							
	<25		25 to 34		34>		Missing	All
	n	%	n	%	n	%		
All treatments	35,183	27.5	53,092	41.4	39,918	31.1	15	128,20
First	17,691	37.5	16,516	35.0	12,956	27.5	2	47,165

Source: Standard Tables prepared for United Kingdom Focal Point by NDEC, 2008

The age of those presenting for cannabis as main drug is lower than for all presentations. In 2006/07 over half (53.4%) were under 20 and three quarters (74.5%) under 35 years of age. The proportion under 20, and more particularly,

between 15 and 19 years has increased substantially over the past four reporting years (Table 4.15).

Table 4.15: Age of individuals reporting cannabis as main drug, 2003/04 to 2006/07

Year	Age						
	<15	15 to 19	<20	15 to 24	25 to 29	30 to 34	15 to 34
2003/04	11.1	32.9	44.0	50.5	12.9	10.5	73.9
2004/05	11.5	36.9	48.4	52.7	11.3	9.8	73.7
2005/06	11.3	40.2	51.5	55.1	11.0	8.9	75.0
2006/07	11.1	42.4	53.4	56.3	10.1	8.1	74.5

Source: Standard Tables prepared for United Kingdom Focal Point

Gender

Seventy-three per cent of presentations were male, 27 per cent female (Table 4.16). There was no difference for first presentations (Table 4.17). This was the same as in previous years.

Injecting status

Half of those presenting to treatment were either current (in the last four weeks) injectors (24.9%) or had previously injected (24.9%) (Table 4.16). Amongst first presentations the proportions having ever injected, but not currently (15.7%) or currently injecting was much lower (15.5%) (Table 4.17). These proportions were very similar to previous years.

Table 4.16: Injecting status by gender in the United Kingdom, 2006/07, all treatments

Injecting status	Male		Female		Total	
	n	%	n	%	n	%
Ever injected, but not currently	19,624	26.4	6,221	22.5	25,845	25.3
Currently injecting (in last month)	18,489	24.9	6,865	24.8	25,354	24.9
Never injected	36,262	48.8	14,572	52.7	50,834	49.8
<i>Sub Total</i>	<i>74,375</i>		<i>27,658</i>		<i>102,033</i>	
Not known/missing	18,610		7,565		26,175	
Total	92,985	72.5	35,223	27.5	128,208	

Source: Standard Tables prepared for United Kingdom Focal Point

Table 4.17: Injecting status by gender in the United Kingdom 2006/07, first treatments

Injecting status	Male		Female		Total	
	n	%	n	%	n	%
Ever injected, but not currently	4,886	16.6	1,451	13.5	6,337	15.7
Currently injecting (in last month)	4,668	15.8	1,563	14.5	6,231	15.5
Never injected	19,961	67.6	7,770	72.0	27,731	68.8
<i>Sub Total</i>	<i>29,515</i>		<i>10,784</i>		<i>40,299</i>	
Not known	4,844		2,022		6,866	
Total	34,359	72.9	12,806	27.2	47,165	

Source: Standard Tables prepared for United Kingdom Focal Point

4.3.4 TDI prevalence trends

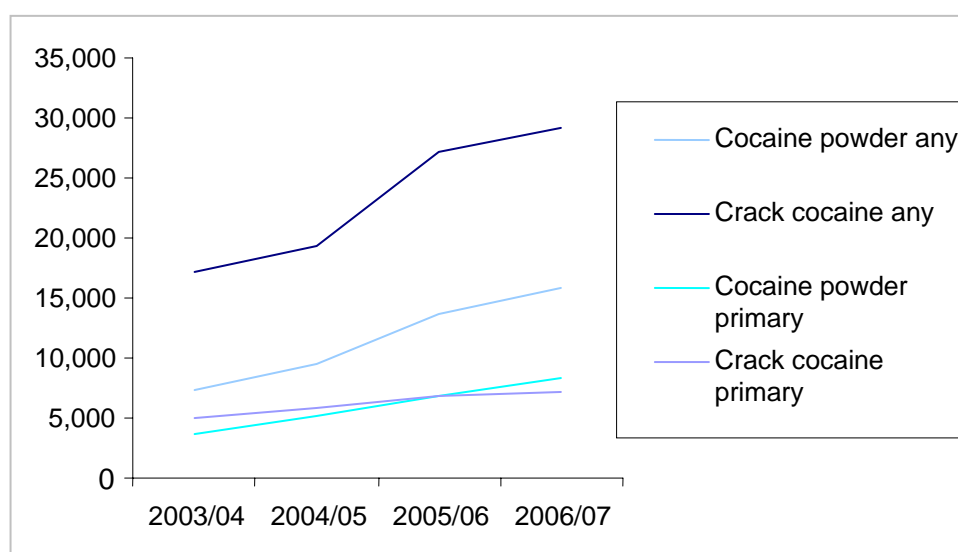
Table 4.18 shows that over the last four reporting periods presentations increased substantially for the first three years, but there has been no significant change in the number presenting in the last year. Main trends are the relative decline in the proportion of presentations for opiates, compared to the steady increases in presentations for cannabis, cocaine powder and crack cocaine, the first two continuing to increase. However, when considering use of any drugs (primary and/or secondary) there has been a much greater increase in use of both crack cocaine and cocaine powder over the last few years (Figure 4.2) with nearly a quarter of presentations reporting crack cocaine use (24%, n = 29,086) and 13 per cent reporting cocaine powder (n = 8,372).

Table 4.18: Number and percentage of drug treatment presentations by primary drug in the United Kingdom, 2003/04 to 2006/07

Drug	2003/04		2004/05		2005/06		2006/07	
	n	%	n	%	n	%	n	%
Amphetamines	3,474	3.7	3,731	3.6	4,134	3.5	4,622	3.8
Benzodiazepines	1,929	2.1	2,503	2.4	2,297	1.9	2,226	1.8
Cannabis	9,849	10.7	14,801	14.1	18,793	15.8	19,108	15.6
Cocaine powder	3,739	4.0	5,093	4.9	6,890	5.8	8,372	6.9
Crack cocaine	4,980	5.4	5,842	5.6	6,857	5.8	7,096	5.8
Opiates	66,012	71.4	70,179	67.0	77,580	65.1	77,849	63.7
Other	2,494	2.7	2,662	2.5	2,540	2.1	2,890	2.4
<i>Sub Total</i>	<i>92,477</i>		<i>104,811</i>		<i>119,091</i>		<i>122,163</i>	
Not Known	7,186		12,970		9,355		6,045	
Total	99,663		117,781		128,446		128,208	

Source: Standard Tables prepared for United Kingdom Focal Point

Figure 4.2: Presentations for cocaine powder and crack cocaine in the United Kingdom, 2003/4 to 2006/07



Source: Standard Tables prepared for United Kingdom Focal Point

While actual numbers reporting for cannabis are increasing, the rate of increase is considerably slower than previously. Of note is the fact that the number presenting with opiates as primary drug remained stable in 2006/07. Presentations for amphetamines have also remained stable, and those for benzodiazepines are declining.

There has been no change in the number of first treatment presentations in the past year, though as with all presentations they showed a rapid increase from 2003/04 to 2005/06 (Table 4.19). Amongst this group, the number of presentations for cannabis has stabilised and presentations for opiates and crack cocaine declined for the first time. Presentations for cocaine powder have increased, but not at the same rate as previously seen within the TDI.

Table 4.19: Number and percentage of first drug treatment presentations by primary drug, in the United Kingdom, 2003/04 to 2006/07

Drug	2003/04		2004/05		2005/06		2006/07	
	n	%	n	%	n	%	n	%
Amphetamines	1,455	5.1	1,619	4.1	1,812	3.9	2,045	4.3
Benzodiazepines	675	2.3	1,226	3.1	1,153	2.5	916	1.9
Cannabis	5,289	18.6	8,653	22.1	11,506	24.8	11,325	24.0
Cocaine powder	1,683	5.8	3,016	7.7	4,197	9.1	4,951	10.5
Crack cocaine	1,722	6.0	2,589	6.6	3,116	6.7	2,900	6.1
Opiates	16,656	57.8	20,464	52.3	23,021	50.0	21,561	45.7
Other	1,329	4.6	1,525	3.9	1,528	3.3	1,468	3.1
<i>Sub Total</i>	<i>28,809</i>		<i>39,092</i>		<i>46,333</i>		<i>45,166</i>	
Not Known	1,056		3,405		3,292		1,999	
Total	29,865		42,497		49,625		47,165	

Source: Standard Tables prepared for United Kingdom Focal Point

4.4 PDUs from non-treatment sources

4.4.1 PDUs identified outside the TDI

The Arrestees Survey

The third sweep of the Arrestees Survey (2005/06) (Boreham *et al.* 2007)⁸¹ found that 52 per cent of arrestees reported having taken one or more drugs in the month prior to arrest. Twenty-six per cent had taken heroin, crack cocaine or cocaine powder; 13 per cent having used heroin; 13 per cent cocaine powder; and 11 per cent crack cocaine.

Across all three surveys it was found that 41 per cent had been in treatment at some point. In the third survey 32 per cent of frequent heroin users (those who used heroin five or more days a week) were currently in treatment. In 2005/06, 26 per cent of those reporting previous treatment for heroin dependency reported no longer using heroin.

For more information on the Arrestees Survey see Chapter 8.3.2.

Statistics from the Northern Ireland Addicts Index 2007

While not strictly from non-treatment sources Northern Ireland Addicts Index provides information about individuals reported to be addicted to drugs classified under the Misuse of Drugs Act 1971. In 2007 the index⁸² showed that:

- 257 persons were registered on 31st December 2007, a decrease of 31 from 288 persons registered on 31st December 2006;
- there were 51 new notifications;
- there were 206 renotifications in 2007, compared to 190 in 2006;
- 133 addicts have been registered between one and five years;
- eighty-two cases were removed from the Addicts Index during 2007;
- the gender profile in 2007 was similar to that in 2006, where 81 per cent of addicts were male in 2007, and 78 per cent in 2006,

⁸¹ 8,027 arrestees were surveyed. The eligible population was aged 17 or older who had been arrested on suspicion of committing an offence and who had not previously been interviewed within the current survey year. The sample design was a stratified two-stage random probability sample. A random selection of custody suites was first drawn and in each suite, a random sample of shifts. CAPI3 interviews with a CASI self completion section were used; respondents were asked to provide an oral fluid sample for analysis of recent drug use. The overall response rate was 23 per cent in 2005–06.

⁸² People are registered on this index if they are known to be, or if a medical practitioner considers them to be, addicted to one or more of 14 controlled drugs.

- the age profile changed slightly, with 29 per cent aged 29 years and under in 2007, compared to 34 per cent in 2006;
- heroin was the most frequently used notifiable drug, reported by 75 per cent, methadone by 28 per cent and cocaine powder by six per cent; and
- forty-four per cent whose injecting behaviour was known reported currently injecting (42% in 2006) (PHIRB/DHSSPSNI 2008).

4.4.2 Contact with non-treatment interventions and social and cultural context

See Chapter 6 for information on needle exchange schemes and drug related infectious disease testing. Also, see Arrestees Survey referred to above.

4.5 Intensive or frequent patterns of use

By their very nature, estimates of problem drug use are concerned with intensive patterns of use.

4.6 Relationship of PDU estimates, TDI data and General Population Survey

New presentations to treatment, as reflected through the TDI, appear to be stabilising in the United Kingdom. As noted earlier, main trends are the relative decline in the proportion of presentations for opiates, compared to the steady increases in presentations for cannabis, cocaine powder and crack cocaine, the first two continuing to increase in this reporting year. Of note is the fact that the actual numbers presenting with opiates has not continued to increase for the first time. Most recent PDU estimates for the United Kingdom are shown in Table 4.4 and primarily concern the use of opiates, but also crack cocaine. The first two sweeps of English estimates appear to show the same stabilisation in use of opiates and/or crack cocaine as that found in the TDI population. Population survey data is based upon a very different population than that reflected in PDU estimates; the former identifying relatively low use of opiates and crack cocaine. In England and Wales there appears to be a fall in drug use, mainly reflected in a decrease in use of cannabis, though cocaine powder is rising, as within the TDI population. Mentions of cocaine on death certificates are also rising (see Chapter 6).

4.7 Treatment engagement

The TDI distinguishes between all new presentations to treatment each year and first ever presentations (that is, first treatment demands). The number and profile of all new presentations has been considered to reflect the wider demands made on the treatment sector, while the number and profile of the first ever treatment demands has been seen as reflecting changes in the emergent population of drug users newly entering treatment. As can be seen in Table 4.18, data on all presentations suggests an increase in demand for cocaine powder and crack cocaine over time. An increase can also be seen for cannabis, a drug not identified in the United Kingdom as problematic, though there are increasing concerns about its use, reflected in its proposed reclassification to Class B. Presentations for crack cocaine and cannabis have not increased in the last year (Table 4.18). The same pattern can be seen with first ever presentations (Table 4.18).

Nevertheless, the TDI cannot be used to consider treatment engagement rates as they do not take account of those individuals already in treatment prior to, and during, the reporting period. The National Drug Treatment Monitoring System (NDTMS) for England provides a better estimate of engagement. NDTMS data show that, of those in treatment in 2006/07, 148,866 were problem opiate and/or crack cocaine users (either using these as primary drug or as a secondary or tertiary drug) (Table 4.20), that is 45 per cent of problem drug users (estimated for the previous year, 2005/06),

this compares with 42 per cent (136,228) in 2005/06. The treatment figure for opiate users was 140,357, constituting 49 per cent (46% in 2005/06, n = 128,630) of the PDU estimate of opiate users, while the treatment figure for crack cocaine users was 46,415 constituting 24 per cent of problem crack cocaine users (21% in 2005/06, n = 39,832), indicating increased engagement. This suggests that a higher number of problem drug users were in treatment in 2006/07 than in the previous year, despite a lack of increase in presentations to treatment for primary opiate or crack cocaine use, though there has been an increase in the number of crack cocaine users in treatment.

Table 4.20: PDU estimates: PDUs identified through English treatment monitoring system (NDTMS)

	PDU estimates (2005/06)		NDTMS (2005/06)*		NDTMS (2006/07)*	
	n	%	n	%	n	%
Opiate and/or crack cocaine users	332,090		136,228	41.0	148,866	44.8
Opiate users	286,566		128,630	44.9	140,357	49.0
Crack cocaine users	197,568		39,832	20.2	46,415	23.5

Source: Hay *et al.* 2007; Standard Tables prepared for the United Kingdom Focal Point

Research

The Drug Treatment Outcomes Research Study

The Drug Treatment Outcomes Research Study (DTORS) is a longitudinal study designed to follow drug users in England seeking treatment over a period of up to 12 months.⁸³ DTORS provides a much wider understanding of the characteristics of those entering treatment than has been available through drug treatment monitoring systems, providing information about education, employment, accommodation, offending behaviour, experience of mental health services, parental status, parental responsibility and risk taking. The study comprises three key elements, operated over a three-year period, namely: a quantitative study of outcomes; a qualitative study of treatment related issues; and a cost benefits analysis. The first report, providing baseline information from interviews conducted with participants as soon as possible after an assessment for treatment, has been published (Jones *et al.* 2007).

These baseline data suggest that the sample is representative of the treatment population identified through the TDI. Three quarters (73%) were male; 20 per cent were aged 16 to 24 years, 45 per cent aged 25 to 34 years, 27 per cent aged 35 to 44 years and seven per cent 45 years and over. The majority were White (89%). In the four weeks prior to interview respondents used a wide range of substances:

- 62 per cent reported using heroin;
- 50 per cent alcohol;
- 49 per cent cannabis
- 44 per cent crack cocaine;
- 25 per cent unprescribed benzodiazepines;
- 22 per cent other opiates;

⁸³ Respondents were recruited via drug treatment agencies within England. One hundred of the 149 Drug Action Teams (DATs) in England were initially selected to take part in DTORS. Within each selected DAT, all agencies providing structured community treatment or residential treatment or referral were eligible to take part, as were all adults presenting with a drug problem (other than alcohol) for a new episode of drug treatment within a sampling window of between four and seven weeks. Participation was voluntary. The final sample represents 1,796 drug treatment seekers interviewed at 342 treatment facilities across 94 DATs; the sample broadly represents the drug treatment-seeking population in England.

- 16 per cent unprescribed methadone; and
- 16 per cent cocaine powder.

Forty-nine per cent of primary heroin users, 24 per cent of primary crack cocaine users and 39 per cent of primary amphetamine users reported injecting it in the last four weeks and 28 per cent of heroin users reported injecting every day, or most days.

For information about other characteristics of DTORS participants see Chapters 6 and 8.

The 2006 NTA survey of user satisfaction – Topping up

The NTA 2006 user survey⁸⁴ provides information about the continued use of illicit drugs by those in treatment (NTA 2007a). While almost 90 per cent agreed or strongly agreed that such use had reduced, many respondents, particularly those receiving substitute treatment, reported using in addition to the substances prescribed, with fewer than 30 per cent reporting never using on top of prescribed substitute drugs and just over half reporting doing so "sometimes". Of the respondents who reported using on top of prescriptions:

- 81.6 per cent reported use of heroin;
- 60 per cent, crack cocaine;
- 57 per cent, cannabis;
- 43 per cent, benzodiazepines; and
- 19 per cent, amphetamines.

A higher level of use on top of prescriptions was reported in the survey of clients using pharmacy based syringe exchange schemes. Of those reporting use on top of a prescription:

- 95 per cent reported using heroin;
- 76 per cent, crack cocaine;
- 27 per cent, amphetamines; and
- 58 per cent, benzodiazepines.

Overall, in both surveys, the majority (58%) of those who used on top of prescriptions used both heroin and crack cocaine.

'Topping up' methadone

In an analysis of patterns of heroin use among a treatment sample of Scottish drug users from the DORIS cohort, Bloor *et al.* (2008)⁸⁵ looked at whether drug users on methadone maintenance used heroin less frequently than their peers following other forms of treatment and also to what extent those on methadone maintenance 'top up' with heroin. It was found that there was no significant difference in the propensity of either group to abstain from heroin with 67 per cent of those on methadone maintenance treatment having 'topped up' on heroin in the three months prior to the

⁸⁴ Questionnaires were distributed to the clients of all structured drug treatment services in England. In addition, a shorter questionnaire consisting of just the harm reduction questions were distributed to clients of pharmacy-based needle exchange services. A total of 1,014 drug services and 1,658 needle exchange pharmacies in England were asked to distribute self-completion questionnaires to their service users. 10,070 responses were analysed (8,765 from the 2006 user survey and 1,305 from the pharmacy survey) Assuming that all questionnaires were distributed, the response rate to the main user survey was just over 12 per cent and the response rate to the pharmacy study was approximately 3.5 per cent.

⁸⁵ Four hundred and one interviewees who responded at all four interview sweeps, recruited as new treatment entrants from 28 drug treatment agencies across Scotland. Sixty-eight respondents were on methadone maintenance treatment.

interview. However it was found that while drug users on methadone maintenance treatment were not more likely to achieve abstinence than drug users receiving another form of treatment they were significantly more likely to reduce the frequency of use.

Characteristics of drug-using patients and treatment provided in primary and secondary settings

In a paper exploring the differences in patient groups served, and treatment offered by primary and secondary care services in Birmingham (Day *et al.* 2007)⁸⁶, it was found that patients treated in primary care were younger, with a mean age of 30.3 years compared to 34.1 years, than those treated in secondary care services; they were more likely to be male, 77.1 per cent compared with 70.5 per cent; and had fewer drug related problems, the mean Christo Inventory for Substance Use Services⁸⁷ was 56.9. A higher percentage of primary care patients were receiving a prescription for maintenance therapy, 73.7 per cent compared with 64.9 per cent, with a greater proportion of these (21.4% compared with 10.0%) receiving buprenorphine, rather than methadone. There was no significant difference in the mean doses of methadone or buprenorphine received in primary or secondary care. The authors suggest that the differences between the primary and secondary care settings were smaller than expected, although they were predominantly in the expected direction.

Problematic drug use, ageing and older people

Beynon *et al.* (2007a)⁸⁸, carrying out research in Cheshire and Merseyside showed that the average age of drug users in contact with treatment services and syringe exchange programmes is increasing, the median age of those in treatment rising from 30.8 years in 1998 to 34.9 in 2004/05. Increases were also seen in those accessing syringe exchange programmes; the median age of those attending being 27.0 years in 1992 and 34.9 in 2004.

⁸⁶ Treatment staff in all statutory and non-statutory agencies were interviewed about the demographic details of all active patients, the treatment that each patient was receiving and their level of drug-related problems. 1,597 patients were being treated by drug treatment services, with 577 (36.1%) of these under the care of the primary care-based agency.

⁸⁷ The Christo Inventory for Substance-misuse Services (CISS) was developed as a single page outcome evaluation tool completed by drug/alcohol service workers either from direct client interviews or from personal experience of their client supplemented by existing assessment notes. For more information see:

<http://www.ingentaconnect.com/content/els/03768716/2000/00000059/00000002/art00117>

⁸⁸ The research is based on information from the monitoring of drug treatment services in Merseyside and cheshire from 1997 and monitoring of syringe exchange schemes since 1991.

5. Drug-Related Treatment

5.1 Overview

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

While providing treatment remains a priority, the role of other service providers; housing, employment, education and training has also become important, more particularly this year with new drug strategies having a much stronger focus on the need for recovery. Coordination and integration between a range of providers is seen as key in helping problem drug users reintegrate into society and all new drug strategies in the United Kingdom focus on this area.

Improving treatment for young people has been prioritised since 2005.

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

5.2 Treatment System

5.2.1 Treatment objectives within new drug strategies

All new drug strategies continue to be concerned with the provision of better access to treatment, particularly for vulnerable and excluded groups and to encourage retention. *Drugs: protecting families and communities* (HM Government 2008a) also looks towards linking treatment to the benefit system, the latter being a United Kingdom wide system; this may have implications for policy outside England (see below). Throughout the United Kingdom, but more particularly in Scotland, it is expected that there will be a cultural shift in treatment services towards a greater emphasis on recovery (see Chapters 1 and 9).

There are a number of treatment objectives for England. One is to target those most at risk. A second objective is to improve the quality and effectiveness of treatment, with action to support more personalised treatment through effective clinical governance, and user and carer involvement; also, with outcome monitoring used to improve treatment targeting and effectiveness. A further objective is a wider use of new treatment approaches; including the use of injectable heroin and methadone; contingency management; mutual support networks; and services making full use of up-to-date evidence on effective treatment. A fourth objective is that there will be a radical new approach to services to help drug users re-establish their lives (see Chapter 9) (HM Government 2008a).

The new drug strategy for Scotland (Scottish Government 2008a) has the promotion of recovery among problem drug users as its key focus (see Chapter 1). Noting the debate in Scotland as to whether the aim of treatment should be harm reduction or abstinence (reported in last year's United Kingdom Focal Point report) the Scottish Government suggests that this is a false dichotomy, but argues that recovery should be made the explicit aim of services for problem drug users. This is defined in the Scottish Strategy as:

“a process through which an individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society.”

It is stated that the concept of recovery as a goal has been pioneered with success in the field of mental health, espoused through the Scottish Recovery Network.⁸⁹ This approach has been put forward following a number of reviews undertaken in the previous year (see last year's United Kingdom Focal Point), and importantly in the *Essential Care* report (SACDM 2008) (see Chapter 9).

Delivery of drug treatment services are to be based on three principles:

- recovery should be made the explicit aim of all services providing treatment and rehabilitation;
- a range of appropriate treatment and rehabilitation services must be available at a local level; and
- treatment services must integrate effectively with a wider range of generic services to address the needs of problem drug users, not just their addiction.

This will involve:

- an appropriate range of drug treatment and rehabilitation services to promote recovery from all types of drug use, not just opiate dependency, which is based on local needs and circumstances and must be available in each part of Scotland;
- better integration of medical treatment with a wider range of services;
- individual care plans; and
- the principles of recovery are to be reflected in training and workforce development programmes that are expected to promote cultural change among practitioners.

Substitute prescribing will continue to remain an important intervention.

In the Welsh substance misuse strategy there is a strong focus on improving access to treatment, treatment engagement and improving treatment outcomes (Welsh

⁸⁹ See: <http://www.scottishrecovery.net/content/>

Assembly Government 2008a). There is an additional focus on helping substance misusers re-establish themselves in the community. Areas for action include: expanding outreach; improving treatment outcomes by conducting proper assessments and by investing in evidence-based, quality services; driving better performance and efficiencies in treatment services; improving the overall capacity of services to tackle waiting times; prioritising services that tackle the areas of greatest harm, that is, those to support the most harmful drug and alcohol misusers; identifying and minimising barriers to accessing treatment; building citizen focused services that meet the needs of a range of specific groups (particularly young people, Black and minority ethnic communities, Welsh speakers and vulnerable women); engaging substance misusers, including children and young people in the planning and design of all services; and ensuring that user satisfaction surveys are conducted, using the results to further improve services; and working towards the full range of integrated treatment options being available in all areas, including the prison estate, prioritising the more deprived areas.

It is noted that there remain gaps in treatment provision and to bridge these it is intended to make better use of existing services, expanding their capacity by training health and social care professionals in the field. There will also be action taken to improve the knowledge of health and social care professionals, to enable them to recognise risk and the potential for treatment, so that they make appropriate referrals to specialist services and continue promoting increased substitute opiate prescribing across Wales, including supervised consumption, in line with the latest evidence. There will also be action to tackle the problem of access to inpatient detoxification and residential rehabilitation services in Wales. It is also planned to establish service users groups and a national peer mentoring scheme.

To improve retention in treatment the Welsh Assembly Government is commissioning a study of the causes and patterns of drop-out rates. They will also pilot motivational interviewing training for care managers and key workers as part of their workforce development plan.

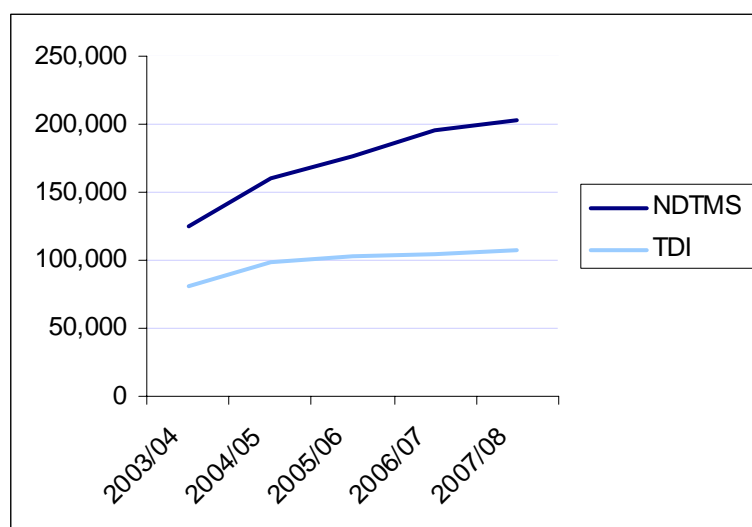
Also in Wales, it is planned to provide a greater focus on over the counter (OTC) medicines and prescription only medicines (POM), noting the United Kingdom-wide All Party Parliamentary Group on Drugs Misuse inquiry into the misuse of POMs and OTC medicines.⁹⁰ The Welsh Assembly Government will be asking their Advisory Panel on Substance Misuse to consider its recommendations. The implementation plan includes a number of actions aimed at: encouraging more responsible prescribing; monitoring the purchase of sensitive products; reducing inappropriately prescribed medicines such as benzodiazepines in primary care; and ensuring that suitable services are available for those dependent on POMs and OTC medicines (Welsh assembly Government 2008b).

5.2.2 Numbers in treatment

Information from the National Drug Treatment Monitoring System (NDTMS) for England shows that in 2007/08, 202,666 individuals were in contact with structured drug treatment services, a four per cent increase since the previous year (195,464) (NTA 2008a). Elsewhere in the United Kingdom drug treatment monitoring systems only measure the number entering treatment (see Chapter 4). Figure 5.1 shows how the steep increase in numbers in treatment in England is now beginning to level off; new presentations having begun to plateau in 2004/05.

⁹⁰ See: http://www.brianiddon.org.uk/media/070724_APPGDMInq.htm

Figure 5.1: Numbers in treatment monitored through NDTMS and new of presentations to treatment measured by the TDI, 2003/04 to 2007/08, England



Source: NTA 2008a; Standard Table prepared for UK Focal Point

5.2.3 Cost of treatment / value for money

The National Treatment Agency for Substance Misuse (NTA) is working with the Department of Health, Home Office and the Treasury to further understand the costs of substance misuse treatment in England.⁹¹ The aim is to provide commissioners with a range of unit costs for interventions, allowing the purchase of the most effective interventions at a transparent price. A pilot was carried out in the South East region and the project was expanded nationwide during 2006/07. Work is now beginning on the 2007/08 exercise following a period of consultation in the field. A web-based tool has been developed for the 2007/08 exercise. Work is on-going to sample primary care based projects across the country as well as some specialist drug treatment services, with a parallel exercise to be conducted for residential services.

Also, the NTA has been asked by the Government to develop a model of drug treatment systems, and a related tool, that can help commissioning partnerships in delivering the best possible outcomes from the available resources for their treatment system. A consultation documents, *Improving the Value of Drug Treatment Systems* was launched in October 2008 (NTA 2008b). The document sets out a number of key assumptions about the treatment needs of opioid and crack cocaine users.

5.2.4 Quality in treatment systems

Guidelines on ethical prescribing

The NTA (2007b) has published guidelines on ethical prescribing⁹², based on *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (DH et.al 2007) and National Institute for Health and Clinical Excellence (NICE) guidance on methadone and buprenorphine for the management of opioid dependence (NICE 2007b), both referred to in the 2007 United Kingdom Focal Point report. The guidance states that the objective in prescribing is to give the patient the right medication at a dose that produces the greatest therapeutic benefit, without incurring

⁹¹ See: http://www.nta.nhs.uk/areas/unit_costs/default.aspx

⁹² See: http://www.nta.nhs.uk/areas/clinical_guidance/clinical_guidelines/docs/statement_on_medication_choice_and_dosing_in_drug_misuse_and_treatment_14_12_07.pdf

unnecessary risk of harm and that it is inappropriate for medications to be used as a reward, or to be withheld, or the dose reduced, solely as a punishment or sanction (see audit of prescribing in 5.2.5).

Other new guidance

The NTA has published guidance for young people's substance misuse treatment, and needs assessment guidance (NTA 2008c). Also, launched is new commissioning guidance for residential (Tier 4) services (NTA 2008d), and guidance for carers (NTA 2008e).

Involving service users

The NTA sponsored eleven service users from across England to attend the International Harm Reduction Association's (IHRA) 18th International Conference in Warsaw, Poland in May 2007. The service user group were asked to collect fresh evidence-based work on reducing drug-related harm and communicating these messages to the wider service user community in England on their return. A report containing recommendations from the group based on their impressions of the conference has been published (NTA 2007d). This has been further developed at the 2008 IHRA conference in Barcelona.

The Scottish Government (2007b) has published new National Quality Standards for Substance Misuse Services in involving service users. There are also plans to develop a user forum in Wales (Welsh Assembly Government 2008b).

5.2.5 Reviews/audits of the drug treatment system

Audit of Prescribing Practitioners

A survey of GPs has been conducted on behalf of the Department of Health and the NTA to identify the extent of inappropriate use of medication by clinicians, either for reward or punishment and to identify reasons why doses may be justifiably altered (COI and GfK-NOP 2007)⁹³. This Audit was commissioned as part of the improvement review of drug services looking into the safety of prescribing (see below) and contributed to developing guidance on ethical prescribing referred to earlier.⁹⁴ It was found that:

- most (86%) would only increase doses of methadone or buprenorphine as part of a patient's care plan or in response to evidence of inadequate dose (82%);
- over 95 per cent would only decrease doses of as part of a planned detoxification or because of concerns that the current dose was excessive (80%);
- twenty-five per cent reported that if the patient continually declared no use of illicit drugs, they would take no action and 25 per cent that they would decrease the dose;
- where patients continually declared use of illicit drugs, half (47%) said they would increase the dose, the rest reported a range of actions, though only four per cent stated they would discharge the patient; and

⁹³ A telephone survey was conducted over a two week period in autumn 2007 with 121 clinicians at practices in England able to prescribe methadone or buprenorphine for the treatment of dependence. The clinicians comprised GPs specialising in addiction, consultants in addiction, and other prescribing practitioners. A database of all identified drug prescribing practices was used as the sample frame, or population, for this survey. This comprised some 380 unique practices. The survey was conducted in a random fashion which elicited a random and representative sample of practices and the questionnaire was designed by and the survey undertaken by independent research experts. A response rate of 32 per cent was achieved.

⁹⁴ Respondents reported an average of 379 patients being treated with methadone or buprenorphine for dependence within their service, practice or centre.

- eighty-one per cent said that they would only prescribe antidepressants in response to a diagnosis of clinical depression, and 19 per cent to assist abstinence from stimulants.

Improvement reviews of drug services

Prescribing drugs safely, planning and coordinating treatment services

A joint review⁹⁵ by the Healthcare Commission and the NTA looked at whether local services prescribe drugs safely and appropriately and how well they plan treatment and coordinate services (Healthcare Commission and NTA 2007). It found that improvements could be made across all areas of community prescribing services and care planning and care coordination. It also found that 27 per cent of prescribing services had not undertaken any clinical audit in the 18 months prior to the review. It was noted that although the majority (95%) of services have good policies on prescribing, some still prescribe insufficient doses to maintain service users and prevent the use of street drugs. In addition, the review revealed the positive benefits of involving service users at all levels; in their own treatment, in planning specific services, and in planning the treatment system at a strategic level. Improvements could also be made in relation to the consistent use of individual care plans with 48 per cent of local drug partnerships being 'weak' in this area, and 32 per cent 'fair'.

Key recommendations were that:

- commissioners and service providers review their activity in relation to the national and local results of the review;
- community prescribing services ensure that clinical governance arrangements are in place, that mechanisms to monitor their practice against guidelines are established, and that they undertake regular reviews or audits to ensure that all staff are treating all service users according to guidelines;
- all services review their assessment and care planning tools, making use of best practice guidance;
- all services ensure that they develop an individual care plan for each service user, involving users in the development and regular review of the plan. They should also ensure that the comprehensive assessment of each person who accesses treatment adequately covers any aspects of risk and looks at how these risks will be managed;
- Strategic Health Authorities and regional NTA teams with responsibility for managing the performance of local drug partnerships and healthcare organisations (NHS and voluntary sector) should ensure that action plans are developed to address all areas of weak performance in the review assessment, and closely monitor the implementation of these plans.

A review of drug treatment and harm reduction services is reported in Chapter 7.

Also in 2006/07, an improvement review was undertaken looking at systems for managing services, to ensure that they meet the needs of their service users and are managed to deliver the best possible treatment to clients.

Improvement reviews for 2007/08 are focusing on the extent to which various parts of the treatment system accommodate the diverse needs of local populations across the full range of service provision and the commissioning and provision of Tier 4

⁹⁵ There are two parts to an improvement review. In the first part, the performance of all organisations taking part in the review is assessed. In the second part, organisations or systems (approximately 10%) that received the weakest assessments are provided with help by NTA to develop an action plan to improve their performance. Reviews assess chosen themes within the context of local drugs partnerships.

services (inpatient detoxification and residential rehabilitation). An assessment framework for these reviews has been published (Healthcare Commission and NTA 2008a).

Healthcare Inspectorate Wales review of substitute prescribing services

The first of a series of comprehensive reviews into the treatment of substance misuse in Wales has been conducted by the Healthcare Inspectorate Wales.⁹⁶ This is to look at the planning, commissioning and delivery of treatments that involve prescribing drug substitutes in the community.

Review of inpatient services, Wales

Last year the Welsh Assembly Government commissioned a review of Tier 4 services in Wales. The key findings of the review were that: services were patchy across Wales and that better use of existing provision by ensuring that individuals are managed properly into, through, and out of, Tier 4 services; with appropriate preparation and support at the outset and effective wrap-around support and relapse prevention at the end of treatment.

Guidance has been issued to all Community Safety Partnerships and they have been asked to prepare plans to increase capacity and improve the local and regional care pathways for Tier 4 services (Welsh Assembly Government 2008a).

Review of relapse prevention and wraparound services, Wales

A review of local provision of relapse prevention and wraparound services is to be undertaken in Wales, with plans developed to ensure that such services are delivered as a core element of an individual's treatment plan with ready access to skills programmes and learning opportunities. A 'Continual Personal Development Opportunities' module is also to be developed as part of the Substance Misuse Treatment Framework for Wales (Welsh Assembly Government 2008b).

Clinical governance

NTA has published a consultation draft of guidance on clinical governance in drug treatment. The consultation closed on the 14th May 2008 (NTA 2008f). In Wales, it is expected that appropriate clinical governance arrangements across all commissioned sectors be in place (Welsh Assembly Government 2008b).

The implementation of the Treatment Outcome Profile

The implementation of the Treatment Outcome Profile (TOP), developed for use at the start of treatment and in care plan reviews, and reported through the National Drug Treatment Monitoring System, is supported by a range of products, all of which can be downloaded from the NTA website⁹⁷, these include guides for managers, keyworkers and service users, and training packs.

A report of the development of the Treatment Outcomes Profile for measuring the effectiveness of substance misuse in England has been published in the journal, *Addiction* (Marsden *et al.* 2008).

Scottish Drug Misuse Database Follow-up Reporting System

In April 2008, the new Scottish Drug Misuse Database Follow-up Reporting System was introduced. It provides outcome information that will, once fully implemented, enable the assessment of treatment effectiveness (Scottish Government 2008a).

⁹⁶ See: <http://new.wales.gov.uk/news/latest/081006review/?lang=en>

⁹⁷ See: http://www.nta.nhs.uk/areas/outcomes_monitoring/rollout_products.aspx

Online directory of drug services

A new online directory of drugs services is now available in Scotland.⁹⁸

Substance misuse assessment toolkit

In Wales a substance misuse assessment toolkit was introduced nationally in 2008. Also, in Wales, a feasibility study is to be undertaken to consider the introduction of a common client record to aid the provision of integrated services (Welsh Assembly Government 2008b).

5.2.6 Funding

The Pooled Drug Treatment Budget, England

The Pooled Drug Treatment Budget (PTB) funding for drug treatment in 2008/09 is being maintained at the 2007/08 level of €582 million (£398m). Current plans are for this amount to continue each year to 2010/11. For 2008/09 a further €36.1m (£24.7m) will be used for young people's treatment. In addition, there is significant expenditure on treatment through mainstream funding.

5.2.7 Pilot treatment projects/trials

Contingency management

As part of the action plan that supports *Drugs: protecting families and communities* the NTA has established pilots to look at whether contingency management works in England and, if so, how best to apply it (HM Government 2008b). Wales is also to pilot contingency management to help engage or maintain some individuals in treatment in certain circumstances (Welsh Assembly Government 2008a).

5.2.8 Medical training

A two-year project funded by the Department of Health (England), and led by a National Steering Committee including representatives from the Council of Heads of Medical Schools, the Department of Health, the Home Office and the General Medical Council has produced a consensus between all those interested in substance misuse in the undergraduate medical curriculum. This was done largely through establishing a panel of experts and others and by developing national guidelines, and support teaching and learning about the subject in various ways. Guidance was published in December 2006, and includes short background sections on substance misuse and some guidance on good practice. The heart of the document, though, is guidance on core aims and objectives: the project analysed the relevant aims and objectives which medical schools provided during the survey, and worked on drafts at and in between meetings of the Expert Panel. The document was reviewed by experts, generalists and the national Steering Group and sent to medical school deans for comment before publication. Funding has now been provided by the Department of Health for the implementation phase over the next three years.⁹⁹

Research

The Drug Misuse Research Initiative

A number of research projects funded by the Department of Health Policy Research Programme, Drug Misuse Research Initiative (DMRI)¹⁰⁰ phase two (ROUTES), have

⁹⁸ See: <http://www.scottishdrugservices.com/sdd/homepage.htm>

⁹⁹ For further details see: http://www.sgul.ac.uk/depts/icdp/our-programmes/substance-misuse-in-the-undergraduate-medical-curriculum/substance-misuse-in-the-undergraduate-medical-curriculum_home.cfm

¹⁰⁰ For more information and executive summaries see:

been completed. The initiative comprised ten projects in areas related to drug treatment and aimed to deliver research-based evidence to underpin the development and delivery of effective services and interventions in the field of drug misuse. The value of the programme is around €2.05 million (£1.4m) from 2005-2008. The programme encompasses issues such as access to services, service configuration, retention in treatment, user outcomes and experiences and cost-effectiveness. It focused especially on routes through services and issues relating to children and families. Projects now completed and in the public domain are reported below.

Barriers to the effective treatment of injecting drug users

The research aims were to provide information on how injecting drug users engagement with services could be improved and the cost/benefit implications of successfully completing uptake (Neale *et al.* 2007).¹⁰¹ Injectors reported that services had improved and become easier to access in recent years. However, there was still insufficient support and many barriers limited service use. These included structural aspects such as waiting lists and bureaucracy, but also individual circumstances and psychological and emotional state, such as poor motivation and feelings of shame and embarrassment. It is suggested that the cost per injector of not entering treatment, with continued use of street drugs, high risk injecting and on-going crime, over the previous six months has been €8,678 (£5,936). Key strategies for reducing barriers to treatment were: providing more services (particularly substitute prescribing, psychiatric and counselling services, and advice/information), as well as targeting provision at those groups currently encountering access problems; improving existing services (for example, by re-organising current provision, investing in staffing and staff training, and addressing the poor communication systems operating within some services); and capitalising on those factors which can facilitate help seeking, such as encouraging and enabling supportive relationships and recognising when life events and changes in injectors' emotional and psychological states of mind present positive opportunities for change. An executive summary of this research is available on the DMRI website.

Early exit: estimating and explaining early exit from drug treatment

In considering the factors that lead to an early exit, Stevens *et al.* (2008)¹⁰² found that a quarter of clients dropped out between assessment and 30 days in treatment. Predictors of early exit were: being younger; being homeless; and not being a current injector. Also, those not in substitution treatment were more likely to leave treatment at this stage. However, there were substantial variations between agencies, which point to the importance of system factors, suggesting that some were better than others at getting the basics right. It appears that drug services may deter some drug users from engaging in treatment by following certain practices including; requiring drug users to go through repeated, lengthy assessment processes and multiple appointments to actually get treatment, not providing the treatment (especially residential rehabilitation and buprenorphine prescriptions) that some had hoped to

<http://www.lshtm.ac.uk/research/dmri/>

¹⁰¹ The study was undertaken in three areas in the North west of England; a large city, a medium sized town and a small town within a rural area. Seventy-five current injectors were recruited from three needle exchange programmes, with additional snowball sampling to ensure inclusivity of gender, ethnicity and primary drug injected (opiates and stimulants)

¹⁰² Quantitative data (n=2,624) was derived from three English Drug Action Team areas; two metropolitan and one provincial. Hierarchical linear modelling (HLM) was used to investigate predictors of early-exit while controlling for differences between agencies. Qualitative interviews were conducted with 53 ex-clients and 16 members of staff from 10 agencies in these areas to explore their perspectives on early exit, its determinants and, how services could be improved.

get, insisting on supervised consumption of methadone, starting methadone prescription at doses that may be too low to help the drug user and mixing drug users who are at different stages of their 'treatment journey' in the same group work sessions. An executive summary of this research is available on the DMRI website.

Exploring young people's views and experiences of specialist substance misuse services

Graham *et al.* (2007) considered the views of young people of specialist substance misuse services.¹⁰³ It was found that young people perceived a range of positive impacts arising from their contact with specialist substance misuse services. In relation to substance use, people described services as helping them to see that their use was problematic, giving them the motivation to address it, and helping them to reduce or stop using. An executive summary is available on the DMRI website.

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

This report describes a study that explored the involvement of people who use drugs in planning, commissioning and delivery of drug treatment services (Patterson *et al.* 2007).¹⁰⁴ There was found to be wide variation in the degree to which user involvement systems and structures have been established and wide ranging views about the rationale for this, nevertheless in the main, there was an attitude of acceptance and acknowledgement that people who use drugs and services had a contribution to make in relation to service development with an overall sense of enthusiasm and hopefulness regarding the potential for user involvement to make a real difference.

Cost and cost-effectiveness of treatment as usual in drug misuse services.

In a study designed to gather information about what actually happens in a sample of drug treatment services in terms of what kind of interventions are delivered and how effective and cost effective these interventions are when judged against key outcome domains (Raistrick *et al.* 2008).¹⁰⁵ Specific objectives were: to describe treatment as usual in a range of different services; to estimate the range of costs of treatment; to estimate the cost effectiveness of treatment and investigate factors that facilitate and hinder successful involvement; and to measure the effectiveness of treatment. All services were found to have made a positive response to those seeking help and all delivered statistically significant health and social gains, taking people out of the criminal justice system, with highly significant public sector cost savings, and getting

¹⁰³ The study involved 43 in-depth interviews with young people aged 12 to 20 who had accessed seven specialist services in five Drug Action Teams areas. Purposive sampling was used and the key selection criteria were age, sex, ethnicity, referral route and nature of substance misuse. The interviews were digitally recorded, transcribed verbatim, and systematically analysed using the Framework method. Recruitment was carried out via drug workers who approached young people on behalf of the research team. This means that the study represents the views of a group of young people who had relatively positive experiences of the services.

¹⁰⁴ This surveyed service commissioners, providers and users in a representative sample of 50 of the 149 English Drug Action Teams (DAT) and conducted in-depth case studies in six DAT areas. Surveys contained a mix of open and closed questions addressing study aims. The response rate for the survey was: commissioners (90%), 21; NHS Trusts (42%) and voluntary sector providers (NGOs) (64%).

¹⁰⁵ The study planned to recruit 400 service users from seven drug misuse agencies, chosen because of their differences. All were community based but from different treatment sectors and were located in very different catchment areas. The cohort was followed up at six months and outcomes determined the costs of treatment and change in the key domains of substance use, substance dependence, social satisfaction, and psychological morbidity. The EuroQol was used as an outcome measure in order to allow comparisons with NICE criteria for cost effectiveness. The seven participating agencies were intentionally.

people into health and social care systems, with some additional public sector cost. The size of the treatment effect was similar to that found in other areas of healthcare and within the NICE approved cost limit. The key findings were:

- the outcome measures package (RESULT) worked well;
- at six months, societal costs were reduced from a mean of €7,915 (£5,414) to €6,042 (£4,133). The mean change of €1,873 (£1,281) at 6 months was the result of reduced criminal justice costs (- €2,650) (-£1,813) and increased uptake on health and social care (+€778) (+£532);
- the mean cost of treatment for the SIX month period was €946 (£647); and
- the mean change in Quality Adjusted Life Years (QALYs) for this study was 0.29 QALY in 6 months (NICE considers €29,240 (£20,000) - €43,860 (£30,000) an acceptable cost per 1.0 QALY gain).

Other projects as part of DMRI awaiting completion are:

- A national survey of care co-ordination in drug treatment services.
- Interventions supporting and meeting the needs of children and young people who have drug misusing carers.
- A randomised trial of an assessment-led brief intervention with young people who use cocaine powder.
- Interventions for children and families where there is problematic drug use.
- Good practice in working with family members.

Benzodiazepine dependence

A survey¹⁰⁶ of healthcare workers and high-dose benzodiazepine-dependent patients was carried out to obtain their views on service improvements for managing high-dose benzodiazepine dependency. It found that respondents distinguished between two types of benzodiazepine users; 'housewives' with anxiety problems and drug misusers. Neither group was felt to have adequate support services (Kapadia *et al.* 2007).

Goals, motivation and treatment

The DTORS baseline report provides information about goals, motivation and treatment amongst participants in drug treatment (Jones *et al.* 2007a). It was found that 71 per cent of participants had previous experience of treatment. Ninety-nine per cent were able to specify their treatment goals when asked about them. Most commonly (72%) the goal was to stop taking all drugs. Other goals included to 'sort life out' (49%); improve health (21%); and improve employment chances (19%).

To measure motivation the Circumstances, Motivation and Readiness (CMR) scale was adopted for the study, measuring external influences to enter treatment, such as legal and family pressure, and external influences that would inhibit retention in treatment, such as relationships. The scale also measures levels of motivation (based on a recognition of the problems caused by drug use and the need to make changes) and a measure of readiness for treatment (i.e. a recognition of treatment being a necessary route in making changes to drug use and a willingness to enter). Respondents average scores for external influences to enter treatment ranged from 8.5 to 10.4 (between chosen subgroups) out of a maximum score of 15, showing relatively neutral levels of external pressures (legal and family) to enter treatment.

¹⁰⁶ Two focus groups were conducted, one of drug workers and high dose benzodiazepine users and one of drug workers and general practitioners. Groups discussed gaps in service provision for benzodiazepine dependency. Based on a thematic analysis of the discussion, a pilot questionnaire was developed. The final version was sent to all 210 GPs and 21 drug workers in one inner-London borough. The response rate was 105 (50%) and 13 (62%), respectively.

The International Treatment Effectiveness Project

The International Treatment Effectiveness Project (ITEP) is part of the NTA effectiveness strategy, which identified areas for enhancing the quality of treatment interventions (Campbell *et al.* 2007).¹⁰⁷ The project was a collaboration between the NTA, the Institute of Behavioural Research (IBR) in Texas and several service providers in the north west of England and London. ITEP utilised a care planning approach (referred to as “mapping”) in the form of a manual, which was used by trained keyworkers with their clients. It is suggested that previous research had shown that these psychosocial interventions had a number of positive outcomes in terms of clients’ treatment experiences and reductions in illicit drug use.

It is reported that staff were positive about the training and psychosocial interventions, most agreed that they were relevant to their needs and useful, but not all made use of them; lack of time was cited as a barrier. However, services that implemented mapping found that clients had better rapport with their keyworkers, there were improved levels of client participation in treatment and clients benefited from better peer support, compared to clients in those services that did not receive mapping, or received very little. It was, therefore, concluded that there was a positive effect on engagement with treatment where mapping was used.

Involving drug users in treatment decisions

Fischer and Neale (2008) explore the problems that can arise when trying to involve illicit drug users in decisions about their own treatment.¹⁰⁸ It was found that problems can be substantial and complex and that difficulties in implementing user involvement in drug treatment decision making could be grouped under five broad headings:

- the perceived characteristics;
- the needs and expectations of drug users;
- the attitudes of professionals;
- the nature of treatment dynamics; and
- structural factors affecting service provision.

They conclude that user involvement is achievable but difficult and that policymakers and practitioners who seek to promote it will consequently need to develop strategies for overcoming the kinds of problems identified in order that participation is not unnecessarily hampered and the benefits of involvement can be maximized.

¹⁰⁷ Four services, comprising 24 sites, in Greater Manchester took part in the project. Two services from London were also involved, but due to differences in training schedules the results from London services were not available prior to publication. Questionnaires were completed by service staff and clients, which assessed the organisational climate and clients’ opinions of their treatment. Data were collected in two waves: one before the implementation of the psychosocial interventions and the other three months after implementation. In addition, two questionnaires were completed by keyworkers trained in implementing the manual, which measured views on training and, at a later period, their views on how useful the manual was.

¹⁰⁸ Data were collected as part of a larger study of drug-user involvement in service planning, service delivery and individual treatment decisions (Fischer *et al.* 2007), reported in last year’s United Kingdom Focal Point report. Semi-structured interviews were conducted in four case-study drug services: two specialist community prescribing agencies (one in Scotland and one in England) and two residential rehabilitation agencies. Semi-structured interviews (n¼187) were conducted in two specialist community prescribing agencies and two residential rehabilitation agencies. Seventy-nine new treatment clients were interviewed, and 59 of these were re-interviewed three months later. Interviews were also conducted with 27 agency staff and 22 individuals who had referred the drug users into treatment.

Women's drug use and treatment in the United Kingdom

In a review, Simpson and McNulty (2008) explore how women's experience of drug use differs from men, and the implications that this has for delivering drug treatment. They conclude that women face different problems; including pregnancy, childcare responsibilities, mental health problems and abuse; many are also engaged in sex work. However, gender tailored services are limited, and they therefore argue that drug services in the United Kingdom need to be better tailored to meet the specific needs of women.

The impact of violence and abuse on engagement and retention rates for women in substance use treatment

In a study to explore what is known about the impact of violence and abuse towards women on their rates of engagement and retention in substance use treatment, Galvani and Humphreys (2007)¹⁰⁹ found that the research literature was extremely limited and no reliable conclusions can be drawn from it. Key informant data resulted in four relevant themes: women facing the "push-pull" of wanting to attend treatment but being pressured not to by perpetrators; women facing an increased risk of abuse if they attend treatment through the perpetrator reasserting control; the enormity of the situation for women coping with dual problems; and practical barriers, for example, a male-oriented service.

Harm reduction findings from NTA 2006 user survey

This report investigates the harm reduction support received by the users of drug services, as well as pharmacy-based needle exchange services (See 7.3.1).

5.3 Pharmacologically assisted treatment

5.3.1 Withdrawal treatment

See the NTA Briefing on naltrexone implants in 5.2.4 above.

Research

Detoxification in rehabilitation services in England

Meier *et al.* (2007) looked at self-reported treatment provision in 87 residential rehabilitation services in England, 34 of whom reported that they offered detoxification services within their treatment programmes. It was found that although there were no differences in self reported treatment philosophies, residential rehabilitation services that offered detoxification were typically of shorter duration overall, had significantly more beds and reported offering more group work than residential rehabilitation services that did not offer detoxification. Outcomes were also different, with twice as many clients discharged on disciplinary grounds from residential rehabilitation services without detoxification facilities. Given these findings the authors question the current United Kingdom classification of residential drug treatment services as either detoxification or rehabilitation and suggest the need for greater research focus on the aims, processes and outcomes of this group of treatment providers.

5.3.2 Substitution treatment

Only in Northern Ireland is substitute prescribing monitored.

Statistics from the Northern Ireland Substitute Prescribing Database: 31 March 2007

It is reported that during 2006/07:

¹⁰⁹ The study comprised a literature review and interviews with 13 key informants drawn from substance use treatment providers.

- 463 individuals were in contact with substitute prescribing treatment services; and
- 95 individuals discontinued from the scheme, the main reason given was 'managed discontinuation of substitute prescribing' (DHSSPSNI 2007a).

The prescribing of heroin

In 2008 the British Medical Journal¹¹⁰ was involved in a debate on the question of whether heroin addicts who are hard to treat should be prescribed heroin. Opinion was divided, whilst some proposed that such treatment is appropriate under specific circumstances, others suggested that it is not appropriate as it merely stabilises the user and does not treat the effects of misuse; also that there is inconclusive evidence with respect to heroin prescribing.

In Scotland three practitioners have a licence to prescribe diamorphine for the treatment of substance misuse but are not currently using it (internal communication from the Scottish Government).

Also see guidelines on ethical prescribing in section 5.2.4, and the audit of prescribing practitioners and the improvement review of prescribing drugs in 5.2.5 above.

Research

Community pharmacies and the provision of opioid substitution services

In a survey of clinical activity and attitudes with regard to the treatment of opioid misusers by community pharmacists in 2005, Sheridan *et al.* (2007)¹¹¹ replicated a survey undertaken in 1995 (Sheridan *et al.* 1996). It was found that there had been a major increase in the number of patients to whom individual pharmacies were dispensing, from 54 per cent in 1995 to three-quarters; the overall number of patients being dispensed opioid prescriptions increased from 5,284 to 12,772. Another change had been the widespread introduction of supervised consumption of methadone and buprenorphine, with nearly two thirds undertaking this supervision.

However, it was suggested that there is still considerable unutilised capacity, in particular for the supervision of substitution treatment, with 92 per cent of dispensing community pharmacies willing to do so. Also, a minority of respondents endorsed an expansion in their role, such as the administration of naloxone in an emergency, supervision of self-administration of injectable opioid maintenance treatment and administration of hepatitis B vaccinations.

¹¹⁰ See: <http://resources.bmj.com/bmj/about-bmj>

¹¹¹ A random one-in-four sample ($n = 2473$) of the approximately 10 000 registered community pharmacies across England was selected. The sample was stratified by the 28 Strategic Health Authorities (SHAs) of England. This replicated a previous survey in 1995, but the 2005 questionnaire was slightly modified to allow entry of information on more patients. A 95 per cent (2349/2473) overall response rate was achieved.

6. Health correlates and consequences

6.1 Overview

The United Kingdom submits two sets of tables to the EMCDDA based on three definitions of drug-related death (DRD); each is slightly different. The EMCDDA definition refers to deaths caused directly by the consumption of one or more illegal drug.¹¹² The definition used by the Office for National Statistics (ONS) is a much wider definition and includes legal drugs.¹¹³ The third definition, used to measure deaths for the United Kingdom Drug Strategy, is where the underlying cause is drug abuse, drug dependence, or poisonings where any of the substances scheduled under the *Misuse of Drugs Act 1971* are involved. This definition has been adopted by the General Mortality Registers (GMRs) across the United Kingdom and is a subset of the ONS definition. Information on deaths is also available from the Special Mortality Register (SMR).¹¹⁴ In the United Kingdom, based on the EMCDDA definition, DRDs rose steadily from 1996, when 1,152 deaths were registered, until 2000, fell until 2003, and have peaked and fallen since. Latest information is for 2006 when there was a fall to 1,785 from 1,812 since the previous year. Males are more likely to suffer DRDs than females, by over 4:1, with the difference reducing over the last decade. Overall, the average age at death has gradually risen, in 2006 it was 36.5 compared to 33.9 in 2000. Males were approximately four years younger than females at death (35.6 years and 40.0 years respectively). Information on deaths in 2007 is also available suggesting a small rise in numbers, but it is not based on the EMCDDA definition for the United Kingdom. There are variations in patterns across the United Kingdom, with Scotland showing a more conspicuous increase over time than elsewhere. Most deaths are associated with opiates, chiefly heroin/morphine and methadone. Deaths where there is mention of cocaine have risen steadily and in 2007 there were 243.

HIV prevalence among injecting drug users (IDUs) in the United Kingdom has been at around one per cent since the mid-1990s, although in London it has been higher at, or near, four per cent. There is emerging evidence that suggests a possible increase in transmission in recent years. There were an estimated 2,000 people living with HIV infection acquired through injecting drug use in 2004, of whom 600 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. Prevalence of antibodies for hepatitis B (anti-HBc) declined in the early 1990s, and has levelled off at around 20 per cent. Other infections among IDUs, such as wound botulism and injecting site infections, are also a continuing problem. Data suggests that prevalence remains stable, although HIV is slightly lower in 2007 than in the previous year, when it increased a little; nevertheless prevalence remains higher than

¹¹² These deaths are known as 'overdoses', 'poisonings' or 'drug-induced deaths'. This definition was agreed by the EMCDDA group of national experts: see methodological notes 'Drug-related death EMCDDA definition' in the 2005 statistical bulletin and DRD standard protocol v3.1.

¹¹³ The ONS definition uses ICD-10 codes equivalent to F11-F16, F18, F19, X40-X44, X60-X64, Y85, Y10-Y14 from 2000, prior to that IC9 codes 292, 304, 305.2-9, E858-8, E950.0-.5, E980.0 -.5, E962.0.

¹¹⁴ The data source for SMR are inquests into drug-related deaths reported by Coroners in England, Wales, Northern Ireland, Guernsey, Jersey and the Isle of Man & Procurators Fiscal in Scotland.

in 2000. There has been little change in the prevalence of hepatitis C in the last year, however, prevalence is again higher than at the beginning of the decade.¹¹⁵

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

Evidence of the extent of other physical health problems associated with problem drug use¹¹⁶ are not readily available.

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

6.2 Drug-related deaths and mortality of drug users

6.2.1 Direct overdoses and indirect drug-related deaths

Using the EMCDDA definition of drug-related death, the latest information across the United Kingdom is for 2006. There were 1,785 deaths, a decrease of 1.5 per cent since 2005 (1,812) (Figure 6.1). Differences exist between parts of the United Kingdom; deaths in Scotland increased from the previous year (from 352 to 416), but in England and Wales fell from 1,429 to 1,345, and in Northern Ireland, 31 to 24.¹¹⁷

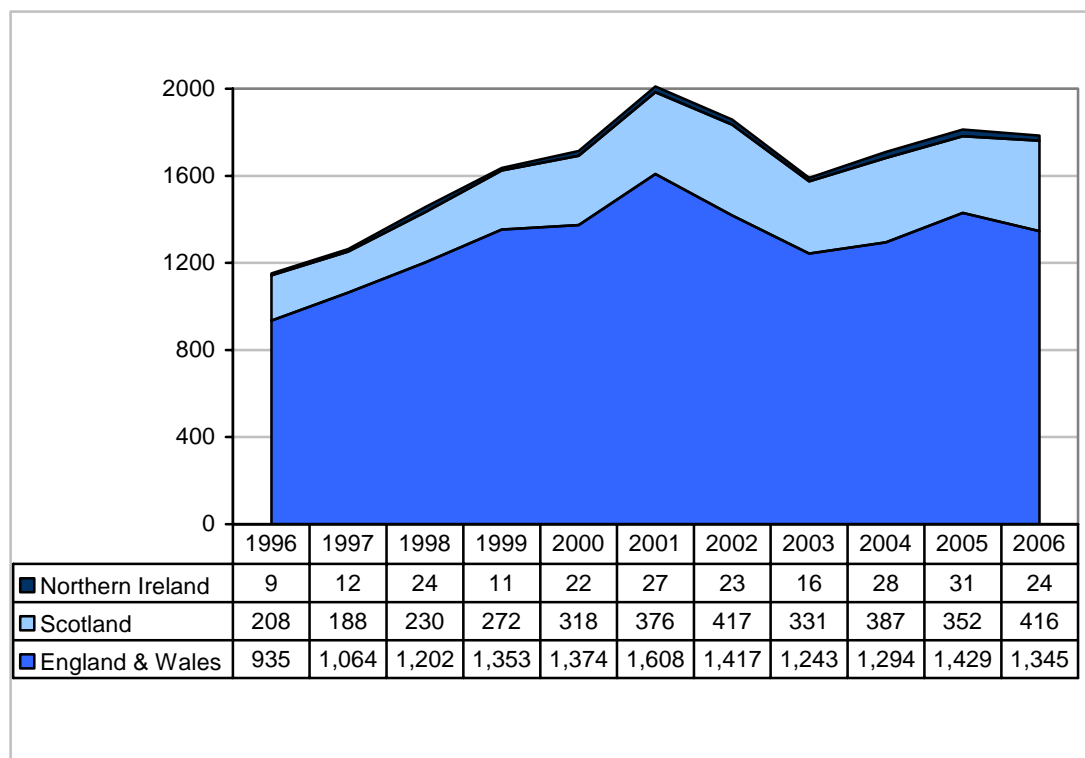
¹¹⁵ Data on the prevalence of blood borne infectious diseases amongst injecting drug users (IDUs) are provided by a number of sources. The Unlinked Anonymous Prevalence Monitoring Programme's (UAPMP) surveys of IDUs in contact with drug services in England, Wales and Northern Ireland (Hope *et al.* 2001; 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.

¹¹⁶ These includes thrombosis, blood clots and gangrene as well as health problems that are associated with problem drug users' lifestyles including poor diet.

¹¹⁷ Information is from GROS for England and Wales and Scotland for year of registration of death. Northern Ireland data is based on year of death, this is because of a backlog in

The rate per 100,000 population was 2.95, but in Scotland the rate was 8.13, in England and Wales, 2.50 and in Northern Ireland, 1.38.

Figure 6.1: Deaths in the United Kingdom 1996-2006: EMCDDA definition



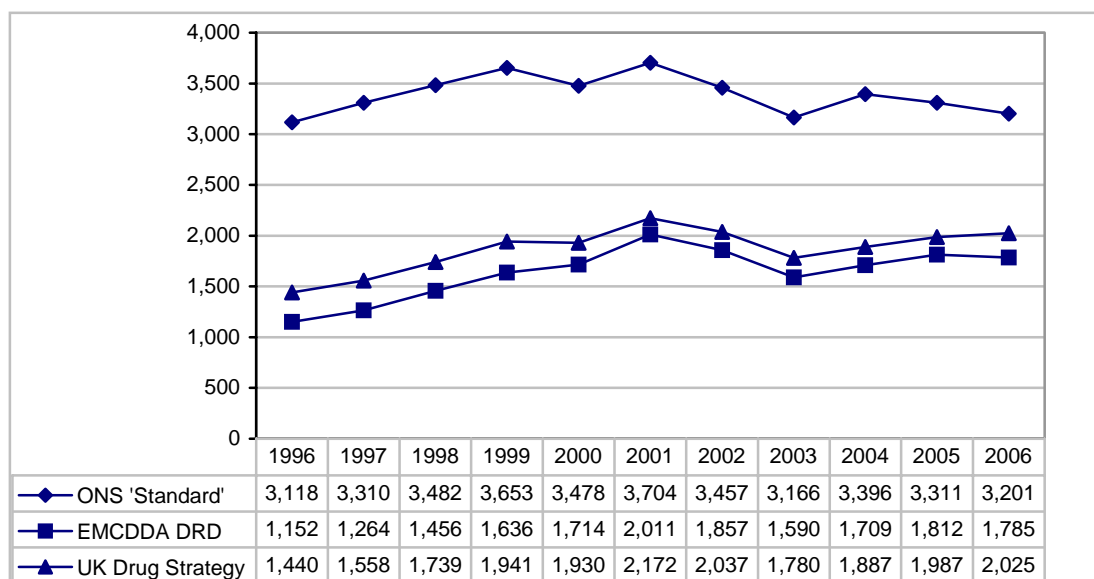
Source: Compiled by J Corkery with data supplied by the General Mortality Registers and NISRA 2008

The slightly different Drug Strategy definition, which measures the impact of the United Kingdom Drug Strategy¹¹⁸, shows the number of deaths in 2006 was 2,025; higher than the EMCDDA definition, a fall of two per cent since 2005 (1,987). The total number of deaths in 2006 using the ONS definition was 3,201, a fall of 3.3 per cent from the previous year (3,311). Deaths fell steadily from 2001 but, since 2004, have risen and continued to do so in 2006 (ONS 2007). Differences between the three definitions are shown in Figure 6.2.

registration mentions means that deaths going back as far as 2001 may not have been registered until 2007, therefore distorting the number of deaths in a given year.

¹¹⁸ This definition is mainly relevant to England, but for the purpose of this report, it used to compile data on DRDs across the United Kingdom.

Figure 6.2: Comparison of total number of deaths using three definitions in the United Kingdom, 1996 – 2006

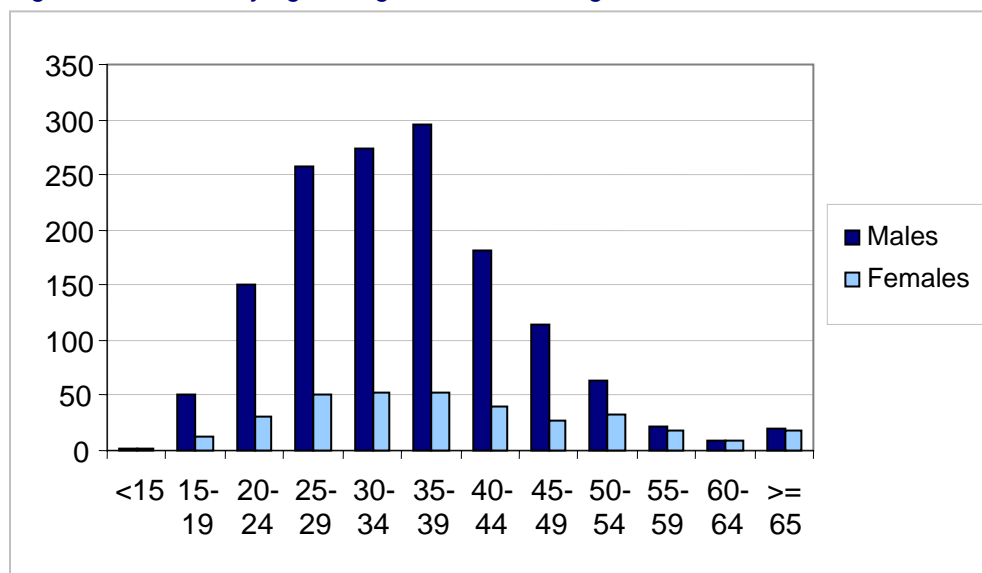


Source: Compiled by J Corkery with data obtained from General Mortality Registers and NISRA 2008

Age and Gender

Based on the EMCDDA definition, 80.6 per cent (1,438) of deaths involved males and 19.4 per cent (347) females. The average age of those dying was 36.5 years (SD 11.4), with males (35.6 years, SD 10.5) tending to be about four years younger than females (40.0 years, SD 14.3) (Figure 6.3). Age at death tended to be higher in Northern Ireland than in the rest of the United Kingdom. Overall, the highest number of deaths occurred in the 35 to 39 age group; this was true for both males and females. Figure 6.3 shows the number of deaths by age group and gender.

Figure 6.3: Deaths by age and gender United Kingdom, 2006: EMCDDA definition



Source: Compiled by J Corkery with data obtained from General Mortality Registers and NISRA 2008

6.2.2 Drug-related deaths in 2007

Statistics on drug-related deaths in England and Wales for 2007 have been published (ONS 2008). This provides information on deaths using both the ONS and drug strategy definition. However, at the time of writing it was not possible to categorise deaths in England and Wales in 2007 using the EMCDDA definition. Information on deaths from Scotland (GROS 2008) and Northern Ireland (NISRA 2008) for 2007, allows for categorisation using all three definitions. Using the EMCDDA definition, deaths in Scotland continued to rise in 2007, by eight per cent, from 416 to 450. Deaths registered to the end of 2007 in Northern Ireland fell substantially, from 24 to six.

Based on the drug strategy definition, deaths in the United Kingdom rose slightly (by 2%) in 2007, from 2,025 to 2,069, this rise being seen in England and Wales (from 1,573 to 1,604) and in Scotland (from 421 to 455), but there was a fall in deaths in Northern Ireland, from 31 to 10.

Based upon the much broader ONS definition, there was a small increase (2.7%) from 3,201 to 3,290. Increases can be seen in England and Wales (from 2,570 to 2,640) and in Scotland (from 578 to 630), but there was a decrease in Northern Ireland from 53 to 20.

Drugs mentioned on death certificates in the United Kingdom

New information on drugs mentioned on death certificates are available for 2006 and 2007 (Table 6.1). Most deaths continue to be associated with opiates (chiefly heroin/morphine and methadone), often in combination with other drugs and alcohol. Table 6.1 shows that mentions of heroin/morphine on death certificates increased by 14.4 per cent in 2007, having fallen in 2006. There was also an increase in mentions of cocaine in both years. Mentions of methadone also increased in 2006 and 2007, with 2007 figures being 50 per cent higher than in 2005.

Table 6.1: Drug mentions on death certificates in the United Kingdom, 2002 to 2007

Drug	Year					
	2002	2003	2004	2005	2006	2007
Heroin/ Morphine	1,120	874	979	1,049	978	1,119
Methadone	297	289	290	294	338	440
Cocaine	160	158	193	221	225	243
Ecstasy	76	67	62	69	66	58
Diazepam	357	287	223	208	178	205
Temazepam	92	106	87	56	55	52

Source: Compiled by J Corkery with data obtained from General Mortality Registers and NISRA 2008

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

Data from the SMR (np-SAD) database are broadly consistent with those from ONS. The np-SAD Annual Report for 2008 (Ghodse *et al* 2008).

- In 2007 there was an increase of about 13 per cent from 1,366 to 1,539.
- The demographic profile remains consistent with previous reports. The majority of cases were males (77%), under the age of 45 years (71%), and White (95%).
- Throughout the period 1997 to 2007 about two-thirds of cases had a history of drug abuse or dependence, and on average death was 14 years earlier than for those without such a history.
- In 2007, 69 per cent of cases died in a defined residential address, 19 per cent in hospital, and 12 per cent elsewhere (e.g. a public place).

- In 2007, 49 per cent of those who died were unemployed. Forty-three per cent lived with others, compared to 45 per cent who lived alone, whilst five per cent were of no fixed abode.
- The principal underlying causes of death were: accidental poisoning (63%); intentional self-poisoning (13%); and poisoning of undetermined intent (12%).
- Opiates/opioids (heroin/morphine, methadone, other opiates/opioid analgesics), alone or in combination with other drugs, accounted for the majority (71%) of fatalities. Heroin/morphine, alone or in combination with other drugs, accounted for the highest proportion (48%) of fatalities.
- Deaths involving methadone were more likely to be the result of illicit (70%) rather than prescribed drugs.
- The proportion of cases involving methadone increased from 17 per cent to 20 per cent; the number of such cases increased from 264 to 295.
- The proportion of cases involving cocaine increased from 11 per cent to 16 per cent; the number of such cases increased from 174 to 239.
- The proportion of cases involving hypnotics/sedatives increased from 17 per cent to 21 per cent; the number of such cases increased from 259 to 309 .
- The proportion of cases involving alcohol in combination with other substances increased from 34 per cent to 38 per cent; from 525 to 554.
- There was one death involving LSD; the first notified since 2002.

To date, there were six cases in both 2006 and 2007 where methamphetamine was reported in the post mortem toxicology to the np-SAD. In one of the cases in 2007, death was due to mixed drug poisoning including methamphetamine. In other cases it seems likely that the presence of the substance was associated with the use of ecstasy.

The np-SAD is aware of a minimum of 12 deaths in England and Wales (there have been none in Scotland or Northern Ireland) up to the end of 2007 where piperazines have been found at post-mortem; one of these has yet to go to inquest. Details for three of the cases are given in the literature review below (Elliot and Smith 2008). For the 11 cases occurring in 2006 to 2007 reported to np-SAD, benzylpiperazine (BZP) and 3-Trifluoromethylphenylpiperazine monohydrochloride (TFMPP) were found in six cases; BZP in four cases, and chlorophenylpiperazine (CPP) in one case. In two cases piperazines (BZP; BZP and TFMPP) were mentioned specifically, along with other substances, in the cause of death. In a further case CPP was included in the substances where the death was described as multiple mixed drug intoxication.

One death from cocaine toxicity, following the swallowing of cocaine powder mixed with water, occurred in 2007. This is believed to be the first such case in the United Kingdom.

6.2.4 Deaths associated with Volatile Substance Abuse

There were 49 deaths associated with volatile substance abuse in 2006 (45 in 2005). This is the third lowest figure since 1981 and compares with a peak of 152 in 1990 (Field-Smith *et al.* 2008). Gas fuels, including 21 lighter fuel deaths, accounted for 27 cases; aerosols for six; nitrous oxide five; 'poppers' three; and other substances accounted for seven cases. Six of the deaths occurred in the under 18 years age group, eight were aged 18 to 24 years, and 17 were aged 25 to 34 years. The median age was 33 years (range 15 to 72 years).

6.2.5 AIDS

Deaths of injecting drug users (IDUs) (including IDUs who have sex between men) accounted for 7.9 per cent (1,269/16,102) of the total number of AIDS deaths in England and Wales up to the end of December 2007. In Northern Ireland the proportion was five per cent (4/79), but in Scotland it was 51 per cent (727/1,438). The decline in the number of deaths of IDUs with AIDS seen in recent years has leveled off. The United Kingdom figure of 51 for 2006 (79 in 2005) is about 37 per cent of the peak level in 1995 (212). By the end of December 2007, 34 deaths had been reported for that year; the number is likely to increase (personal communication to John Corkery from Health Protection Agency).

Research

Geographical variation in DRD in England and Wales

A paper accompanying the publication of the latest drug-related death figures in England and Wales, considered geographical variations in death (based on the drug strategy definition) between 1993 and 2006 (Griffiths *et al.* 2008). The Government regions with the highest mortality rates over this period were the North West, Yorkshire and the Humber, and London; however, by 2004 to 2006 London had amongst the lowest rates anywhere. Rates were highest in urban areas and lower in rural areas.

Problems associated with defining and classifying drug-related deaths

The problems associated with defining and classifying drug-related deaths is the subject of an article by Corkery (2008). This summarises different approaches to defining what constitutes a DRD and how they can be classified. DRDs usually fall into two broad categories: those directly attributable to the consumption of drugs (both illegal and licit), for example, overdose and poisoning, and indirect, those which occur as a consequence of having a drug habit that exposes individuals to the risk of dying in some other way, e.g. blood-borne infections or accidents. Most attention is currently given to direct or acute DRDs rather than the long-term consequences of drug abuse. Problems associated with accurately deriving DRD statistics are outlined. It is suggested that despite limitations, such information is essential for identifying issues related to drug use and measuring progress against targets set for reducing DRDs.

Drug deaths in the North Staffordshire area

Smith and Crome (2007) report that the annual reports for drug abuse deaths in the North Staffordshire area are, as a whole, about average for the country. The figures for the period 2001 to 2005 indicate an average of just over eight deaths *per annum* in the under 30 age group, with a peak of 13 in 2002 and only six in 2005. Interestingly, deaths from drug abuse, which invariably involve heroin in all age groups, typically and increasingly take place in the older age groups.

Deaths identified in the DORIS cohort

Secondary analysis of the DORIS cohort study¹¹⁹ found that 38 deaths occurred, giving a standardised mortality ratio for the cohort of 1,244 (Bloor *et al.* 2008) but only 22 were classified as drug-related deaths. From estimates of the size of the problem drug using populations in both England and Scotland, the contribution of deaths in drug users to national death rates was estimated; the attributable risk fraction for Scotland is 17.3 per cent and that for England is 11.1 per cent. Excluding estimated numbers of deaths in drug users brings down the age-standardised mortality at ages 15 to 54 years from 196 to 162 per 100,000 in Scotland and from 138 to 122 per 100,000 in England; 32 per cent of the extra mortality in Scotland is due to drug use.

¹¹⁹ 1,033 Scottish drug users recruited in 2001/02 and followed up at 33 months.

The researchers conclude that the standardised mortality ratio for Scottish drug users is 12 times as high as for the general population. The higher prevalence of problem drug use in Scotland than in England accounts for a third of Scotland's excess mortality over England.

Drug deaths in Fife, 2005 to 2007

The Fife Drug Deaths Monitoring and Prevention Group investigated drug deaths in Fife in 2005-07 (Baldacchino *et al.* 2008). The number of deaths was higher in 2006 (19) and 2007 (20) than in 2005 (15) but below the Scottish average. The investigation found that deaths were more likely to occur in socially deprived areas and areas with other drug-related problems. The mean age of decedents was 31 years (range 17 to 48). Multiple morbidities were present in the youngest and oldest individuals; the youngest tending to have psychological conditions; the oldest had physical health problems. Most deaths occurred in Spring and at the weekend. Heroin/morphine (80%), diazepam (43%) and alcohol (35%) were the three main substances of misuse detected. Benzodiazepines are the substances most commonly implicated (89%). Psychostimulants (for example, MDMA) were involved in 10 per cent of deaths; however there is a recent emergence (2007) of deaths involving cocaine. These findings are consistent with Scotland-wide research but not reflected in United Kingdom national research where heroin/morphine, alcohol and other opioids are the most frequently detected substances of misuse. Twenty-two per cent were receiving pharmacological treatments; most were prescribed methadone (18%). Of these decedents, 16 per cent were still on a methadone programme when they died.

Withdrawal of co-proxamol

Legislative changes in 2005 led to a phased withdrawal of co-proxamol from the United Kingdom market. Sandilands and Bateman (2008) undertook a retrospective, observational study of mortality relating to poisoning by single agents in Scotland for the period 2000 to 2006. Mortality data were obtained from the General Register Office Scotland, and primary care prescribing data from the Information and Statistics Division of the Scottish Executive Health Department. A significant reduction in the proportion of poisoning deaths involving co-proxamol was observed following the changes in legislation (mean 2000 to 2004, 37 deaths, 21.8% of total poisoning deaths; 2006, 10 deaths, 7.8% of total poisoning deaths). The most significant reduction was seen in male out-of-hospital deaths (mean 2000 to 2004, 17 deaths 21.8% of total poisoning deaths; 2006, two deaths 2.9% of total poisoning deaths). This was associated with a decline in prescriptions by 60 per cent within six months of legislation. The authors argue that legislation has resulted in a major reduction in the number of deaths associated with co-proxamol poisoning in Scotland, with no compensatory increase in mortality from poisonings from other common analgesics. They extrapolate that a minimum of 300 lives across the UK have been saved by the withdrawal of co-proxamol.

Suicide and homicide by people with mental illness

In June 2008 the Centre for Suicide Prevention published its findings for Scotland on suicide and homicide by people with mental illness (CSP, 2008).¹²⁰ Amongst the range of issues explored were the roles of alcohol and drug misuse in such deaths.

There was a history of alcohol misuse in 785 suicides by patients with mental illness (an average of 131 deaths per annum) and a history of drug misuse in 522 (an average of 87 deaths per annum). Dual diagnosis (severe mental illness and drug or

¹²⁰ The study covers 1,373 patient suicides in the period January 2000 to December 2005; and 58 homicides by patients in the period January 2000 to December 2004.

alcohol dependence/misuse) was found in a quarter of patient suicides, 343 in total, an average of 57 deaths per annum.

More than three quarters (45) of patients who were perpetrators of homicide had a history of drug misuse. Almost three quarters (41) had a history of alcohol misuse. About a quarter (13) were identified as having a dual diagnosis.

In both suicide and homicide, most were not under the care of addiction services. The report concludes that alcohol and drugs are the most pressing mental health problems in Scotland and makes recommendations for development of services.

Confidential enquiries into maternal deaths in the United Kingdom

The seventh report on confidential enquiries into maternal deaths in the United Kingdom reported on deaths between 2003 and 2005 (Lewis 2007). Maternal deaths are extremely rare; 295 women died from causes directly or indirectly related to their pregnancy, out of more than two million mothers who gave birth in the United Kingdom during this period. Eleven per cent of those who died of any cause had problems with drugs or alcohol; 60 per cent of the latter were known to drug services. Fifty-seven women out of the 98 women whose deaths were attributable to psychiatric causes had problems with substance abuse; 45 were misusing drugs and 12 were alcohol dependent. One death resulted from volatile substance abuse. The majority of those who were drug dependent were using heroin, but most were also using methadone, amphetamines, cocaine, benzodiazepines and some were also using alcohol. A small number died from suicide, the rest died from an accidental overdose, physical consequences of their abuse or related medical conditions. Some died from domestic abuse. Many of the subjects were socially excluded; most being homeless or living in very inadequate conditions. The report concludes that substance misuse makes a significant contribution to maternal mortality in general, and especially to psychiatric causes.

Drug-related deaths among newly released prisoners

Farrell and Marsden (2008) investigated drug-related deaths among newly released prisoners in England and Wales.¹²¹ They recorded 442 deaths, of which 261 (59%) were drug-related. In the year following release, the drug-related mortality rate was 5.2 per 1,000 among men and 5.9 per 1,000 among women. All-cause mortality in the first and second weeks following release for men was 37 and 26 deaths per 1,000 per annum, respectively (95% of which were drug-related). There were 47 and 38 deaths per 1,000 per annum, respectively, among women, all of which were drug-related. In the first year after prison release, there were 342 male deaths (45.8 were expected in the general population) and there were 100 female deaths (8.3 expected in the general population). Drug-related deaths were attributed mainly to substance use disorders and drug overdose. Coronial records cited the involvement of opioids in 95 per cent of deaths, benzodiazepines in 20 per cent, cocaine in 14 per cent and tricyclic antidepressants in 10 per cent. They concluded that newly released prisoners are at acute risk of drug-related death.

Alcohol and heroin/opiate overdose

Hickman *et al.* (2008a) reviewed the evidence in support of the hypothesis that alcohol increases the risk of a heroin/opiate overdose through a pharmacological interaction. A few facts are already well established, including that: opiate overdose deaths rarely involve a single drug; alcohol is the most common substance involved; there is a negative association between alcohol and morphine concentration at post mortem; and post-mortem levels of morphine are often below the levels expected of

¹²¹ They took into account a national sample of 48,771 male and female sentenced prisoners released during 1998-2000 with all recorded deaths included to November 2003.

highly tolerant individuals. Although the existing evidence, according to the authors, is consistent with the hypothesis that heroin users who drink alcohol may require less heroin to overdose than those who do not drink (all other factors being equal), other causal (and non-causal) pathways could not be ruled out. They suggested that alcohol could be associated negatively with tolerance, or confounded by other factors.

Mortality and piperazines

Elliott and Smith (2008) used ultraviolet and liquid chromatography-mass spectrometry data to distinguish the structures of positional isomers of TFMPP and CPP, and confirm the presence of BZP and 3-TFMPP in three UK fatalities (road traffic deaths and a fatal fall), with two cases involving both drugs. These are the first reported cases of 3-TFMPP in post-mortem fluid. In all cases, other drugs and/or ethanol were found. BZP was found at concentrations of 0.71, <0.50, and 1.39 mg/L and 3-TFMPP was found at concentrations of 0.05 and 0.15 mg/L in post-mortem blood. Concentrations were also measured in urine. Although BZP and 3-TFMPP were not the direct cause of death, it is suggested that the toxicological findings may assist the interpretation of future cases involving these drugs.

Patterns of mortality amongst injecting and non-injecting drug users in contact with treatment services

Hurst *et al.* (2007) studied the causes of death amongst individuals in contact with treatment services in the North West of England.¹²² There were 285 individuals confirmed as having died over the period, three-quarters of whom were male. According to the drug strategy definition of DRD, 93 (33%) of those confirmed as dead, died from a DRD. Those who died from a DRD were significantly younger (mean age 33.2 years) than those who died of other causes (mean age 39.9 years). Seventy-six had an injecting history. Individuals with an injecting history were significantly more likely to die from a DRD than those with no injecting history. They were also more likely to die from heart complications, 23 per cent (n=19) compared to 7 per cent (n=5) of non-injectors. The study also found that a large minority of non-DRDs were attributable to liver disease (16%, n=31), with 24 deaths being directly linked to alcohol. The authors conclude that the disparate causes of death amongst injectors and non-injectors highlight the need to address general physical and psychological health of those in treatment rather than concentrate on specific diseases.

6.3 Drug-related infectious diseases

Information on infectious disease is based on *Shooting Up: Infections among injecting drug users in the United Kingdom 2007. Update 2008* (HPA *et al.* 2008).

6.3.1 HIV

The overall prevalence of HIV seen among IDUs in 2007 was similar to that seen in recent years, and remains higher than that seen in the late 1990s. The Unlinked Anonymous Prevalence Monitoring Programme (UAPMP) survey of current and former IDUs in England, Wales and Northern Ireland indicates an overall HIV prevalence of 1.1 per cent in 2007 (HPA *et al.* 2008). In London, the prevalence was 3.9 per cent, whilst elsewhere in England it was 0.56 per cent. Combining data for

¹²² The regional National Drug Treatment Monitoring System (NDTMS) dataset were interrogated to identify individuals who treatment services reported as having died between April 2003 and March 2006. Death certificates were obtained from the Office for National Statistics (ONS) and injecting status was determined by NDTMS data and information from the Cheshire and Merseyside Inter Agency Database, which collects data on those in contact with agency and pharmacy exchanges in the region.

2006 and 2007, the prevalence of HIV infection among IDUs in the UAPMP agency survey in Northern Ireland was 1.9 per cent and in Wales, 1.1 per cent.

There is evidence that ongoing HIV transmission among IDUs within the United Kingdom has increased in recent years. In particular, HIV prevalence amongst recent initiates (those injecting for less than three years) in England, Wales and Northern Ireland has been elevated since 2003. The prevalence among the recent initiates participating in the UAPMP survey was 1.0 per cent in 2007 compared to 0.25 per cent in 2002.

In Scotland, the prevalence of HIV among IDUs is monitored through the surveillance of people undergoing voluntary confidential HIV testing. This found a HIV prevalence of 0.3 per cent among IDUs undergoing testing during 2007; this compares with prevalences of 1.4 per cent to 3.2 per cent in the early to mid-1990s and 0.5 per cent to 0.9 per cent during the period 1998 to 2006.

The annual number of HIV diagnoses among IDUs in recent years has been low and relatively stable, at an annual average of 144 reports during the period 1998 to 2007. By the end of June 2008, 152 HIV diagnoses, where infection was thought to have been acquired through injecting drug use, have been reported in the United Kingdom for 2007 (62 in London, six in Scotland, and 84 elsewhere). This figure is likely to rise further as additional reports are received for 2007. Whilst the annual number of reports of newly diagnosed HIV infections associated with injecting drug use has not changed greatly over recent years, the proportion of the reports from outside London and Scotland has increased from 34 per cent during the period 1993 to 1997 to 49 per cent during 2003 to 2007. Of the 152 new diagnoses in 2007, probable country of infection was reported for 61 per cent (93). Where reported, 48 per cent (45) of infections were thought to be acquired within the United Kingdom and 52 per cent (48) outside of the United Kingdom, mostly in Southern Europe.

In 2007, 1,065 HIV-infected IDUs were seen for HIV-related treatment or care in England, Wales and Northern Ireland, a 22 per cent increase since 2000 when 870 IDUs were seen for care. In Scotland, 364 HIV-infected IDUs were seen for HIV-related treatment or care in 2007, a 13 per cent decrease since 2000 when 417 IDUs were seen for care.

6.3.2 Viral hepatitis

The prevalence of hepatitis C infection among IDUs remains high overall. Of the current and former IDUs participating in the UAPMP agency survey in 2007, two-fifths (39%) had antibodies to hepatitis C¹²³, which is similar to that seen in recent years (2006, 41%). The overall hepatitis C prevalence in England was 42 per cent, however, there were very marked regional variations from 21 per cent in the North East to 58 per cent in London and 60 per cent in the North West (data from 2006 and 2007 combined). The prevalence in Wales and Northern Ireland was lower than most of the English regions; combining data from 2006 and 2007, hepatitis C prevalence in Wales was 21 per cent, and in Northern Ireland it was 29 per cent.

Those IDUs participating in the UAPMP survey who had ever been homeless were more likely to have antibodies to hepatitis C (42%) than those who had not (29%).

¹²³ The sensitivity of the oral fluid test used in the UAPMP agency survey is approximately 93 per cent.

Amongst current IDUs participating in the UAPMP survey the prevalence of hepatitis C has increased since the beginning of the decade, from 33 per cent in 2000 to 40 per cent in 2007. There were higher prevalences of hepatitis C infection among several sub-groups of current IDUs. Those who reported injecting crack cocaine in the past four weeks were more likely to have hepatitis C (56%) than those who had not (32%), as were those who reported injecting cocaine powder (48%, compared with 39% of those who had not). Higher prevalence was also associated with the use of some injection sites; those who had injected into their groins in the past four weeks were more likely to have hepatitis C (53%) than those who had not (35%).

In 2007, the estimated sero-prevalence of hepatitis C was 74 per cent among 358 IDUs surveyed at needle exchanges in Glasgow, similar to the estimated sero-prevalence of 71 per cent found among 435 Glasgow IDUs recruited from needle exchanges in 2005. Among 57 current IDUs surveyed in Glasgow in 2007 who had commenced injecting in the previous five years, the sero-prevalence of hepatitis C was 57 per cent; this compares to a sero-prevalence of 50 per cent among 81 equivalent IDUs surveyed in 2005.

Research

Needle Exchange Surveillance Initiative (NESI) in Scotland

In a survey of 667 IDUs recruited from needle exchanges in three NHS Boards in Scotland in 2007¹²⁴, prevalence of antibodies to hepatitis C was 61 per cent (Palmateer *et al.* 2008). Prevalence was highest amongst those aged over 25 and those who had started injecting over three years ago.

Homelessness and the risk of Hepatitis C

In a critical review of homelessness and the risk of hepatitis C, Neale (2007) suggests that although it is difficult to estimate the number of homeless people who are misusing drugs or the number of drug users who are homeless, United Kingdom and international literature indicates a significant overlap between the two groups; a situation described as a 'double jeopardy'.

Hepatitis C infection among female IDU sex workers

A study of female IDU sex workers in Glasgow¹²⁵ identified an hepatitis C antibody prevalence of 81 per cent; a considerably higher rate than the wider injecting population of Glasgow (Taylor *et al.* 2008).

6.3.3 Sexually transmitted infections

Research

Sexual health risk amongst dance drug users

A study by Mitcheson *et al.* (2008) using data taken from the 2003 Mixmag survey, compared sexual health risk amongst dance drug users with general population data from the United Kingdom National Survey of Sexual Attitudes and Lifestyles 2000 Survey (NATSAL 2000).¹²⁶ They found that dance drug users were more likely to

¹²⁴ All clients attending selected needle exchanges in Greater Glasgow and Clyde, Lothian and Lanarkshire NHS Boards were invited to take part if they had injected drugs on a least one occasion. 667 participants completed the survey during May through December 2007 and 640 participants (96%) voluntarily provided a saliva sample for testing for HCV antibodies.

¹²⁵ All women attending the health and social care drop-in centre situated in Glasgow's "Red Light Area" during a four-week period in 1999 were invited to participate. 98 female sex workers provided a saliva sample for anonymous HCV testing and completed a questionnaire.

¹²⁶ Data on dance drug users were taken from the 2003 Mixmag Drug Survey, a self-selecting survey of readers of a dance music magazine. The questionnaire was printed in the

have concurrent sexual partnerships and to have had unprotected sex in the past year; 39.2 per cent of men and 41.1 per cent of women with two or more sexual partners in the last year reported unprotected sex compared to 15.4 per cent and 10.1 per cent respectively in the NATSAL sample. Both males and females in the Mixmag sample were more likely to have been diagnosed with a sexually transmitted infection than those in the NATSAL sample with the difference more pronounced amongst females; 23.3 per cent of females in the Mixmag sample had been diagnosed with a sexually transmitted infection (STI) compared to 12.6 of the NATSAL sample.

DTORS

Baseline data from the Drug Treatment Outcomes Research Study (DTORS) (see Chapter 4.6) show that 48 per cent of treatment seekers had unprotected sex in the past three months, although 70 per cent of those involved regular partners only (Jones *et al.* 2007).

6.3.4 Other infectious morbidity

The following information is reported in *Shooting Up: Infections among injecting drug users in the United Kingdom 2007. Update 2008* (HPA *et al.* 2008).

Cases of wound botulism continue to occur among IDUs in the United Kingdom. In 2007, 11 suspected cases were reported, fewer than in each of the previous three years, with 22, 28 and 41 cases reported in 2006, 2005, and 2004 respectively.

Cases of tetanus continue to occur albeit at lower numbers than in 2003 and 2004. In the three year period 2005 to 2007, seven of the 14 cases of tetanus reported in the United Kingdom were IDUs (four in 2005, one in 2006, and two in 2007) indicating tetanus continues to affect IDUs, albeit at lower levels than in 2003 and 2004.

Cases of severe infection related to both meticillin resistant *Staphylococcus aureus* and *Group A streptococci* continue to occur among IDUs.

Symptoms of a possible injecting site infection appear to be common among IDUs, with 34 per cent of IDUs participating in the UAPMP survey in 2007 reporting they had experienced either an abscess, sore or open wound, possible symptoms of an injecting site infection, during the previous year. The reporting of such a symptom was associated with having been homeless in the last year, with 39 per cent of those homeless during the last year reporting a symptom compared with 32 per cent of those not homeless.

These symptoms of possible injecting site infections were found to be associated with a number of factors among current IDUs. Overall, 40 per cent of the current IDUs participating in the UAPMP survey in 2007 reported these symptoms during the last year. Current IDUs who used the following injection sites during the last four weeks reported higher levels of symptoms: hands (52%, compared with 35% of those who had not), groin (45%, compared with 37% of those who had not), legs (63% compared with 34% of those who had not) and feet (67%, compared with 36% of those who had not). Higher levels of symptoms were also found among those who

September edition of the magazine and was also available online. In 2003, 1,105 people living in the UK completed the sexual behaviour questionnaire. The NATSAL survey used postcode randomisation to generate a sample and 11,161 interviews were completed, a response rate of 65.4%. There are clear differences between the sampling strategies of the two surveys.

in the last four weeks had injected crack cocaine (49%, compared with 34% of those who had not) or cocaine powder (51%, compared with 38% of those who had not).

In July 2008, the Health Protection Agency issued an alert about the possible presence of contaminated heroin.¹²⁷ In the previous month, two cases of a rare wound infection involving the bacterium *Clostridium Novyi* had been identified in Southern England, one of which had resulted in a fatality. A similar outbreak of severe systemic sepsis related to soft tissue inflammation occurred in IDUs in 2000 and again in late 2003/early 2004.

A survey recruiting IDUs from community settings at seven locations across England from 2003 to 2005 collected self-reported information on injecting practice, symptoms of injection site infections (abscess or open wound) and health service utilisation data using a questionnaire (Hope *et al.* 2008). This study also made cost estimates by combining questionnaire data with information from national databases and the scientific literature. It found that 36 per cent of the 1,058 participants reported an injection site infection in the last year. Those reporting an injection site infection were more likely to be female and aged over 24, and to have: injected into legs, groin, and hands in last year; injected on 14 or more days during the last four weeks; cleaned needles/syringes for reuse; injected crack cocaine; have antibodies to hepatitis C; and previously received prescribed substitute drugs. Two-thirds of those with an injection site infection reported seeking medical advice; half attended an emergency department and three-quarters of these reported hospital admission. Simple conservative estimates of associated healthcare costs range from €22.7 million (£15.5m) per year to as high as €44 million (£30m); though if less conservative unit cost assumptions are made the total may be much higher, €69 million (£47m)). The vast majority of these costs are due to hospital admissions and the uncertainty is due to little data on length of hospital stays (Hope *et al.* 2008).

6.4 Psychiatric co-morbidity (dual diagnosis)

6.4.1 Prevalence

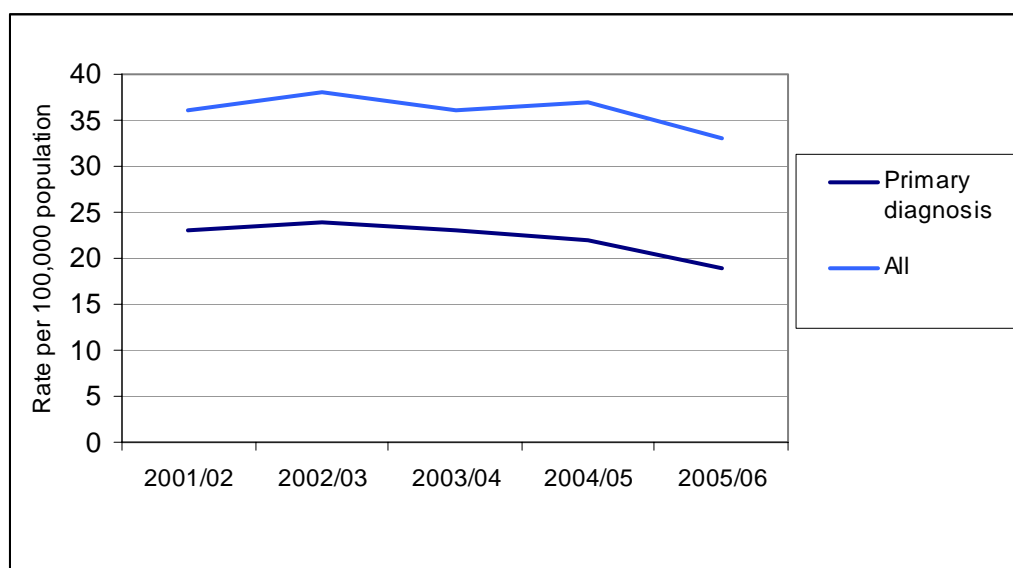
Scotland

In Scotland during 2006/07, 42 per cent of new clients accessing treatment services reported mental health problems as a co-occurring health issue (ISD 2007).

Inpatient hospital data from Scotland show that, in 2005/06, 6.6 per cent of psychiatric inpatient discharges had a diagnosis of drug misuse (as either a main or supplementary diagnosis), a rate of 33 discharges per 100,000 population. Drug misuse was the primary diagnosis in 58 per cent of these discharges. The rate per 100,000 population has remained stable since 2001/02 with a decrease in 2005/06 (Figure 6.4).

¹²⁷ See: <http://www.info.doh.gov.uk/doh/embroadcast.nsf/vwDiscussionAll/9AAE30210778592A8025749100426322>

Figure 6.4: Psychiatric inpatient discharges with a diagnosis of drug misuse in Scotland, 2001/02 to 2005/06; rate per 100,000 population



Source: ISD 2007

Fifty-three per cent of psychiatric inpatient discharges with a discharge diagnosis of drug misuse, recorded use of multiple drugs or other psychoactive substances. Opioid use was the most commonly recorded drug (26%) followed by cannabinoids (16%).¹²⁸

Research

Co-morbid substance misuse in psychiatric patients

Sinclair *et al.* (2008) reported on the prevalence of substance misuse in patients admitted for psychiatric inpatient care in a Mental Health Trust in England.¹²⁹ Alcohol was the most common substance of misuse, with 51 per cent of men and 29 per cent of women screening positive for harmful use of alcohol (defined as a score of eight or more on the Alcohol Use Disorders Identification Test (AUDIT)). Thirty per cent of participants reported use of one or more illicit substances in the month prior to admission; the most commonly reported illicit drug was cannabis followed by cocaine powder. There were statistically significant differences between genders in last month use of cannabis (35% of males reported use compared to 11% of females), amphetamines (9% and 2% respectively), and ecstasy (10% and 2% respectively). Almost two-thirds (64%) of those reporting illicit substance use screened positive for harmful use of alcohol.

Dual diagnosis in psychiatric and drug treatment services

Manning *et al.* (2008) explored the differences in dual diagnosis disorders among patients in psychiatric and drug treatment services.¹³⁰ Prevalence rates of dual

¹²⁸ Figures for 2005/06 are provisional (due to two areas having incomplete information) at the time of writing and may therefore, be subject to revision.

¹²⁹ The study examined rates of co-morbid substance use in patients admitted for psychiatric inpatient care in Oxfordshire Mental Health Trust between 1 July 2005 and 31 October 2005. Of the 238 patients admitted during the study period, 178 (74.8%) agreed to participate in the study, 52 per cent were male and 48 per cent were female. A structured data collection proforma was completed for all patients including class of non-prescribed drug use in the month prior to admission.

¹³⁰ Patients were recruited from four treatment services in one London Borough. Of the 456 patients at the four treatment sites, 222 screened positive for dual diagnosis and 159 took

diagnosis (including alcohol) differed between treatment services, they were: community mental health service (37%), inpatient psychiatry service (56%) and drug dependence treatment service (91%). There were differences between the severity of psychiatric and drug disorders and the authors suggest that the term dual diagnosis can be misleading, masking the diverse range of complex needs amongst patients. They highlight the difference between drug dependent patients with anxiety and depressive problems and patients with serious mental illness such as psychosis, who abuse drugs such as cannabis.

DTORS: Baseline study

Twenty-three per cent of treatment seekers in DTORS had been diagnosed with a mental health condition in their lifetime and 37 per cent had been referred to a psychiatrist, psychologist or other mental health worker. Twenty-eight per cent had received psychiatric treatment, with 11 per cent receiving treatment in the last three months (Jones *et al.* 2007).

6.4.2 Personality disorders

Research

Genotype effects in schizophrenia and interactions with cannabis

Zammit *et al.* (2007) examined whether variants within the cannabinoid receptor (CNRI) genes are associated with schizophrenia and whether these effects vary according to cannabis use.¹³¹ They found that there was no evidence of association between schizophrenia and CNRI genotypes or of interactions between cannabis use and CNRI. Similarly, there was no evidence for any association between COMT variation and cannabis use in the sample of those with schizophrenia.

Effects of cannabidiol on schizophrenia-like symptoms

A study of the effects of cannabidiol on schizophrenia-like symptoms in people who use cannabis¹³² found that participants with both delta-9-THC and cannabidiol (CBD) present in hair samples had lower levels of unusual experiences (hallucinations and delusions) than those with delta-9-THC only (Morgan and Curran 2008). The authors suggest the findings may support previous work showing the antipsychotic properties of CBD. They stress the importance of distinguishing between different cannabinoids and suggest that this has implications for the debate over the link between cannabis use and psychosis.

Prevalence and incidence of schizophrenia in the UK, 1996 to 2005

A study carried out by Frisher and Crome for the Advisory Council on the Misuse of Drugs (ACMD) examined the prevalence and incidence of schizophrenia and psychoses among 900,000 patients attending 183 general practices in the United Kingdom between 1996 and 2005 (ACMD 2008). This tested the projections of

part in the study (72%). A number of standardised measures were used to screen for mental health and substance misuse disorders.

¹³¹ Genotype effects of CNRI were studied in a case-control sample of 750 individuals with schizophrenia and 688 controls, with interactions for these genes studied in small sub-samples. A case-only design of 493 of the schizophrenia group was used to examine interactions between cannabis use and catechol-O-methyltransferase (COMT) (research has suggested that variations in the COMT gene can increase the risk of psychosis in adolescent cannabis smokers)

¹³² The sample consisted of 140 individuals taking part in a longitudinal study involving groups categorised as current and former ketamine users, other drug users and non-users. Using hair analysis, 54 individuals screened positive for cannabis. The sample was divided into three groups: those with delta-9-THC only (n=20); those with delta-9-THC and CBD (n=27); and those with no cannabinoids (n=85). The short form of the Oxford Liverpool Inventory of Life Experiences (OLIFE) was used to assess psychosis proneness.

Hickman *et al.* (2007) (reported in UK Focal Point 2007 Annual Report) which claimed that an increase in cannabis use would lead to an increase in schizophrenia. However, Frisher and Crome found that, despite the increase in cannabis use, both the prevalence and annual incidence of schizophrenia and psychoses have decreased.

Incidence of psychotic disorders

Kirkbride *et al.* (2008) looked at whether the incidence of first episode psychoses had changed over a 20 year period in a single setting.¹³³ The study found that, while the incidence of non-affective or affective psychoses had not changed, there was a linear increase in the incidence of substance-induced psychosis. They conclude that there has been a change in the syndromal presentation of non-affective psychoses over time away from schizophrenia towards other non-affective disorders such as substance-induced psychosis, which is consistent with increases in substance toxicity rather than prevalence or vulnerability to substance misuse.

6.4.3 Anxiety

In the study by Manning *et al.* (2008) (see 6.4.1), eight out of 14 drug treatment patients were diagnosed with anxiety.

6.4.4 Affective disorders

In the study by Manning *et al.* (2008) (see 6.4.1), six out of 14 drug treatment patients were diagnosed with an affective disorder.

6.5 Other drug-related health correlates and consequences

The ACMD published a report summarising the available United Kingdom and international evidence on the impact of cannabis on public health (ACMD 2008a) (see Chapter 1.2.1).

6.5.1 Somatic co-morbidity

In Scotland police issued a warning about poor quality “red heroin”, which crystallises quickly. This means that users are likely to inject more quickly which could cause vein damage, abscesses and deep vein thrombosis.¹³⁴

Research

Crack cocaine-heroin speedball injecting

Rhodes *et al.* (2007) reported on a qualitative study with crack cocaine-heroin speedball injectors.¹³⁵ The latter was associated with a higher level of vein damage and a shift towards groin injection. Participants identified deep vein thrombosis, septicaemia and bacterial infections as complications associated with groin injection and the authors identified five main strategies used by injectors to reduce risks

¹³³ Data from three similar studies that took place in Nottingham, England between 1978 and 1999 were obtained. The entire population at-risk aged 16-54 over three time periods (1978-80, 1993-95, and 1997-99) were followed up and all participants presenting with ICD-9/10 first episode psychosis were included. Standardised incidence rates were calculated at each time period with possible change assessed using Poisson regression.

¹³⁴ See: http://news.bbc.co.uk/1/hi/scotland/south_of_scotland/7533614.stm

¹³⁵ Exploratory qualitative interviews with 44 crack-heroin injectors were undertaken in 2006 as part of a wider project using video-recorded observations of injecting drug use and injecting environments (see Focal Point Annual Report 2006). Purposive sampling was employed weighted towards current and recent injectors with recent experience of unstable housing. The sample comprised of current injectors who reported ever having injected crack-heroin speedball. The study took place in Bristol and London.

associated with groin injecting. They are: checking the colour of the blood flushing into the syringe; seeking assistance from other injectors to help locate and administer an injection; rotating injections between groins; selecting an appropriate-length needle; and cleaning the injection site. The article concluded that speedball injection, and crack cocaine specifically, increase health harms such as abscesses, cellulites and other skin infections.

6.5.2 Non-fatal drug emergencies

It is difficult to monitor trends in non-fatal drug emergencies as classification is based on ICD-10 codes, clinical judgement and disclosure by patients. Furthermore, data may also include patients who would not be classified as drug misusers in the context of this report.¹³⁶ Data are available across the United Kingdom but cannot be combined as there may be differences in recording practices.¹³⁷

Data are collected for England through Hospital Episode Statistics.¹³⁸ In 2006/07 there were 870 inpatient finished consultant episodes (FCEs) due to a primary diagnosis of acute substance intoxication, a five per cent decrease from 2005/06. Seventy-seven per cent of these were classed as emergencies, most commonly, 'multiple or other psychoactive substances' (32%).

In England, during 2006/07, there were 9,777 episodes of poisoning by drugs (ICD-10 code T40 which includes overdose but excludes intoxication meaning inebriation), 99 per cent of which were emergencies. This is a reduction of two per cent on the 2005/06 figure. The majority of episodes (56%) were due to 'other opioids' (including codeine and morphine) and a quarter (24%) were due to heroin or methadone. The recent increases in heroin poisonings reported last year were not seen in 2006/07, in fact there was a nine per cent decrease from 1,908 episodes to 1,738. There were also 2,061 FCEs with a diagnosis of poisoning by psychostimulants with abuse potential (ICD-10 code T43.6), 91 per cent of which were emergencies.

Since 2000/01 there has been a large increase in the number of cocaine poisonings from 262 episodes to 833 in 2006/07. Over this period the proportion of all poisonings which are attributable to cocaine has risen from 3.5 per cent to 8.5 per cent. However, the number of cocaine poisonings and proportion of all poisonings in 2006/07 is only slightly higher than in 2005/06 suggesting that the recent increases in cocaine related poisonings may have slowed (Table 6.2).

Table 6.2: Hospital Episode Statistics: Inpatient episodes due to poisoning by cocaine in England, 2000/01 to 2006/07

Primary diagnosis	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07
Poisoning by cocaine	262	317	360	520	641	807	833

Source: The Information Centre (2008)

Data from the Information Services Division, Scotland (ISD) show that during 2006/07 there were 1,541 inpatient episodes with a primary diagnosis of poisoning by drugs (ICD-10 code T40), the majority of which (59%) involved other opioids. Heroin

¹³⁶ For example, poisoning by drugs also include those who may have overdosed on drugs such as codeine.

¹³⁷ For example, data from England refer to all patients treated in NHS hospitals in England and could include patients from Wales, who may also be counted in statistics from Wales.

¹³⁸ Hospital Episode Statistics (HES) is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. Data refer to finished consultant episodes (FCEs) and not persons. See:

<http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/HospitalEpisodeStatistics/index.htm>

poisoning was responsible for 20 per cent of episodes, methadone for seven per cent and cocaine for four per cent. There were a further 244 episodes with a diagnosis of poisoning by psychostimulants with abuse potential (ICD-10 code T43.6). No information on how many were emergencies is available. Over the same period there were 50 episodes of acute substance intoxication.

Data from Health Solutions Wales show that, during 2006/07, there were 652 episodes with a primary diagnosis of poisoning by drugs (ICD-10 code T40), almost all of which were emergencies. Fifty-seven per cent were due to other opioids, 24 per cent due to heroin and five per cent due to cocaine. Over the same period, there were 82 inpatient episodes with a primary diagnosis of acute substance intoxication, 91 per cent of which were emergencies. This is half the number recorded in 2005/06 (internal communication from Health Solutions Wales).

The Welsh Assembly Government is currently carrying out a study of non-fatal drug emergencies. The research will review near misses in the Accident and Emergency department of a Swansea hospital and is due to be published at the end of 2008 (internal communication from the Welsh Assembly Government).

Data from the Department of Health, Social Services and Public Safety Northern Ireland (DHSSPSNI) show that, in 2006/07, there were 790 inpatient episodes with a diagnosis of poisoning by drugs (ICD-10 code T40), 97 per cent of which were emergencies (internal communication from DHSSPSNI).

6.5.3 Other health consequences

Seventeen per cent of treatment seekers participating in DTORS reported poor health with older users more likely to perceive their health as poor; 24 per cent of those aged 35 and over reported poor health compared to 14 per cent of those aged 25 to 34 and 13 per cent of those aged 16 to 24 (Jones *et al.* 2007).

Research

Real-world memory and executive processes in cannabis users and non-users

A study by Fisk and Montgomery¹³⁹ (2008) found that cannabis users did not differ significantly from non-cannabis users on any of the measures of executive functioning or associative learning. However, cannabis use did appear to have an adverse impact on real-world memory.

6.5.4 Pregnancies and children born to drug users

Hospital Episode Statistics show that in England during 2006/07, there were 172 episodes of foetus and newborn affected by maternal drugs of addiction (ICD10 code P04.4) and 1,269 episodes of babies with neonatal withdrawal symptoms from maternal use of drugs of addiction (P96.1), of which 5.5 per cent were emergencies. Table 6.3 shows the change from 2003/04 to 2006/07.

¹³⁹ Samples of cannabis users and non-cannabis users were drawn from an existing database containing a range of measures for substance abusers and drug naive individuals. Members of the database were recruited from university students and the snowball method and were aged between 20 and 22. A number of measures were used to test individuals with different sample sizes for each test.

Table 6.3: Effect of maternal drugs of addiction in England, 2003/04 to 2006/07

Primary diagnosis	2003/04	2004/05	2005/06	2006/07
Foetus and newborn affected by maternal use of drugs of addiction	205	262	170	172
Neonatal withdrawal symptom from maternal use of drugs of addiction	1,096	1,246	1,276	1,269

Source: The Information Centre (2008)

Data from Wales show that in 2006/07 there were 6 episodes of foetus and newborn affected by maternal drugs of addiction (ICD10 code P04.4) and 57 episodes of babies with neonatal withdrawal symptoms from maternal use of drugs of addiction (P96.1), 19 per cent of which were emergencies.

There were fewer than five inpatient episodes in 2006/07 with a diagnosis of foetus and newborn affected by maternal use of drugs of addiction.

7. Responses to health correlates and consequences

7.1 Overview

In 2001 an action plan to reduce DRDs was introduced in England and Wales (DH 2001). This was updated as part of *Reducing Drug-related Harm: An Action Plan* with a focus on three key areas: campaigns, improving delivery and surveillance (DH and NTA 2007). In Scotland a strategy and action plan to reduce DRDs was published in 2005 (SACDM 2005).

In the 1980s, United Kingdom drug policy was led by a public health approach aimed at containing HIV transmission. The subsequent action, involving harm reduction measures, is regarded as having been successful in helping to contain HIV amongst injecting drug users (IDUs); providing free needles and syringes, promoting the safe disposal of used equipment, information campaigns on safer sex and safer injecting, and HIV/AIDS counselling, support and testing. Treatment for infectious diseases is provided as part of the National Health Service (NHS), including the provision of anti-retroviral treatment for HIV and HCV.

A *Hepatitis C Action Plan for England* was published in 2004 (DH 2004), prioritising prevention of infection and disease progression and *Reducing Drug-related Harm: An Action Plan* is also concerned with infectious disease. A *Hepatitis C Action Plan for Scotland* was launched in 2006 (Scottish Executive 2006b) and a second phase of the plan, supported by €63 million (£43m) over three years, was launched in May 2008 (see section 7.3.1 below). An *Action Plan for the Prevention, Management and Control of Hepatitis C* was launched in Northern Ireland in 2007. The National Institute for Health and Clinical Excellence (NICE) in England has published clinical guidelines that recommend the use of contingency management in order to encourage testing for and vaccination against infectious diseases (NICE 2007c).

Standards of care for problem drug users with mental health problems were agreed in 2001 (HAS 2001). Guidance on good practice (DH 2002a) and the provision of services were developed in England. The Department of Health highlighted the need for generic health services to work in partnership with other agencies, such as drug services (DH 2002b).

Treatment for wound infections is available through primary care, A&E departments, and in some areas, through needle exchange schemes and specialist drug services. Those in prison have access to HIV and hepatitis testing, and vaccination against HBV.

Increasingly there is a recognition of the needs of pregnant drug users, with systems in place to ensure that they are identified and that their needs, and those of their babies, are met.

7.2 Prevention of drug-related deaths

The National Treatment Agency (NTA) reports on its website that throughout 2007/08 a programme of initiatives aimed at reducing drug related harm¹⁴⁰ will be introduced under the three main headings of campaigns, improving delivery and surveillance, which were outlined in the *Reducing Drug-related Harm: An Action Plan* (DH and NTA 2007). In October 2008 a campaign to reduce drug-related death (and drug-related infectious disease) was launched as part of the action plan.

¹⁴⁰ See: http://www.nta.nhs.uk/areas/drug_related_deaths/default.aspx

In Scotland, the National Forum on Drug-related Deaths¹⁴¹ recommended in its latest annual report that the Scottish Government should allocate dedicated funding with the specific aim of reducing drug-related deaths. It also recommended that suicide prevention in drug users should be a key priority as around a quarter of drug-related deaths were either intentional or of undetermined intent (Scottish Government 2007c). In its response to the report the Scottish Government has stated that funds have been allocated to take this action forward (Scottish Government 2008c).

7.2.1 Overdose prevention

Protocols in emergency setting

The Welsh Assembly Government (2008b) is to develop protocols within emergency settings to develop, test and introduce interventions to reduce unnecessary deaths to those at most risk and encourage entry to services.

Investigation into drug-related deaths in Scotland

An investigation into DRDs in Fife, Scotland (see Chapter 6), made a series of recommendations for reducing the number of DRDs including: an integrated approach towards care for those who had recently been released from prison and sharing of information between agencies; overdose training, for the family of drug users and others who may witness an overdose, covering such areas as Cardio-Pulmonary Resuscitation (CPR)¹⁴² and the administration of naloxone; prevention/treatment of a benzodiazepine overdose; monitoring and sharing of information on near misses and integrated care for complex cases; a review of current drug and alcohol education provision for 15 to 16 year olds; investigating the possibility of introducing arrest referral and early intervention schemes; local analysis of heroin composition, to establish purity levels and cutting agents, in order to inform overdose strategies relative to the composition and quantity of heroin consumed (Baldacchino *et al.* 2008).

A review of drug treatment and harm reduction services

A review by the Healthcare Commission and NTA assessing the provision of treatment for substance misusers looked at the commissioning of drug treatment and the provision of harm reduction services across the 149 local drug partnerships in England. It was reported that some good progress has been made in relation to the provision of harm reduction services, and that there has been significant progress in developing systems and protocols to reduce the number of DRDs. However, it was also reported that more needs to be done to further reduce DRDs (Healthcare Commission and NTA 2008b).

Database on drug-related deaths in Scotland

In the July 2008 edition of the National Forum on Drug Related Deaths' 'Drug Death matters' newsletter it is reported that the Scottish Government will be developing a national database of drug-related deaths and an examination of the circumstances behind them (Scottish Government 2008d).

¹⁴¹ The National Forum on Drug Related Deaths was established as a result of the Scottish Executive's 2005 action plan 'Taking Action to Reduce Scotland's Drug Related Deaths'. The forum is made up of representatives from the medical profession, police, prison service, ambulance service, government and academia. The forum investigates trends in drug-related deaths and disseminate good practice through the 'Drug Death Matters' newsletters. One of its main remits is to produce an annual report for Scottish ministers with recommendations for further action as required.

¹⁴² See: <http://www.sja.org.uk/sja/first-aid-advice/lifesaving-procedures/cpr-for-adults.aspx>

Information campaign

The National Forum on Drug-related Deaths report also called for a national information campaign targeting drug users to highlight the dangers of combining substances such as methadone with alcohol, and cocaine and alcohol (Scottish Government 2007c). This has been accepted by the Scottish Government (Scottish Government 2008d).

Safer nightlife guidance

The Home Office and London Drug Policy Forum¹⁴³ have launched a second edition of guidance designed to promote good practice in bars and nightclubs. It aims to protect individuals who go to bars, nightclubs and other events, and those who work in them, with a particular emphasis on those who use drugs. In particular, it is aimed at licensing authorities, police and fire officers, venue managers/promoters and health promotion workers (London Drug Policy Forum/ Home Office 2008).

Consumption rooms

The National Forum on Drug-related Deaths recommended the identification of intensive support techniques for those at high risk of overdose and a review of methods used in other countries, including consumption rooms. It is suggested that if schemes such as those in Australia, Canada and Switzerland have been evaluated as effective in reducing drug-related deaths, then service commissioners should carefully consider the possibility of them being set up in Scotland (Scottish Government 2007c). In response to this, the Scottish Government states that it does not support the need for drug consumption rooms and has no plans to introduce them (Scottish Government 2008c).

Pharmacological antagonists

The National Forum on Drug-related Deaths in Scotland recommends that a pilot scheme of take-home naloxone (running in Glasgow since early 2007) should be evaluated and, if it has been successful, an extension of the scheme across Scotland should be considered. In the pilot project, drug users and their families are given naloxone to prevent heroin overdoses and training is given in basic life support and overdose awareness (Scottish Government 2007c). In the July 2008 edition of its 'Drug Death matters' newsletter, the Forum reported that there is a plan to introduce take-home naloxone to more individuals in Scotland following a successful pilot. It is hoped that the project will be adopted by the local NHS as a core harm reduction intervention that is available to family and friends as well as service users (Scottish Government 2008d).

The Welsh Assembly Government has commissioned research into the use of naloxone by family/friends in the event of an illicit drug overdose. The pilot study is due to take place during 2008 (internal communication from the Welsh Assembly Government). Protocols and guidelines in the use of naloxone are to be issued (The Welsh Assembly Government (2008b).

Briefing on naltrexone implants

The NTA has issued a briefing on naltrexone implants, noting that in its technological appraisal of naltrexone, NICE did not comment on implants. NTA suggest that while such implants have been prescribed privately, following discussion with the

¹⁴³ The London Drug Policy Forum is based in the City of London local authority, supporting and advising on policy and practice regarding drug issues. It develops resources for a range of stakeholders and promotes good practice on education and prevention, community safety and improving services for drug users. See: http://www.cityoflondon.gov.uk/Corporation/LGNL_Services/Community_and_living/Community_advice/London_Drug_Policy_Forum/

Department of Health, the NTA is not in a position to promote such treatment, particularly as naltrexone implants are not licensed for relapse prevention, nor is there sound evidence for this treatment (NTA 2007c).

Research

Witnessing heroin overdose

Strang *et al.* (2008) carried out a study to assess carers' experiences of witnessing heroin overdose, whether they would be interested in training on overdose treatment and their specific training requirements.¹⁴⁴ Eighty-eight per cent of carers were interested in receiving training on how to treat an overdose while waiting for an ambulance. Thirty-three per cent had heard about naloxone but only 26 per cent had ever previously been given advice on it. The authors conclude that there is an extensive population of carers who have been overlooked and would benefit from overdose training. They suggest that piloting such training would be appropriate.

7.3 Prevention and treatment of drug-related infectious diseases

Hepatitis C Action Plan for Scotland: Phase two

Phase one of the *Hepatitis C Action Plan for Scotland*, covering the period September 2006 to March 2008, aimed at increasing awareness of hepatitis C among professionals and gathering evidence through numerous surveys and other investigations to inform proposals for the development of hepatitis C services. The results of phase one have been published by Health Protection Scotland (HPS 2007). The second phase of the Hepatitis C Action Plan for Scotland was launched in May 2008 and covers the three years 2008/09 to 2010/11 and will be supported by a budget of €63 million (£43m). Key aims are to raise awareness of the disease, reduce the number of new infections and to increase the numbers in treatment. The action plan covers 34 specific areas such as improved treatment, testing, diagnosis, support services and care for those at risk of contracting the disease in addition to those who are already infected. In addition annual surveys of hepatitis C prevalence and incidence among IDUs across Scotland are to be undertaken, and there is to be a survey of hepatitis C prevalence and incidence among prisoners (Scottish Government 2008e).

7.3.1 Prevention

Reducing Drug-related Harm: An Action Plan

As part of the implementation of the *Action Plan on Reducing Drug-related Harm* in England (DH and NTA 2007), in October 2007 new data were provided to local partnerships about hepatitis C prevalence for their local area. In October 2008 a campaign to reduce drug-related infectious disease (and drug-related death) was launched as part of the action plan.

Hepatitis C Action Plan for Scotland and Northern Ireland

In phase two of the *Hepatitis C Action Plan for Scotland* there is a specific focus on prevention and education amongst injecting drug users with an aim of improving links between support and health services (see above) (Scottish Government 2008e).

An *Action Plan for the Prevention, Management and Control of Hepatitis C* in Northern Ireland was launched in 2007 (DHSSPSNI 2007b). Objectives are to increase awareness and understanding and to improve treatment. Actions include a

¹⁴⁴ Self-completion questionnaires were distributed through nine support groups in England for families affected by drugs and alcohol. 147 carers responded, 80 per cent of whom were parent-carers. Heroin was the main drug of abuse for 86 per cent of users, of whom half had already had an overdose.

review of surveillance arrangements for hepatitis C. Amongst IDUs specific actions are: training, information and guidance on blood borne viruses for professionals; the development of local multi-agency arrangements for hepatitis C prevention; and to further develop needle exchange schemes.

ACMD Prevention Working Group on hepatitis C prevention

An inquiry has been undertaken by the Prevention Working Group on hepatitis C prevention¹⁴⁵ (consisting of ACMD members, HPA staff and co-opted experts) into preventing HCV amongst injecting drug users (IDUs). They will consider:

- the epidemiology of hepatitis C;
- evidence on the effectiveness of interventions against hepatitis C; and
- effective interventions and delivery (e.g. coverage, intensity) in the United Kingdom.

The results of the inquiry are due to be reported in 2009.

Assessment of harm reduction services in Wales

The Welsh Assembly Government is to assess the range of safe, effective and cost-effective services currently targeted at injecting drug users against international practice to inform the delivery of the National Public Health Service *Blood-Borne Virus Action Plan for Wales* (Welsh Assembly Government 2008b). There is also to be consideration of how harm reduction services can respond to the needs of stimulant users.

Review of harm reduction services

The review by the Healthcare Commission and NTA assessing the provision of harm reduction services found significant deficiencies were reported in the provision of hepatitis B vaccination and the testing and treatment of hepatitis C (Healthcare Commission and NTA 2008b). The majority (95.3%) reported that less than 50 per cent of their service users had a recorded test date for hepatitis C. Just over a third (37%) did not have access to HIV testing with access to pre and post-test counselling. In addition, 36 per cent of partnerships did not have hepatitis C testing integrated into their open access services.

Harm reduction findings from the NTA 2006 user satisfaction survey

The NTA in England reported on client satisfaction levels with harm reduction services received by users of specialist drug services and, via a separate survey, with clients of pharmacy-based needle exchanges. It found that whilst many service users received a range of harm reduction advice, many did not.

The results of the surveys found that 65 per cent had a care plan (66% who attended specialist services and 59% of those attending pharmacies) and harm reduction goals were included in most plans; these included goals to reduce the risk of the spread of blood borne viruses. However, a substantial amount of clients responded that they had not received many of the harm reduction interventions that they were asked about. Around 20 per cent of current injectors had not received hepatitis B immunisation, but felt it would be appropriate for them. Nearly a third of current injectors thought a general health check would be appropriate, but they had not received one and a quarter stated that they would like to have their injecting sites checked, but they had not received this service.

The report concludes that harm reduction services require enhancement across the whole treatment system (NTA 2007a).

¹⁴⁵ See: <http://drugs.homeoffice.gov.uk/publication-search/acmd/ACMD-minutes-may-2007?view=Binary>

Information campaigns

Drugs: Protecting Families and Communities. Action Plan 2008-2011 (action number 78), proposes a national information campaign to raise awareness of blood-borne viruses (HM Government 2008b).

The Health Protection Agency issued a warning to injecting heroin users about a batch of the drug that has been linked to an infection caused by *Clostridium novyi* (See Chapter 6.6.1).

Vaccination

The proportion of IDUs in the Unlinked Anonymous Prevalence Monitoring Programme (UAPMP)¹⁴⁶ survey who have taken up an offer of hepatitis B vaccination has increased markedly over time, rising from 25 per cent in 1998 to 66 per cent in 2007.¹⁴⁷ Self-reported vaccination uptake varied by region and country (combining 2006 and 2007 data), and in Wales was 57 per cent and in Northern Ireland 79 per cent (HPA *et al.* 2008).

The Needle Exchange Surveillance Initiative (NESI) established in Scotland to measure and monitor the prevalence of hepatitis C, HIV and injecting risk behaviour among injecting drug users, has reported on the results of data collected in two Scottish Health Boards. It found that rates of uptake of hepatitis B vaccination (at least one dose) ranged from 62 to 75 per cent. Three-quarters reported having been tested for hepatitis C in the past, though far fewer had been tested in the last year. Between 64 per cent and 80 per cent had been tested for HIV (Palmateer *et al.* 2008)¹⁴⁸

The 2006/07 Healthcare Commission and NTA joint improvement review in England highlighted limitations in existing provision of hepatitis B vaccine to IDUs with only four per cent of local areas rated as either excellent or good in relation to it (Healthcare Commission and NTA 2008b). *Reducing Drug-related Harm: An Action Plan* contains plans for a campaign on hepatitis B vaccination targeted at drug users most at risk of contracting an infectious disease (DH and NTA 2007).

In its substance misuse strategy, the Welsh Assembly Government suggests that there is a case for using rewards (contingency management) to engage or maintain some individuals in treatment in certain circumstances, for example, to increase the percentage of injecting drug users completing vaccination courses against hepatitis B. They will work with partners to develop criteria for supporting and are evaluating a number of contingency management pilots across Wales. In addition, the numbers of drug users completing immunisation for hepatitis B is to be measured as part of a key performance indicator (Welsh Assembly Government 2008b).

Syringe provision

The 2006/07 Healthcare Commission and NTA review indicated that most local areas had weaknesses in their service provision with only 12 per cent rated as either good or excellent in relation to the provision out-of-hours needle exchange services (Healthcare Commission and NTA 2008b). A shortfall in the provision of out-of-hours needle exchange was also reported. Just under half (44%) of local drug partnerships scored 'weak' in this area. Only 21 per cent of partnerships opened most of their

¹⁴⁶ See Chapter 6 for methodology.

¹⁴⁷ Vaccination uptake data should be interpreted with caution as they are based on self-reports.

¹⁴⁸ 667 participants completed a voluntary anonymous survey from May to December 2007.

needle exchange services on Saturdays and only two per cent opened them on Sundays.

In 2007, almost all (92%) of the current and former IDUs participating in the UAPMP survey in England, Wales and Northern Ireland reported ever accessing a needle exchange scheme, and amongst recent initiates (those who reported first injecting during the previous three years) it was 86 per cent (HPA *et al.* 2008).

Northern Ireland has a national syringe exchange database, which has been monitoring activity since 2001 in the nine pharmacies that offer syringe exchange. In 2007/08:

- there were 11,387 visits to participating pharmacies by users of the scheme, an increase of 14 per cent from 2006/07;
- 116,935 syringes were issued in 2007/08, an increase of 20 per cent from 2006/07;
- 42 per cent of visits involved the return of used equipment; and
- 86 per cent of visits were made by male clients (PHIRB/DHPSSPNI 2008).

Since the scheme started, the number of visits per annum has doubled while the number of syringes issued has risen by more than 70 per cent. However, the proportion of visits that involve the return of used equipment has fallen from 67 per cent in 2001/02 to 42 per cent in 2007/08 (Table 7.1).

Table 7.1: Syringe provision: number of visits, syringes issued and proportion involving return of used equipment in Northern Ireland, 2001/02 to 2007/08

Year	Number of visits	Number of syringes issued	% visits involving return of used equipment
2001/02	5,213	67,989	67
2002/03	6,043	67,516	61
2003/04	7,508	82,731	59
2004/05	7,440	86,056	54
2005/06	8,797	85,801	44
2006/07	9,997	97,684	40
2007/08	11,387	116,935	42

Source: DAIRU/DHSSPSNI 2003; 2005; 2006; PHIRB 2008

Results from two Scottish Health Boards participating in NESI showed that around 60 per cent of current IDUs obtained an average of at least two needles/syringes per day, mostly from pharmacy exchanges (Palmateer *et al.* 2008).¹⁴⁹

Needle exchange monitoring systems

A new national web based system to collect information from local needle exchange services in England was introduced in April 2008 in order to improve the quality and consistency of data collection.¹⁵⁰ It collects information such as the number of syringes exchanged; the return rate; the estimated number of clients in contact with services; paraphernalia distributed and the main drug that is being injected by clients. In order to fulfil the criteria set out in the *Reducing Drug Related Harm Action Plan* (DH and NTA 2007), and so that partners such as the HPA can use the data to support their work and quantify the public health benefits of needle exchange

¹⁴⁹ Six hundred and sixty-seven participants completed a voluntary anonymous Survey from May to December 2007.

¹⁵⁰ See:

http://www.nta.nhs.uk/areas/drug_related_deaths/needle_exchange_monitoring_system/default.aspx

services, the aim of the system is to monitor the amount of activity in services so that benchmarks can be set and distribution can be increased in future.

As part of phase two of the *Hepatitis C Action Plan for Scotland* a data collection system to monitor the provision of injection equipment in Scotland is to be developed (Scottish Government 2008e).

Needs assessment for needle and syringe facilities

A needs assessment for needle and syringe exchange facilities is to be carried out in Wales, that will inform future plans to deliver accessible services which meet the identified demand (Welsh Assembly Government 2008b).

Guidance on Needle Exchange Services

The National Institute for Health and Clinical Excellence (NICE) is due to publish guidance on the optimum provision of needle exchange services in February 2009.¹⁵¹ A supporting review of effectiveness, qualitative data and health economic evidence has been undertaken and has been released for consultation. The importance of this guidance is underscored by an earlier review of syringe exchange provision which found that there were no national monitoring and reporting systems in place at needle exchange services and the data that were collected were often inconsistent and low quality (NTA 2008g).

Research

Stigma and injecting drug use

Simmonds and Coomber (2007) consider how social stigma impacts on populations of injecting drug users (IDUs) and operates within them; and the consequences this has for drug prevention and harm reduction.¹⁵² It was found that IDUs concern for being recognised or 'seen' as IDUs affected service uptake and/or their interaction with services. It went on to say that 'normal' IDUs tended to stigmatise those they believed to be 'worse' than them, primarily the homeless.

Paraphernalia and condom provision

Research

Distributing foil to promote transitions from heroin injecting to chasing: an evaluation

Research was conducted into an intervention that distributed special foil packs to IDUs from four needle exchange services in order to promote the transition from injecting heroin to the less risky practice of smoking or 'chasing' (Pizzey and Hunt 2008). It was reported that an increased number of clients attended the services, including non-injecting heroin users, with over half of the total clients (54%) taking the foil packs when they were available. The authors suggest that the distribution of the foil packs is a useful way of engaging with clients attending needle exchange services about harm reduction in terms of reducing injecting risks and making the transition away from injecting to less harmful methods of consumption.

Safety, risks and outcomes from the use of injecting paraphernalia

In Scotland, paraphernalia items and injection preparation methods were laboratory tested to identify any theoretical health benefits/risks they posed, in order to establish those that presented the least risk to health (Scottish Government 2008f). An

¹⁵¹ See: <http://www.nice.org.uk/guidance/index.jsp?action=download&o=37995>

¹⁵² This paper is based on research into barriers into safer injecting in the south west of England. Qualitative interviews were conducted with safer injecting service providers (syringe exchange schemes and injectors users of these services). Interviews were undertaken with 12 of the pharmacists from all 13 local pharmacies. Ninety-one injecting drug users were interviewed.

investigation was also conducted to establish the impact that the supply of paraphernalia had on health, and sharing practices in IDUs. In addition to needles and syringes, the results found that the least (theoretical) risks were posed by: cleaning of hands before preparation; sterile citric or ascorbic acid sachets with clear usage information; use of Sterifilt filters; the use of single use cookers accompanied by equipment and preparation advice. Qualitative data gained in this study supported the supply of such items although the quantitative data was inconclusive.

Citrate provision at syringe exchange programmes

Beynon *et al.* (2007b) examined the impact of citrate provision¹⁵³ at syringe exchange programmes in the North West of England, to investigate whether its introduction had an effect on the number and/or frequency of injecting drug users accessing the services and the number of syringes dispensed. The results showed that in general the introduction of citrate did not have an effect on the number of injectors attending the services, but long term clients did attend more frequently after the introduction of citrate. This meant that staff had more opportunities to engage with these longer term clients and therefore the potential to increase the number of harm reduction interventions and referrals to other support services.

Provision of injecting paraphernalia by pharmacists

With pharmacies comprising over three-quarters of needle exchange outlets in the United Kingdom, Scott *et al.* (2007)¹⁵⁴ considered whether pharmacists offering needle exchange were aware of legal changes in 2003 permitting the supply of injecting paraphernalia. Forty-two per cent of pharmacists said they were. However, just two per cent were able to fully describe it, 41 per cent could partially describe it, and 59 per cent were either out of date, wrong or did not know. It was found that 34 per cent supplied one or more items of paraphernalia; most commonly citric acid. The authors suggest that pharmacists appear to have little involvement with decisions around supply and recommended that knowledge of the new law should be improved and that involving pharmacists more in local decisions may increase their feelings of accountability for the service they provide to injectors.

7.3.2 Counselling and testing

One of the aims of the *Hepatitis C Strategy* for England is to utilise voluntary confidential testing in order to increase the proportion of IDUs who know that they are infected. It is recommended that everyone who attends a drug treatment service should be offered a test. According to the 2007 Health Protection Agency annual report there has been around a ten-fold increase between 2002 and 2006 in the amount of tests carried out in these services, reportedly due to oral fluid screening. This is in addition to a high number of tests carried out by GPs at their surgeries. Diagnosis of hepatitis C infection is increasing in England with a ten per cent increase in new cases between 2005 and 2006 (HPA 2007).

As part of phase two of the *Hepatitis C Action Plan for Scotland*, NHS Quality Improvement Scotland (QIS) will develop standards for hepatitis C testing and the treatment, care and social support of individuals infected with hepatitis C. In addition, a surveillance system to monitor hepatitis C testing practice in Scotland will be developed (Scottish Government 2008e).

¹⁵³ In the United Kingdom it has been legal to provide citrate to injecting drug users to solubilise heroin since 2003.

¹⁵⁴ A survey of pharmacy based needle exchanges in the South West of England (N = 143), undertaken using telephone interviews six months after the main law change.

Research

Dried blood spot testing for hepatitis C

A study to assess whether an uptake in hepatitis C testing among IDUs would follow on from the introduction of dried blood spot testing in drug treatment and prison settings found some preliminary evidence to support its use (Hickman *et al.* 2008b).¹⁵⁵ The study was based on the premise that dried blood spot testing would increase the opportunity for testing as it did not have some of the drawbacks that came with venous blood collection (the usual method for testing) such as problems finding a suitable vein, lack of trained staff or willingness to take blood and risk of needle stick injuries. It found that six months after the introduction of dried blood spot testing at these sites there had been a positive effect on the percentage of patients who had had a hepatitis C test carried out in all but one of the sites, with an average increase of 14.5 per cent.

7.3.3 Infectious disease treatment

2008 Audit of Hepatitis C Action Plan for England

Following on from a 2006 audit of hepatitis C healthcare (APPHG 2006), in which it was found that less than ten per cent of Primary Care Trusts (PCTs) were effectively implementing the *Hepatitis C Action Plan* for England (DH 2004), a further review was conducted in 2007 in PCTs and NHS Trusts across England. It reported that although services have improved markedly since the last review there are still discrepancies depending on country of residence. Services for particular groups such as prisoners, IDUs and children are provided in 80 per cent of PCTs (an improvement from 68% since 2006). Nearly three-quarters of PCTs (95 out of the 128 that responded) reported making special provisions for drug users and the report recommends that all PCTs should make extra provision for each of the specific groups (including drug users) in future (APPHG 2008) in line with the recommendations made in the *Hepatitis C Action Plan*.

Research

Scoping study on services for those with hepatitis C

In a scoping study to consider services for those with hepatitis C (not only drug users) in Scotland, Wilson *et al.* (2008)¹⁵⁶ found that 80 per cent had not received treatment. Of these, 21 per cent attributed this to a continuing use of alcohol or other drugs. However, results from the report by the Needle Exchange Surveillance Initiative found that between 56 per cent and 76 per cent of those reported as having received a HCV-positive test result had been referred to a specialist hospital appointment (Palmateer *et al.* 2008).

¹⁵⁵ The research was conducted in England in Wales at 22 specialist drug clinics and six prisons.

¹⁵⁶ Seventy-nine participants in the study were recruited by using convenience and snowball sampling at three sites in Glasgow, two peer support services for people living with hepatitis C (c-level and Anan Cara) and via those involved in the Scottish Drugs Forum. Individuals were eligible if they had ever received a positive hepatitis C antibody test.

7.4 Intervention related to psychiatric co-morbidity

7.4.1 Guidance for practitioners

NICE guidance: Severe Mental Illness with Problematic Substance Misuse

NICE have commissioned the National Collaborating Centre for Mental Health to develop clinical guidelines for the assessment and management of severe mental illness in conjunction with problematic substance misuse.¹⁵⁷

Guidance for Criminal Justice Integrated Teams

The Home Office Drug Interventions Programme (DIP) and the Drug Strategy Unit have commissioned the Specialist Clinical Addiction Network (SCAN) to produce a practice guide for Criminal Justice Integrated Teams (CJITs). The guide will include contributions from a wide range of stakeholders including clinicians, commissioners, and practitioners, informed by a working group from SCAN. While it is not the core role of CJITs to manage or treat the mental health element of a client's co-occurring mental health problems, the guide will enable them to recognise and refer clients to appropriate care.¹⁵⁸

Closing the Gaps – Making a Difference

Following a review of existing guidance, care and support that is available for individuals in Scotland with co-occurring substance use and mental health problems, the Scottish Government has published a series of recommendations for change and improvement including: increased awareness of co-morbidity and a reduction in the stigma associated with it; and improved support and service provision for individuals and their carers. Specific recommendations made in the report include: training of frontline substance misuse staff in suicide risk assessment and prevention; an agreed assessment tool to be used by substance misuse services and mental health agencies to identify co-morbidity; developing the ability of substance misuse services to meet the mental health needs of their clients in terms of psychological treatments; and developing a training needs plan for psychological therapies (Scottish Government 2007d).

Protocols between mental health and substance misuse services, Wales

Protocols between mental health and substance misuse services are being developed in Wales to ensure there are clear lines of accountability between services for the care of individuals with co-occurring substance misuse and mental health problems. Progress on delivering the protocols will be monitored through the Welsh Assembly Government's performance management framework for the NHS (Welsh Assembly Government 2008b).

7.4.2 Community orders and mental health

The Community Order is a generic community sentence. There is a choice of 12 different requirements that can be attached to an order including drug and alcohol treatments and a Mental Health Treatment Requirement (MHTR). It is reported that the use of community sentencing is increasing and suggested that the application of the MHTR is infrequent and differential (Seymour and Rutherford 2008). It is also reported that as part of their community sentence, offenders who have both mental health and drug problems are more likely to be issued with an alcohol or drug treatment requirement rather than an MHTR, and that this group may face particular

¹⁵⁷ See: <http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11815#keydocs>

¹⁵⁸ For more information see: http://drugs.homeoffice.gov.uk/drug-interventions-programme/guidance/throughcare-aftercare/Mental_Health/ and: www.scan.uk.net

difficulties accessing necessary treatment and services. The authors claim that the MHTR may be a viable alternative to custodial sentences for offenders with mental health problems, but are unable to substantiate this as there is currently “an absence of a clear understanding of its application and effect”. In response to this, the Sainsbury Centre for Mental Health will be conducting research across nine London Boroughs in 2008 regarding the use of MHTR, how it is delivered and the impact that it has made.

Research

A brief screening instrument to detect the possibility of substance misuse problems in community patients with severe mental illness.

This study aimed to develop a brief screening tool which could be used in community settings to detect the possibility of harmful substance use amongst community-based patients with severe mental illness. It was based on the Dartmouth Assessment of Lifestyle Instrument (DALI) (Ley *et al.* 2007).¹⁵⁹ The Simple Substance Use Screening Scale (SUSS) was developed, which correctly classified 86 per cent of participants for problematic alcohol use (sensitivity 88%, specificity 84%) and 84 per cent for problematic drug use (sensitivity 82%, specificity 84%). It is suggested because of its brevity and simplicity, SUSS would be a useful screening tool for use in routine community mental health practice.

7.5 Interventions related to other health correlates and consequences

Research

Needle fear among female injecting drug users

In research looking at elements of needle phobia amongst female injecting drug users Tompkin *et al.* (2007)¹⁶⁰ found that most were fearful of needles prior to their first experience of injecting drug use and that for some, their fear of needles continued during their later injecting experiences. It was found that this fear was not limited to injecting drug use, but many feared medical procedures that involved needles. This resulted in their refusing or delaying such procedures, including blood tests and immunisations.

7.5.1 Non-fatal drug emergencies and general health related treatment

Research

Club specific ambulance referral guidelines

A set of guidelines was developed by medical professionals with input from club owners/ promoters to improve pre-hospital care for recreational drug users who had become unwell whilst in a clubbing environment (Wood *et al.* 2008). It included guidance for assessing unwell clubbers, when to call an ambulance, hospital transfer, and training of club medic staff to use the guidelines. Club medic staff were trained to use the guidelines and reported that after training they were able to assess unwell clubbers, use the guidelines and know when to call an ambulance. The authors conclude that a range of individuals with varying medical knowledge can be trained to use the guidelines and recommend that they are disseminated widely to potentially reduce morbidity and mortality associated with recreational drug toxicity in clubs.

¹⁵⁹ The Dartmouth Assessment of Lifestyle Instrument (DALI) is an 18-item self-report screening questionnaire which was developed to identify DSM-IV substance use disorder amongst patients with severe mental health problems in a simple and efficient manner. In this study a random sample of 400 potential participants were selected from a Community Mental Health Team case-load census population. Interviews were completed with 282 people.

¹⁶⁰ Forty-five injecting drug using (IDU) women who had experience of being injected with illicit drugs by other drug users

7.6 Interventions concerning pregnancies and children born to drug users

All Wales maternity record

An all Wales maternity record is being introduced in Wales which will include questions to help identify mothers with a substance misuse problem (Welsh Assembly Government 2008b).

Research

Specialised maternity care

A study looking at the provision of care in a specialised maternity unit for drug users¹⁶¹ suggested that it was a model of good practice (Toner *et al.* 2008). Particular aspects of the service were highlighted as making a positive contribution to maternal-child outcomes including: effective multi-agency and multidisciplinary working; early engagement; a non-judgemental approach; consistency and clarity across complex services; and continuous development. The need for more postnatal provision was identified as one area for development.

Managing pregnant injecting drug users

Problems associated with managing pregnant injecting drug users were discussed in the British Medical Journal (Bell and Harvey-Dodds 2008). The authors suggest that these patients often present late to health professionals, may have chaotic lifestyles, including poor care of themselves, and their capability to care for their children may be compromised. It is also noted that injecting drug use can have adverse effects on pregnancy and perinatal outcomes such as an increased risk of still birth, neonatal death, placental abruption, premature birth or small for gestational age. Methadone maintenance is recommended for pregnant opioid dependant women as it has been reported that it can improve birth weight (when compared to heroin use); it can help to engage women with specialist drug services; it produces more pharmacological stability than heroin; withdrawal from methadone in pregnancy has been shown in some studies to be associated with a relapse to heroin. However, methadone is associated with an increased risk of neonatal abstinence syndrome; few recent, long term studies have been carried out on postnatal development.

7.7 Drug driving

7.7.1 Prevention and reduction of driving accidents related to drug use

Following a consultation exercise earlier in the year, the Sentencing Guidelines Council (SGC)¹⁶² published definitive guidelines regarding sentencing and associated issues around death caused by dangerous driving. It covers four offences, including causing death by careless driving while under the influence of drugs (or alcohol) or failing to provide a specimen without a reasonable excuse. The maximum sentence for this offence is 14 years imprisonment. It is recommended that the seriousness of the offence is associated with the level of impairment caused by the consumption of drugs with the implication that as the degree of intoxication increases, so therefore, should the sentence (SGC 2008).

¹⁶¹ The study used a mixed-methodology approach utilising quantitative data from administrative systems and qualitative data from semi-structured interviews with 18 professionals and six service users. Service users were recruited by midwives and members of the hospital team.

¹⁶² The Sentencing Guidelines Council Assist courts in England and Wales by reviewing and providing sentencing guidelines see: <http://www.sentencing-guidelines.gov.uk/news/index.html>

The British Medical Association has called on the government to undertake a campaign to educate the public about the effect of illegal and certain prescribed drugs on driving ability and to ensure speedier and more specific and co-ordinated research to establish appropriate drug testing devices.¹⁶³

¹⁶³ See: <http://www.bma.org.uk/ap.nsf/Content/DrugsDriving>

8. Social correlates and consequences

8.1 Overview

A number of studies in the United Kingdom have shown that there is a strong association between problem drug use and social exclusion; drug problems are most serious in those communities where social exclusion is acute. A recent study suggests that up to 240,000 drug users in England receive out of work benefit; three quarters of the estimated number of problem drug users. A high proportion of the homeless are problem drug users, evidence suggests up to 80 per cent, and lacking educational qualifications; studies suggest up to 40 per cent lack any GCSEs¹⁶⁴. Also, vulnerable young people (those in care, the homeless, truants, school excludees and young offenders) are more likely to use drugs, use more often, and use a wider range of drugs.

Drug use *per se* is not a crime in the United Kingdom, but possession, dealing and trafficking are specific offences under the *Misuse of Drugs Act 1971*. While within the United Kingdom recorded crime is falling, recorded drug offences continue to rise. In addition, the number of persons dealt with by the courts for drug offences, cautioned or issued formal cannabis warnings, has also risen, mainly for cannabis related offences.

General criminal offences routinely recorded by the police do not contain information on the offenders' drug habits, neither do specific drug law offences. It is therefore not possible to provide an accurate estimate of the number of offences that are drug-related, but there is substantial research evidence of the link between drug use, particularly use of heroin and crack cocaine, and acquisitive crime. Around three-quarters of the users of these drugs admit to committing crime to support their habit. Over two-thirds of those in custody are reported to be problematic drug users. However, acquisitive crime, to which drug-related crime makes a substantial contribution, has continued to fall in recent years.

The economic and social costs of Class A drug use in England and Wales combined are estimated to have been around €22.2 billion (£15.4bn) in 2003/04¹⁶⁵. This equates to €66,693 (£44,231) per year per problematic drug user. The associated confidence range is between €22.0 billion (£15.3bn) and €23.2 billion (£16.1bn). The total economic and social costs of Class A drug use in Wales has been estimated to be around €1,140 million (£780m), with drug-related crime accounting for 90 per cent of this; health service costs are estimated to be €25.7 (£17.6m) per year. The Scottish Government has commissioned research to produce an initial estimate of the economic and social costs associated with illicit drug use.

¹⁶⁴ GCSEs (General Certificate of Secondary Education) are the principal means of assessing pupil attainment at the end of compulsory secondary education in England, Northern Ireland and Wales; see: <http://www.dfes.gov.uk/qualifications/mainSection.cfm?sld=1>. The equivalent in Scotland is the Standard Grade see: <http://www.scotland.gov.uk/Publications/2007/03/20130930/1>.

¹⁶⁵ Conversion rate is the December 2004 monthly average spot exchange rate quoted by the Bank of England.

8.2 Social exclusion

8.2.1 Homelessness

Baseline data from DTORS (see Chapter 4.7) shows that 60 per cent of drug users seeking treatment had stayed in stable accommodation¹⁶⁶ in the four weeks prior to interview, a further 18 per cent stayed in a mix of stable and unstable accommodation, and the remaining 21 per cent stayed in unstable types of accommodation only (Jones *et al.* 2007).

8.2.2 Unemployment

In a feasibility study aimed to estimate the number of problem drug users accessing benefits through the Department of Work and Pensions, Hay and Bauld (2008)¹⁶⁷ estimated that, of the approximately 330,000 problem drug users (opiate and/or crack cocaine users) in England in 2006, 81 per cent (266,798) were in receipt of benefit, representing 6.6 per cent of all those receiving benefit. Over three-quarters were male, a much higher proportion than within the general population (52%) (Table 8.1). A high proportion of problem drug users receiving benefits were aged from 25 to 34 (43%), this compares with 19 per cent of all those receiving benefits (Table 8.2).

Table 8.1: Gender of all persons receiving benefit and of problem drug users estimated to be receiving benefits in England, 2006

	Male		Female		Total
	n	%	n	%	
Problem drug users	202,987	76.1	63,527	23.8	266,798
All receiving benefit	2,083,020	51.6	1,951,850	48.5	4,034,870

Source: Hay and Bauld 2008

Table 8.2: Age of all persons receiving benefit and of problem drug users estimated to be receiving benefits in England, 2006

	Age						Total n
	<25		25-34		>34		
	n	%	n	%	n	%	
Problem drug users	45,124	17.9	114,645	43.0	104,356	39.1	266,798
All receiving benefit	607,450	15.1	761,300	18.9	2,666,950	66.1	4,034,870

Source: Hay and Bauld 2008

The Green Paper (consultation document) on welfare reform, *No one written off: reforming welfare to reward responsibility* (see Chapter 9.2.3) suggest that 100,000 problem drug users receiving benefit are not in treatment (DWP 2008).¹⁶⁸

DTORS reported that around three-quarters (77%) of drug users recruited to the study were unemployed. With only nine per cent in paid employment, 28 per cent reported that they were unemployed but looking for work or training; 24 per cent were

¹⁶⁶ Stable accommodation was defined as accommodation that you own or rent, accommodation owned by friends or family (stay rent free), accommodation owned by friends/family (where you pay rent), in a hostel (residential). Unstable accommodation was defined as in-patient or drug or alcohol treatment, in prison or other custody, slept rough on the streets, in a park etc. (without a roof), in a squat, other medical establishment, in a hostel (night drop-in centre), in a mobile home or caravan.

¹⁶⁷ This combined capture recapture estimates of the number of problem drug users (see Chapter 4) with DTORS (see Chapter 4), and the Work and pensions Longitudinal Study, see: <http://www.dwp.gov.uk/asd/tabtool.asp>

¹⁶⁸ This report suggests that there are up to 240,000 problem drug users receiving out of work benefit. This number excludes those receiving Disability Living Allowance; Hay and Bauld estimate the number of the latter to be around 24,766.

unemployed but not looking for work; and 25 per cent reported they were unable to work and receiving long-term sickness/disability benefits, a lower proportion than estimated by Hay and Bauld (33%, n = 86,869) (2008). Four per cent were in residential treatment; four per cent reported that they were temporarily unable to work, and two per cent reported that they were doing something else (Jones *et al.* 2007).

The Scottish Government's drug strategy suggests that only about 15 per cent of treatment-seeking drug users are currently in employment or training (Scottish Government 2008a).

8.2.3 School drop out

Baseline data from DTORS reported that 38 per cent of clients seeking drug treatment had left school before the statutory minimum age of 16, with a further 49 per cent having left full-time education at age 16 or 17 (Jones *et al.* 2007a).

8.2.4 Sex workers

In the DTORS baseline report ten per cent of females and one per cent of males reported being engaged in prostitution in the previous four weeks; all had taken heroin and/or crack cocaine (Jones *et al.* 2007).

8.2.5 Families

DTORS baseline data also reported on the number of drug misusers seeking treatment whose partner used drugs, and also those who were parents (Jones *et al.* 2007). Thirty-eight per cent of respondents had a partner who took drugs, most commonly women (61% compared with 25% of men). Recent heroin use was associated with an increased likelihood that the partner also took drugs.

Forty-nine per cent had children under the age of 16. However three-quarters (75%) of these lived apart from all their children who were aged under 16, and three per cent lived apart from some of them. Forty-four per cent of mothers, compared with 17 per cent of fathers had at least one of their children living with them. For 52 per cent of these respondents their children were living with the other parent, for 20 per cent they were living with other family members, for eight per cent their children were in care and for five per cent they were living elsewhere.

In the new Welsh substance misuse strategy it is estimated that as many as 17,500 children and young people in Wales live in families affected by parental drug use (Welsh Assembly Government 2008a).

Research

The impact of Parental Drug/Alcohol Problems on Children and Parents

Reporting on research into the impact of parental drug/alcohol problems on children and parents, Fraser *et al.* (2008)¹⁶⁹ supported previous research finding that most parents recognised their need for help; had obtained treatment for their drug/alcohol use; and were often ambivalent or self-critical about their parental ability. It was suggested that parents preferred help from treatment services, with drug misusers suggesting that methadone had helped stabilise the lives, rather than help from social workers. Furthermore, a desire to look after their children properly or to

¹⁶⁹ This was a small-scale research project which used semi-structured interviews and a 'Draw and Write' technique for children under the age of ten. Twenty-five parents from 18 families and eight children (four under the age of ten).

resume responsibility for their care, were powerful motivators for them to stop using drugs/alcohol.

8.3 Drug-related crime

8.3.1 Drug offences

DTORS reported that ten per cent of those seeking treatment sold drugs in the four weeks prior to interview (Jones *et al.* 2007).

Recorded crime: drug offences

Police recorded crime statistics¹⁷⁰ show that while in the United Kingdom as a whole, crime decreased in 2007/08, there was a substantial increase in drug offences. Table 8.3 shows that in England and Wales drug offences rose by 18 per cent between 2006/07 and 2007/08 (Kershaw *et al.* 2008). Increases in recent years have been largely attributable to increases in the recording of cannabis possession offences which account for 69 per cent of all recorded drug offences. In 2007/08 cannabis possession offences increased by 21 per cent, following increases of nine per cent in 2006/07 and 36 per cent in 2005/06. This rise is largely associated with the increased use of police powers to issue warnings for the possession of cannabis. The number of these warnings increased by 28 per cent in 2007/08, a rise of 22,900 detections compared with 2006/07. There was an increase in possession of other drugs of 15 per cent in 2007/08 compared with the previous year.¹⁷¹ Recorded drug crimes also increased in Northern Ireland, with an increase of 13 per cent between 2006/07 and 2007/08 (PSNI 2008). In Scotland (latest data is for 2006/07), which has a different legal system to that in England, Wales and Northern Ireland, and which does not issue cannabis warnings (cannabis warnings are not issued in Northern Ireland either), there was a four per cent reduction in the number of drugs crimes recorded between 2005/06 and 2006/07 (Scottish Government 2008g).

¹⁷⁰ Data is recorded by the police for notifiable offences. These include all offences that could possibly be tried by jury (these include some less serious offences, such as minor theft that would not usually be dealt with this way). For more information see: www.countingrules.homeoffice.gov.uk

¹⁷¹ For more information on cannabis warnings see *Policing cannabis - use of cannabis warnings- ACPO Guidance* available at : <http://www.acpo.police.uk/policies.asp>

Table 8.3: Recorded crime: Drug offences in the United Kingdom by offence type and country, 2002/03 to 2007/08

	Year					
	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
<i>England and Wales</i>						
Trafficking*	22,435	24,628	24,190	25,276	26,550	28,130
Possession	119,896	118,006	120,866	152,602	167,003	200,019
Other drug offences**	989	877	781	601	680	809
<i>Total offences</i>	<i>143,320</i>	<i>143,511</i>	<i>145,837</i>	<i>178,479</i>	<i>194,233</i>	<i>228,958</i>
<i>Northern Ireland</i>						
Trafficking	291	405	375	349	473	529
Possession	1,633	2,184	2,247	2,595	1,938	2,191
<i>Total offences</i>	<i>1,924</i>	<i>2,589</i>	<i>2,622</i>	<i>2,944</i>	<i>2,411</i>	<i>2,720</i>
<i>Scotland</i>						
Trafficking	10,148	9,537	9,333	9,613	10,890	9,827
Possession	30,510	32,463	32,268	34,440	31,329	30,559
Other drug offences***	280	275	222	194	203	360
<i>Total offences</i>	<i>40,938</i>	<i>42,275</i>	<i>41,823</i>	<i>44,247</i>	<i>42,422</i>	<i>40,746</i>
<i>United Kingdom</i>						
Trafficking	32,874	34,570	33,898	35,238	37,913	38,486
Possession	152,039	152,653	155,381	189,637	200,270	232,769
Other drug offences	1,269	1,152	1,003	795	883	1,169
<i>Total offences</i>	<i>186,182</i>	<i>188,375</i>	<i>190,282</i>	<i>225,670</i>	<i>239,066</i>	<i>272,424</i>

* Trafficking usually includes production, supply, possession with intent to supply, possession on a ship, carrying on ship and unlawful import and export.

** For England and Wales 'other drug offences' mainly concerns permitting premises to be used for the production, supply and use of drugs.

*** For Scotland 'other drug offences' includes production and manufacture of drugs (not illegal cultivation), money laundering related offences and other drugs offences not designated as trafficking or possession.

Source: Kershaw *et al.* 2008; NISRA 2004; PSNI 2006; PSNI 2008; Scottish Government 2008g

Arrests for drug offences

Information on persons arrested for drug offences is also available for England and Wales, and for Northern Ireland. Table 8.4 shows that in England and Wales in 2006/07, 89,200 persons were arrested for drug offences, an increase of less than one per cent from 2005/06. Data for England and Wales for 2007/08 are not yet published. In Northern Ireland in 2007/08, 1,896 persons were arrested for drug offences, an increase of 9.8 per cent from the previous year (Table 8.4). Arrests for possession have reduced considerably since 2004 with the introduction of a 'cannabis warning', rather than an arrest for possession of cannabis for personal use.

Table 8.4: Number of persons arrested for drug offences in England and Wales, and Northern Ireland, 2002/03 to 2007/08

	Year					
	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
England and Wales	131,100	113,100	84,800	88,600	89,200	
Northern Ireland	1,295	1,754	1,356	1,440	1,726	1,896
<i>Total</i>	<i>132,395</i>	<i>114,854</i>	<i>86,156</i>	<i>90,040</i>	<i>90,926</i>	

Source: Ministry of Justice 2008a; PSNI 2004; 2006b; 2008b

Convictions for drug offences

Data presented to the EMCDDA over the last few years has been for persons found guilty, cautioned or dealt with by compounding for drug offences, which is recorded in such a way as to be able to be broken down by drug. Latest data is on an all offence basis rather than a principal drug offence basis; data provided in previous Focal Point Reports was based on principal drug offence. New information reported this year for the United Kingdom as a whole is for both 2005 and 2006 (Table 8.5). There were

118,706 offences in 2005 and 124,344 in 2006, an increase of 4.5 per cent. There were 55,984 cannabis-related offences in 2006, an increase of 2.1 per cent since 2005 (54,813). There were 15,471 convictions for heroin offences, a very marginal increase since 2005 (15,629). There were 7,422 offences concerning amphetamines in 2006, an increase of 8.1 per cent since 2005 (6,864); 6,233 offences concerned ecstasy in 2006, a small decrease of 1.6 per cent since the previous year (6,337). The largest increase was for cocaine powder, with 15,470 offences in 2006, an increase of 28.6 per cent since 2005 (12,028).

Table 8.5: Persons found guilty or cautioned for drug offences in the United Kingdom 2000 to 2006 by individual drug

	Year						
	2000	2001	2002	2003	2004	2005*	2006*
Amphetamines	6,637	4,950	5,820	6,163	6,249	6,864	7,422
Cannabis	75,989	72,691	83,152	85,768	82,845	54,813	55,984
Cocaine powder	5,451	3,090	6,990	7,905	9,382	12,028	15,470
Crack cocaine	1,216	1,460	1,830	2,270	2,450	3,734	4,076
Ecstasy	6,630	7,880	6,590	5,940	6,209	6,337	6,233
Heroin	12,297	12,380	11,860	11,277	12,412	15,629	15,741
LSD	260	150	90	150	90	183	172

* Data for 2005 and 2006 is on an all offence basis rather than a principal drug offence basis; data for 2000 to 2004 is based on principal drug offence.

Source: Standard Table prepared for the United Kingdom Focal Point

8.3.2 Other drug-related crime

DTORS reports that amongst those seeking drug treatment 43 per cent reported having committed at least one of 15 different offences in the previous four weeks, some of which were related to offences under the *Misuse of Drugs Act* (see above). Seventy-three per cent reported committing an offence in the previous 12 months. Forty-four per cent of clients reported that they had reduced their offending rates in the four weeks prior to interview. Thirty-nine per cent reported committing an acquisitive crime during this period, offences committed included:

- shoplifting (26%);
- buying or selling stolen goods (20%);
- stealing something else (8%); and
- selling drugs (10%) (Jones *et al.* 2007).

Use of heroin and crack cocaine was a key determinant of offending, with those who used both heroin and crack cocaine (59%), and those who used crack cocaine only (51%), being more likely to report offending than those who used heroin only (39%) or those that used neither drug (24%). Nine per cent reported committing more than one offence a day. An average (median) of €190 (£130) was obtained via offending over the last four weeks, which was higher for those using heroin and crack cocaine, €380 (£260).

The third sweep of the Arrestees Survey (2005/06) (Boreham *et al.* 2007)¹⁷² found that 52 per cent of arrestees reported having taken one or more drugs in the month previous to arrest.

¹⁷² 8,027 arrestees were surveyed. Respondents were interviewed in 72 custody suites across England and Wales. Interviews were conducted throughout the year on all days of the week and at all times of the day. The eligible population was defined as people aged 17 or older who had been arrested on suspicion of committing an offence and who had not previously been interviewed within the current survey year. The sample design was a stratified two-stage random probability sample. A random selection of custody suites was first drawn. Within each suite, a random sample of shifts was then selected. Interviews were

Of these:

- 41 per cent had taken cannabis;
- 13 per cent heroin;
- 13 per cent cocaine powder;
- 11 per cent crack cocaine; and
- eight per cent ecstasy.

Of those who reported taking heroin, crack cocaine or cocaine powder in the month previous to arrest, 26 per cent had taken heroin and crack cocaine, 40 per cent had taken cocaine powder only, and 17 per cent had taken heroin only. It is reported that this pattern of polydrug use was different from 2003/04 and 2004/05, reflecting a consistent trend of a relative decrease in the use of heroin and crack cocaine and a relative increase in the use of cocaine powder. Overall, 26 per cent had taken heroin, crack cocaine or cocaine powder in the previous month.

As in previous surveys regular users (at least weekly) of heroin and crack cocaine were more likely to have committed acquisitive crime in the 12 months previous to arrest (81%) than those who did not take heroin or crack cocaine regularly (30%). Also, 79 per cent of regular heroin or crack cocaine users had been arrested in the year previous to being surveyed compared to 48 per cent who reported occasional/no use of heroin or crack cocaine. Self reported heroin and crack cocaine use by those reporting multiple drug use fell over the three sweeps of the survey, but use of cocaine powder increased. The proportion of respondents who had ever injected drugs decreased from 18 per cent to 13 per cent.

There was an increase in those reporting treatment for heroin in the 12 months previous to arrest, from 34 per cent to 41 per cent. Also, there was an increase from 23 per cent to 32 per cent in the proportion of frequent heroin users (those who used heroin five or more days a week) currently in treatment. In 2005/06, 26 per cent of those reporting previous treatment for heroin dependency reported no longer using heroin.

Property crimes

See the DTORS baseline report above.

Illegal prostitution

See 8.2.6 above.

Prescription offences

Information is not available pertaining only to drugs classified under the *Misuse of Drugs Act*.

Violence under the influence

In the DTORS baseline report two per cent reported committing violent theft and a further six per cent other violent crime (Jones *et al.* 2007). However, it is not reported whether these crimes were committed under the influence drugs.

attempted with all eligible respondents within the selected shifts. This design meant that the sample would be representative of all arrest events over a 12-month period. The interview consisted of a CAPI3 interview of around 20 minutes with a substantial CASI self completion section, which contained the most sensitive questions about offending behaviour, drug and alcohol use and treatment for drugs. Audio-CASI was available for respondents with literacy problems. In addition, respondents were asked to provide an oral fluid sample for analysis of recent drug use. The overall response rate was 23 per cent in 2005–06.

Driving offences

For England and Wales information on recorded crime for the offence of 'causing death by careless driving when under the influence of drink or drug' is available. In 2007/08 there were 418 such offences. There has been a steady increase in such offences since 1997 (291), but latest data show a nine per cent fall from the previous year (459) (Kershaw *et al.* 2008).

8.4 Drug use and prison

8.4.1 Drug use in prison

Review of treatment in prison

In a review of prison-based drug treatment funding, Pricewaterhouse Coopers (2007) suggest that there are over 81,000 people in prison (annual turnover estimated to be 135,000 per annum) in England and Wales, with over half of these thought to be problem drug users (see Chapter 9.3.1 for more information on the review).

Mandatory Drug Testing in prisons in England and Wales

Under Mandatory Drug Testing (MDT) in England and Wales¹⁷³, prisoners are subject to random mandatory tests for amphetamines, barbiturates, benzodiazepines, cannabis, cocaine, methadone and opiates. The overall random MDT positive rate has dropped from 24.4 per cent in 1996/97 to 9.1 per cent in 2007/08. The breakdown of these figures shows positive tests for cannabis coming down from 20.2 per cent in 1996/97 to 4.1 per cent in 2007/08. Positive tests for opiates have dropped from 5.4 per cent in 1996/97 to 4.3 per cent in 2007/08. This is the first year that the overall figures for England and Wales have shown a higher percentage of positive tests for opiates than cannabis (internal communication from the Ministry of Justice).

Buprenorphine misuse in Prisons in England and Wales

Following concern about the misuse of buprenorphine in prisons in England and Wales, during February to April 2007 all MDT samples were screened for buprenorphine. It was found that the misuse was a significant problem. The rate for positive MDT tests for all prisons in the survey period excluding buprenorphine was 8.9 per cent. Inclusion of universal buprenorphine test results increased the rate to 10.2 per cent, an increase of 1.3 per cent. The rate of positive tests was as high as 20.4 per cent of testing in one prison (Ministry of Justice 2007a).

Addictions Testing Measure (ATM)

In Scotland, Addiction Prevalence Testing¹⁷⁴ was carried out across all prisons during July 2007 and January 2008. The results confirmed that 64 per cent of prisoners

¹⁷³ The other forms of mandatory drug testing used in prisons are; suspicion testing, frequent testing, risk testing and on-reception testing. Voluntary drug testing (VDT) is also used to provide prisoners with additional incentives and support to stay drug free. In 2007/08, 32,808 VDT compacts were in place.

¹⁷⁴ An Addictions Testing Measure (ATM) was introduced in 2007 in Scotland to provide evidence of progress and distance travelled towards the Offender Outcome of '*reduced or stabilised substance misuse*'. SPS aims to ensure that prisoners make positive progress towards the Offender Outcomes during their time in custody. This can be referred to as the "prisoner journey". All admissions arriving in custody in two months of the year are tested for the prevalence of illegal drugs. Similarly all prisoners leaving custody are tested on a similar basis to assess the positive impact of addictions programmes. These tests are designed to support measurement of SPS' progress in achieving a reduction in the number of prisoners testing positive for drug use on entry compared with exit. Prisoners are tested at other times during their sentence to support their own participation in addictions programmes and prescribing, or to inform other operational decisions such as prisoner management.

tested on reception had illegal drugs in their system. By way of comparability, liberation testing revealed that 26 per cent tested positive for drugs on release.

The Scottish Prison Service Prisoner Survey

The 10th prisoner survey undertaken in 2007 by the Scottish Prison Service found that:

- seven out of ten of prisoners (69%) reported that they had used illegal drugs in the year before coming into prison;
- half (51%) reported that they had used drugs in prison at some point in the past;
- a majority of these individuals (82%) reported that their drug use had changed during their current period in prison with a majority (74%) reporting a decrease in drug use;
- less than a third of prisoners (30%) reported that they had used illegal drugs in the month immediately prior to survey completion;
- a small minority (3%) reported injecting drugs in prison in the last month. Of these the majority (80%) stated that they had shared injecting equipment;
- nearly half (45%) reported that their drug use was a problem for them on the outside and that they were under the influence of drugs at the time of their offence (50%); and
- a quarter (26%) indicated that they committed their offence to get money for drugs.

Amongst those reporting drug use in the 12 months prior to custody (69%) the most commonly reported drugs used were:

- cannabis (79%);
- benzodiazepines (60%);
- cocaine (60%); and
- heroin (53%).

The most common drugs reported in the last month while in custody were:

- heroin (70%);
- cannabis (64%);
- benzodiazepines (45%);
- other opiates (25%);
- methadone (not on prescription) (18%);
- cocaine (17%);
- temazepam (12%);
- ecstasy (9%); and
- amphetamines (5%).

There has been a small decrease in those having used drugs in prison from 55 per cent in 2003 to 51 per cent in 2007 (Scottish Prison Service 2008).

A report about minimising the supply of drugs into prisons in Northern Ireland suggests that there is no evidence of a significant problem with the use of Class A drugs (NIPS 2008). However, there have been small amounts of heroin, cocaine and associated paraphernalia found in the past year. Cannabis remains the primary drug used by prisoners in Northern Ireland, commonly in resin form, with in the past year over 650g found, which would have a monetary value of about €14,600 (£10,000) in the prison environment. Also, around 3,600 benzodiazepine tablets have been found in the past year, in some cases in large quantities.

8.5 Drug use in the workplace

Most drug testing in the United Kingdom is conducted in safety-critical industries such as shipping, railways and construction, where pre-employment and random drug testing is mandatory. Employers conducting random drug tests found a 34 per cent increase in positive tests for cocaine in 2007, with one in 145 employees testing positive for cocaine, suggesting they had consumed it in the previous two days.¹⁷⁵

8.6 Social costs

Based on the methodology used in research into the social and economic costs of problem drug use in England (Gordon *et al.* 2006) it is estimated that the costs in Scotland are approximately €3.9 billion (£2.6bn).¹⁷⁶ It is of note that research has been commissioned to refine this estimate (Scottish Government 2008a). Also so based on research by Gordon *et al.* the total economic and social costs of Class A drug use in Wales has been estimated to be around €1,140 million (£780m), with drug-related crime accounting for 90 per cent of this; health service costs are estimated to be €25.7 (£17.6m) per year (Coles and Pates 2008).

¹⁷⁵ See: <http://www.ft.com/cms/s/0/a9b96b42-d69e-11dc-b9f4-0000779fd2ac.html>

¹⁷⁶ Conversion rate is the December 2006 monthly average spot exchange rate quoted by the Bank of England.

9. Responses to social correlates and consequences

9.1 Overview

Social reintegration is a key element of recovery within new strategies in England, Scotland and Wales. The strategy for Northern Ireland, published in 2006 also recognises the need to provide support with housing and employment and wider support with social reintegration. There are various programmes to help drug users. The Supporting People Programme, introduced in 2003, provides housing related support to vulnerable groups generally, including people with drug problems. Progress2work (p2w), initiated in 2002 supports those who are drug free or stabilised in gaining employment. The Building Safer Communities Fund aims to build communities that are resistant to drugs. Social inclusion programmes such as Positive Futures can bridge the gap between universal and targeted services (see Chapter 3). Attention is also focused on the impact of parental drug use on children. In addition, there are a growing number of responses to neighbourhood problems associated with problem drug use, including drug dealing. For example, the *Anti-Social Behaviour Act 2003* seeks to stop the use of premises for drug dealing. Also, there is guidance to tackle the inappropriate disposal of drug paraphernalia.

The Drug Interventions Programme is a key part of the Government's strategy for tackling drugs and reducing crime in England and Wales. Introduced in 2003, new elements have been phased in each year since. The programme aims to get drug-misusing offenders out of crime and into treatment and other support. Some interventions operate right across England and Wales, while additional intensive elements operate in those areas with the highest acquisitive crime.

In Scotland, Drug Treatment and Testing Orders (DTTOs) provide offenders with access to treatment services as a requirement of the order whilst piloting is taking place of drug testing of arrestees to enable individuals to engage on a voluntary basis with treatment services.

There are a range of measures to prevent drugs entering prison including clearly-defined searching procedures covering all possible routes; passive and active drug dogs, with passive dogs available to all prisons; CCTV surveillance of all social visit areas and low-level fixed furniture; and comprehensive measures to tackle visitors attempt to smuggle drugs, including closed visits, visit bans and police arrest. New initiatives including mobile phone blocking to prevent contact with dealers, and body orifice searches are also being introduced. Since April 2006, in England and Wales, responsibility for prison health services has been fully devolved to the National Health Service (NHS), and an Integrated Drug Treatment System (IDTS) has been developed to improve the availability and quality of drug treatment in prison, bringing it on a par with treatment in the community. Scotland is reviewing the feasibility of placing responsibility for health care with the NHS. For the first time in the United Kingdom a syringe-exchange programme will be piloted in a Scottish prison.

9.2 Social reintegration

All new drug strategies in the United Kingdom are concerned with helping problem drug users recover and re-establish themselves in the community by aligning strategies on social exclusion and poverty, housing, education and training, and by providing support to avoid relapse.

In England key actions are:

- pooling of budgets for treatment and other interventions;

- individual budgets for treatment and wider support;
- personalisation of treatment; and
- a renewed focus on outcomes (HM Government 2008a).

These are expected to identify more effective incentives and delivery mechanisms for treatment and support for housing, training, employment and State benefits for drug misusers. There will be six initial pilot areas by late 2008.

In Wales, the Welsh Assembly Government is to produce a module of the Substance Misuse Treatment Framework for Wales on Continual Personal Development Opportunities, which includes education, training, volunteering, work experience, employment, day services and leisure pursuits. There are also plans to explore opportunities to access European Structural Funds to support provision of these services (Welsh Assembly Government 2008a).

In Scotland, the new drug strategy has its main focus on recovery and therefore it is considered that policies and services need to be designed to enable drug users to reintegrate. This is seen to require a cultural change within treatment services for drug users (see Chapter 1). In anticipation of this the Scottish Government commissioned a report by the Scottish Advisory Committee on Drug Misuse (SACDM) (2008) to address the additional non-medical aspects of services required to ensure that people with substance use problems are given every opportunity to recover. The Committee suggested that the approach to treatment be more aspirational and that this will involve the development of a national philosophy of care with a focus on recovery.

Key actions, within the Scottish Government's Action Plan in this area are:

- the setting up of a Drug Recovery Network to promote and support the concept of recovery;
- an appropriate range of drug treatment and rehabilitation services to promote recovery;
- setting up a national support function to take forward the development and implementation of the recovery model in drugs services;
- developing an outcomes based framework for assessing and managing performance at a local level focused clearly on recovery;
- establishing a National Evidence Group to develop a co-ordinated approach to identify gaps in research and encourage innovation (Scottish Government 2008a).

9.2.1 Housing

A further aim of *Drugs: protecting families and communities*, mainly relevant to England, is to improve access to accommodation with updated guidance to Local Authorities on their strategic housing role, a new rough sleeping strategy, identifying improvements in services available to rough sleepers, and an increase in the number moving on from hostels and homelessness services. There will also be continuing investment in the *Supporting People*¹⁷⁷ and *Adults Facing Chronic Exclusion* programmes.¹⁷⁸ Local Authorities are to receive at least €219 million (£150m) over three years to help them prevent and tackle homelessness.

¹⁷⁷ See: <http://www.spkweb.org.uk/>

¹⁷⁸ See: <http://www.communities.gov.uk>

http://www.cabinetoffice.gov.uk/social_exclusion_task_force/news/2007/070618_steps.aspx

The Home Office Drug Interventions Programme (DIP), Communities and Local Government, the Ministry of Justice National Offender Management Service (NOMS), the Housing Corporation, the Department of Health's Care Services Improvement Partnership (CSIP) and the National Treatment Agency for Substance Misuse have identified the need to consider the issue of housing and related support services for drug users. They are working with a national stakeholder group from both housing and the drug fields to identify practice and solutions which may inform the prevention of homelessness amongst drug users. A practice paper will be produced in 2008. The paper is being written to support the development, planning and delivery of housing and housing support services for drug users. It builds on recent practice findings and work undertaken by the Audit Commission (2004), Homeless Link (2007), McKeown (2006), CSIP (2007) and Addaction (Stephenson 2006). It will also take account of provisions such as The Respect Standard for Housing Management (Home Office and Communities and Local Government 2006).

Emerging findings suggest that housing¹⁷⁹ and related support services for drug users can contribute to improving outcomes on crosscutting areas such as preventing homelessness, reducing evictions and abandonments, increasing engagement and retention in drug treatment, improving health and social well-being, reducing re-offending, acquisitive crime and the causes and effects of anti-social behaviour (internal communication from the Home Office).

Working Together to Reduce Harm – the Substance Misuse Strategy for Wales 2008-2018 also highlights the need for housing to be a core element of services for drug misusers, noting that over the next year the Welsh Assembly Government will be developing a ten-year plan to tackle homelessness, reviewing actions required to meet the needs of homeless substance misusers (Welsh Assembly Government 2008a). There is a dedicated funding stream within the *Social Housing Grant* programme to address accommodation needs.

Research

Homelessness, substance use, and the effect of material marginalisation and psychological trauma

Research into homelessness supports previous findings that substance use, both alcohol and drugs, precipitates and exacerbates homelessness and marginality (McNaughton 2008).¹⁸⁰ The author suggests that once housed, a key problem was isolation and boredom, with deterioration in mental and physical health, leading some who had stopped using to relapse. It is concluded that for many who have been marginalised it is not enough to gain employment and be housed, much wider support is required to prevent relapse.

Effective Services for Substance Misuse and Homelessness in Scotland

In a review of the international literature, Pleace (2008) found that research suggests that there is a strong mutually reinforcing relationship between substance misuse and homelessness. The report highlighted the need to ensure that there is awareness in general homelessness and substance misuse services of the needs of homeless people with a substance misuse problem and to set realistic service outcomes that are tailored to the service user.

¹⁷⁹ Housing is taken to include a range of options, including social housing, the private rented sector, home ownership including low cost home ownership and supported housing.

¹⁸⁰ Twenty-eight people who were or had recently been homeless, selected from a sampling frame of 70 who had taken part in an earlier stage of research.

9.2.2 Education, training

In Wales the new strategy seeks to raise awareness amongst local partnerships of the needs of substance misusers to improve their access to skills programmes and learning opportunities (Welsh Assembly Government 2008a).

For Scotland see 9.2.3 below.

9.2.3 Employment

As referred to in Chapter 5, a strategic objective of *Drugs: protecting families and communities* is a new focus on services to help drug users re-establish their lives. Key actions include:

- Government departments to agree good practice guidance on securing treatment and support in gaining employment for drug users in receipt of benefits, in particular:
 - the referral of drug users in receipt of benefits into treatment;
 - provision of an appropriate 'safety net' of support, to which other claimants would be entitled;
 - for drug users in treatment, the use of the housing, employment and other indicators within the Treatment Outcome Profile to monitor the effectiveness of provision;
 - guidance for carrying out medical assessments of fitness for work; and
 - joint planning by Primary Care Trusts, Jobcentre Plus¹⁸¹ and local authorities to co-ordinate the management of drug misusers in treatment into work;
- annual agreement between treatment providers, jobcentres and housing support services on cross-agency support for drug users in receipt of benefit; and
- a requirement through the use of Jobseeker's Direction or Work Focused Interview process¹⁸², that drug misusers claiming working age benefits attend a discussion with a drug treatment provider, where they are not already in contact.

These actions are proposed in the new Green Paper on reform of the welfare system, *No one written off: reforming welfare to reward responsibility* which proposes action to meet a Government target of an 80 per cent employment rate (DWP 2008). It is proposed that legislation be introduced underpinning people's obligations to work, including a requirement for those identified as having problems with crack cocaine or opiates to take action to stabilise their drug habit and to take steps towards employment, in return for receiving benefits. The Green Paper suggests that of the estimated 240,000 problem drug users¹⁸³ who are in receipt of out-of-work benefits, 100,000 are not in treatment.

The Department of Work and Pensions (DWP) is responsible for benefits throughout the United Kingdom. However, Scotland, Wales and Northern Ireland have responsibility for treatment and therefore these proposals will have implications for treatment systems outside England.

In Scotland, *The Road to Recovery* suggests that action to improve employability must become more aspirational, with treatment and care services providing ongoing support to help with recovery (Scottish Government 2008a). The *Employability Framework, Workforce Plus*¹⁸⁴ is seen as central to this and is consistent with the

¹⁸¹ For more information see: www.jobcentreplus.gov.uk

¹⁸² For more information see: <http://www.dwp.gov.uk/>

¹⁸³ This figure differs from that in the feasibility study by Hay and Bauld reported in Chapter 8 as it excludes problem drug users identified as receiving disability allowance.

¹⁸⁴ For more information see:

broader approach to integrating services emphasised in the *Essential Care* report (SACDM 2008).

One area emphasised in the Scottish strategy is the need for greater flexibility in prescribing and supervised dispensing to meet the needs of those entering employment.

Research

Getting drug users back into the labour market

The United Kingdom Drug Policy Commission has commissioned a study concerned with getting problem drug users (back) into the labour market. The aims are to:

- review the particular challenges problem drug users (PDUs) face in re-entering the employment market (e.g. skills, medication, work experience, support mechanism, homelessness etc);
- consider the impact of the current legislative frameworks and benefit structures on PDUs participation in the labour market;
- understand the perceptions, attitudes, practice and experiences of employers with respect to employing this group;
- identify some examples of effective support systems for PDUs; and
- identify the subsequent implications for national policy and service delivery bodies.

Drug treatment and the achievement of paid employment

In a paper aimed at identifying which aspects of drug treatment are most closely associated with recovering drug users' ability to obtain paid employment it was found that there is a close relationship between the cessation of illegal drug use and individuals' ability to obtain paid employment (McIntosh *et al.* 2008).¹⁸⁵ It was suggested that while abstaining from drug use is unlikely to be successful on its own, the factor that showed the strongest independent association with the achievement of paid employment was assistance with finding work, and the authors suggest that these findings strongly support the provision of employment support programmes as the most important mechanism for helping recovering drug users to obtain employment.

9.2.4 Children of drug using parents

In both Scotland and Wales concern about the impact of parental substance misuse upon children has been of major concern (see previous United Kingdom Focal Point reports).

<http://www.scotland.gov.uk/Publications/2006/06/12094904/0>

¹⁸⁵ This article reports on a logistic regression analysis of the factors associated with the achievement of paid employment 33 months after the initiation of treatment for drug dependency. It is based on data collected in the course of the Drug Outcome Research in Scotland (DORIS) study. The study has involved over a 1,000 problem drug users recruited from 33 drug treatment agencies located across Scotland, with recruitment sites chosen to represent a range of drug treatment modalities, including prison based treatments. The socio-demographic profile of DORIS respondents is nearly identical to that of individuals in Scotland starting a new drug treatment in 2001, as reported in the Scottish Drug Misuse Database. Respondents were 69 per cent male, with a mean age of 28. The great majority of respondents reported that their main drug was heroin. The first round of interviews was conducted with 1,033 individuals seeking treatment for a drug problem in 2001/02 (DORIS1). Respondents were followed up at 8, 16 and 33 months (DORIS2, DORIS3 and DORIS4). The employment outcome variable used in the analysis is based upon the data collected at DORIS4. The analysis focused on paid employment.

In the new Scottish drug strategy a dedicated chapter, *Getting it right for children in substance misusing families*, outlines the approach to supporting children affected by parental substance misuse, with key actions to improve their life chances, including:

- provision of ongoing multi-agency training to help identify children at-risk at an early stage;
- supporting sharing and embedding of good practice on single and inter-agency assessment of, and planning for, children;
- developing more accurate prevalence figures for children affected by substance misuse;
- strengthening the focus of adult substance misuse services on the needs of children and families by including relevant outcomes in the commissioning framework;
- promoting the creation of integrated services to provide equality of access to treatment for all drug users;
- in the context of the *Early Years Framework*¹⁸⁶, work to improve parenting capacity, recognising the role of wider family and community networks in promoting resilience in children and their families;
- promoting support for young carers;
- promoting collaborative working between Child Protection Committees and Alcohol and Drug Action Teams in planning and meeting the needs of this group; and
- promoting good practice in supporting children affected by parental substance misuse (Scottish Government 2008a).

Also in Scotland, social work legislation has been examined in the light of this issue. Social workers were found to have sufficient powers to compel parents not engaging with services to do so, where this is appropriate (internal communication from the Scottish Government).

In Wales, the strategy suggests that a proposed *Legislative Competency Order for Vulnerable Children and Child Poverty*¹⁸⁷ will enable legislation in relation to the welfare of children and young people. The Welsh Assembly Government is to consult on a strategy for vulnerable children in the context of this new legislative framework. This will include support to parents who may need help for their mental health, substance misuse or other problems that may affect a child's opportunities and well-being. As noted in the previous United Kingdom Focal Point report a number of family intervention projects have been established in Wales, including the Early Parental Intervention Projects, 'Option 2' and 'Families First' (see below). The Welsh Assembly Government is to develop an integrated family support tool to assist local authorities working with families where substance misuse is an issue. Young carers are identified as a group needing support in *Caring about Carers*.¹⁸⁸ Guidance on the identification and assessment of young carers is included in *Health and social care for adults: creating a unified and fair system for assessing and managing care*.¹⁸⁹ Similarly, there is concern that support should be offered to parents and the *Strengthening Families*¹⁹⁰ programme for parents of young people aims to reduce

¹⁸⁶ For more information see: <http://www.scotland.gov.uk/Topics/People/Young-People/Early-years-framework>

¹⁸⁷ See: <http://www.assemblywales.org/bus-home/bus-guide-docs-pub/bus-business-documents/bus-business-documents-written-min-state.htm?act=dis&id=55768&ds=7/2007>

¹⁸⁸ For more information see: <http://www.wales.nhs.uk/documents/Jane-Hutt-reports-to-Assembly-Members-on-a-strategy-for-carers-in-Wales-e.htm>

¹⁸⁹ For more information see: <http://new.wales.gov.uk/publications/circular/circulars2002/NAFWC092002?lang=en>

¹⁹⁰ For more information see:

and prevent substance misuse and other problem behaviours in young people. An evaluation has been commissioned which will be published later in 2008.

Drugs: protecting families and communities also places an increased priority on children and families affected by substance misuse, suggesting that there will be increased support for carers taking responsibility for the children of substance misusing relatives. Also, as part of this, it is recommended that substance misuse training for social workers should be provided.

All strategies acknowledge that access to effective treatment should enhance the parenting capacity of drug misusers and that treatment services must act where substance misusers have children or there are children in the household, and recognise that they have a responsibility, in partnership with others, to ensure the child's well-being.

Drug courts

Drug Courts, already available in Scotland, have been established in England following a process evaluation of two pilot courts.^{191,192} The evaluation found that continuity of the judiciary, ability to understand offender motivation and, in particular, the points at which an offender is most likely to make progress in reducing or stopping drug use, were key components of success (Matrix Knowledge Group 2008).

Training for social workers

The British Association of Social Workers have called for employers and educators to provide more support in working with substance misusing clients, suggesting that specialist modules on substance misuse should be taught on both qualifying and post-qualifying training programmes, in order to meet the demands of a growing prevalence in social workers' cases. Currently, substance misuse is not a mandatory part of a social work degree.¹⁹³

Research

Evaluation of the 'Option 2' service

The 'Option 2' service, funded by the Welsh Assembly Government, has been operational in Wales since 2000. It is an early intervention service for families where children are at risk of harm and the parents have drug or alcohol problems. It offers brief and intensive support to the families to prevent the children being placed into care, wherever possible. An evaluation of the service has recently been published (Forrester *et. al* 2007) investigating differences between children receiving the

<http://www.childreninwales.org.uk/inyourarea/parentingprojects/5358.html>

¹⁹¹ The Dedicated Drug Court (DDC) framework for England and Wales provides for specialist courts which exclusively handle cases relating to drug-misusing offenders from conviction through sentence to completion (or breach) of a community order with a Drug Rehabilitation Requirement (DRR). This framework establishes five distinguishing core characteristics: specialism, the DDC exclusively handles cases relating to drug-misusing offenders from conviction through sentence, to completion or breach of their orders; continuity, the DDC will try to ensure sustained continuity of magistrates' bench or district judge throughout the period an offender comes before the DDC; training, sentencers and other court staff receive additional training on working with drug-misusing offenders and the DDC model; processes, processes are designed to ensure all necessary information is before the court when required; and partnership, the DDCs are designed to ensure effective multidisciplinary working with other criminal justice system agencies and professionals.

¹⁹² See: <http://www.justice.gov.uk/news/newsrelease010408b.htm>

¹⁹³ For more information see:

<http://www.communitycare.co.uk/Articles/2008/08/07/109065/basw-group-social-workers-need-more-substance-misuse-training.html>

'Option 2' service and a comparison group. It was reported that the service did not reduce the proportion of children entering care but the time spent in care by those children was significantly reduced for varying reasons, that is, they tended to stay in care for a shorter time, they took longer to enter care and a higher proportion returned home after a spell in care. It also found that at the end of the study a third of children in the comparison group were in care and a quarter of the 'Option 2' children were in care. It was reported that the 'Option 2' project brought about significant financial savings in terms of reducing the need for public care and its associated costs.

Families First

The Families First project in Middlesbrough works with families who are facing problems related to substance misuse and who have reached a 'crisis point' and is based on the 'Option 2' service. The Department of Health in England has commissioned an evaluation of the project. Results from the latest interim report¹⁹⁴ showed that at the twelve month follow up stage a range of positive outcomes for the families involved were reported including reduced conflict within the family, children kept out of the care system and drug and alcohol use stabilised. The final report will be available in December 2008.

'Mind the Gap' Grandparents Project

An evaluation report has been published regarding the short-term impact of information resources that were developed as a result of the 'Mind the Gap' grandparents' project. The aim of the project was to develop resources for support agencies of grandparent carers (e.g. drug treatment agencies, social services). The project yielded a resource pack for grandparents who are providing care for their grandchildren as a result of substance use. There is also a resource pack available for professionals working with these groups. The evaluation found that in general, support agencies had a greater understanding of grandparents' needs as a result of the project, although it was reported that it may be too soon to expect major changes in service provision (McWhirter 2008). A series of reports has been published by Mentor UK regarding the development of these information materials¹⁹⁵.

The Welsh Assembly Government has commissioned research in the following areas.

- A pilot study of a Family Support Service to collect evidence on the applicability and effectiveness of an American, evidence based model of family support. Emerging findings are due in December 2008 and the full report is due in April 2009.
- Family/carer support services in North Wales are to conduct a community engagement research project to identify the type of family support services required.
- An evaluation of the Early Parental Intervention Pilot Projects, commissioned in five areas, which are intended to improve outcomes of children in families where one adult member has substance misuse problems, by working with the adults. This will be carried out between February 2008 and October 2009.

9.3 Prevention of drug related crime

The mainstay of preventing, or reducing drug related crime continues to be through identifying drug-misusing offenders as early on as possible in the criminal justice process and engaging them in appropriate treatment and support.

¹⁹⁴ See: <http://www.cph.org.uk/substanceuse/index.aspx?teamid=23>

¹⁹⁵ See: http://www.mentorfoundation.org/projects_around_the_world.php?nav=3-27-34-86&id=91

In England and Wales the Drug Interventions Programme (DIP) was initiated to ensure that those committing such crimes access treatment and support. The Programme is a key component for delivering against a range of cross-Government targets and indicators concerned with reducing offending and drug misuse, improving health and combating social exclusion.

In Scotland drug misusers, identified through the justice system are referred into treatment through the use of Drug Treatment and Testing Orders (DTTOs). These orders provide disposals for high tariff offenders who might otherwise receive a custodial sentence.

9.3.1 Assistance to drug users in prisons

There has been increased concern about the ability of prisons to cope with the health care needs of a rising prison population. The British Medical Association (BMA) has been critical, not only of the failure to provide additional funding for healthcare, rehabilitation programmes and post-release monitoring services, but also with the continued availability of drugs within prisons and have recommended that there need to be new measures to address drugs problem in prisons (see below).¹⁹⁶

The United Kingdom Drug Policy Commission has argued that more evidence is needed to support the range of drug interventions in prisons.¹⁹⁷

Issues arising from the continuing increase in the prison population have been considered by Lord Carter (2007) in his review of the prison system, suggesting that as well as an expansion of prison capacity, changes are needed in existing sentencing legislation to modify the use of custody for certain types of low risk offenders and offences, reserving custody for the most serious and dangerous offenders. Following this review it has been suggested by the Ministry of Justice that community sentences, including drug rehabilitation programmes, can be a more effective punishment than short prison sentences.

In Scotland, the Scottish Prison Service is to publish a new Substance Misuse Strategy, which will complement the Scottish Government's drugs strategy (Scottish Government 2008a). Following the report from the Independent Prisons Commission in Scotland, there will be a review of chaotic drug users who stay for short periods in custody.¹⁹⁸

The Welsh Assembly Government has commissioned an evaluation of the Transitional Support Scheme which provides mentoring support for short-term prisoners who have a substance misuse problem. The scheme aims to increase access to substance misuse treatment, and also to help with homelessness, unemployment, and relationship problems.

Prevention

Supply Reduction

With concerns expressed by the BMA, the Ministry of Justice called for a review of measures to disrupt the supply of illicit drugs into prison in England and Wales, including recommendations to improve the effectiveness of such measures.¹⁹⁹ The

¹⁹⁶ See: <http://www.bma.org.uk/ap.nsf/Content/Prisonreforms>

¹⁹⁷ For more information see: : <http://www.ukdpc.org.uk/Publications.shtml#RDURR>

¹⁹⁸ See: <http://www.scotland.gov.uk/News/Releases/2007/10/23103516>

¹⁹⁹ See: <http://www.justice.gov.uk/news/announcement110308c.htm>

review report was published in July 2008. It stressed the difficulties faced by prisons in trying to keep out drugs and made ten recommendations, all of which were accepted by the Government.²⁰⁰ These included the further introduction of mobile phone blocking technology and body orifice security scanners (BOSS), and the further development of intelligence frameworks.

Following a recent survey of buprenorphine misuse in prisons (Ministry of Justice 2007a) (see Chapter 8.4.1) testing for it as part of mandatory drug testing was introduced in prisons in England and Wales from 1 April 2008.²⁰¹

A report concerned with minimising the supply of drugs into prisons in Northern Ireland makes a number of recommendations including:

- the introduction of mandatory drugs and alcohol testing ;
- increased searching of prisoners leaving the visits area;
- taking further steps to explore the deployment of mobile phone blockers;
- closer co-operation between the Prison Service and the police to target known drug users and traffickers;
- improved use of CCTV to observe prisoners suspected of drugs possession; and
- the introduction of random searching of staff and contractors by passive drugs dog (NIPS 2008).

Harm reduction

As part of the *Hepatitis C Action Plan for Scotland Phase 2* (Scottish Government 2008e), the Scottish Prison Service (SPS) has developed a harm reduction awareness session given to all prisoners on admission, which is repeated pre-release. This provides information on overdose risk due to loss of tolerance, blood-borne viruses, and how to access treatment and support. SPS also plan to pilot an in-prison needle exchange. This action has been carried over from the Phase 1 of the action plan, but has been delayed due to union opposition. In 2008 SPS implemented the provision of harm reduction packs for prisoners engaged in injecting behaviour. The packs consist of water ampoules, citric acid, Sterispoons, swabs, filter and foil. Condoms, lubricant and dental dams have been available in the since March 2007 (internal communication from the Scottish Government).

Following a pilot in 2007, disinfectant tablets are provided in all adult prisons in England and Wales (HM Prison Service *et al.* 2007). Possible uses are reported to be the cleaning of shaving equipment, toothbrushes, cutlery, crockery and cleaning cell toilets. Also, it is noted that they may be used to disinfect illicitly held needles used for injecting and tattooing.²⁰²

Treatment

A review of prison-based drug treatment funding in England suggests the need for a more strategic and evidence-based approach to service delivery (PricewaterhouseCoopers 2008). The report recommended eight steps which should be taken to build upon and improve delivery and extract better value from resources invested. The principal recommendation is to set up a National Offender Drug Strategy Group to commission a series of projects that would:

- articulate and agree the key outcomes needed both in prison and on release into the community;
- establish a set of national minimum standards for drug treatment;

²⁰⁰ See: <http://www.justice.gov.uk/news/announcement070708a.htm> for review and the Government's response.

²⁰¹ See: <http://www.justice.gov.uk/news/announcement130308a.htm>

²⁰² Disinfectant tablets have been available in Scottish prisons since 1993.

- identify opportunities for achieving efficiency savings to invest in prison and offender drug treatment services;
- examine the case for prioritising some groups of prisoners and offenders;
- develop a commissioning model at national, regional and local level;
- develop a single health and criminal justice funding stream to target services more effectively; and
- agree systems for improved information sharing to support better quality performance management and case management.

A Prison Drug Treatment Review Group to oversee the development of prison drug treatment has been established.²⁰³

The Department of Health (DH) and the National Offender Management Service (NOMS) have jointly developed the Integrated Drug Treatment System (IDTS). This aims to provide more effective and needs based treatment in prison through the closer integration of prison clinical drug services and Counselling, Assessment, Referral, Advice, Throughcare services (CARATs). The €18.6 million (£12.7m) allocated to IDTS in the 2007/08 financial year will rise to €37.1 million (£25.4m) in 2008/09, and DH has indicated further increases to £39 million in 2009/10 and €63 million (£43m) the year after. As of April 2008, 29 prisons had received funding for full IDTS (i.e. enhanced clinical treatment and psychosocial support), with a further 24 having received funding for enhanced clinical treatment only. DH's planned investment will lead to introduction of enhanced clinical services in a further 38 prisons in 2008/09 and all prisons by 2011.

In the 2007 Scottish Prison Service Prisoner Survey, half (51%) of problem drug users responding to the survey reported having been assessed for drug use upon arrival in custody. Forty per cent stated that they had asked if they required treatment for their drug use, and 35 per cent reported that they had received treatment during their sentence. Thirty per cent expressed concern that their drug taking would be a problem upon release (Scottish Prison Service 2008).

The Scottish Government are to review the feasibility of a potential transfer of primary health care to the NHS (Scottish Government 2008a).

In Wales there is to be a review of treatment and support services within the prison estates against the treatment module for offenders, with plans to be developed to improve service provision (Welsh Assembly Government 2008b).

Throughcare and aftercare and social reintegration

There is growing evidence that providing support for families of drug misusers helps alleviate their own stress and enables them to better support the latter throughout their rehabilitation and reintegration. Further, the existence and maintenance of good family relationships can also help reduce re-offending and improve treatment outcomes for those leaving custody and/or treatment (Home Office 2007c). The Home Office Drug Interventions Programme is currently focusing on work that supports the needs of families of drug misusing offenders at arrest and release.²⁰⁴

A new package of measures aimed at helping prisoners become drug free and into work has been announced by the Ministry of Justice (2008b).²⁰⁵ Measures include

²⁰³ See: <http://www.justice.gov.uk/news/announcement170308a.htm>

²⁰⁴ For more information see: <http://drugs.homeoffice.gov.uk/drug-interventions-programme/guidance/throughcare-aftercare/UnlockingPotential/>

²⁰⁵ See: <http://www.justice.gov.uk/news/newsrelease310108a.htm>

the launch of a new drive to involve more employers, from the corporate, public and voluntary sectors, in training offenders and offering them employment, and the drawing up of contracts with prisoners in return for opportunities to learn new skills.

In Scotland, there is to be a review of a pilot project to improve the integration of medical treatment with wider 'wraparound' therapeutic support; to give consideration to establishing it in all prisons; and the development and implementation of an information sharing protocol between Throughcare Addiction Services (TAS)²⁰⁶ and the Enhanced Addiction Casework Service (EACS)²⁰⁷ (Scottish Government 2008a).

Research

Literature review of programmes for drug-using offenders

A review of the international literature²⁰⁸ on programmes for problem drug-using offenders, including those in the prison system, suggests that the strongest evidence for the most effective strategies in reducing drug use and offending behaviours is for therapeutic communities and interventions modelled on the court approach and substitute treatments, with little evidence for the effectiveness of drug testing and intensive forms of supervision (McSweeney *et al.* 2008a; UKDPC 2008c; and UKDPC 2008d). In the custodial setting it is suggested there is evidence to support the use of methadone and lofexidine for the management of opioid detoxification, and that trials of methadone maintenance in prison indicate that retention in such treatment is associated with reduced reincarceration, hepatitis C and mortality. There is also strong evidence for the effectiveness of therapeutic communities in reducing drug use and/or recidivism. Abstinence based treatment developed along the lines 12-step programmes have also been shown to achieve significant and sustained reductions in drug use and offending, and recidivism. It is suggested that, although founded on solid principles from community treatment, there has been little evaluation of most interventions in the prison setting, including CARATs. There has also not been an evaluation of the effectiveness of drug-free wings.

A review of drug and alcohol treatments in prison and community settings

A review of drug and alcohol treatments in prison and community settings commissioned and conducted on behalf of the Prison Health Research Network²⁰⁹ found that there was a lack of high-quality research in this area, particularly clinical trials from the United Kingdom, with a lack of evidence for some recommended interventions such as brief psycho-social sessions focusing on advice, information and support (Roberts *et al.* 2007). It is further argued that the evidence from community settings shows that psychosocial interventions are effective for opioid dependence only when delivered in combination with pharmacological detoxification treatment. The authors argue that the interaction between approaches is of particular importance to prison populations where the aim is to keep prisoners drug-free on release and that the 28-day psychosocial intervention recommended for prisoners with problematic drug misuse does not have a strong evidence base behind it and should be evaluated as a priority.

²⁰⁶ For more information see:

<http://www.scotland.gov.uk/Topics/Justice/criminal/16910/tas>

²⁰⁷ For more information see:

http://www.cjscotland.org.uk/index.php/cjscotland/dynamic_page/?title=addictions_prison

²⁰⁸ Quantitative evaluative research studies were graded by use of the Scientific Methods Scale, with an additional category.

²⁰⁹ The Prison Health Research Network is funded by Offender Health at the Department of Health, and is a collaboration between several universities, based at the University of Manchester. For more information see: www.phrn.nhs.uk/prison/

The authors also suggest that the pharmacological evidence base for treating offender populations is severely lacking in the England and Wales, with policy on methadone maintenance based heavily on one study from Australia. The evidence for treating dependence on substances other than opioids shows very limited success to date in community settings, and is non-existent in offender settings. The one area where there is evidence is for therapeutic communities; this is based on a Cochrane review which concluded that the latter may be favourable to prison alone or other treatment programmes, but that the studies that have been conducted are lacking in methodological quality. They suggest that there should be offender-specific research rather than importing findings from community based treatments.

Experiences of prison among injecting drug users

In research looking at found that whilst negative experiences of prison and drug treatment prevailed, users identified recent policy and practice changes had positively influenced healthcare provision for drug users in prison, in particular the provision of maintenance prescribing (Tompkins *et al.* 2007). Also, it was found that drug users often saw prison as an opportunity to detoxify and consider their drug use.

9.3.2 Urban security policies in the prevention of drug related crime

The Drug Interventions Programme

The Drug Interventions Programme continues to be the main focus of action in England and Wales to reduce drug-related crime with continued work to engage those identified through the criminal justice system into treatment and/or other help and support. It includes interventions such as drug testing on arrest or charge, required assessment, restriction on bail, and conditional cautions with a drug rehabilitative condition (the DIP Condition).²¹⁰ Following an evaluation of the early schemes (Blakeborough and Pierpoint 2007) conditional cautioning was implemented throughout England and Wales by the end of March 2008. Approximately 5,900 conditional cautions²¹¹ were issued by the Crown Prosecution Service and police between April 2005 and January 2008.²¹² The new Drug Strategy seeks to increase the number of conditional cautions with a DIP condition to 2,000 by March 2009, which means doubling current usage.²¹³ Revised guidance on the use of conditional cautioning with a DIP condition has been published (Home Office 2008b).

Drug Rehabilitation Requirements (DRRs) are also to be extended with plans for 1,000 such orders by 2009.²¹⁴ To this end the probation service is to receive an additional €58.8 million (£40m) to pilot intensive alternatives to custody and the provision of more rigorous non-custodial regimes, as well as an investment of €20.3 million (£13.9m) over the next three years to fund six new intensive alternatives to custody projects.^{215,216} Such regimes will not be limited to drug-using offenders.

²¹⁰ Such cautions are given to offenders aged 18 or over, on admission of the offence, who agree to complete a set of conditions instead of being charged and prosecuted.

²¹¹ Conditional cautions are an alternative to prosecution. They are intended to be a swift and effective means of dealing with straightforward cases where the offender is willing to admit the offence and agree to comply with specified conditions.

²¹² See:

<http://frontline.cjsonline.gov.uk/search/index.php?searchterm=conditional&page=46>

²¹³ May 2008 edition of the monthly e-bulletin from the Drug Interventions Programme.

²¹⁴ See:

http://www.publications.parliament.uk/pa/cm200708/cmhansrd/cm080131/wmstext/80131m0005.htm#column_37WS

²¹⁵ See: <http://www.justice.gov.uk/news/newsrelease110308c.htm>

²¹⁶ See: <http://www.justice.gov.uk/news/announcement310108b.htm>

Also, new guidance for the management of drug users under probation supervision has been published (Home Office 2007d).

See also DIP work around the provision of support for families in section 9.3.1 above.

In addition, DIP continues to work with a range of partners to identify and promote practice which supports rehabilitation. The specific focus is on those activities and approaches adopted by local partnerships, projects and service users which have contributed to building steps towards employability. Practice examples available on the DIP webpage identify common themes alongside a framework of questions designed to support and capture further information on local examples of success.²¹⁷

Self-funded intensive DIP work

A total of 176 police custody suites can now conduct testing on arrest or charge; 14 of these, across seven police forces in England and Wales, have the power to test only on charge rather than at any point during custody. Some areas have expressed interest in self-funding of drug testing and detailed guidance has been issued on the criteria that need to be met to qualify for self-funded intensive status. Merseyside Police was the first force to achieve self-funded intensive status and now operates drug testing across the force (internal communication from the Home Office).

DIP Guidance on working with prostitutes

Good Practice Guidance to Increasing the Engagement of Adults Involved in Prostitution within the Drug Interventions Programme provides an overview of the issues associated with involvement in street-based prostitution and problematic drug use, and suggests how local CJITs can forge effective links with local specialist projects working with adults involved in prostitution (Home Office 2007e). It also describes the types of support and services required.

Offender Management Bill

The Offender Management Bill aims to reduce re-offending and better protect the public by improving the way in which offenders are managed. In particular, the Bill seeks to remove the public sector monopoly on the provision of probation services and enable the Secretary of State to commission services from the best available provider in the public, private or voluntary sector. The Bill, supporting documents, and progress through parliament are published on the United Kingdom Parliament website.²¹⁸

Young offenders

A new Joint Youth Justice Unit for England and Wales, based within the Ministry of Justice, will merge the responsibilities of the former Ministry of Justice Youth Justice and Children Unit with those of the Young Offender Education Team from the Offenders Learning and Skills Unit, formerly part of the Department for Education and Skills (DfES). Youth justice policy and sponsorship of the Youth Justice Board were made the joint responsibility of the Ministry of Justice and the newly created Department for Children Schools and Families (DCSF) following Machinery of Government changes in June 2007.

Citizen participation

The concept of community justice is part of the Government's agenda to tackle anti-social behaviour and the crime associated with it. Community justice brings the

²¹⁷ See:

<http://drugs.homeoffice.gov.uk/drug-interventions-programme/guidance/throughcare-aftercare/UnlockingPotential/>

²¹⁸ See: http://www.publications.parliament.uk/pa/pabills/200607/offender_management.htm

justice system and the community together to solve problems, reduce crime and build confidence. Community courts have now started hearing cases at nine locations. Section 178 of the *Criminal Justice Act 2003* provides the power for the court to review offenders' progress as they carry out community orders; some offenders will be drug users subject to treatment orders. This means that when an offender is given a community penalty the court can order that the offender comes back to court on a regular basis and for their behaviour during the sentence to be considered. This increased oversight by the judge or magistrates brings increased responsibility and encouragement for offenders to comply with the conditions of the sentence. It will also give the court the opportunity to support the offender as they face challenges and adapt the conditions of the sentence if conditions change.²¹⁹

The first evaluations of community courts in North Liverpool (McKenna 2007) and Salford (Brown and Payne 2007) found that of the offenders surveyed, 79 per cent indicated that problem-solving meetings had helped them to address their problems. Seventy-six per cent of them thought the support they received was better than previously received in a traditional court.²²⁰

Structured Deferred Sentence

Following an evaluation, there are plans to extend the Structured Deferred Sentence in Scotland which has been piloted in five courts (Macdivitt 2008).²²¹ This is a low-tariff intervention providing structured social work for offenders post-conviction, but prior to final sentencing, primarily aimed at offenders with underlying substance misuse problems (and also mental health, learning difficulties or unemployment). The purpose is to provide a relatively short period of focused supervision as part of a deferred sentence with the specific objectives of assessing need and therefore matching more effectively intensity of intervention/supervision, as well as building offender motivation for positive change; reducing the frequency of seriousness of offending behaviour; avoiding premature or unnecessarily intensive periods of supervision in the community; and meeting the needs of the courts.

Drug Treatment and Testing Orders: Scotland

Drug Treatment and Testing Orders (DTTOs) continue to be the main community sentence imposed on drug using offenders in Scotland, although until recently, used only with high tariff offenders. In June 2008, two pilots extending them to lower tariff offenders commenced. A total of 696 DTTOs were made in 2006/07, up 16 per cent from 599 in 2005/06 (Scottish Government 2007h).

Research

The effectiveness of DIP in reducing offending

Skodbo *et al.* (2007), in research into the effectiveness of DIP, found that when comparing offending levels pre- and post- DIP contact, levels in the six months following DIP were lower than in the six months before.²²² The research also found that Tough Choices²²³ increased through-flow and reduced attrition from the

²¹⁹ See: <http://www.communityjustice.gov.uk/>

²²⁰ The evaluations are based mostly on interviews with staff, community members and offenders early on in the life of the projects.

²²¹ See: <http://www.scotland.gov.uk/News/Releases/2008/04/15102026>

²²² Methodological limitations (the absence of a control group) mean that this does not represent a full outcome evaluation and accordingly was not possible to calculate how much of the observed change in offending was due to DIP. Two cohorts were examined. All those who tested positive for heroin, crack or cocaine in DIP intensive areas in England during two time frames; 7,727 individuals who tested positive at the point of charge during the period 1 July to 31 October 2005 and 11,015 testing on arrest from 1 April to 30 June 2006.

²²³ For more information see: <http://www.homeoffice.gov.uk/rds/pdfs07/horr02c.pdf>

programme. It is, therefore, suggested that the criminal justice system can be an effective route for getting drug misusing individuals into treatment and that the use of semi-coercive approaches can improve engagement in intervention programmes. However, there was a subgroup of around a quarter for whom offending increased following contact and it is argued that more work is required to identify those who have successfully continued through DIP, as well as those who have not done so, to establish why DIP is associated with good outcomes for some individuals and not for others. It is also suggested that there is a need to explore the circulation of individuals through DIP to establish how many times individuals pass through, the frequency of their contact, and the impact of this on outcomes and offending.

Treatment Retention in DIP

In looking at treatment retention in DIP, Best *et al.* (2008) ask whether those who are in the programme primarily because their drug use leads to offending fare better than those whose offending is not necessarily associated with their drug use, examining completion rates in one DIP programme by crime behaviours and drug use.²²⁴ It was found that relatively few cases had positive outcomes, although treatment retention exceeded expectations in around one quarter of cases; less than five per cent of cases were successfully completed, some form of positive outcome was reported in 14 per cent of cases, but that 57 per cent had negative outcomes, such as breaching the requirements of the order or failure to attend. Twenty-nine per cent were still open six months after the start of the programme.

A case-study of substitute opiate prescribing for drug-using offenders

In a case study of DIP clients, Keene *et al.* (2007) found that of 180 offenders offered treatment as part of the programme, 103 (57%) successfully engaged and 59 (32%) stayed six weeks or more. The majority of referrals (94%) were for heroin misuse and 45 per cent also reported crack cocaine use. Twenty-seven per cent injected. Those who engaged initially were more likely to be injectors (70% compared to 30% of those who did not engage), females, polydrug users, and older clients. But those who stayed in treatment for at least six weeks were more likely to be non-injectors (60% stayed in treatment compared to 40% who did not), male and from ethnic minority groups. Qualitative analysis of 40 semi-structured interviews with clients emphasised the benefits of fast access and friendly helpful staff. However, clients believed that drug use itself was interlinked with social, economic and psychological problems and identified a need for comprehensive wraparound services and help with housing and employment. The complexity of the relationship between drug use and crime was seen as reflecting the complexity of these underlying problems.

Drug users assessed by DIP teams in non-intensive areas

In a report highlighting emerging trends in DIP client characteristics, Duffy and Beynon (2008)²²⁵ found that:

- clients under 25 comprised the largest group (29%);
- there was no significant difference in gender between those under 25 and older clients;
- both sets of clients were predominantly White (96%);
- drug use profiles were different, while heroin was the most common drug in both age groups, the percentage using it amongst younger clients was significantly lower (46% compared with 75%), rates of crack cocaine use were also higher

²²⁴ This was a retrospective case-note study based on all files opened over a three-month window, examining outcomes three months after the last case was opened. A total of 123 files were examined.

²²⁵ Data for the assessment completed by DIPs team in 31 DAATs in England during 2006/07 were used. Any client under 18 were removed, as were any clients who reported they had not used drugs in the month prior to assessment. Data on 5,242 clients were analysed.

- amongst older clients (41% compared with 26%), and those under 25 were more likely to report use of cocaine powder, cannabis, amphetamines and ecstasy;
- combined use of heroin, methadone, crack cocaine or cocaine powder were also higher amongst the older group;
 - much of the evidence presented points to a less problematic profile of drug use amongst those under 25, with greater levels of cannabis and cocaine powder use but lower levels of heroin and crack cocaine use;
 - those under 25 were significantly less likely to report lifetime injecting or to have injected in the previous month, however amongst this group those who had injected were more likely to have injected recently;
 - older clients were more likely to have been in treatment in the past two years; and
 - a higher proportion of the older group reported daily alcohol use.

Literature review of programmes for drug-using offenders

In their literature review of programmes for drug-using offenders McSweeney *et al.* (2008a) suggest that the evidence is equivocal as to the impact of drug testing as part of a community order on drug use and offending, and engagement in treatment. However, they note that there is some evidence of the success of DIP in improving treatment engagement and reducing drug use and offending. Similarly, DTTOs appear to be successful in promoting reductions in drug use and offending for those completing them, however, more than half fail to do so. There is also evidence that Prolific and other Priority Offender schemes are associated with reduced offending. In addition, there is some evidence of the success of drug courts, mainly based on evidence from users, but also noting the evidence from Scotland. Restriction on bail was found to have some positive effects in terms of compliance and treatment engagement, but the impact on offending and retention is unclear.

The effect of drug treatment upon the commission of acquisitive crime

Research as part of the longitudinal Drug Outcome Research in Scotland (DORIS) study examining the association between acquisitive crime and drug treatment found a strong independent effect of drug consumption and drug consumption-related variables in accounting for acquisitive crime (Mckintosh *et al.* 2007).²²⁶ Results showed substantial reductions in acquisitive crime following treatment, but the influence of treatment is indirect and mediated by its effect on drug use. However, it is suggested that, insofar as drug treatment reduces the need for individuals to engage in acquisitive crime by moderating their use of illegal drugs, the social and economic benefits to society from such programmes are likely to be substantial.

Street policing of problem drug users

A study carried out for the Joseph Rowntree Foundation²²⁷ found that policing encounters with problem drug users were primarily aimed at managing a 'risky' population and were rarely initiated in response to a specific crime (Lister *et al.* 2008). Encounters often involved running name checks, enquiring about their presence and behaviour and moving them elsewhere. Rarely were formal police

²²⁶ Follow-up interviews were conducted with 1,033 individuals who started treatment for problem drug use in, 2001/2. Respondents were interviewed on four occasions over a 33-month period. Stepwise logistic regression models were constructed to test the independent effect of 22 co-variables upon the commission of acquisitive crime or the likelihood of being arrested for it.

²²⁷ The study was conducted over an 18-month period in three police force areas in England and Wales and focused on one division in each. The main sources of data were interviews with 42 police officers and 62 problem drug users and over 100 hours of observation accompanying policing personnel in street contexts. Fieldwork data was supplemented by administrative data supplied by the three police forces.

powers used and welfare-orientated activities (such as referrals to drug treatment services) were, similarly, not common. Problem drug users resented such regular low-level use of police authority and felt that it was not a deterrent to involvement in drugs and/or crime. The authors suggest that the frequent contact between policing personnel and problem drug users could be used constructively to help users access treatment and harm reduction services. They argue that the strategy of moving problem users elsewhere will not address problem drug users' problems and suggest the need for a multi-agency approach to street policing issues.

Evaluation of mandatory drug testing of arrestees pilots in Scotland

The Scottish Government is seeking to commission a formative evaluation of the pilots for mandatory drug testing of arrestees in three police stations in Scotland (Aberdeen, Edinburgh and Glasgow). The pilots are running for two years, from June 2007 until June 2009.²²⁸

9.4 Drug driving

The police are empowered to conduct compulsory tests on drivers for impairment and for the presence of drugs. Tests for impairment are already carried out using Field Impairment Testing, simple tasks of cognition and physical co-ordination. Tests for the presence of a drug have to be carried out using a device of a type approved by the Secretary of State. A specification for such a device is currently being finalised, it will then be for manufacturers to prepare devices in line with the specification and submit them for testing (internal communication from the Home Office).

During the Association for Chief Police Officers' (ACPO) 2007 Christmas Drink/Drug Driving Campaign in England and Wales²²⁹, 550 field impairment tests were carried out on drivers under the suspicion of drug driving, of which 28 per cent were subsequently arrested. This is a lower proportion than in the 2006 campaign when 38 per cent of the 666 field impairment tests resulted in an arrest.

9.5 Drug testing in the workplace

A survey of employers in the United Kingdom found that 22 per cent of respondents test employees for drug and alcohol use, either randomly or when hiring new individuals and that a further nine per cent said they were planning to introduce testing (CIPD 2007).²³⁰ Sixty-five per cent of responding organisations do not test and have no plans to do so. Fifteen per cent had dismissed at least one person because of drug problems in the past two years. Manufacturing and production organisations are much more likely to test employees, with more than a third having a testing regime in place and a further 16 per cent planning to do so. Safety-critical organisations are most likely to carry out testing of employees, with 53 per cent doing so. The most common approach is to test when an employee is suspected of drug or alcohol misuse as a result of performance issues or because of inappropriate behaviour, the next most common approaches are post-incident testing and pre-employment testing. Only two per cent of non-profit organisations test employees.

²²⁸ See:

http://www.drugmisuse.isdscotland.org/publications/abstracts/express_of_int_drug_testing.htm

²²⁹ See: http://www.acpo.police.uk/pressrelease.asp?PR_GUID=%7BAB561A46-787C-471D-BB44-4A92E487B272%7D

²³⁰ The analysis is based on replies from 505 United Kingdom-based Human Resource professionals in organisations employing a total of more than 1.1 million people. No information is given about the survey methodology.

In Wales, substance misuse policies in the workplace will be encouraged through the Corporate Health Standard and by launching small workplace awards for Small and Medium Enterprises (SMEs), and by promoting links between Community Safety Partnerships and local SMEs. A seminar on substance misuse in the workplace will be held in January 2009 (internal communication from the Welsh Assembly Government).

10. Drug markets

10.1 Overview

The United Kingdom Threat Assessment of Serious Organised Crime 2008/09 suggests that despite law enforcement efforts, “the market in the United Kingdom remains attractive to traffickers and dealers because of the high profits to be made.” Class A (heroin, cocaine and ecstasy) and other drugs are widely available throughout England, Scotland and Wales while in Northern Ireland the Class A drug market is relatively small (SOCA 2008).

Heroin: Most identified supply chains to the United Kingdom follow well-established trafficking routes. The primary trafficking route is overland from Afghanistan to Europe, transiting from Iran through Turkey and also through Armenia and Azerbaijan, before being moved to the Balkans, and then overland to Europe. Most of the heroin moved along these routes ends up in the Netherlands before entering the United Kingdom. In addition, a quarter of Afghan heroin arrives directly by air routes from Pakistan, via couriers and parcels.

Cocaine: The Iberian Peninsula, predominantly Spain, and the Netherlands, continue to be the main entry points into Europe for shipments of cocaine from South America (primarily Colombia and Venezuela) destined for the United Kingdom. Shipment routes transiting the Caribbean and west Africa are also common with organised crime groups. It is believed cocaine enters the United Kingdom via ports in the south east of England. Commercial flights are also used to import ‘little and often’ from the Caribbean.

Ecstasy: Almost all of the ecstasy consumed in the United Kingdom is manufactured in the Netherlands or Belgium, and commonly enters by sea through Dover, Felixstowe and Harwich. A number of sites making up tablets have been found, mostly in the North of England. Synthetic drug production in the Netherlands and Belgium relies heavily upon precursor chemicals made in China, obtained through criminal networks from Chinese companies.

Cannabis: Cannabis is imported into the United Kingdom from Europe in bulk by organised criminals, sometimes in mixed loads alongside Class A drugs, and in smaller amounts for sale, and for personal use. In addition, there has been an increase in intensive hydroponic cultivation of cannabis within the United Kingdom, predominantly run by Vietnamese.

The overall picture of United Kingdom drugs distribution appears increasingly complex and diverse. Many traffickers in the United Kingdom, particularly White British criminals import and distribute more than one type of drug. London, Birmingham and Liverpool continue to be important centres for drugs distribution but other smaller cities and towns are also involved. In Scotland, the main source of heroin is from Liverpool via the Glasgow area.

In general the quantity of seizures has been rising in the United Kingdom, cannabis being the most seized drug. The number of herbal cannabis seizures has increased since the introduction of cannabis warnings and there have been increasing seizures of cannabis plants. However, seizures mainly in Class A drugs have achieved short-term disruptions rather than a sustained reduction in the size of the United Kingdom drugs market. The Serious Organised Crime Agency (SOCA) suggests that drug seizures are more likely to impact on purity of drugs at street level than price.

Purity of cocaine powder has fallen since 2003 at street level although the average purity of seizures by HM Revenue and Customs (HMRC) is stable suggesting increasing adulteration within the United Kingdom. Heroin purity has increased since 2003 while crack cocaine has seen a reduction in purity. The potency of cannabis seized by police and sent to the Forensic Science Service (FSS) has decreased in recent years but a number of studies suggest that the potency of the increasingly market dominant sinsemilla (skunk) cannabis is much higher.

The price of cocaine powder, heroin and ecstasy has decreased since 2003 while the price of other drugs has remained stable.

The most recent estimate of the size of the illicit drug market in the United Kingdom is €7.6 billion (£5.3bn) in 2003/04²³¹, with a wide margin of error of €5.8 billion (£4bn) to €9.5 billion (£6.6bn).²³²

10.2 Availability and supply

10.2.1 Availability in the general population

The 2006 Scottish Crime and Victimization Survey (Brown and Bolling 2007) found that 38 per cent of those reporting taking any drugs in the last month found it 'very easy' to acquire their most regularly used drug. A further 42 per cent said it was 'fairly easy' to do so. However, it is suggested that it had become more difficult to acquire drugs since the previous survey in 2004, when 68 per cent said it was 'very easy' to obtain their main drug.

10.2.2 Availability amongst school children and young people

A survey of school children in England (Fuller 2008) (see Chapter 2) asked pupils whether they had ever been offered drugs and how easy it would be to obtain them. In 2007:

- 36 per cent of pupils reported ever being offered drugs;
- the likelihood of ever having being offered drugs increased with age, 60 per cent of 15 year olds had been offered drugs compared to 13 per cent of 11 year olds;
- boys were slightly more likely to have been offered drugs than girls, 38 per cent compared to 34 per cent;
- 30 per cent of pupils thought it was easy to obtain drugs, a slight decrease from 33 per cent in 2001; and
- there has been a small increase in the proportion of pupils believing it is easy to obtain cocaine from 15 per cent in 2001 to 18 per cent in 2007.

Trends

The proportion of pupils reporting ever having been offered drugs has decreased since 2003 (Table 10.1). There has been a steady decline since 2002 in pupils reporting being offered cannabis, from 28 per cent to 22 per cent and little change in the figures for other drugs.

²³¹ Conversion rate is the December 2004 monthly average spot exchange rate quoted by the Bank of England.

²³² The study used a survey-based demand side approach to estimate market size. Data from the Schools Survey 2003, the Offending Crime and Justice Survey 2003 and the Arrestees Survey 2003/04 were analysed to estimate the prevalence of drug use, frequency of use quantity used and expenditure on drugs by juveniles, the general adult population and adult arrestees. Estimates of price and quantities were compiled from a number of sources including NICS price data and FSS purity data. The estimate was based on data sources for England and Wales and extrapolated to the United Kingdom as a whole.

Table 10.1: Percentage of pupils who reported ever being offered individual drugs in England, 2001 to 2007

Drug	2001	2002	2003	2004	2005	2006	2007
Any drug	42	40	42	36	39	35	36
Cannabis	27	28	27	25	25	23	22
Cocaine powder	9	9	9	8	9	9	10
Crack cocaine	9	7	9	8	8	7	8
Ecstasy	10	9	9	7	8	7	7
Heroin	7	6	7	5	6	5	6
Base	9,357	9,859	10,390	9,715	9,175	8,132	7,813

Source: Fuller 2008

In Northern Ireland, results from the Young Person's Behaviour and Attitudes Survey (YPBAS) show that 17 per cent of pupils had been offered cannabis and just over a quarter (26%) believed it would be easy to obtain (NISRA 2008a).

Cannabis supply and young people

Ninety-three per cent of young cannabis users interviewed for a qualitative study on cannabis supply²³³ in England said that cannabis was either 'very easy' or 'fairly easy' to obtain, with 79 per cent saying they could get hold of it in less than an hour (Duffy *et al.* 2008). Over half (55%) bought cannabis from a known seller, with 69 per cent of these describing their main seller as a friend. Around a quarter (23%) never bought cannabis themselves but were given it by a friend, a further 16 per cent reported that a friend bought it on their behalf and only six per cent bought from an unknown seller. Age was an important factor in the way young people obtained cannabis with the average age of those buying direct from a seller higher than those whose friends gave them cannabis or bought it on their behalf. Respondents who bought from an unknown seller were older than those who bought from a known seller.

Young people tended to buy cannabis from people on average three years older than themselves and often financed the purchase by 'chipping in' with friends. Over three-quarters (78%) reported sharing cannabis with friends. The majority of respondents stated that their sellers supplied only cannabis, although a quarter of respondents stated that their seller supplied other drugs, mostly ecstasy. Cannabis sellers who supplied other drugs were more common in rural areas. Forty-five per cent of respondents had either sold or brokered access to cannabis, the majority (72%) had brokered access to cannabis or sold on only one or two occasions.

The authors suggest that cannabis supply to young people is different from conventional descriptions of drug markets and is primarily based around friendship and social networks.

Sources of supply amongst school children

The 2007 school survey in England found similar results to Duffy *et al.* (2008). Eighty-two per cent of pupils who reported last year cannabis use obtained it on the most recent occasion from a friend, around half of whom were the same age. Only one per cent of pupils obtained cannabis from a stranger. Pupils who had used

²³³ The study comprised of semi-structured interviews with young people aged between 11 and 19. Respondents were purposively selected to fit one of two criteria: they had used cannabis at least once in the last three months and/or had brokered access or sold cannabis in the last 6 months. Interviews were undertaken with 182 young people from sites in the South-West of England and London. The majority were recruited from youth centres with the remainder from school/college, Youth offending teams, school exclusion units or snowballing.

Class A drugs in the last year were more likely than cannabis users to obtain their drugs from a stranger, six per cent of pupils reported doing so (Fuller *et al.* 2008).

10.2.3 Availability and supply in the 2005/06 Arrestees Survey

Availability

The Arrestees Survey²³⁴ asked respondents about the availability of heroin, crack cocaine and cocaine powder (Boreham *et al.* 2007). In 2005/06, amongst those who had used heroin in the last year, 75 per cent said heroin was available all the time with a further 18 per cent saying it was available most of the time. Only three per cent said heroin was not available often. Crack cocaine and cocaine powder availability showed a similar pattern to heroin availability but respondents were less likely to say cocaine powder was available all the time (68%).

Selling drugs

In 2005/06, six per cent of respondents had ever sold heroin, four per cent crack cocaine and five per cent cocaine powder. Those who had used individual drugs in the last year were more likely to have ever sold them; 31 per cent of those who used heroin at least once a week had ever sold it compared to three per cent who did not. Similarly 21 per cent of those who used crack cocaine once a week reported ever selling it compared to three per cent of other respondents.

10.2.3 Production, sources of supply and trafficking patterns within the country and from and towards other countries

Cannabis production, supply and market

Cannabis continues to be imported into the United Kingdom in significant quantities but commercial cultivation of cannabis within the United Kingdom is rising, particularly the high potency sinsemilla type known as skunk (SOCA 2008). A report by the Advisory Council on the Misuse of Drugs (ACMD) on cannabis and classification claims that United Kingdom-sourced cannabis now supplies the majority of users in the United Kingdom (ACMD 2008a).

In late 2007, an Association of Chief Police Officers (ACPO) Survey of police forces in England and Wales found that 1,564 factories had been discovered across 19 areas. In Scotland in 2006/07, 70 factories were discovered, an increase from under ten in 2005/06 (ACMD 2008a). Between 1 April 2007 and 31 March 2008, 3,032 cannabis factories were discovered in the United Kingdom (internal communication from the ACPO). Factories are mostly run by Vietnamese and located in residential properties. Often illegal immigrants smuggled into the country work in these factories to pay off debts to smugglers (SOCA 2008).

Research

The market share of different types of cannabis

Hardwick and King (2008) found that the market share of sinsemilla has increased markedly over recent years from 15 per cent in 2002 to 81 per cent in 2008²³⁵ (Table 10.2). However, the authors found a statistically significant difference in the market share of herbal cannabis across different regions in England and Wales.

²³⁴ The Arrestee Survey was a nationally representative survey of arrestees in 75 custody suites in England and Wales carried out for three years 2003/04 to 2005/06. Further details on survey methodology can be found in section 4.4.1

²³⁵ Methodology for each estimate differs and are all taken from publications where the main focus is on potency.

Table 10.2: Estimated market share of different cannabis types

Year	Sinsemilla	Traditional Herbal	Cannabis Resin
2002	15%	15%	70%
2004/05	55%	45%*	
2008	81%	3%	16%

*market share between traditional herbal and resin not stated in study

Source: Hardwick and King 2008; Potter *et al.* 2008

In Duffy *et al.*'s (2008) qualitative study amongst young people, 43 per cent said they usually bought skunk, 33 per cent bought herbal cannabis and 10 per cent bought resin.²³⁶ A study by Rethink, the mental health charity, found that three-quarters of recent drug users had used skunk, but only 35 per cent of cannabis users preferred using skunk with 50 per cent preferring to use herbal cannabis (Rethink 2008).

Drug markets and the illicit drug trade in the United Kingdom

Two reports looking at aspects of the drug market in the United Kingdom were published in the last year. The Home Office commissioned a qualitative study of drug traffickers and dealers²³⁷ to understand how high level drug dealers operate and how markets for illicit drugs work (Matrix Knowledge Group 2007) and the United Kingdom Drug Policy Commission commissioned a literature review looking at strategies to tackle illicit drug markets and distribution networks (McSweeney *et al.* 2008b). Both concluded that the drug trade in the United Kingdom is flexible and adaptable.

The illicit drug trade in the United Kingdom

The Home Office study (Matrix Knowledge Group 2007) found that there is a high and stable demand for illegal drugs, the market is fragmented, there is a tendency for dealers of heroin and cocaine to specialise and that there are higher mark-ups for heroin than cocaine across the supply chain. It also found that the majority of those interviewed entered the market through family and friends and suggests that, for individuals with contacts, barriers to entry to the market are negligible.

The study also found huge diversity between drug dealing enterprises in terms of their structures and operations although there was homogeneity in the fact that profits came primarily through revenue generation rather than cost control. The majority of dealers (around three-quarters) attempted to grow their operations with those able to adapt to new circumstances and exploit new opportunities, the most successful.

Significant numbers of dealers felt that the risk of imprisonment was not a deterrent but were more troubled by asset recovery efforts. The report concluded that it is possible to gather new and insightful information about the market conditions of the illegal drugs trade by interviewing convicted high-level dealers.

Strategies to tackle illicit drug markets and distribution networks

The United Kingdom Drug Policy Commission report (McSweeney *et al.* 2008b) concludes that drug markets are intractable, and that tackling drug markets requires a range of responses, and there needs to be a mix of supply and demand reduction measures. The study also recommends that the effectiveness, cost-effectiveness and value for money of drug strategies, particularly law enforcement strands, be

²³⁶ 144 young people specified what type of cannabis they bought.

²³⁷ The research team interviewed 222 offenders, the large majority of whom were serving sentences of seven years or more. The study adopted purposive sampling using Home Office data and information from the Police National Computer (PNC).

examined and that measurable outcomes be developed that focus on harm reduction.

10.3 Seizures

Latest information on seizures in the United Kingdom is for 2006/07. Previous data were published on a calendar year basis. Data are provided by all law enforcement agencies in England and Wales and police only in Scotland and Northern Ireland. There were 209,566 seizures of drugs in the United Kingdom in 2006/07, an 11 per cent increase from the previous year (Table 10.3). Since 2004, the number of seizures has increased by 57 per cent, largely due to the introduction of cannabis warnings in England and Wales, which has resulted in increased seizures of cannabis. There was a 44 per cent increase in seizures of herbal cannabis between 2005 and 2006/07 and a 36 per cent increase in the number of cannabis plant seizures. The latter reflects the growing discovery of cannabis factories since 2004 (see section 10.2.3 above); numbers of cannabis plant seizures have doubled and the quantity of cannabis plants seized has risen by 285 per cent (Table 10.4). Possibly as a result of changing markets for cannabis, cannabis resin seizures have fallen, as has the quantity seized.

Table 10.3: Number of seizures of drugs by law enforcement agencies in the United Kingdom, 2003 to 2006

Drug	2003	2004	2005	2006/07*	% change from 2005
Amphetamines	6,952	7,254	8,656	9,291	+ 7.3
Cannabis – herbal	36,839	42,814	74,575	107,424	+ 44.1
Cannabis – resin	60,068	52,218	59,204	43,128	- 27.2
Cannabis plants	2,904	2,995	4,331	5,906	+ 36.4
Cocaine powder	7,707	8,763	13,272	18,064	+ 36.1
Crack cocaine	4,814	4,974	6,479	6,812	+ 5.1
Ecstasy type substances	7,577	7,388	7,539	9,620	+ 27.6
Heroin	12,965	13,674	16,402	16,552	+ 0.9
LSD	131	152	229	191	- 16.6
Total	133,716	133,288	189,032	209,566	+ 11

*in 2006/07 seizures data moved to a financial year basis

Source: Standard Table prepared for the United Kingdom Focal Point

The number of cocaine powder seizures has continued to increase, although the quantity has decreased with 63 per cent of all cocaine powder seizures in England and Wales under one gram in weight (Smith 2008). Between 2005 and 2006/07, the number of heroin seizures remained stable, although quantity decreased. Crack cocaine seizures increased both in number and in weight. Ecstasy seizures also increased and the number of tablets seized more than doubled between 2005 and 2006/07.

Table 10.4: Quantity of seizures of drugs by law enforcement agencies in the United Kingdom 2004 to 2006

Drug	Unit measure for quantities	2003	2004	2005	2006/07*	% change from 2005
Amphetamines	Kg	1,424	1,389	2,330	1,660	- 28.8
Cannabis – herbal	Kg	29,412	21,496	20,650	25,760	+ 24.8
Cannabis – resin	Kg	65,379	64,920	50,395	23,850	- 52.7
Cannabis plants	Plant	83,972	95,103	212,971	366,057	+ 71.9
Cocaine powder	Kg	7,773	4,644	3,862	3,321	- 14.0
Crack cocaine	Kg	253	135	58	67	+ 15.5
Ecstasy type substances	Tablet (000s)	7,435	4,991	3,244	6,849	+ 111.1
Heroin	Kg	2,732	2,260	1,970	1,087	- 44.8
LSD	Dose (000s)	2	82	1,090	7	- 99

*in 2006/07 seizures data moved to a financial year basis

Source: Standard Table prepared for the United Kingdom Focal Point

Other seizures

There has been a significant increase in the quantity of opium seized entering the United Kingdom. Since the beginning of 2006 more than 500kg of opium has been seized, with three seizures in excess of 150kg (SOCA 2008). There has also been a rise in the proportion of tablets seized by police which have been found to contain piperazines (BZP, TFMPP and CPP) (see Standard Table 15).

Two seizures of bromo-benzodifuranylisopropylamine²³⁸, commonly called 'bromo-dragonfly', have been recorded in 2008. These are the first known seizures of the drug in the United Kingdom (internal communication from LGC Forensics).

10.4 Price/purity

The price of drugs in the United Kingdom appears to be influenced by the purity or potency of the substance involved. The price of weaker cannabis strains such as resin is lower than the stronger herbal cannabis, which in turn is cheaper than more potent strains of sinsemilla. There are also anecdotal reports that a 'two-tier' market exists for cocaine powder, with a more adulterated product selling for less than higher quality cocaine powder. Furthermore, reports suggest that, within the ecstasy market, low purity pills are being sold for very little while higher quality crystal/powder MDMA is sold at a much higher price (DrugScope 2007).

10.4.1 Price of drugs at street level

Drug prices in the United Kingdom come from a number of sources. Law enforcement agencies²³⁹ collect national data on drug prices while the Independent Drug Monitoring Unit (IDMU)²⁴⁰ survey festival goers. DrugScope conduct a random

²³⁸ Bromo-benzodifuranylisopropylamine is a synthetic drug, which is one of a group of drugs closely related to MDMA. It has hallucinogenic properties and is more potent than ecstasy but less potent than LSD.

²³⁹ Figures provided are derived from returns by police forces in the United Kingdom. The information is obtained from a number of sources including: prisoner interviews, informants, test purchases, recording procedures and intelligence. The figures shown in this chapter are the averages of the police force data returns, rather than the most representative price, and therefore may differ from figures quoted elsewhere from the same source (See Standard Table 16 for fuller details of methodology).

²⁴⁰ IDMU is an independent commercial research organisation conducting research including surveys of drug users. They estimate drug prices by distributing random questionnaires at

snapshot of drug prices in different areas of the United Kingdom but until recently only provided local estimates.²⁴¹

Mean price of illicit drugs in the United Kingdom

Data from law enforcement agencies suggest that the price of heroin and cocaine powder has again fallen. Prices for other drugs remain stable while the apparent rise in cannabis prices can be explained by a change in methodology (Table 10.5). There are considerable regional variations in the price of drugs across the United Kingdom, for example, heroin costs an average of €64.33 (£44) in the North of England compared to €131.58 (£90) in Northern Ireland.

Table 10.5: Law enforcement agencies: Mean price of illegal drugs in the United Kingdom, 2003 to 2007

Drug	Price per gram except where otherwise stated				
	2003	2004	2005	2006	2007
	Exch. rate: £1=€1.425*	Exch rate: £1=€1.440	Exch. rate: £1=€1.4725*	Exch. rate: £1=€1.486*	Exch rate: £1=€1.462*
Amphetamines	£9.00	£8.00	£10.00	£9.00	£9.00
	€12.82	€11.52	€14.73	€13.37	€13.16
Cannabis herb**	£2.54	£2.54	£2.64	£2.68	** £3.95
	€3.62	€3.66	€3.89	€3.98	** €5.78
Cannabis resin**	£2.32	£2.00	£1.94	£2.12	** £2.82
	€3.31	€2.88	€2.86	€3.15	** €4.39
Cannabis (sinsemilla)					£6.21
					€9.09
Cocaine powder	£55.00	£51.00	£49.00	£49.00	£46.00
	€78.35	€73.45	€72.15	€72.81	€65.79
Crack cocaine***	£19.00	£18.00	£19.00	£18.00	*** £65.00
	€27.07	€25.92	€27.98	€26.75	*** €95.02
Ecstasy (per tablet)	£5.00	£4.00	£4.00	£3.00	£3.00
	€7.12	€5.76	€5.89	€4.46	€4.39
Heroin	£62.00	£55.00	£54.00	£52.00	£48.00
	€88.33	€79.21	€79.52	€77.27	€70.17
LSD (per dose)	£3.00	£3.00	£3.00	£3.00	£3.50
	€4.27	€4.32	€4.42	€4.46	€5.12

Note : The source data were provided rounded, usually to the nearest pound.

*Conversion rates are the December monthly average spot exchange rates quoted by the Bank of England

**Before 2007 the cannabis values were based on the price for an ounce. In 2007 this changed to being based on a usual street deal of 1/8oz. The price has been converted to gram equivalent

*** Crack cocaine prices before 2007 were provided per rock (0.2g) not per gram. 2007 prices cannot be compared to earlier prices

Source: United Kingdom Law Enforcement Agencies

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pop festivals combined in recent years with a web-based survey. In 2007 the survey was web-based only resulting in a smaller sample.

²⁴¹ Information collected by journalists from Druglink, the organisation's magazine, who call 100 drug services, DATs, police forces and service user advocates in 20 areas of the United Kingdom.

DrugScope published price data for the United Kingdom in 2008 (DrugScope 2008), which are broadly comparable to other price data sources. Although cannabis prices appear lower than other sources, they are based on an ounce price not 1/8 ounce. The figures show that the price of ketamine and ecstasy has fallen since 2006 while crystal or powder MDMA has also fallen slightly. The figures suggest an increase in the price of heroin in 2008. In their 2007 survey, DrugScope reported that for cocaine powder a more heavily cut product sold for €44 (£30) a gram and a purer form of the drug for around €73 (£50) a gram (DrugScope 2007). Prices shown in euros in Table 10.7 should be interpreted with caution as there was a substantial change in the exchange rate between 2007 and 2008.

Table 10.7: DrugScope: Mean price of drugs at street level in the United Kingdom, 2006 to 2008

Drug	Price per gram except where otherwise stated		
	2006	2007	2008
	Exch. rate: £1=€ 1.486*	Exch. rate: £1=€1.462*	Exch. rate: £1=€1.262*
Amphetamines	£9.70	£9.80	£9.00
	€14.41	€14.33	€11.35
Cannabis herb** (standard quality)	£2.47	£3.07	£3.14
	€3.67	€4.49	€3.96
Cannabis resin**	£1.91	£1.94	£1.80
	€2.84	€2.84	€2.27
Cannabis (high quality)**	£4.27	£4.73	£4.63
	€6.35	€6.91	€5.84
Cocaine powder	£43.00	£43.00	£42.00
	€63.90	€62.86	€52.98
Ketamine	£28.00	£25.00	£20.00
	€41.61	€36.55	€25.23
Ecstasy (per tablet)	£3.00	£2.40	£2.30
	€4.46	€3.51	€2.90
Heroin	£46.00	£43.00	£49.00
	€68.36	€62.86	€61.81
MDMA	£40.00	£38.00	£39.00
	€59.44	€55.55	€49.20

* Conversion rates are the monthly average spot exchange rates quoted by the Bank of England (December monthly averages for 2006 and 2007, July average for 2008)

** Cannabis prices are converted from ounce prices

Source: DrugScope 2008

A qualitative study of drug traffickers and dealers (Matrix Knowledge Group 2007) (see section 10.2) found that there was a perception among dealers that law enforcement activity impacts on price. The study reports that there is price variation across different geographical areas in the United Kingdom. Data from law enforcement agencies supports this claim, with average cocaine powder prices ranging from €59 to €80 (£40 to £55) across different regions.

10.4.2 Purity of drugs at street level and composition of drugs/tablets

Information on the purity of drugs is from the FSS, covering most of England and Wales.²⁴² Latest data are for 2007 (Table 10.8). Purity of amphetamines has remained stable since 2003 while the mean MDMA content of ecstasy has fallen. However, the mean MDMA content of ecstasy seized in 2007 was slightly higher than in 2006. Heroin purity has continued to increase although there have been reports in 2008 of a lack of 'good' quality heroin at street level (DrugScope 2008).

Table 10.8: Street level mean percentage purity of certain drugs in the United Kingdom, 2003 to 2007

Drug	2003	2004	2005	2006	2007
Amphetamines	10.8	9.0	10.1	10.6	10.9
Cocaine powder	51.2	42.4	42.7	34.5	33.2
Crack cocaine	69.6	63.7	64.8	49.5	52.3
Ecstasy	64.5	66.7	66.3	48	51.8
Heroin (brown)	32.7	39.9	46.5	43.5	49.8

Source: Forensic Science Service Ltd 2008

Cocaine purity

The mean purity of cocaine powder at street level continues to fall and is now at 33.2 per cent compared to 51.2 per cent in 2003. The decrease reflects the emergence of more sophisticated cutting agents such as benzocaine, phenacetin and lignocaine, which are able to bind to the cocaine. While the average purity of cocaine powder seized by police has fallen, the average purity of cocaine powder seized by HMRC has remained stable suggesting increased adulteration within the United Kingdom (SOCA 2008). There has also been a fall in the purity of crack cocaine, reflecting the trend in cocaine powder.

Cannabis potency

Data provided to the ACMD by the FSS show that the potency of traditional imported herbal cannabis and cannabis resin has fallen since the late 1990s but the potency of sinsemilla has increased (Table 10.9). The data show that in the last two years there has been a decline in the potency of sinsemilla. However, it is difficult to monitor trends from these data as samples are not generally representative of what is available on the street and relate only to samples sent to FSS for evidential purposes.²⁴³

²⁴² All police seizures submitted to FSS for purity analysis in England and Wales.

²⁴³ Further information on methodology and limitations of the data can be found in Standard Table 14.

Table 10.9: Mean THC content (%) of different types of cannabis in England and Wales, 1995-2007

Year	Sinsemilla	Herbal cannabis	Resin
1995	5.8	3.9	-
1996	8.0	5.0	-
1997	9.4	4.0	-
1998	10.5	3.9	6.1
1999	10.6	5.0	4.4
2000	12.2	8.5	4.2
2001	12.3	-	6.7
2002	12.3	-	3.2
2003	12.0	-	4.6
2004	12.7	-	1.6
2005	13.7	1.9	5.5
2006	10.8	2.1	2.7
2007	10.4	2.6	4.5

Source: ACMD 2008a

The potency levels reported in the FSS data are lower than in the Home Office Potency Study described below.

Research

Home Office Cannabis Potency Study 2008

Hardwick and King (2008) report on the potency²⁴⁴ of various types of cannabis confiscated by police forces in England and Wales in late 2007.²⁴⁵ The mean THC concentration of sinsemilla was 16.2 per cent (range = 4.1 to 46%), median potency 15 per cent and the mean THC concentration of traditional imported herbal cannabis was 8.4 per cent (range 0.3 to 22%), median potency nine per cent. The mean potency of cannabis resin was 5.9 per cent (range = 1.3 to 27.8%) with a median potency of five per cent. The mean CBD content of cannabis resin was 3.5 per cent (range = 0.1 to 7.3%) while the CBD content of herbal cannabis was less than 0.1 per cent in almost all samples.

Potency of cannabis in England in 2005

Potter *et al.* (2008) studied the potency of cannabis seized by police in England in 2004/05.²⁴⁶ They found that the mean potency²⁴⁷ of sinsemilla was 13.3 per cent (range = 1.15 to 23.17%) and the median 13.98 per cent. The mean potency of herbal cannabis was 3.1 per cent (range = 0.28 to 11.81%), median 2.14 per cent and the mean potency of resin was 3.7 per cent (range = 0.44 to 10.76%), median 3.54 per cent. Potency levels differed across geographical areas. Like Hardwick and

²⁴⁴ Potency of cannabis is defined as the concentration (%) of tetrahydrocannabinol (THC), the main active ingredient of cannabis. Cannabis also contains other cannabinoids, one of which is cannabidiol (CBD). CBD is thought to have anti-psychotic properties.

²⁴⁵ In late 2007, police were requested to submit samples of cannabis confiscated from street-level users when issuing a warning to their usual service provider for laboratory examination. 2,921 samples were submitted for analysis. Samples were visually examined and a random selection of herbal cannabis samples were submitted for detailed microscopic examination to distinguish sinsemilla from traditional imported cannabis. Further random samples were examined to determine THC and CBD content. Concentrations of total THC and CBD were determined using either gas-chromatography or gas-chromatography coupled to mass-spectrometry with THC and CBD as external standards.

²⁴⁶ 452 samples were collected from the police property stores of five constabularies in England and visually assessed. Chromatographic analysis was undertaken using the method developed by de Meijer *et al.* (2003).

²⁴⁷ THC concentration.

King (2008), the study found there to be overlaps in the potency of the different types of cannabis. The authors also note the low levels of CBD in herbal cannabis and sinsemilla and stress the need to measure CBD in addition to THC content.

10.4.3 Price and purity of drugs in the Arrestees Survey

Respondents to the Arrestees Survey 2005/06 were asked whether the relative price and purity of drugs had increased, decreased or stayed the same over the past six months. Overall, a net proportion²⁴⁸ of respondents believed that the price of individual drugs had decreased although crack cocaine (14%) had not decreased as much as heroin (29%) or cocaine powder (27%). There were also net decreases reported for the purity of each individual drug although cocaine powder (8%) had not decreased as much as other drugs. The survey suggests that the price of heroin, cocaine powder and ecstasy decreased in relative terms (controlling for purity) while the price of crack cocaine increased marginally.

Table 10.10: Proportion of arrestees reporting that the price and purity of individual drugs had increased, stayed the same or decreased in the past six months and the net decrease in England and Wales 2005/06

Drug	Increased	Same	Decreased	Net decrease
Price				
Heroin	14%	43%	43%	29%
Crack cocaine	18%	50%	32%	14%
Cocaine powder	14%	45%	41%	27%
Ecstasy	11%	30%	59%	48%
Purity				
Heroin	7%	64%	29%	22%
Crack cocaine	7%	69%	23%	16%
Cocaine powder	9%	74%	17%	8%
Ecstasy	6%	69%	25%	19%

Source: Boreham et al. 2007

²⁴⁸ Net proportion is the difference between those reporting the price had increased and those saying it had decreased.

PART B

Selected issue

11. Sentencing statistics

11.1 Options available

In the United Kingdom, the law regarding drug possession, production, dealing and trafficking is principally covered by the *Misuse of Drugs Act 1971*. The Act divides drugs into three classes²⁴⁹ depending upon their relative harm and sets maximum criminal penalties for related offences (see Chapter 1). However, while the law covering these drug offences is the same across the United Kingdom, there are three separate criminal justice systems that are responsible for administering the law: one each for England and Wales; Northern Ireland; and Scotland. These systems have evolved over a considerable period of time and differences in policing and prosecution mean that the options available for dealing with drug offences differ across the United Kingdom.

The methods used by police in dealing with those suspected of drugs offences depend on the nature of the offence, the class/type of drug involved, the options available and the codes and guidelines that have been issued by the appropriate professional bodies.

11.1.1 Measures available for drug offences

In the United Kingdom the possession of drugs is a criminal offence but the use of drugs is not. At all stages of the prosecution system there is a large amount of discretion with police, prosecutors and judges all able to decide on an appropriate level of action.

Police

Since 1st April 2004 the main recording codes for drug possession in England and Wales have been split into two categories: possession of controlled drugs (excluding cannabis); and possession of controlled drugs (cannabis). The difference between the two offences is that an extra police disposal, the cannabis warning, exists for the latter offence. A cannabis warning can be given for possession of small amounts of cannabis only. The offender is not arrested nor does the disposal result in a police criminal record.

While police have the discretion to issue a simple caution for drug offences, both possession and trafficking²⁵⁰, conditional cautions can only be administered with the agreement of the Crown Prosecution Service (CPS) and only for possession cases. Guidelines on the use of different measures are published in England and Wales. For example, the Association of Chief Police Officers (ACPO) has published guidelines on the use of cannabis warnings (ACPO 2007) and in 2008 the Home Office issued an updated circular on the use of simple cautions.²⁵¹ Guidance on the use of conditional cautioning was updated in 2007.²⁵² The measures available to police to deal with offenders outside of the court system have also been set out in a police booklet (Office for Criminal Justice Reform 2007) (Table 11.1).

²⁴⁹ See: <http://drugs.homeoffice.gov.uk/drugs-laws/misuse-of-drugs-act/>

²⁵⁰ The term trafficking is used in this chapter to refer to drug production, supply, possession with intent to supply and unlawful import/export

²⁵¹ See Home Office Circular 016/2008: Simple cautioning of adult offenders <http://www.knowledgenetwork.gov.uk/HO/circular.nsf/79755433dd36a66980256d4f004d1514/6409b89613fc4d908025747f003f66a6?OpenDocument>

²⁵² See:

http://www.cps.gov.uk/publications/directors_guidance/conditional_cautioning.html#05

Table 11.1: Measures which can be used by police for drug offences in England and Wales

Action	Possession	Trafficking	Restrictions
Cannabis warning	YES	NO	Over 18 yrs, cannabis only
Caution - simple	YES	YES	Over 18 yrs
Caution - conditional	YES	NO	Over 18 yrs, possession only, with CPS approval
No further action	YES	YES	
Reprimand or final warning	YES	NO	Aged 10 to 18 yrs only

In Northern Ireland, similar disposals to England and Wales exist for police. Although ACPO guidelines on cannabis warnings extend to Northern Ireland, this disposal is not used by police in Northern Ireland.

Prosecution

In Scotland, the police do not have the same powers to issue cautions to offenders for drug offences, although it is a fundamental principle of policing that police retain the discretion to issue informal verbal warnings for trivial or minor offences of any nature. The system of police fixed penalty notices does not extend to offences under misuse of drugs legislation.

If a case is reported to the Crown Office and Procurator Fiscal Service (COPFS), which is responsible for the prosecution function in Scotland, the Procurator Fiscal has at his or her disposal a wider range of measures than the Crown Prosecution Service (CPS) in England and Wales, and the Public Prosecution Service (PPS) in Northern Ireland does (Figure 11.1).

Figure 11.1: Measures available to prosecution services other than prosecution at court in the United Kingdom

- | |
|--|
| <p>By CPS (England and Wales)</p> <ul style="list-style-type: none"> • No further action • Refer to police for caution <p>By PPS (Northern Ireland)</p> <ul style="list-style-type: none"> • No prosecution • Require police to administer informed warning • Require police to administer caution <p>By COPFS (Scotland)</p> <ul style="list-style-type: none"> • A warning by the Procurator Fiscal • Option of paying a fine • Option of referral for specialist support or treatment • Option to carry out unpaid work in the community • Option of paying compensation • No further action |
|--|

In England, Wales and Northern Ireland cautions can only be administered by police although the prosecution service can refer the case back to the police where they believe a caution, or in Northern Ireland an informed warning, is the best option. Each prosecution service has its own code for prosecution which includes evidential standards and public interest considerations and sets out the options for alternatives to prosecution.²⁵³

²⁵³ See: The Code for Crown Prosecutors: http://www.cps.gov.uk/victims_witnesses/code.html; COPFS Prosecution Code:

Courts

A number of disposals are available at a court level and are at the discretion of the magistrate, sheriff or judge.

Custodial sentence

The most punitive measure available at court is a custodial sentence. The maximum sentence that can be given is set out in the *Misuse of Drugs Act 1971* and depends upon the class of drug and the type of offence. The only circumstances where a minimum sentence is stipulated is in cases where an adult is convicted of a third Class A drug trafficking offence; in these cases the *Crime (Sentences) Act 1997* specifies a minimum seven year tariff.

The maximum sentence length that can be given across the United Kingdom is also determined by the type of court the offender is tried in.

Suspended sentence

A suspended sentence can be given when the court feels that a sentence of less than 12 months is appropriate. The maximum length of the order is two years and during that time a number of requirements can be set (see community sentence requirements below).

Community sentence

For all crimes committed on or after 4th April 2005, a single community order with a range of possible requirements can be given. These requirements are: compulsory (unpaid) work; participation in any specified activities; programmes aimed at changing offending behaviour; prohibition from certain activities; curfew; exclusion from certain areas; residence requirement; mental health treatment (with consent of the offender); drug treatment and testing (with consent of the offender); alcohol treatment (with consent of the offender); supervision; and attendance at an Attendance Centre.

Fine

A court may impose a fine for any offence although more serious crimes are more likely to receive a fine in conjunction with another penalty. The maximum fine depends on the type of court; in England and Wales, Crown Courts can impose an unlimited fine while the maximum fine that can be imposed by a Magistrates Court is €7,300 (£5,000).²⁵⁴

Absolute/conditional discharge

A person can receive an absolute or conditional discharge where the court feels no punishment is necessary. Absolute discharges require nothing from the offender while conditional discharges may impose restrictions on future conduct (for a maximum period of three years).

Other disposals

Other disposals include binding over (either to keep the peace or be of good behaviour), confiscation orders, where a court can confiscate the value of the estimated proceeds from drug trafficking, forfeiture orders where property can be forfeited in relation to the offence, and compensation orders.

<http://www.copfs.gov.uk/Publications/2001/05/prosecutioncode> ;and PPS Code for Prosecutors: <http://www.ppsni.gov.uk/site/default.asp?CATID=77>

²⁵⁴ For more information on maximum fines see:

http://www.cps.gov.uk/legal/section10/chapter_a.html

Compounding

In addition to the above measures, Her Majesty's Revenue and Customs (HMRC) in the United Kingdom have the option of 'compounding', an administrative sanction involving a financial penalty for those found carrying no more than ten grams of cannabis.

11.1.2 Drug driving

The offence of driving while under the influence of drugs is covered by a different Act of Parliament than possession/trafficking offences. The *Road Traffic Act 1988* makes it a criminal offence for any person who, when driving, or attempting to drive, a motor vehicle on a road or other public place, is unfit to drive through drink or drugs. An offence is also committed if a person, unfit through drink or drugs, is in charge of a motor vehicle in the same circumstances. A further offence of failure to provide a specimen for analysis is also included in the Act. The penalties for drug driving are similar for drink driving, reflecting the fact that the offences are grouped together as one offence.

Measures available are: disqualification; a fine; community order; and imprisonment. In almost all cases the offender is likely to go to court with more severe punishment likely for those with additional offences such as causing death by careless driving while under the influence of alcohol or drugs.

11.2 Data Collection Systems

A fundamental principle of policing in the United Kingdom is police discretion. This is exercised at many different levels from deciding whether to stop and search a person to deciding whether to arrest and put forward the offender for prosecution. Consequently, sentencing statistics do not provide a comprehensive picture of the outcome of drug offences but, in most cases, are a reflection of administrative systems and police priorities, and relate only to drug offences where a formal action is taken.

It is worth bearing in mind that data collection systems relating to crime recording (including drug offences) are principally designed to be of operational use, not to be used as a research tool. This means that query tools are geared towards individual case or offender level information retrieval rather than complex interrogations based on common criteria. Similarly, extracts from these systems on the level and outcomes of crime are essentially performance management driven, which dictates the level of detail required.

All police forces in the United Kingdom have local computerised recording systems. The actual system used differs across forces and are often standalone databases which mean that informal procedures, such as cannabis warnings, may not be consistently recorded from force to force, nevertheless the crime should still be recorded as the United Kingdom has a National Crime Recording Standard (NCRS). Providing a judicial sanction such as a formal caution or a conviction takes place then this will be accurately recorded on the Police National Computer System (PNC).²⁵⁵ Technological advances in the capabilities of specialised police recording system software means this picture is improving and data quality should therefore become more reliable.

Data on drug law offences are drawn from different sources across the United Kingdom reflecting the differences in legal systems.

²⁵⁵ See: <http://www.npia.police.uk/en/5977.htm>

11.2.1 England and Wales

Crime and arrests data

Local police forces have a legal requirement to provide specified information to the Secretary of State.²⁵⁶ The annual data requirement (ADR) stipulates what data forces are required to collect and what they must submit to the Home Office. This includes data in relation to recorded crime, arrests (for notifiable offences which includes drug offences) and cautions. Since 1st April 2004, police forces have been required to provide data centrally on cannabis warnings and ACPO have recently recommended including cannabis warnings in the ADR to improve the quality of these data (internal communication from ACPO). Data are recorded on local police systems and extracts from these administrative systems are collated centrally.

Stop and search

At the first point of the criminal justice system, when a member of the police stops a suspect, any search of that person carried out under the *Police and Criminal Evidence Act 1984* (PACE) must be recorded. Records must include, amongst other items, the following:

- name of person or description;
- person's self-defined ethnic background;
- purpose for search;
- grounds for search; and
- the outcome.

This means that it is possible to identify the proportion of stop and searches carried out under the suspicion of drug offences and how many of these result in an arrest for drug offences.

Recorded crime

Statistics on recorded crime are provided by local police forces at an aggregated level so drug offences are not available by individual drug. This breaks down drug offences into the main codes of: trafficking; possession; and other drug offences, and gives absolute numbers only. Police forces submit monthly CrimSec 3 returns which contain these data and are generated from their local databases. Recorded drug offences are governed by the Home Office Counting Rules (HOCR)²⁵⁷ which specify how many crimes should be recorded against an offender. The general rule is one crime for each offender or group of offenders meaning that, for example, if one offender is found in possession of various drugs, only the drug offence which carries the highest maximum penalty will be recorded. Similarly, if three people are caught manufacturing a controlled drug only one crime would be recorded.

Arrests data

Data on arrests for recorded crime are also provided via aggregated returns to the Home Office drawn from police force databases. Information is published at offence category level only so it is not possible to break arrests down into supply and trafficking offences. Data are for offender and include sex, age group and ethnicity. Where a person has been arrested for more than one recorded crime at the same time, the offence with the highest maximum penalty is recorded. Arrests data cannot be compared to recorded crime data because, as the last example above shows, one crime could result in three arrests. In addition, recorded crime includes cannabis possession offences which may be dealt with by a cannabis warning and therefore does not constitute an arrest.

²⁵⁶ *The Police Act 1996*, section 45(1)

²⁵⁷ See PACE Code A 2008: [http://police.homeoffice.gov.uk/publications/operational-policing/PACE_CODE_A_\(July_2008\).pdf](http://police.homeoffice.gov.uk/publications/operational-policing/PACE_CODE_A_(July_2008).pdf)

Sentencing data

Cautions data

Data on cautions are provided to the Ministry of Justice by police forces on a monthly basis from extracts drawn from local police databases, and collated in a central database, the cautions database. This provides data on the number of offenders brought to justice (OBTJ) by means of a caution and contains information on offence type, sex, age and police force area. Data are available by individual drug type. If an offender is arrested for multiple related offences, the decision to issue a caution should be based on the most serious offence (Home Office Circular 16/2008). Cautions data cannot be compared with recorded crime data as one crime could result in multiple cautions being issued. Furthermore, they cannot be directly compared with arrest data as the offence for which a caution was administered may differ from the offence for which the offender was originally arrested.

Court data

Data on court proceedings in England and Wales are collated in a central database, the Ministry of Justice's court proceedings database, with information supplied directly from courts. Various extract files are produced on a monthly basis including one for drug offences (Home Office 2004). The data extracted are on a 'principal offence' basis, which records the court disposal for the most serious offence dealt with and uses the offender as the statistical unit.²⁵⁸ It is possible, however, to extract data on a different basis; for example, the United Kingdom Focal Point's Standard Table 11 is produced on an 'all offence' basis. Data are provided on offence type, disposal, gender and age, and can be presented by individual drug type.

Her Majesty's Revenue and Customs data

There have been no reliable data on compounding for drug offences since 2000 (Home Office 2004).

Importation/exportation

Data on importation and exportation offences are available but by drug class only not individual drug type.

Data Linkage

Court and police databases are administrative systems and are not linked at present. Information about the outcome of offences and offender details are contained on the PNC which is used purely for operational purposes. The PNC is not designed to be the repository of statistical information and lacks an interrogation tool to allow this (Francis and Crosland 2002).

Statistical data are based on extracts from large complex databases and it is not possible to compare crime and arrests data with cautions and court proceedings data. This is due to a number of factors: the offence classification numbers for court proceedings do not directly compare to the aggregated offence categories used for crime and arrests data; court proceedings data refer to the year of the final court decision rather than year of arrest; and the offence that a person is finally dealt with may be different from the offence for which he/she was originally arrested or charged with. Furthermore, crime and arrests data are published on a financial year basis while cautions and court outcomes are published on a calendar year basis.

²⁵⁸ The principal offence is the offence where the heaviest penalty was given or, if the same penalty is given for two different offences, the offence where the statutory maximum penalty is highest.

11.2.2 Scotland

Data on recorded crime in Scotland are provided by police forces to the Justice Analytical Service section of the Scottish Government. The method of recording is governed by the Scottish Crime Recording Standard (SCRS), which was introduced in 2004. Scottish data on recorded crime are not directly comparable to data from England and Wales due to differences in the counting rules.

Police forces send returns to the Scottish Government containing a simple count of the number of offences recorded by offence type. Data cannot be compared to statistics on action taken against offenders, as one offence may lead to several persons being charged. Equally, an offender may be charged with several offences.

All cases to be reported to the Crown Office Procurator Fiscal Service must initially be recorded on the Criminal History System (CHS) at the Scottish Police Services Authority (SPSA) (previously the Scottish Criminal Records Office), which has an interface with the PNC. The COPFS uses a live, operational database to manage the processing of reports submitted by the police and holds information at charge level. Outcomes are recorded against charges and data on disposals and reasons for no further action are published on an aggregated level for all offences.²⁵⁹

The Scottish Court Services' 'COP2' system holds data on disposals and feeds this into the CHS. Data are recorded at offender level and on a principal offence basis. Data on court outcomes are extracted from the CHS for the Scottish Government's Court Proceedings Database and published annually by offence type.

The CHS is the hub of the Integration of Scottish Criminal Justice Information Systems (ISCJIS) programme²⁶⁰, which aims to allow communication between the IT systems of the various criminal justice organisations in Scotland. However, this is primarily for operational use and is not designed for research purposes.

11.2.3 Northern Ireland

Crime and arrests data

Data on recorded crime in Northern Ireland are provided by police forces to the Police Service of Northern Ireland (PSNI). As in England and Wales, the recording of crime is governed by HOCR and the NCRS. Arrest and charge information is recorded on a central NICHE²⁶¹ custody database. Data on arrests and charges are extracted as two separate data files but there are some common fields such as custody reference number that could be used to match charges to arrests.

Cautions and court data

Data on cautions are provided by police forces and extracted from the PSNI's Integrated Crime Information System (ICIS). Cautions data cannot be matched to arrest charge data at present but, in future, may be included on the NICHE database.

Court data are also obtained from ICIS data extracts. PSNI are responsible for collecting the data which means that coverage is restricted to criminal proceedings where PSNI are involved (NIO 2008). Data are available by class of drug only and refer to the principal offence.

²⁵⁹ See: <http://www.copfs.gov.uk/About/corporate-info/Introduction>

²⁶⁰ See: http://www.spsa.police.uk/services/information_services/criminal_justice_information/criminal_history_system_chs/iscjis

²⁶¹ NICHE is a specialist records management system software for law enforcement agencies

11.2.4 Drug driving data collection

Police data on drug driving is not collected separately from data on driving while under the influence of alcohol. A review of road traffic offence statistics concluded that, while there is a desire for better recording of drug driving offence data, the issue needs to be addressed from a legal aspect not a statistical one (Home Office 2001). Until the law distinguishes between the two causes of impairment, it will not be possible to provide these data and changes in the law are dependent on technological advances in the ability to prove drug impairment. At court level there is some breakdown of data by type of drink/drug driving offence.

11.3 Results available

11.3.1 Recorded crime

In the United Kingdom in 2006/07 there were 200,270 drug possession offences (see Chapter 8, Table 8.3) and 37,913 drug trafficking offences recorded by the police. In the same period crime statistics show that there were 90,926 arrests for drug offences (arrest data is not available for Scotland).²⁶²

11.3.2 Stop and search

Data on searches of persons or vehicles under PACE and other legislation in England and Wales show that, in 2006/07, 42 per cent of all searches by the police were carried out on suspicion of a drug offence. Of the 406,451 searches carried out for drugs, eight per cent (33,030) resulted in an arrest for drugs. Of the 65 intimate searches made for drugs, six per cent (n=4) resulted in a Class A drug being found (Ministry of Justice 2008a).

11.3.3 Outcomes for drug possession offences

It is not possible to provide data on a United Kingdom basis due to differences in law, available disposals and recording systems. These differences are discussed in 11.1 and 11.2.

England and Wales

Data on offenders found guilty of, or cautioned for, drug offences are published in the annual Crime Statistics publication by drug class and offence type. The figures contained in the 2006 publication (Ministry of Justice 2007b) are slightly different from those presented here as they refer to those found guilty not those sentenced and it is possible for somebody to be found guilty in one year and sentenced in another. Supplementary tables to this publication can be found on the Ministry of Justice website and data there are available on sentence outcome by offence type and drug class. Data by individual drug presented here have been provided by the Ministry of Justice and extracted from the same dataset as the published drug offence data.

Data provided are for offenders who have been sentenced after a finding of guilt at court or issued a caution for drug offences. The latest year of complete data is 2006, presented on a principal offence basis. The sentence shown is the most severe sentence or order given; data on secondary sentences are not included. Data refer to the year in which the offence was dealt with not when the offence was committed.

²⁶² Scotland accounted for 17.7 per cent of all drug offences recorded by police in the United Kingdom. The differences between recorded crime and arrests may be due to the fact that cannabis warnings do not result in an arrest.

For this reason, and reasons discussed in 11.2, it is not possible to link recorded crime or arrests with outcomes.

In England and Wales in 2006 there were 62,561 persons sentenced or cautioned for drug offences²⁶³ and 80,500 cannabis warnings were issued. Just over half of drug possession offences dealt with by the police were for cannabis (52.5%). Cocaine powder possession offences (14.6%) and heroin possession offences (8.9 per cent) were the next most common (Table 11.2).

Table 11.2: Number and proportion of all possession offences by individual drug in England and Wales, 2006

Drug	Number	%
Amphetamines	4,058	6.5
Cannabis*	32,822	52.5
Cocaine powder	9,140	14.6
Crack cocaine	1,431	2.3
Ecstasy	3,481	5.6
Heroin	5,570	8.9
LSD	91	0.1
Other drugs**	5,968	9.5
All drugs	62,561	100

*excludes 80,500 formal warnings for cannabis

**all other drugs classified under the *Misuse of Drugs Act 1971*

Source: Ministry of Justice

In 2006, 34,626 offenders were cautioned for drug possession offences, the majority of which (59%) were for cannabis possession. There were 1,090 offenders sentenced to immediate custody for possession, around a third of which (n=370) were for heroin possession (Table 11.3).

Table 11.3: Number of offenders receiving each disposal for drug possession offences by individual drug in England and Wales, 2006

Drug	Caution	Fine	Community Sentence	Immediate custody	Suspended sentence	Discharge	Other	Total
Cannabis*	20,370	6,368	2,527	141	66	3,069	281	32,822
Heroin	1,631	1,159	1,208	370	98	978	126	5,570
Cocaine powder	5,159	2,055	984	187	93	578	84	9,140
Crack cocaine	458	392	292	86	32	156	15	1,431
Amphetamines	1,899	940	429	85	38	601	66	4,058
Ecstasy	1,957	672	478	62	38	256	18	3,481
LSD	43	22	15	2	3	5	1	91
Other drugs**	3,109	1,024	763	157	68	748	99	5,968
All drugs	34,626	12,632	6,696	1,090	436	6,391	690	62,561

*excludes 80,500 formal warnings issued for cannabis possession

**all other drugs classified under the *Misuse of Drugs Act 1971*

Source: Ministry of Justice

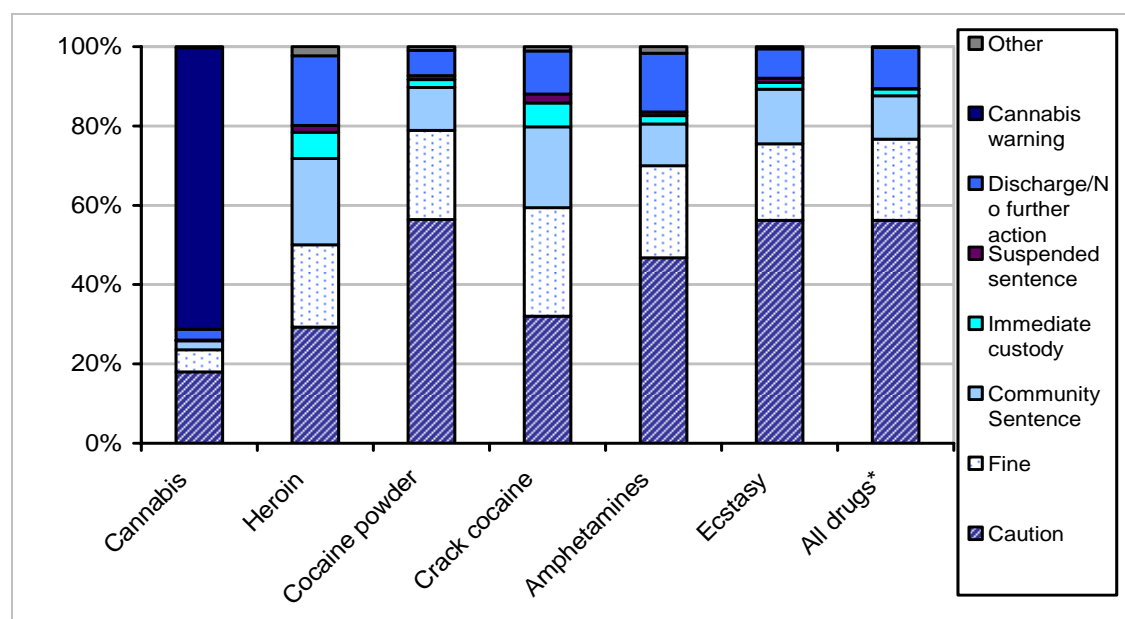
Seventy-one per cent of cannabis possession offences were dealt with by issuing a cannabis warning. Overall, for possession offences, excluding those where a cannabis warning was issued, the most common disposal was a police caution (55%). The most common disposal for drug possession offences used by a court was a fine (45.2% of court actions), followed by a community sentence (24% of court actions) and no further action/discharge (22.9% of court actions).

²⁶³ Data refer to offenders on a principal offence basis and are drawn from the cautions database and court proceedings database. These cannot be compared with figures provided in Chapter 8 or Standard Table 11 as they are calculated on a different basis.

Overall, two per cent of drug possession offences resulted in immediate custody (Figure 11.2). However, possession offences involving heroin and crack cocaine, were more likely to receive immediate custody, seven per cent and six per cent respectively, or a community sentence, 22 per cent and 20 per cent respectively (compared to 11% of all drug offences). Conversely, those found guilty of heroin or crack cocaine possession were less likely to receive a police caution, 29 per cent of heroin offences and 32 per cent of crack cocaine offences received a police caution (compared to 55% of all drug offences²⁶⁴).

The difference between methods of disposal for possession of cocaine powder and possession of crack cocaine is shown clearly in Figure 11.2; 78 per cent of cocaine powder offences were dealt with by a caution or fine compared to 59 per cent of crack cocaine offences.

Figure 11.2: Outcomes of drug possession offences by individual drug in England and Wales, 2006



*excludes formal warnings for cannabis possession

Source: Ministry of Justice

Scotland

Data for Scotland does not include out-of- court disposals. Although the police and PF office collect data, this is as part of a management system and resources are not available to extract the requested information from administrative systems. Data provided are on a principal offence basis and are provided by the Scottish Government. Data on penalties handed down by courts for drug offences are published in an annual statistical bulletin, the latest is for 2006/07 (Scottish Government 2008i). However, this is published at an aggregated level only and does not provide information by drug offence type or by drug type.

In Scotland, in 2006/07, there were 7,001 offenders found guilty at court for drug possession offences (Table 11.4). Of these, three-quarters received a fine and four per cent were sentenced to immediate custody. Where a drug was recorded, cannabis and heroin were the most common drugs, 19 per cent for each drug. However, in 38 per cent of reports, no drug type was recorded. It is therefore difficult to comment on the use of different disposals by individual drug.

²⁶⁴ Excluding cannabis warnings

Table 11.4: Number of offenders receiving each disposal for drug possession offences by individual drug in Scotland, 2006/07

Drug	Fine	Community Sentence	Immediate custody	Discharge	Other	Total
Cannabis	947	29	22	4	308	1,310
Heroin	738	79	121	-	368	1,306
Cocaine powder	648	15	19	3	72	757
Amphetamines	181	8	6	-	40	235
Ecstasy	390	6	5	3	62	466
Other drugs*	2,378	53	82	3	411	2,927
All drugs	5,282	190	255	13	1,261	7,001

*includes 2,669 offenders where no drug was recorded

Source: Scottish Government

Northern Ireland

Data for Northern Ireland are available by class of drug only (see 11.3). In 2006, 1,354 offenders were either cautioned or found guilty at court of drug possession offences, the majority (81%) for Class C offences (Table 11.5).

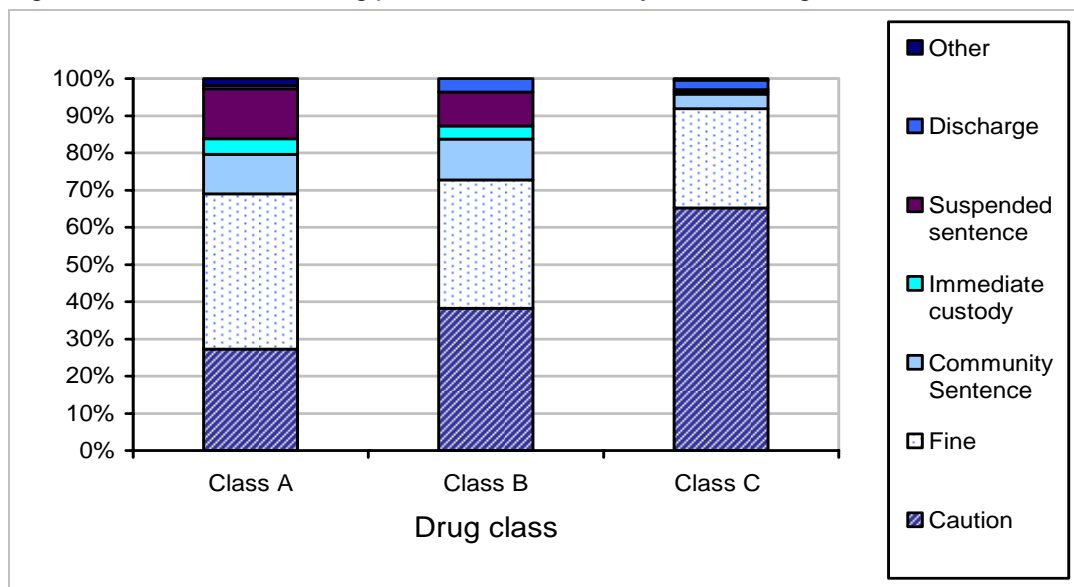
Table 11.5: Number of offenders receiving each disposal for drug possession offences by class of drug in Northern Ireland, 2006

Drug	Caution	Fine	Community Sentence	Immediate custody	Suspended sentence	Discharge	Total
Class A	59	90	23	9	29	2	216
Class B	21	19	6	2	5	2	55
Class C	712	292	43	8	6	27	1,093
All drugs	782	401	72	19	40	31	1,354

Source: Northern Ireland Office; Police Services Northern Ireland

Fifty-eight per cent of all drug possession offenders were dealt with by a caution in 2006. Only one per cent of offenders were sentenced to immediate custody. Penalties were proportionately harsher for drugs in higher drug classes, with only 27 per cent of Class A offences given a caution compared to 65 per cent of Class C offences. Class A offenders were six times more likely to receive an immediate custodial sentence than Class C offenders (Figure 11.3).

Figure 11.3: Outcomes of drug possession offences by class of drug in Northern Ireland, 2006



Source: Northern Ireland Office; Police Services Northern Ireland

11.3.4 Outcomes for drug trafficking offences

England and Wales

In 2006 there were 12,764 offenders cautioned or sentenced at court for drug trafficking offences²⁶⁵, just over a third of whom (35%) were guilty of cannabis trafficking. The next most common trafficking offence involved heroin, 2,331 offenders (18% of offenders) were cautioned or found guilty of heroin trafficking in 2006 (Table 11.6).

Table 11.6: Number of offenders receiving each disposal for drug trafficking offences by individual drug in England and Wales, 2006

Drug	Caution	Fine	Community Sentence	Immediate custody	Suspended sentence	Discharge	Other	Total
Cannabis	1,877	378	961	566	411	275	33	4,501
Heroin	57	8	366	1,659	207	12	22	2,331
Cocaine powder	147	23	168	1,139	144	17	15	1,653
Crack cocaine	30	7	82	435	41	4	4	603
Amphetamines	43	4	89	163	77	13	7	396
Ecstasy	92	24	124	337	89	3	6	675
LSD	11	0	1	4	4	0	1	21
Other substances*	256	70	529	1,231	398	62	38	2,584
All drugs	2,513	514	2,320	5,534	1,371	386	126	12,764

*all other drugs classified under the *Misuse of Drugs Act 1971*

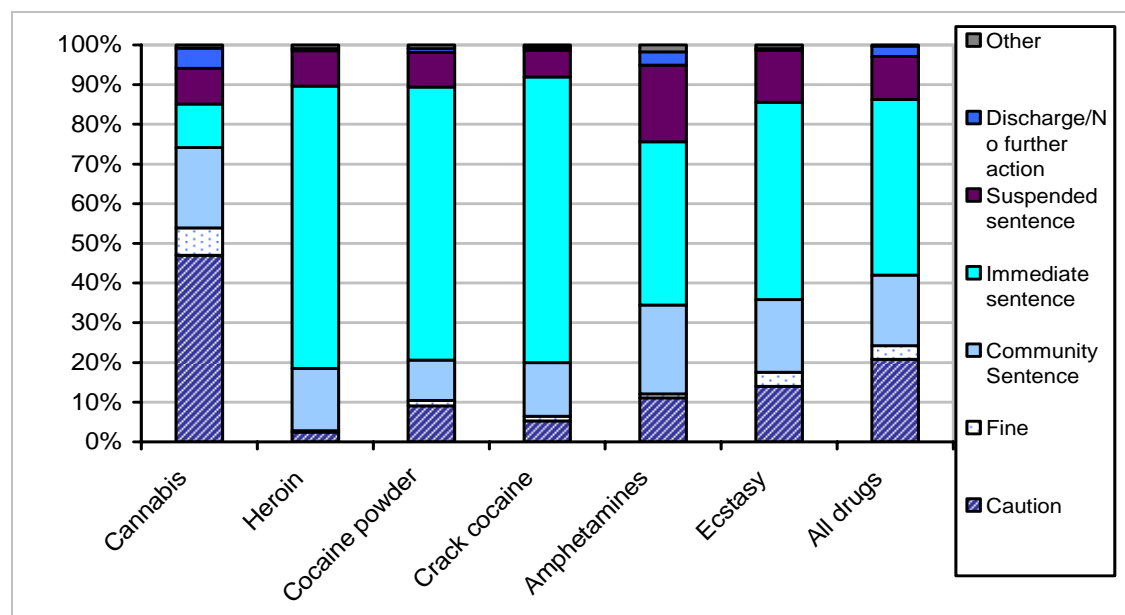
Source: Ministry of Justice

The most common disposal for drug trafficking offences was immediate custody (45%) followed by a caution (20%) and community sentence (19%). Cannabis and LSD offences were the only trafficking offences where immediate custody was not the most common disposal (Figure 11.4).

The difference between disposals used for cocaine powder and crack cocaine is less pronounced when looking at drug trafficking offences. In 2006, 69 per cent of offences involving cocaine powder trafficking were given immediate custodial sentences compared to 72 per cent of crack cocaine offences and 71 per cent of heroin offences. The use of fines was low with only four per cent of all drug trafficking offences receiving a fine as the main sentence.

²⁶⁵ Excludes offences of importation and exportation of drugs

Figure 11.4: Outcomes of drug trafficking offences by type of drug in England and Wales, 2006



Source: Ministry of Justice

The trafficking offences above do not include the offence of unlawful importation or exportation of drugs as they can only be broken down by drug class not by individual drug type. In 2006, there were 856 offenders sentenced at court or cautioned for importation of drugs; 92 per cent received immediate custody and one per cent were cautioned by police. In the same year there were 55 offenders sentenced at court or cautioned by police for exportation of drugs; 53 per cent received immediate custody and 44 per cent received a caution.

There were a further 668 offenders sentenced or cautioned for 'other drug offences'; 38 per cent received a caution, 16 per cent a fine, 14 per cent immediate custody and 12 per cent a conditional discharge.

Scotland

In Scotland in 2006/07 there were 1,817 persons found guilty of drug trafficking offences at court. Of these, 465 (27%) were for heroin offences, 391 (22%) for cannabis offences and 120 (7%) were for cocaine powder offences (Table 11.7). Almost half of all offenders (48%) found guilty of trafficking offences were sentenced to immediate custody with a further 19 per cent given a community sentence and 16 per cent receiving a fine. As Scotland data refers to court actions only and includes a large number of cases where the individual drug is not known, it is difficult to comment on the use of available disposals by individual drug.

Table 11.7: Number of offenders receiving each disposal for drug trafficking offences by individual drug in Scotland, 2006/07

Drug	Fine	Community Sentence	Immediate custody	Discharge	Other	Total
Cannabis	133	104	83	1	70	391
Heroin	27	50	297	-	91	465
Cocaine powder	9	24	77	-	10	120
Amphetamines	5	12	38	-	5	60
Ecstasy	18	32	25	1	8	84
Other substances*	97	127	347	1	121	693
All drugs	289	349	867	3	305	1,813

*includes 575 cases where drug is not known

Source: Scottish Government

Northern Ireland

In 2006 there were 178 offenders cautioned or found guilty at court of drug trafficking. Over half of these (54%) were guilty of a Class C drug offence, 28 per cent of a Class A offence and 17 per cent of a Class B offence (Table 11.8).

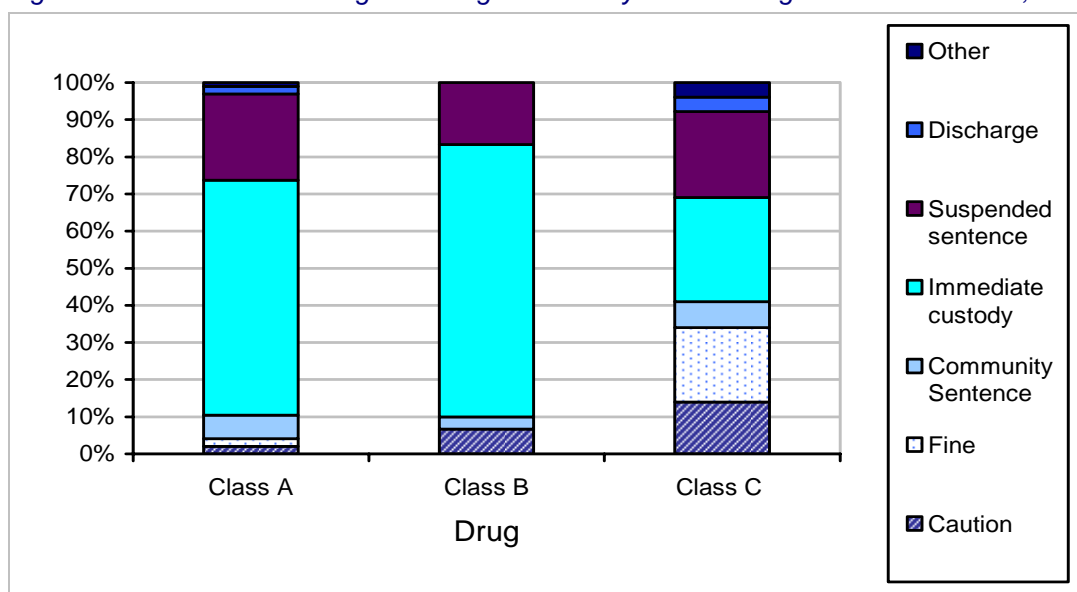
Table 11.8: Number of offenders receiving each disposal for drug trafficking offences by class of drug in Northern Ireland, 2006

Drug	Caution	Fine	Community Sentence	Immediate custody	Suspended sentence	Discharge	Total
Class A	1	1	3	30	11	1	49
Class B	2	0	1	22	5	0	30
Class C	14	20	7	28	23	4	97
All drugs	19	21	11	80	39	5	178

Source: Northern Ireland Office; Police Services Northern Ireland

Similar to elsewhere in the United Kingdom, immediate custody was the most common disposal for drug trafficking offences, 45 per cent of offenders were sentenced to immediate custody in 2006. However, those convicted of Class A and Class B offences were more likely to receive a custodial sentence, 61 and 73 per cent respectively, compared to 29 per cent of those convicted of a Class C offence. The use of cautions decreased with the severity of the offence and fines were used almost exclusively for Class C offences (Figure 11.5).

Figure 11.5: Outcomes of drug trafficking offences by class of drug in Northern Ireland, 2006



Source: Northern Ireland Office; Police Services Northern Ireland

11.3.4 Average sentence length

England and Wales

The average sentence handed down for trafficking offences is much larger than the sentence for possession offences, around three years compared to less than one year (Table 11.9). In 2006, the average length of a prison sentence for trafficking was highest for those drugs categorised as Class A while amphetamines (Class B) and cannabis (Class C) received lower sentences.

Table 11.9: Average custodial sentence length in months for drug offences in England and Wales, 2006 by offence and individual drug

Drug	Possession	Trafficking
Amphetamines	2.9	24.5
Cannabis	2.8	14.8
Cocaine powder	5.2	38.3
Crack cocaine	5.1	36.2
Ecstasy	7.4	29.0
Heroin	9.7	36.6
LSD	1.5	44.8
Other drugs	6.6	35.0

Source: Ministry of Justice

In 2006, seven people were sentenced under the *Power of Criminal Courts (Sentencing) Act (2000)*, which imposes a minimum seven year prison sentence for those found guilty of a third Class A trafficking offence (House of Commons Written Answers 8/7/08).

However, there were no offenders sentenced to the maximum penalty for supplying drugs in 2006 (House of Commons Written Answers 28/4/08).

Northern Ireland

In Northern Ireland, average sentence lengths were similar to England and Wales; the average sentence length was longer for Class A drugs and for those found guilty of trafficking (Table 11.10).

Table 11.10: Average custodial sentence length in months for drug offences in Northern Ireland, 2006 by offence and drug class

Drug	Possession	Trafficking
Class A	7	31
Class B	2	26
Class C	3	22
All drugs	5	26

Source: Northern Ireland Office

Scotland

No data on average sentence length by individual drug type are available for Scotland.

11.3.5 Outcomes for drug driving offences

As discussed in 11.2, driving while under the influence of drugs is recorded alongside alcohol related driving offences. The vast majority of these offences will be for the consumption of alcohol not drugs. In the 2006 ACPO Christmas Drink/Drug Driving Campaign only 2.5 per cent of those found to be impaired were believed to be under the influence of drugs.²⁶⁶

²⁶⁶ See: http://www.acpo.police.uk/pressrelease.asp?PR_GUID=%7BAB561A46-787C-471D-BB44-4A92E487B272%7D

Court statistics show that, in 2006, there were 88,700 offenders (principal offence basis) proceeded against at a Magistrates Court and 101,400 offences of driving after consuming drink or taking drugs (Ministry of Justice 2008c). Courts returned guilty verdicts for 92,671 offences and five per cent (4,400) of these were sentenced to immediate custody. Supplementary tables on motoring offences break the offence type down further and show that, in 2006, there were findings of guilt for 414 offences of being 'unfit to drive through drugs' and 26 offences of being 'in charge of a motor vehicle while unfit through drugs'; no information on outcomes is available (Ministry of Justice 2008d).

PART C

Bibliography and Annexes

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List of tables used in text

Table 1.1: Public expenditure by COFOG in England, 2006/07 and 2007/08	29
Table 1.2: Public expenditure in Northern Ireland, 2007/08	30
Table 2.1: Percentage of 16-59 year olds reporting having used individual drugs in lifetime, last year and last month in England and Wales, 2007/08	36
Table 2.2: Percentage of 15-64 year olds reporting having used individual drugs in lifetime, last year and last month in Northern Ireland, 2006/07 (DPS)	37
Table 2.3: Percentage of 16 to 59 year olds reporting lifetime, last year and last month use of any drug in Northern Ireland, 2003/04 to 2006/07(NICS)	38
Table 2.4: Percentage of 16-24 year olds and 16-34 year olds reporting last year use of individual drugs in England and Wales, 2007/08 by gender	39
Table 2.5: Frequent use: percentage of 16 to 24 year olds (all respondents) who have used any drug more than once a month in the past year in England and Wales, 2002/03 to 2007/08	41
Table 2.6: Percentage of 15-24 year olds and 15-34 year olds reporting last year use of individual drugs in Northern Ireland, 2006/07 by gender (DPS)	42
Table 2.7: Percentage of 16-24 year olds and 16-34 year olds reporting last year use of individual drugs in Northern Ireland, 2006/07 by gender (NICS)	43
Table 2.8: Percentage of pupils reporting use of individual drugs in the last month, in the last year and in lifetime, by gender in England, 2007	44
Table 2.9: Percentage of pupils reporting use of individual drugs in the last year, by age in England, 2007	44
Table 2.10: Percentage of pupils reporting last year use of individual drugs in England, 2001 to 2007	45
Table 2.11: Percentage of pupils reporting use of individual drugs in the last month, in the last year and in lifetime, by gender in Northern Ireland, 2007	47
Table 2.12: Drug tests and percentage positive in the British Armed Forces, 2000 to 2007	49
Table 4.1: Problem drug user estimates and rates per 1,000 population aged 15 to 64 in England, 2005/06	60
Table 4.2: Prevalence rate per 1,000 population of opiate and/or crack cocaine users by gender in England, 2005/06	60
Table 4.3: Prevalence rate per 1,000 population of opiate and/or crack cocaine users by age group in England, 2005/06	61
Table 4.4: Estimates of problem drug use in the United Kingdom: number and rate per 1,000 population	61

Table 4.5: Estimates of injecting drug use in the United Kingdom: number and rate per 1,000 population	62
Table 4.6: Estimates of problem drug use: number and rate per 1,000 population, aged 15 to 64 in the United Kingdom	62
Table 4.7: Estimates of number of injecting drug users and rate per 1,000 population, aged 15 to 64, United Kingdom	62
Table 4.8: Presentations by centre type in the United Kingdom, 2003/04 to 2006/07	64
Table 4.9: Number of units covered by centre type in the United Kingdom, 2006/07	64
Table 4.10: Number and percentage of drug treatment presentations by primary drug of use in the United Kingdom, 2006/07	65
Table 4.11: Primary drug by centre type in the United Kingdom, 2006/07	65
Table 4.12: Number and percentage of first drug treatment demands by primary drug of use in the United Kingdom, 2006/07	66
Table 4.13: Primary drug by centre type, first drug treatment, 2006/07	66
Table 4.14: Age of drug users identified through TDI in the United Kingdom, 2006/07	66
Table 4.15: Age of individuals reporting cannabis as main drug, 2003/04 to 2006/07	67
Table 4.16: Injecting status by gender in the United Kingdom, 2006/07, all treatments	67
Table 4.17: Injecting status by gender in the United Kingdom 2006/07, first treatments	67
Table 4.18: Number and percentage of drug treatment presentations by primary drug in the United Kingdom, 2003/04 to 2006/07	68
Table 4.19: Number and percentage of first drug treatment presentations by primary drug, in the United Kingdom, 2003/04 to 2006/07	69
Table 4.20: PDU estimates: PDUs identified through English treatment monitoring system (NDTMS)	71
Table 6.1: Drug mentions on death certificates in the United Kingdom, 2002 to 2007	92
Table 6.2: Hospital Episode Statistics: Inpatient episodes due to poisoning by cocaine in England, 2000/01 to 2006/07	105
Table 6.3: Effect of maternal drugs of addiction in England, 2003/04 to 2006/07 ..	107

Table 7.1: Syringe provision: number of visits, syringes issued and proportion involving return of used equipment in Northern Ireland, 2001/02 to 2007/08	114
Table 8.1: Gender of all persons receiving benefit and of problem drug users estimated to be receiving benefits in England, 2006	123
Table 8.2: Age of all persons receiving benefit and of problem drug users estimated to be receiving benefits in England, 2006	123
Table 8.3: Recorded crime: Drug offences in the United Kingdom by offence type and country, 2002/03 to 2007/08	126
Table 8.4: Number of persons arrested for drug offences in England and Wales, and Northern Ireland, 2002/03 to 2007/08	126
Table 8.5: Persons found guilty or cautioned for drug offences in the United Kingdom 2000 to 2006 by individual drug	127
Table 10.1: Percentage of pupils who reported ever being offered individual drugs in England, 2001 to 2007	153
Table 10.2: Estimated market share of different cannabis types	155
Table 10.3: Number of seizures of drugs by law enforcement agencies in the United Kingdom, 2003 to 2006	156
Table 10.4: Quantity of seizures of drugs by law enforcement agencies in the United Kingdom 2004 to 2006	157
Table 10.5: Law enforcement agencies: Mean price of illegal drugs in the United Kingdom, 2003 to 2007	158
Table 10.6: Independent Drug Monitoring Unit: Mean price of drugs at street level in the United Kingdom, 2004 to 2007	158
Table 10.7: DrugScope: Mean price of drugs at street level in the United Kingdom, 2006 to 2008	159
Table 10.8: Street level mean percentage purity of certain drugs in the United Kingdom, 2003 to 2007	160
Table 10.9: Mean THC content (%) of different types of cannabis in England and Wales, 1995-2007	161
Table 10.10: Proportion of arrestees reporting that the price and purity of individual drugs had increased, stayed the same or decreased in the past six months and the net decrease in England and Wales 2005/06	162
Table 11.1: Measures which can be used by police for drug offences in England and Wales	166
Table 11.2: Number and proportion of all possession offences by individual drug in England and Wales, 2006	173

Table 11.3: Number of offenders receiving each disposal for drug possession offences by individual drug in England and Wales, 2006	173
Table 11.4: Number of offenders receiving each disposal for drug possession offences by individual drug in Scotland, 2006/07	175
Table 11.5: Number of offenders receiving each disposal for drug possession offences by class of drug in Northern Ireland, 2006	175
Table 11.6: Number of offenders receiving each disposal for drug trafficking offences by individual drug in England and Wales, 2006	176
Table 11.7: Number of offenders receiving each disposal for drug trafficking offences by individual drug in Scotland, 2006/07	178
Table 11.8: Number of offenders receiving each disposal for drug trafficking offences by class of drug in Northern Ireland, 2006	178
Table 11.9: Average custodial sentence length in months for drug offences in England and Wales, 2006 by offence and individual drug	179
Table 11.10: Average custodial sentence length in months for drug offences in Northern Ireland, 2006 by offence and drug class	179
Table A.1: Percentage prevalence of illegal drugs amongst adults in the United Kingdom by drug and country	215
Table A.2: Percentage of 16-34 year olds reporting having used individual drugs in lifetime, last year and last month in the United Kingdom, 2006/07	216
Table A.3: Percentage of 16-24 year olds reporting having used individual drugs in lifetime, last year and last month in the United Kingdom, 2006/07	217

List of figures used in text

Figure 2.1: Percentage of 16 to 59 year olds reporting having used drugs in the last year in England and Wales, 1996 to 2007/08	36
Figure 2.2: Percentage of 16 to 34 year olds reporting having used drugs in the last year in England and Wales, 2002/03 to 2007/08	40
Figure 2.3: Percentage of 16 to 24 year olds reporting having used drugs in the last year in England and Wales, 1996 to 2007/08	41
Figure 2.4: Drug use amongst school children in England, 2001 to 2007	45
Figure 4.2: Presentations for cocaine powder and crack cocaine in the United Kingdom, 2003/4 to 2006/07	68
Figure 5.1: Numbers in treatment monitored through NDTMS and new of presentations to treatment measured by the TDI, 2003/04 to 2007/08, England	77
Figure 6.1: Deaths in the United Kingdom 1996-2006: EMCDDA definition	90
Figure 6.2: Comparison of total number of deaths using three definitions in the United Kingdom, 1996 – 2006	91
Figure 6.3: Deaths by age and gender United Kingdom, 2006: EMCDDA definition	91
Figure 6.4: Psychiatric inpatient discharges with a diagnosis of drug misuse in Scotland, 2001/02 to 2005/06; rate per 100,000 population	102
Figure 11.1: Measures available to prosecution services other than prosecution at court in the United Kingdom	166
Figure 11.2: Outcomes of drug possession offences by individual drug in England and Wales, 2006	174
Figure 11.3: Outcomes of drug possession offences by class of drug in Northern Ireland, 2006	175
Figure 11.4: Outcomes of drug trafficking offences by type of drug in England and Wales, 2006	177
Figure 11.5: Outcomes of drug trafficking offences by class of drug in Northern Ireland, 2006	178

List of abbreviations used in the text

A&E	Accident and Emergency
ACMD	Advisory Council on the Misuse of Drugs
ACPO	Association of Chief Police Officers
ADATs	Alcohol and Drug Action Teams
ADHD	Attention Deficit Hyperactivity Disorder
ADR	Annual Data Requirement
AIDS	Acquired Immunodeficiency Syndrome
APPHG	All-Party Parliamentary Hepatology Group
ASB	Anti-Social Behaviour
ASBO	Anti-Social Behaviour Order
ATM	Addictions Testing Measure
AUDIT	Alcohol Use Disorders Identification Test
BCS	British Crime Survey
BMA	British Medical Association
BMJ	British Medical Journal
BOSS	Body Orifice Security Scanners
BZP	Benzylpiperazine
CAPI	Computer Assisted Personal Interviewing
CARATS	Counselling, Assessment, Referral, Advice and Through-care Services
CASI	Computer-Aided Self-administered Interviewing
CBD	Cannabidiol
CCTV	Closed Circuit Television
CDSC	Communicable Disease Surveillance Centre
CHS	Criminal History System
CI	Confidence Interval
CIPD	Chartered Institute of Personnel and Development
CISS	Christo Inventory for Substance-misuse Services
CJITs	Criminal Justice Interventions Teams
CLG	Communities and Local Government
CMR	Circumstances, Motivation and Readiness scale
SCFOG	Classification of the Functions of Government
COI	The Central Office of Information
COMT	Catechol-O-methyltransferase
COPFS	Crown Office and Procurator Fiscal Service
CPP	Community Planning Partnership
CPP	Chlorophenylpiperazine
CPR	Cardio-Pulmonary Resuscitation
CPS	Crown Prosecution Service
CSPs	Community Safety Partnerships
CSP	Centre for Suicide Prevention
CSR	Comprehensive Spending Review
DAATs	Drug (and Alcohol) Action Teams
DACTs	Drug and Alcohol Coordination Teams
DAIRU	Drug and Alcohol Information and Research Unit
DATs	Drug Action Teams
DCSF	Department for Children, Schools and Families
DDC	Dedicated Drug Court
DfES	Department for Education and Skills
DH	Department of Health
DHI	Drug Harm Index
DHSSPSNI	Department of Health, Social Services and Public Safety Northern Ireland
DIP	Drug Interventions Programme
DIR	Drug Interventions Record
DORIS	Drug Outcome Research in Scotland
DRD	Drug-Related Deaths
DRR	Drug Rehabilitation Requirement
DTORS	Drug Treatment Outcomes Research Study
DTTO	Drug Treatment and Testing Order

DVLA	Driver and Vehicle Licensing Agency
DWP	Department for Work and Pensions
EACS	Enhanced Addiction Casework Service
EDDRA	Exchange on Drug Demand Reduction Action
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESPAD	European School Survey Project on Alcohol and Other Drugs
EU	European Union
FCE	Finished Consultant Episodes
FSS	Forensic Science Service
GAE	Grant Aided Expenditure
GBL	Gamma-butyrolactone
GCSE	General Certificate of Secondary Education
GDP	Gross Domestic Product
GHB	Gamma hydroxybutyrate
GLADA	Greater London Alcohol and Drug Alliance
GMR	General Mortality Register
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
HES	Hospital Episode Statistics
HFA	High Focus Area
HIV	Human Immunodeficiency Virus
HMRC	HM Revenue and Customs
HOCR	Home Office Counting Rules
HPA	Health Protection Agency
HPS	Health Protection Scotland
HSSB	Health and Social Service Boards
ICD-10	International Statistical Classification of Diseases and Related Health Problems – tenth edition
ICIS	Integrated Crime Information System
IDMU	Independent Drug Monitoring Unit
IDTS	Integrated Drug Treatment System
IDUs	Injecting Drug Users
ISCJIS	Integration of Scottish Criminal Justice Information Systems
ISD	Information Services Division
ISO	Individual Support Order
ITEP	International Treatment Effectiveness Project
LAA	Local Area Agreement
LSD	Lysergic Diethylamide acid
MDMA	3,4-Methylenedioxy-n-methylamphetamine
MDT	Mandatory Drug Testing
MHRA	Medicines and Health Care Products Regulation Agency
MHTR	Mental Health Treatment Requirement
NACD	National Advisory Committee on Drugs
NatCen	National Centre for Social Research
NATSAL	National Survey of Sexual Attitudes and Lifestyles
NCRS	National Crime Recording Standard
NDEC	National Drug Evidence Centre
NDTMS	National Drug Treatment Monitoring System
NESI	Needle Exchange Surveillance Initiative
NHS	National Health Service
NI	National Indicator
NICE	National Institute for Clinical and Health Excellence
NICS	Northern Ireland Crime Survey
NIDPS	Northern Ireland Drug Prevalence Survey

NIO	Northern Ireland Office
NIPS	Northern Ireland Prison Service
NISRA	Northern Ireland Statistics and Research Agency
NOMS	National Offender Management Service
np-SAD	National Programme on Substance Abuse Deaths
NTA	National Treatment Agency
NTORS	National Treatment Outcome Research Study
OBTJ	Offenders Brought to Justice
Ofsted	Office for Standards in Education
OLIFE	Oxford Liverpool Inventory of Life Experiences
ONS	Office for National Statistics
OTC	Over The Counter (medicines)
p2w	Progress2Work
PACE	Police and Criminal Evidence act 1984
PCTs	Primary Care Trusts
PDI	Partnership Drugs Initiative
PDU	Problem Drug Users
PHIRB	Public Health Information and Research Branch
PNC	Police National Computer
POM	Prescription Only Medicine
PPO	Prolific and other Priority Offender
PPS	Public Prosecution Service
PSA	Public Service Agreement
PSHE	Personal, Social and Health Education
PSNI	Prison Service Northern Ireland
PTB	Pooled Treatment Budget
QIS	Quality Improvement Scotland
RSA	Royal Society for the encouragement of Arts, manufactures and commerce
SACDM	Scottish Advisory Committee on Drugs Misuse
SALSUS	Scottish Schools Adolescent Lifestyle and Substance Use Survey
SCIEH	Scottish Centre for Infection and Environmental Health
SCRS	Scottish Crime Recording Standard
SCVS	Scottish Crime and Victimisation Survey
SD	Standard Deviation
SHA	Strategic Health Authority
SMACAP	Scottish Ministerial Advisory Committee on Alcohol Problems
SMR	Special Mortality Register
SOA	Single Outcome Agreements
SOCA	Serious Organised Crime Agency
SPS	Scottish Prison Service
SPSA	Scottish Police Services Authority
STI	Sexually Transmitted Infection
TAS	Throughcare Addiction Services
TDI	Treatment Demand Indicator
TFMPP	3-Trifluoromethylphenylpiperazine monohydrochloride
THC	Tetrahydrocannabinol
TOP	Treatment Outcomes Profile
UAPMP	Unlinked Anonymous Prevalence Monitoring Programme
UK	United Kingdom
UKADCU	United Kingdom Anti Drugs Co ordination Unit
UKDPC	United Kingdom Drug Policy Commission
UV	Ultraviolet
VDT	Voluntary Drug Testing
VSA	Volatile Substance Abuse
WAG	Welsh Assembly Government
YOT	Youth Offending Team
YPBAS	Young Person's Behaviour and Attitude Survey

Appendix A: United Kingdom prevalence estimates from population surveys

By combining data from the British Crime Survey (BCS) 2006/07, the 2006 Scottish Crime and Victimization Survey (SCVS) (Brown and Bolling 2007) and the 2006/07 Drug Prevalence Survey in Northern Ireland, estimates of drug use have been produced for the United Kingdom

Table A.1: Percentage prevalence of illegal drugs amongst adults in the United Kingdom by drug and country

	British Crime Survey 2006/07	Northern Ireland Crime Survey 2006/07	Drug Prevalence Survey in Northern Ireland 2006/07	Scottish Crime & Victimization Survey 2006	United Kingdom estimate*
	16 to 59 year olds	16 to 59 year olds	15 to 64 year olds	16 to 59 year olds	16 to 59 year olds
<i>Lifetime prevalence</i>					
Any illicit drug	35.5	27.3	28.0	36.6	35.4
Amphetamines	11.9	6.3	5.8	14.1	11.9
Cannabis	30.1	20.1	24.7	32.9	30.2
Cocaine	7.7	3.4	5.2	8.9	7.7
Ecstasy	7.3	5.6	7.7	9.9	7.5
LSD	5.4	3.6	6.6	7.7	5.6
Magic mushrooms	7.1	4.6	6.7	7.2	7.1
<i>Last year prevalence</i>					
Any illicit drug	10.0	8.4	9.4	12.6	10.2
Amphetamines	1.3	0.5	1.0	2.2	1.4
Cannabis	8.2	6.3	7.2	11.0	8.4
Cocaine	2.6	0.9	1.9	3.8	2.7
Ecstasy	1.8	0.9	1.8	3.2	1.9
LSD	0.2	0.1	0.2	0.6	0.2
Magic mushrooms	0.6	0.2	0.2	0.9	0.6
<i>Last month prevalence</i>					
Any illicit drug	5.9	4.3	3.6	8.0	6.0
Amphetamines	0.5	0.3	0.3	0.9	0.5
Cannabis	4.8	3.0	2.6	6.8	4.9
Cocaine	1.3	0.5	0.3	1.8	1.3
Ecstasy	0.8	0.4	0.8	1.6	0.9
LSD	0.1	0.1	0.0	0.2	0.1
Magic mushrooms	0.1	0.1	0.0	0.3	0.1
Total sample size	31,054	2,390	2,002	3,158	N/A

Source: Standard Tables provided for the United Kingdom Focal Point

Table A.2: Percentage of 16-34 year olds reporting having used individual drugs in lifetime, last year and last month in the United Kingdom, 2006/07

	British Crime Survey 2006/07	Northern Ireland Crime Survey 2006/07	Drug Prevalence Survey in Northern Ireland 2006/07	Scottish Crime & Victimization Survey 2006	United Kingdom estimate*
	16 to 34 year olds	16 to 34 year olds	15 to 34 year olds	16 to 34 year olds	16 to 34 year olds
<i>Lifetime prevalence</i>					
Any illicit drug	46.4	38.6	40.2	54.3	46.9
Amphetamines	16.5	10.4	9.1	22.1	16.8
Cannabis	41.4	30.9	35.0	49.6	41.9
Cocaine	12.7	5.7	9.1	15.5	12.8
Ecstasy	13.0	10.9	14.3	19.4	13.5
LSD	7.1	5.6	9.4	11.6	7.5
Magic mushrooms	9.3	5.3	8.3	9.1	9.2
<i>Last year prevalence</i>					
Any illicit drug	18.6	16.0	17.3	23.7	19.0
Amphetamines	2.7	1.1	1.7	4.1	2.8
Cannabis	15.6	13.0	12.4	20.4	15.9
Cocaine	5.4	2.1	3.5	8.0	5.6
Ecstasy	3.9	2.0	3.4	6.9	4.1
LSD	0.5	0.2	0.0	1.2	0.6
Magic mushrooms	1.4	0.4	0.5	1.8	1.4
<i>Last month prevalence</i>					
Any illicit drug	11.2	8.0	5.9	14.9	11.3
Amphetamines	1.0	0.7	0.3	1.5	1.0
Cannabis	9.2	6.0	3.7	12.6	9.3
Cocaine	2.7	1.2	0.6	4.1	2.7
Ecstasy	1.8	0.7	1.4	3.3	1.9
LSD	0.2	0.2	0.0	0.4	0.2
Magic mushrooms	0.3	0.2	0.1	0.4	0.3
Total sample size	11,973	920	714	1115	N/A

Source: Standard Tables prepared for United Kingdom Focal Point

Table A.3: Percentage of 16-24 year olds reporting having used individual drugs in lifetime, last year and last month in the United Kingdom, 2006/07

	British Crime Survey 2006/07	Northern Ireland Crime Survey 2006/07	Drug Prevalence Survey in Northern Ireland 2006/07	Scottish Crime & Victimization Survey 2006	United Kingdom estimate*
	16 to 24 year olds	16 to 24 year olds	15 to 24 year olds	16 to 24 year olds	16 to 24 year olds
<i>Lifetime prevalence</i>					
Any illicit drug	44.7	38.7	38.4	52.9	45.2
Amphetamines	11.2	7.6	5.7	15.6	11.4
Cannabis	39.5	29.8	33.0	48.9	41.9
Cocaine (including crack)	11.2	5.8	7.7	15.6	11.5
Ecstasy	7.8	6.7	12.0	14.8	10.7
LSD	3.2	2.4	4.6	5.0	3.4
Magic mushrooms	7.0	4.2	4.4	5.0	6.8
<i>Last year prevalence</i>					
Any illicit drug	24.1	22.0	19.0	31.0	24.5
Amphetamines	3.5	1.4	1.9	5.6	3.6
Cannabis	20.9	17.8	13.7	27.1	21.2
Cocaine (including crack)	6.1	2.0	2.3	11.0	6.4
Ecstasy	4.8	3.0	3.7	9.2	5.1
LSD	0.8	0.2	0.0	2.0	0.9
Magic mushrooms	1.8	0.8	0.6	2.6	1.8
<i>Last month prevalence</i>					
Any illicit drug	14.3	9.5	6.3	20.4	14.6
Amphetamines	1.2	0.8	0.3	2.3	1.3
Cannabis	12.0	6.7	3.5	16.6	12.1
Cocaine (including crack)	3.2	1.2	0.0	6.3	3.4
Ecstasy	2.5	0.8	2.2	5.0	2.7
LSD	0.3	0.2	0.0	0.5	0.3
Magic mushrooms	0.4	0.4	0.0	0.5	0.4
Total sample size	5,749	342	299	426	N/A

Source: Standard Tables prepared for United Kingdom Focal Point