APPENDIX II

GLOSSARY OF TERMS AND DEFINITIONS

Drugs

Drugs in a purely biological, scientific sense are any substances, natural or artificial, that by their chemical nature alters the structure or function of the living organism (24). In this report the word drugs carries the limited meaning of applying only to those drugs specified as controlled, with varying degrees of stringency, under the four schedules of the Irish Misuse of Drug Acts 1977 and 1984. They do not include alcohol or tobacco or the un-restricted drugs, such as, tea, coffee and cola (25).

Drug users

A neutral term referring to persons' non-medical use of the drugs controlled under the Irish Misuse of Drugs Acts 1977 and 1984.

Misuse of drugs

A term which applies to the drug rather than the user and refers to the improper non-medical use of controlled drugs. With the exception of certain specified data where type of misuse has been defined according to ICD 9 criteria, for example, non-dependent, dependent, or opiate misuse, the term is imprecise and unspecified as to type or extent of drug misuse.

Drug abuse

Now generally regarded as an unstandardised value – laden and highly relative term used with a great deal of imprecision and confusion (26). It is used in the report when this is the term employed by the author or in the paper being quoted.

Addict/addiction

The terms are avoided unless they are used by the author or in the paper being quoted.

First treatment demand

In Dublin this refers to drug users who receive treatment at the city's primary medical treatment centre for the first time.

Hospital admissions

The term adheres to the WHO definition of "a stay in hospital lasting one night or more, irrespective of whether the patient is admitted for the first time, re-admitted ... or transferred from another hospital" (27). The term hospital admissions is used in relation to admissions to psychiatric hospitals while hospital discharges refer to discharges from general hospitals.

Viral hepatitis

The most detailed and consistent information on viral hepatitis relates to the monitoring of H Bs Ag positive cases by the virus reference laboratory in University College Dublin.

Drug-related deaths

These deaths refer to .the deaths of drug users known by both the Garda Drug Squad and the Jervis Street Drug Centre and occurring within a given year.

Police arrests

In the Irish situation statistics are available for persons charged by the police rather than arrested by them. A person is charged with committing a specific offence under, for example, the Misuse of Drugs Acts 1977 and 1984 after being first arrested on evidence to support the charge made. Not all persons arrested are subsequently charged.

APPENDIX III

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REPORT ON DRUG MISUSE IN HAMBURG

by

Mr K J Lange

INTRODUCTION

The Minister of Youth, Family Affairs and Health of the Federal Republic of Germany recommended Hamburg as a major metropolitan area for this study. Other cities might as well have been selected, for example, West Berlin, Frankfurt or Munich. Hamburg was chosen because an administrative monitoring system on drug misuse was to some extent already operating in this city. Hamburg shares with Bremen and West Berlin the characteristic of constituting a federate state ("Land"). This fact facilitates data collection related to drug misuse.

At present it seems that illicit drug use has not been increasing in recent years. This is the impression in Hamburg as in the Federal Republic of Germany. In particular, indications of "stagnancy" can be found as to the heroin abuse scene. In recent years considerable amounts of cocaine have been smuggled into the country. As yet health and social problems associated with cocaine intake have not been observed. Hashish and marihuana still remain by far the most frequently used illicit drugs. However, it seems that in comparison with the early seventies, these drugs have lost some ground in the present adolescent population.

A. DESCRIPTION OF THE CITY

A.1 History of drug misuse

Non-medical use of psychotropic drugs by young people was not observed until 1967. After the Second World War several hundred veterans were registered as morphine addicts. This number decreased steadily to approximately 150 in 1967-68. The idea of taking drugs for reasons of mind expansion, spiritual awakening, perceptual change was first introduced by foreign rock groups.

In the course of the 1968 student rebellion certain life-styles were publicised which often recommended experimentation with psychedelic drugs such as cannabis and LSD. In 1969-70, when the media reported frequently on the sub-cultural hippie world, hashish smoking became popular among academic young people who regarded themselves as being “hip”. Before this period the drug scene consisted mainly of jazz and rock musicians who supplied themselves by individual import of “dope” from North Africa and the Near or Middle East. Drug-takers returned from these countries with hashish or raw opium in their luggage.

As from 1970 organised trafficking on a grand scale could be observed. It was estimated that about one third of the younger generation belonging to the middle and upper classes had tried hashish or marijuana. A markedly smaller proportion had experimented with LSD which was partly illicitly imported from the United States and partly manufactured in illicit laboratories. Out of this psychedelic subculture a group of drop-outs emerged who proclaimed the “mainlining” of opiates to be better for themselves. These people rapidly developed into being hard-core addicts. This new addict population supplied itself in 1971 and 1972 with mixtures of opium and/or morphine base dissolved in acetic acid. Large seizures were made of morphine base coming from Turkey and which could be traced to the so-called “French Connection”. When the French Connection was smashed and the growing of opium poppies in Turkey was brought to a temporary halt, addicts tended to burgle pharmacies in order to steal substances containing opiates. Better safety devices and a reduction in the stocks kept, led to some shortage on the illicit market.

In 1974 heroin from the Far East appeared on the drug scene for the first time. It had come in via Amsterdam. The price for one “fix” (the usual dose injected) was quadrupled. Presumably due to this fact many addicts in Hamburg tried to obtain prescriptions for methadone from doctors in order to support their habit. Since the prescription of opiates to addicts contravened the professional code of general practitioners the generous and “semi-licit” distribution of opiates from the doctor’s surgery was soon stopped. A substance called tilidinum now became popular among addicts as a substitute and was often demanded from doctors. Since this substance turned out to be completely cross-tolerant with opiates it was classified as opioid, and in 1978 became subject to narcotic law regulations.

In 1976-77 large amounts of heroin from the Near East and Middle East arrived on the illicit market. It was comparatively cheap and pure and became extremely attractive to the "junkie" scene. Over the years the price rose to match that of heroin from other regions. In 1981 there was an extreme shortage of heroin due to action taken in Turkey, Afghanistan and Iran. That year the heroin user in Hamburg had to pay between 600 and 800 DM for one gramme of heroin. Since the average addict could not afford this money, and since in general he avoided crimes such as serious robbery, there was a tendency to take barbiturates as substitute drugs. As from 1982 the heroin supply was restored, mainly from Pakistan. The illegal heroin supply never again reached the peak level of the late seventies. The price levelled off to about 400 DM for one gramme of heroin.

Since the mid-seventies the use of LSD has been steadily losing ground. The use of amphetamine derivatives was quite popular in the hip culture during the early seventies but also lost ground since more stringent conditions governing prescription of stimulants were introduced. Stimulant use can traditionally-be found in surroundings associated with night life and prostitution.

Hashish is by far the most widely used illicit drug in Hamburg. Although numbers and amounts of cannabis confiscations have increased over the years, it seems that the demand for hashish is waning in contrast with the early seventies. Since 1983 the use of cocaine has emerged in show-business and artistic circles, yet this still cannot be described as a mass phenomenon.

A.2 General policy; legislation

Policy on drug abuse prevention in the Federal Republic of Germany originates in the belief that non-medical use of certain substances is harmful and therefore detrimental to society. Non-medical hedonistic consumption of narcotics and psychedelic drugs is commonly regarded as drug misuse (or drug abuse) which has to be prohibited. Traditional and current laws ultimately serve this end by controlling production, use and authorisation for certain listed drugs.

On the other hand there is a widespread belief that the consuming of traditional psychotropic drugs, for example by drinking alcoholic beverages and smoking tobacco, bears a comparatively much smaller risk. The term misuse denotes here use in large dosages or unsuitable use in inappropriate situations.

The current "law on the traffic in narcotic drugs" came into force in 1982. It is adapted to the 1971 United Nations Convention on Psychotropic Substances. Following the recommendation of the Convention the law distinguishes between those drugs which are not accepted for any use and are therefore completely banned, other drugs which are raw material for the production of specific medicines and drugs which are to be prescribed by physicians on special prescription forms. Category I lists pharmacologically diverse substances such as heroin, LSD, PCP and cannabis. Category II contains raw substances

such as coca leaves and dexamphetamine. Category III lists opioids, amphetamines, barbiturates and other substances, all of which are prescription drugs. The term narcotic is applied for all drugs listed, although only certain drugs present narcotic properties in the pharmacological sense. This somewhat incorrect labelling has historical reasons. The first drugs for which (in the early twenties) control by a special law was introduced were the opiates (which are narcotics) and cocaine.

The current law expresses three main intentions, namely:

– repression of illicit traffic, trade and circulation by means of high penalties. Penalties have generally been higher since 1982;

– consideration of the case where a person possesses only a small quantity of a listed drug for personal use. It is intended that such a case will result in a mild punishment, or no punishment at all;

– consideration of the fact that drug-dependent persons are sick, disabled persons, who are unable to abstain from drug use and who tend to loose control over their behaviour. This statement is derived from a supreme court decision in 1968. It is intended to refer drug-dependent or drug-addicted persons to treatment and to avoid their imprisonment.

According to the penal code a person must be punished if he/she, without authorisation from the Federal Health Bureau, has

– cultivated and produced drugs listed in Categories I, II and III;
– carried out commercial trade in these drugs;
– imported these drugs;
– supplied these drugs to others.

Providing financial support for such activities, or opportunities for passing or using the listed drugs, is also punishable, as is propaganda for illicit drug use. The general rule is that any person who acquires and possesses the listed drugs, without having authorisation from the health administration, is to be punished. Even the fact that other substances are falsely declared to be one of the listed drugs and that these “fake” substances are supplied is to be punished. The court might forego penalties if a person has acquired or possesses drugs in small amounts for personal use.

If a person violates the regulations and prohibitions with more than small amounts, this constitutes a serious case. The minimum penalty is one year’s imprisonment; the maximum penalty is 15 years in very serious cases. If an adult person passes a drug or administers a drug to a minor (below 18 years of age) this is regarded as a serious case. Cultivation, production, import and trafficking of the listed drugs by gangs is regarded as a serious crime and will be punished by a minimum sentence of two years’ imprisonment.

Special legal provisions concerning drug-dependent persons:

Apart from possible release on probation, the drug legislation contains special passages concerning the treatment of drug-dependent persons on trial. If a drug-dependent person receives a prison sentence of less than two years, and if the sentence does not fulfil certain criteria, the drug-dependent person may enter a treatment facility instead of going to prison. Time spent in prison because a case is deferred, or time spent in treatment is considered as part of the sentence. Moreover there is a clause which permits the public prosecutor to suspend or discontinue consideration of a case if the drug-addicted person has already been in treatment for three months before his/her case is brought to trial. If a client leaves a treatment facility early and discontinues treatment the facility is obliged to inform the court about this fact.

For the better understanding of criminal statistics it must be pointed out that in the Federal Republic of Germany any suspected or detected case of punishable law violation must be investigated and is therefore reported on by the law enforcement agencies ie the police. Preliminary proceedings are supervised by the public prosecutor. The prosecutor may drop a case or give up the claim to prosecution if a law violation is of minor significance, but only if a law permits the dropping of a case under defined circumstances. Law enforcement agencies are bound to carry out an investigation.

Summary of the present policy:

– Prosecution concerning, and repression of, illegal supply of drugs such as heroin, cocaine and cannabis in order to reduce availability;

– Provision of a sufficient number of counselling and treatment facilities in order to bring a significant proportion of the addict population into treatment care. However maintenance treatment approaches are rejected.

– Preventive campaigns to reduce the demand for illicit drugs. For reasons of credibility these campaigns cover also dangerous use of alcoholic beverages, tobacco and pills.

A.3 Demographic information

The city of Hamburg is one of the eleven states which constitute the Federal Republic of Germany. The area covered is 754,69 km2. At the end of 1984 Hamburg's population was 1,592,447 residents; 9.6% are foreigners. Hamburg's population has been declining in recent years (for example, in 1982 1,694,307 residents were counted), yet it still holds second place: only Vest Berlin has a larger population. The general age and sex breakdown at the end of 1982 is shown in Table 1 (Appendix I).

In 1984 the unemployment rate was 11.2% of the working population: 79,821 persons were unemployed; 18,444 unemployed persons were below 25 years of age. In March 1985 the unemployment rate had risen to 12.6%

A.4 Surveys on drug misuse

Self-report surveys by means of questionnaires filled in by school students have been carried out in Hamburg in 1971, 1973 and 1975, the age of the samples ranged from 13 to 19 years in these studies. The last survey in 1981-82 was a household survey which was not only addressed to students but used a sample representing the young population between 12 and 24 years of age. This sample of 720 subjects represented 317,000 young people. The study was part of a larger study which was carried out also in other federal states. It has to be noted that no reliability and validity checks preceded these surveys. Consideration of age-group related results permitted a tentative comparison of these four studies. No conclusions can however be reached from these survey data as regards non-medical opiate use, since the number of subjects admitting opiate use is so small that statistical errors are likely.

A.5 Treatment and social care systems/facilities

The bulk of treatment and rehabilitation in the Federal Republic of Germany is based in principle on the voluntary decision of the drug-dependent person to “kick the habit”, that is, the user has to seek help if he/she wants to be free of the addiction. However, these voluntary decisions are to a great extent psychologically determined by the pressure which law enforcement agencies and the criminal court system put upon the addicted delinquent. In short, most clients seek treatment in order to avoid imprisonment.

In Hamburg there are two counselling centres for drug users, one for adolescents and the other for young adults over the age of 18 years. 20 professional social workers care for the clients. Associated is a hostel or sleeping place for drug-dependent persons who have no place to stay. While the hostel belongs to a private organisation receiving financial support from the city authorities, the counselling centres are run by the city’s social department. Drug users turn to these agencies when first requesting help. The case workers try to persuade clients – if necessary – to accept long-term “de-addiction” treatment within the setting of a therapeutic community. They clarify the formal “who pays” issue and organise the contact between the client and a facility. For those clients who need no long-term residence in a facility (or who are not willing to join a therapeutic community) there is continuous care on ‘an out-patient basis. Parents of drug users find counselling in an office set up at the initiative of a parent organisation.

It must be pointed out that any kind of "methadone maintenance" treatment for opiate-dependent persons is strictly rejected by social agencies and the health administration. Emphasis is on long-term residential treatment within the setting of a therapeutic community (TC). Methadone is only used for detoxification in the special unit of a large hospital. Here patients receive on a daily basis gradually declining dosages of methadone in grapefruit juice. Only opiate-dependent persons who declare themselves willing to enter a therapeutic community afterwards are accepted for admission to this detoxification programme. Except for emergency cases of intoxication other hospitals in general do not accept opiate addicts for withdrawal treatment.

Four therapeutic communities provide places for 115 residents in Hamburg. There are no admission problems since the drop-out rate is quite high. Hamburg clients are not only transferred to Hamburg TC's but – if the client so wishes – also to TC's in other parts of the Federal Republic of Germany. The same is true for Hamburg's facilities: on average 50% of their residents come from other areas. Common features of therapeutic communities are:

– The staff consists mainly of professional social workers and psychologists. There are no self-help groups of the Synanon type in Hamburg;

– Within an individual facility there are not more than 15 residents;

– Treatment concepts consist of different stages, through which every resident must pass;

– Only clients who have been detoxified in a clinical setting are accepted;

– The period of time which must be spent in the programme is defined as being approximately 18 months;

– Financing is assured by social insurance and/or social welfare agencies.

Aside from these common features, TC's are quite heterogeneous. For example, some of them favour experiential psychotherapeutic approaches while others practise cognitive teaching. Moreover one observes large differences in average treatment time.

A.6 Control systems and resources (law enforcement)

Before 1967 only one police officer was responsible for violations of drug legislation. Since the onset of the illicit drug use epidemic in the late sixties the narcotics division of the police has been continuously strengthened. In 1971, 27 officers plus 16 constables were already investigating illicit drug trafficking. Since 1971 a squad consisting of police and customs officers has been working on illicit import and trafficking of drugs.

At the present time (1985-86) 35 detectives, six constables and six office aids are employed in Hamburg's narcotic division. In addition the efforts of 13 customs officers are integrated. Preliminary proceedings are supervised by a special department of six public prosecutors. Law enforcement work in drug abuse prevention is supported by an extensive computer information system. Any detected case is notified and can easily be processed or retrieved.

A.7 Monitoring systems

Since the mid-seventies the commissioner for illicit drug use issues in Hamburg has, together with the narcotics division of the police, developed an administrative monitoring system. The current reporting system of the police distinguishes between cases and persons, between illicit trafficking and use-related- law violations, and between different drugs.

The office of the "drug commissioner" keeps a file or register of persons involved in non-medical opiate use. Since 1973 the commissioner's office has received each month lists of persons who are notified as being opiate users. The main source for this information is the police but until recently there were occasionally other sources. Indicators or criteria for being categorised as an opiate addict are the acknowledgement of the person, the presence of needle marks and/or the possession of opiates.

Until 1985 the opiate-user register kept core data such as name, date of birth, notification and the information source. Since July 1985 the mention of a name is no longer permitted and a code system is used. Those core data enable the police to follow-up computerised police notifications on opiate addicts-In 1982 and 1985 studies were carried out on the "maturing out of opiate addiction" hypothesis and in 1983 a sturdy was made of changes in the age distribution of opiate users at the time of first notification.

Death cases related to drug abuse are processed by the police. Any death where there are signs that drug abuse might be involved, must be reported to the narcotics division of the police. In cases

where the death cause is uncertain, a bio-chemical test is carried out by the Institute of Forensic Medicine whereby presence of recent morphine intake can be demonstrated.

Another monitoring system is provided by criminal court statistics on sentences for violation of drug legislation. Since detailed analyses of verdicts are time-consuming and require the undivided attention of one person, routine reports include only information on the proportion of probation measures to prison sentences.

Shortcomings in routine data collection and/or data transmission appear in the field of treatment and rehabilitation. Only the detoxification hospital and one therapeutic community transmit data on a regular basis (monthly or annually) on admissions, drop-outs and cases where treatment has been completed. Other facilities refuse to provide such information. This situation makes evaluation of treatment effectiveness rather difficult.

B. INDICATORS

B.1 First treatment demand

This term is understood as the number of persons who for the first time request some kind of aid from drug counselling centres in a given time period. In Hamburg there is no systematic reporting of new treatment requests according to this definition. The counselling centre, which arranges the financial side of “de-addiction” treatment, reports that on average 250 “new” persons each year make a request for aid. The agency defines any person who did not come to the counselling centre during the previous year to be a “new” case. From 1980-84 the number of drug-dependent persons was reported to be 1,117 persons. Since the definition of a new case is quite vague (counting formerly known drug addicts who did not show up for a year as new cases) it has no value as a lagged indicator for epidemiological trends. The true number of new persons coming for support every year still remains unclear. One has reason to believe that the true number is lower than 250 persons a year. It should be possible to make available the true number of new cases; however it seems that some institutions providing aid are not very Interested in detailed data collection which would enable the exploration of epidemiological trends. In short, precise data on first help requests (new clients) are hardly available at present.

B.2 Hospital admissions

Admission figures for drug addicts are reported only by the detoxification clinic. Other hospitals in Hamburg do not accept drug addicts as patients except in the case of emergency treatment for overdose, intoxication etc. As there is no obligation to report such emergency cases, figures are hardly available.

The number of admissions to the detoxification clinic reflects the degree of treatment motivation in the addict population. On average there are 200 admissions every year; it seems that the proportion of addicts seeking abstinence is fairly constant. It has to be noted that the figures reported annually do not necessarily represent new cases, for it is well known that a considerable proportion of addicts relapse and go into treatment several times.

B.3 Viral hepatitis

Traditionally hepatitis cases have been reported by the medical profession to the city health administration. Since 1983 a breakdown of categories (hepatitis A, B, non A, non B) has been introduced. It is not known how many of the hepatitis figures are associated with intravenous use of drugs.

Theoretically hepatitis figures reflect long-term dangerous effects on health by inappropriate syringe use. Surprisingly it seems that the occurrence of serious contagious hepatitis cases among drug addicts is not as frequent as theoretically expected.

B.4 Drug-related deaths

Any death case where there are signs that drug abuse could have been involved is to be reported to the narcotics division of the police. In cases where the death cause is uncertain or doubtful, a bio-chemical test is carried out by the Institute of Forensic Medicine. By investigation of the hair root, presence of recent morphine intake can be demonstrated with high validity. The

definition of deaths affected by drug abuse is not restricted to cases of fatal intoxication and overdoses. Accidents while "being on drugs", suicide of notified users by other means and other causes (for example long-term disease effects of chronic drug abuse) are also regarded as drug abuse related cases. Excluded are suicides by means of depressants of the central nervous system and other substances where no indication of chronic use can be found. Also excluded are death cases related to long-term misuse of "over the counter drugs" and those prescribed by medical doctors.

These definitions are used throughout the Federal Republic of Germany. Notified users whose origins are in Hamburg but who die (because of their drug abuse) in other areas will not be counted in Hamburg; such cases will be counted in the area where death occurred. The reason for this regulation is to avoid double-counting. From 1980-85 there have been 136 death cases in Hamburg affected by drug abuse.

The distribution of these cases according to sex, age, death causes and whether or not the persons were notified users, is shown in Appendix I. If one looks at these annual figures for death cases among the population of notified opiate abusers, it will be found that the annual death rate varies between 1% and 2% on average. But this kind of mortality assessment is somewhat misleading. In Hamburg follow-up research over long time periods has suggested that the proportion of premature deaths among notified opiate users is approximately 20%

B.5 Police arrests

The application of the term "police arrest" in Hamburg for exploring epidemiological trends is inappropriate. The term "police arrest" usually expresses the fact that someone is arrested and held in custody. In Hamburg these cases are not counted separately. The units counted by the police are detected cases and charged persons. It is important to remember that in the Federal Republic of Germany the police has to investigate any detected supposed law violation, which implies that any event is notified as a case. Thus the police monitoring system reports notified cases and notified persons who are suspected of having committed specific law violations. The report categories usually include:

– general violations of drug legislation (mainly illegal possession of drugs for personal use);
– cases of illegal import and trafficking;
– type of drug involved;
– new notified users of heroin, other opiates and cocaine.

Since in past years changes in police resources and police priorities have not been observed it is assumed that in Hamburg the police monitoring system is comparatively the most comprehensive. It is believed that significant changes in certain aspects of police notifications do, to a sufficiently reliable extent, reflect changes in the epidemiological situation. This has been demonstrated, for example, with follow-up data concerning notified opiate abusers.

Police statistics give unequivocal evidence that the so-called drug problem has statistically for the past 15 years consisted of the illegal consumption of cannabis products, in the large majority of cases. The following table from recent years illustrates this fact:

Table 1: Percentage of different drugs involved in all offences against drug legislation

	1983	1984	1985
Cannabis	75.5	72.5	72.7
Heroin	15.6	16.7	16.9
Cocaine	4.0	6.5	6.3
Other drugs	4.7	4.4	4.1

B.6 Imprisonment

Figures on imprisonment for offences against the drug legislation have been subject to detailed analysis. For example, until 1981 it was possible to assess the treatment of notified addicts in trial and to review the criminal court sentence practice concerning cannabis users.

From 1982 onwards (when the current drug legislation came into force) the work of regular coding and evaluation of approximately 600 verdicts per year could not be continued because it is very time-consuming. Since that time the city department of justice has transmitted every year a simple summary table which contains the following figures:

– the total number of persons sentenced for offences against drug legislation;
– the number of adult offenders sentenced to imprisonment;
– the number of adult offenders put on probation;
– the number of adolescent offenders sentenced to imprisonment;
– the number of adolescent offenders put on probation;

Annual countings of these figures give a heuristic measure of the average harshness of penalties for offences against drug legislation in Hamburg. The figures of recent years (see Appendix I) give evidence that the percentage of imprisonment sentences declined from *337a* in the years 1980-81 to approximately 23% in 1983-84. These percentages seem somewhat to accord with figures on cases of illegal import and trafficking provided by the police.

B.7 Seizures of illicit drugs

Since the figures of detected and notified cases of drug law violation encompass seizure frequencies, numbers of seizures are not separately reported by the police monitoring system. Amounts of seizures are however regularly reported; these are taken to indicate the dimension of the illicit market which in turn is taken to reflect the level of demand in the city. There is no double counting; all data are reported through one channel.

In recent years awareness has grown among police reporters that single seizures of large amounts distort inferences drawn from seizures, especially if it later appears that these amounts were not earmarked for the local drug scene. Recent interpretations take

account of this bias, and the police report single “extraordinary” amounts separately. It has to be pointed out that usually the narcotics division of the police considers figures of use-related cases (excluding figures on illegal import and trafficking) to be a more appropriate indicator of the demand level than amounts of seizures.

Considering numbers and amounts of seizures leads to the fundamental question: In what way do seizures reflect the illicit market? It is commonly believed that the more drugs are seized by law enforcement agencies the more drugs are left over to be available in the streets. In other words, it is postulated that there exists a high positive correlation between seized and non-seized amounts of drugs. This belief emerged from the classical “iceberg” model which states that we see usually only a relatively small fraction of the true volume of the iceberg on the water surface. On the other hand experts in the field agree that frequency and amounts of seizures chiefly reflect the success of police efforts. If one takes both assumptions to be reliable it will follow that a higher degree of success of police work shown by more seizures implies nevertheless a higher availability of non-seized drugs. This is the classical Sisyphean (“you can never make it”) situation.

Alternative interpretations of seizure data have rarely been formulated. Most comments on seizures consist of stereotyped replicas of the “iceberg” model. An alternative formulation would be based on the premise that frequent and large seizures might as well represent an essential loss in illegal supply. It would predict that this leads to a lower degree of purity of street drugs and on average to higher prices in street sales.

B.8 Price/purity of illicit drugs

Information regarding the price of illicit drugs at street level comes from the police. The police question arrested users and street dealers about prices and obtain information from undercover agents who simulate a bargain. Price assessments usually refer to one gramme of an illicit drug.

In Hamburg the price for one gramme of heroin has been on average between 350 and 400 DM since 1983. (At present one injection of heroin, which requires much less than a gramme, costs 150 DM). One gramme of cocaine costs on average 250 DM; this price level has been constant in recent years. The price for hashish has been constant in the eighties: about 20 DM for one gramme.

Purity tests have been carried out intermittently in the past. Since 1984 this has been included in the annual report system. Separate tests are done for seizures in general and for small amounts seized from users. There are no detailed analyses reported for cannabis but it is said that hashish has a constant good (ie not adulterated) quality.

As for heroin the average heroin base content of seizures was 32.7% in 1984; it was 25.5% in 1985. Testing the street amounts below one gramme showed an average 28.5% in 1984 and 18.6% in 1985. The range in 1985 was 3.1% to 60%. In 1985 the highest purity was in a 1.2 kg seizure: 79.1%.

Cocaine purity was almost the same in 1984 and 1985: 58.7% and 55.5%. Street amounts below one gramme had an average purity of 62%; the range is between 5.2% and 91%. The highest purity was found in a 356 g seizure in 1985: 96.4%.

B.9 Survey data

The last survey on licit and illicit drug use was carried out in 1981-82. It had the following main results:

– Although 20% of the 720 subjects (representing 317,000 young people) responded that they at some time had used a drug, it was found that 8% had done so during the last six months before the survey. Only 5% had used a drug during the month before being questioned;

– The majority of drug-experienced subjects were 18 to 24 years old;

– If we speak of drug experience, this means in 90% of all cases cannabis smoking;

– Minors below 18 years of age had – if at all – only had experience of cannabis smoking (3% between 12 and 14 years). In contrast 30% of the age group 21 to 24 years had used cannabis.

Comparisons with earlier student surveys of 1971, 1973 and 1975 (which had subjects of the age range between 13 and 19 years) showed that in the “ever used” category the self report of adolescents declined from 27% in 1971 to 13.6% in 1981-82. The percentage of subjects admitting drug use during the last six months before the survey dropped from 20.5% in 1971 to 7.6% in 1981-82. According to these findings illicit drug use of adolescents had been declining in the course of a decade. No conclusions can be derived from these surveys with regard to opiate misuse since the number of admitted users is so small that reliability and validity of such results are very doubtful. As pointed out earlier, cannabis is the most “popular” illegal drug which is used. The second place (though it has decreased over time) is held by non-medical use of stimulant prescription drugs.

B.10 Other indicators; comments on AIDS

In Hamburg no data are available on severe drug use related emergencies seen by medical doctors and in casualty departments. In the future some reporting might be possible, since the establishment of a special casualty department for drug users is planned.

At present a point of major concern is the finding that opiate addicts using syringes are a high-risk group for AIDS, especially if there is needle-sharing. Another route for the HTLV III virus infection is homo- and heterosexual prostitution by drug addicts. Regular tests of patients at the detoxification clinic in 1985 showed that approximately 30% of the patients had positive HTLV III findings. It is empirically evident that the AIDS risk is much higher for drug injecting persons than Hepatitis B. In fact, AIDS is now the major health danger associated with intravenous drug abuse.

C. ASSESSMENT OF THE USE AND VALUE OF INDICATORS

C.1 Use of indicators in the city

As pointed out above, the most comprehensive and detailed data are reported regularly by the narcotics division of the police. The monthly list of persons who are notified for the first time *as* being users of "hard" drugs such as heroin, other opiates and cocaine, is the major source for a register of notified opiate abusers introduced in 1973. Until July 1985 it was possible to avoid double countings with data from other sources. At that time data from medical sources were discontinued. They may again be made available if these sources participate in a coding system developed to ensure anonymity.

These data are used to monitor incidence of opiate abuse in the Hamburg area. For reasons of measuring more or less the "true" incidence, the number of persons who grew up in Hamburg and who started using opiates are counted separately from users who have mostly lived in other areas but who were charged or arrested in Hamburg. A third category are foreign opiate users.

Table 2 shows the number of new notified opiate abusers from 1980 to 1985. It seems that there is a slight decrease in the incidence rate.

Table 2: Numbers of persons notified for the first time as opiate abusers from 1980 to 1985

Year of first notification	Living in Hamburg	Coming from other areas	Foreigners
1980	224	8	17
1981	179	11	12
1982	167	6	18
1983	120	5	24
1984	117	14	7
1985	78	7	17
Total	885	51	95

Also deduced from these data is the number of opiate users at a specific point in time. According to this register 2,942 persons -who were still alive at the end of 1985 – have been involved in illicit opiate use from 1969 through to 1985. 290 users died during that period. The total of 3,232 persons who have been notified as opiate abusers since 1969 is a cumulative number. It should be mentioned that the register has usually included 300 opiate users who were up until then not known by the police, at least not as opiate users. This global cumulative figure does not take into account findings that it is likely that a significant proportion of users succeed in "kicking" (ending) their habit after several years. In 1982 and 1985 follow-up research on police records of opiate abusers was carried out. It was found that approximately one fifth of users who had started injecting opiates in the mid-seventies died in the course of their addiction. This is a rather high mortality rate.

However, it was also found that approximately 50% of opiate abusers who had for the first time been notified in the early and mid-seventies no longer had any police record in the eighties. It is admitted that some further validation, using different criteria, is needed for these findings. Nevertheless the magnitude of these figures strongly supports a hypothesis which has been called "maturing out of addiction" (see Robins: Handbook on Drug Abuse; 1979). Of course the "maturing out" figure includes (hose persons who were treated successfully. Taking this figure into account, it is suggested that the absolute number of "active" opiate addicts did not increase during the eighties, which means that the prevalence figure remained at the same level. Since it was also found that a large proportion of addicts had contacts with agencies providing help it is believed that the network of counselling and rehabilitation facilities somewhat contributed to the "maturing-out" figure.

In December 1985 the prevalence figure was 1,764 persons using opiates illicitly (for comparison, not even 200 persons have been notified as cocaine users).

The prevalence rate of opiate abuse is 1.1 per 1,000 of the general population. However, it is more appropriate to calculate the prevalence rate for the "young" population between 15 and 39 years of age. The prevalence rate is 3 per 1,000 of the young population.

A specific study concerned with age developments in the opiate-using population used the monthly notifications of the police between 1970 and 1983. It was found that in recent years the proportion of "teenage" opiate users decreased considerably. For example, in the early seventies the proportion of new opiate users who were younger than 23 years was almost 80%. In 1983 this proportion had dropped to approximately 30% among opiate abuse beginners. Today opiate abuse is associated predominantly with persons older than 23 years.

C.2 Relationship between indicators

In Hamburg the following variables, sampled routinely, constitute an indicator group which monitors changes in drug abuse trends:

- figures about use-related offences against drug legislation, specified for different drugs such as heroin, cocaine, cannabis, others;
- numbers of persons charged for these violations;
- first notifications of opiate and cocaine abusers.

If the annual comparison of these data reveals differences for these variables which go in the same direction (ie plus or minus) and if the magnitude of the differences is considerable, an increase or decrease might be tentatively inferred. If the differences are more or less small it is suggested that the situation is levelling off. The presumption of a trend is reinforced if data of the following year point in the same direction.

The variables mentioned serve to assess incidence of drug abuse over time as it is investigated by the police forces. To assess overall prevalence of illicit drug use one has to distinguish between the wider field of cannabis (hashish, marihuana) smoking and

pill-taking on the one side and the smaller field of opiate abuse on the other side. The use of cannabis, over the counter drugs and perhaps cocaine can be adequately explored by student and household surveys (questionnaires administered to adolescents and young adults). However, prevalence of heroin use should not be estimated from survey data because of sample errors, and sometimes unknown reliability and validity of responses to the questionnaire. It is believed that a central register of notified opiate users which obtains information from different sources is more appropriate. This register excludes double countings and continuously notifies new persons. It also takes account of those persons who do not reveal any evidence of opiate use in the past five years. Another dimension is illegal availability of drugs, ie the extent of supply by an illegal market. This is assessed by the following indicators:

– the number of cases of illegal import and trafficking specified for different drugs;

– the number of persons charged for import and trafficking of specified drugs;

– price and purity of different drugs at street sale level; this concerns especially heroin and cocaine seizures.

If the number of charged traffickers is considerably lover in a given year this might indicate that traffickers have become more “tricky” in their activities or it could be interpreted as the result of a deterrent effect. In the latter case one should theoretically expect a rise of average prices and perhaps less purity.

Another useful information source concerning availability of heroin are users who come for support to counselling and rehabilitation facilities. Occasionally numbers of cases of death caused by overdose of narcotics (heroin) might add some information about availability, if there is a sharp contrast with deaths related to intoxication due to the use of other substances.

It appears that data supposed to reflect the supply are incongruous with data reflecting the demand. In Hamburg the number of detected cases of import and trafficking of cocaine increased in recent years. Quite large amounts were seized. On the other hand no real increase in the number of use-related cases could be found. In fact, the number of notified cocaine users is remaining rather small. This somewhat puzzling situation admits several interpretations. The first interpretation is an application of the “iceberg model” which asserts that an increase in the number of detected cases of cocaine trafficking and the amounts of seizures indicates a high availability. Although the police has obtained only sparse information about the user “scene” it is maintained that there is a large hidden population which seeks out cocaine. The police simply have no access to this scene, it is said. A second interpretation goes like this: Cocaine is continuously imported into the country, but trafficking is seriously hindered by police action. Even though there might be considerable interest in cocaine (stimulated and launched unintentionally by mass media reports) the real user scene remains comparatively small because there are few occasions to try and buy cocaine, which is expensive.

Another interpretation would be: Even if there is more or less widespread availability (which is doubted), demand for cocaine is still concentrated in comparatively small groups, mainly in the artistic milieux.

D. CONCLUSIONS

The majority of the data tables (presented in the Appendix), which are accessible every year, do not reveal large deviations. A clear upward or downward trend cannot be inferred from these data. Police figures concerning detected cases show some upward and downward variations in the years between 1980 and 1986, but they remain rather close to the average.

Of course, as from 1981 there was an enormous increase in the illicit import and trafficking of cocaine, and an increase in the number of notified users. Nevertheless the number of notifications involving cocaine intake remained comparatively small. Possible explanations for this situation have been discussed in the previous chapter. As regards the illicit use of cannabis products the survey data showed evidence that the popularity of hashish smoking has declined gradually during the past decade. Yet the demand for cannabis is still sufficient to pay for illegal import and trafficking.

The large majority of all offences against drug legislation deal as much as before with cannabis. There are some indications that opiate (ie heroin) abuse has been changing in the present decade. Not only has the population of opiate addicts grown older, (as a master of fact this is true even for the average age of “beginners”), but also it appears that during the eighties there has been no increase in the addict population. This finding is attributed to the phenomenon called “maturing out of addiction”. It seems that a considerable proportion of those opiate abusers who started abuse during the first half of the seventies have “matured out” of their addiction. In recent years the annual numbers of new notified opiate abusers have been somewhat lower than before. Yet it is premature to interpret this as a consistent downward trend of incidence. Altogether the impression is that illicit drug use is levelling off in Hamburg, especially opiate abuse. However there remains the unsolved fundamental issue of hidden populations which are not notified. This author believes that the simple application of the “iceberg” model, so often mentioned in the media, is not appropriate. The validity of this model for opiate abuse has not been proved.

Theoretically some elucidation of this issue could be expected if modern statistical research designs using extensions of the classic capture-recapture approach cited by Hunt (1979), and developed by Bishop and Company (1975), were applied.

APPENDIX I

DATA

Table 1: Population of Hamburg, December 1982: breakdown by age and sex

Age	Male	Female	Total
below 15	107,682	104,307	211,989
15 to 19	62,207	60,007	122,214
20 to 29	121,755	116,384	238.139
30 to 39	119,228	106,764	225,992
40 to 49	199,738	122,999	322,737
50 and older	219,607	353,629	573,236
Total	830,217	864,090	1,694,307

Table 2: Admissions to the detoxification clinic

1980	1981	1982	1983	1984	1985
147	182	206	199	202	185

Table 3: Number of drug addicts referred to therapeutic communities from detoxification clinic

1980	1981	1982	1983	1984	1985
63	112	95	117	129	130

Table 4: Hepatitis cases in Hamburg grouped by type and by sex

	Hepatitis A	Hepatitis B	Hepatitis Non A B	Hepatitis total
	m f	m f	m f	m f
1980				355 276 631
1981				496 304 800
1982				487 337 824
1983	138 127 265	183 94 277	75 62 137	396 283 679
1984	192 144 336	178 91 269	74 64 138	444 299 743
1985	176 136 312	203 88 291	46 37 83	425 261 686

Table 5: Drug-abuse related death cases in Hamburg from 1975 to 1985

	Year										
	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
males	3	17	11	14	23	28	15	19	15	9	13
females	5	3	4	7	4	8	3	10	8	3	5
Total	8	20	15	21	27	36	18	29	23	12	18
Known as users	8	18	13	20	20	28	14	22	21	10	11
Age distribution											
16-17 years	-	-	-	-	3	1	1	-	-	-	-
18-20 years	-	4	1	2	2	2	1	1	1	-	1
21-24 years	6	12	8	8	12	10	4	5	6	1	4
25-29 years	1	4	6	8	10	12	10	15	11	5	9
30 years and older; age unknown	-	-	-	3	-	11	2	8	5	6	4
Average age of deceased											
					23	28.3	25.7	27.3	26.7	30.2	26.6

Table 6: Distribution of specific death causes of drug-abuse related death cases

Cause \ Year	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
overdose of narcotics	2	8	3	5	13	15	4	3	5	7	15
intoxication and/or other central nervous system depressants	2	5	5	9	8	11	3	19	14	2	1
accidents being on drugs	-	2	2	5	-	3	7	4	1	-	-
suicide by other means	3	5	1	1	2	5	3	2	2	1	1
other causes, longterm effects	1	-	4	1	4	2	1	1	1	2	1

Table 7: Number of detected (notified) cases of offences against drug legislation

Year	offences against drug legislation total	offences related to drug use	cases of trafficking and illegal import
1981	2,392	1,614	778
1982	2,875	2,124	751
1983	2,712	1,934	777
1984	2,724	2,054	670
1985	2,489	1,905	584

Table 8: Number of persons suspected of having committed offences against drug legislation. Also proportion of foreigners involved (1)

	All detected persons having committed offences against drug legislation					Peddlers and smugglers				
	1981	1982	1983	1984	1985	1981	1982	1983	1984	1985
total	2,053	2,516	2,004	2,235	2,046	692	643	563	556	511
foreigners	359 (17.5%)	672 (26.7%)	468 (23.4%)	470 (21.0%)	430 (21.0%)	185 (26.7%)	259 (40.3%)	235 (41.7%)	191 (34.4%)	188 (36.6%)

(1) Figures for trafficking and illegal import cases are not included in Tables 8, 9, 10, and 11.

Table 9: Number of detected cases related to cannabis use (1)

Year	No.
1981	1,210
1982	1,693
1983	1,549
1984	1,583
1985	1,498

Table 10: Number of detected cases related to heroin use (1)

Year	No.
1981	249
1982	210
1983	247
1984	281
1985	270

Table 11: Number of detected cases related to cocaine use (1)

Year	No.
1981	25
1982	27
1983	54
1984	89
1985	63

Table 12: Number of detected cases related to the use of other drugs (opium, synthetic opioids, LSD, stimulants)

Year	No.
1981	130
1982	194
1983	85
1984	101
1985	74

(1) Figures for trafficking and illegal import cases are not included in Tables 8, 9, 10, 11

Table 13: Percentage of different drugs involved in all offences against drug legislation in recent years

	1983	1984	1985
Cannabis	75.5	72.5	72.7
Heroin	15.6	16.7	16.9
Cocaine	4.0	6.5	6.3
Other drugs	4.7	4.4	4.1

Table 14: Number of persons notified for the first time as opiate abusers (source: register of commissioner for drug use issues)

Year of first notification	Living in Hamburg	Coming from other areas	Foreigners
1980	224	8	17
1981	179	11	12
1982	167	6	18
1983	120	5	24
1984	117	14	7
1985	78	7	17
Total	885	51	95

Table 15: Drug seizures in recent years in kg (an exception is LSD which is counted in units)

	1983	1984	1985
Hashish	153.76	40.39	43.27
Marijuana	326.72	28.13	5.45
Heroin	8.03	20.01	9.61
Cocaine	0.82	7.27	0.63
Opium	11.34	1.69	1.11
Amphetamines	0.02	0.01	2.07
LSD	396 units	60 units	922 units

Table 16: Criminal court statistics on the outcome of trials concerning offences against drug legislation

	1980	1981	1982	1983	1984
Number of persons sentenced for offences against drug legislation (total)	483	513	347	665	628
Number of imprisonments: adults	155	166	77	138	133
Number of adults whose sentence has been commuted to probation	152	146	74	156	140
Number of imprisonments: adolescents	6	8	10	14	23
Number of adolescents whose sentence has been commuted to probation	68	32	14	11	4

Among those sentenced in 1980, 102 persons were foreigners. In 1981 106 foreigners were sentenced, in 1982 this number was 114 persons, in 1983 198 foreigners (or people without nationality) and in 1984 133 foreigners.

Table 17: Data from surveys: percentage of persons who admitted to having tried a drug. Age group: 13 to 19 years

Year of survey	Percentage in the "ever tried" category
1971	27.0%
1973	18.0%
1975	15.0%
1981-82	13.6%

Table 18: Data from surveys: percentage of persons who admitted to having used a drug during the last six months before the survey. Age group: 13 to 19 years

Year of survey	Percentage "drug use six months before"
1971	20.5%
1973	9.0%
1975	8.4%
1981-82	7.6%

APPENDIX II

GLOSSARY OF TERMS AND DEFINITIONS

Drug abuse or drug misuse

Non-medical, hedonistic consumption or intake of drugs which are listed in the “law on the traffic in narcotic drugs”. Any use of these drugs which has not been licensed by the Federal Health Bureau is regarded as abuse or misuse. Both terms are also used nowadays in relationship to excessive intake of licit drugs such as alcoholic beverages and over-the-counter or prescription drugs.

Drug addict or drug-dependent person

These terms are used interchangeably. They describe a person for whom the intake of a psychotropic drug has become an integral part of his lifestyle. Non-availability of the drug or non-use result in subjective distress.

Incidence

This term relates to the number of persons who are notified as being opiate abusers in a given year.

Narcotic

A generic term commonly used to refer to opioids. In the Federal Republic of Germany the equivalent of this term is used in legal language to characterise all substances which are listed in the legislation.

Maturing-out of addiction

A hypothetical term which was introduced by addiction researcher Ch Winick in 1962. It characterises the phenomenon that after several years of manifest chronic opiate intake a significant proportion of addicts tend to discontinue the habit.

Prevalence figure

This term refers to the number of persons who presumably are abusing opiates at a moment in time. This figure is lower than the cumulative number of persons who have ever been notified for opiate abuse.

Prevalence rate

This term refers in epidemiological work to the rate calculated from the prevalence figure and the population size. This value is commonly calculated per 1,000 persons of a population.

Use-related case

This term is used by Hamburg’s police drug division. It refers to events or cases concerning possession of drugs which were intended for personal use by the persons charged. These cases are to be distinguished from cases of illegal import and trafficking of larger amounts.

APPENDIX III

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REPORT ON DRUG MISUSE IN GREATER LONDON

by

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A. DESCRIPTION OF LONDON

A.1 History of drug misuse

The 1960s

In the years before and immediately following World War II, there was little evidence of drug misuse. There were a few hundred addicts, either middle aged ‘therapeutic addicts’, or doctors, midwives etc..

The situation started to change in the late 1950s and early 1960 s. Amphetamines, from medical sources, gained popularity as ‘stay-awake’ party drugs, primarily amongst working class youngsters. At the same time, cannabis emerged within ‘beat’, jazz and West Indian circles. Later in the 1960s cannabis, and subsequently LSD, expanded in middle-class student and ‘hippy’ cultures.

Within these wider changes, a small group centred around jazz clubs in the West End of London started to use heroin and cocaine. These drugs were then taken up by other young people around the West End. The 1960s ‘epidemic’ occurred primarily amongst adolescent and young adult white males. The focus remained in the West End (Piccadilly) and in certain areas in Inner London, though heroin use was also found in certain new towns near London. Although the rate of increase was rapid, the absolute numbers remained relatively small. The likely total by 1970 was perhaps a tenth of today’s estimates. At that time, both heroin and cocaine were always used by injection. Excessive prescribing by a small number of doctors was virtually the exclusive source of supply. Until 1969, there was no significant black market in illicitly imported heroin (or cocaine).

The Dangerous Drugs Act 1967 ended this period of ‘heroin on demand’, and led to the transfer of responsibility for the treatment of addicts from general practitioners to special drug treatment centres.

The 1970s

Over the first half of the 1970s although the situation appeared to be stabilising, significant changes were taking place.

The number of known narcotic addicts continued to increase but at a slower rate. Moreover, the new addicts who emerged were progressively older each year, suggesting that the problem had been contained to one generation. The supply of surplus heroin from prescriptions diminished as the new drug treatment centres reduced the quantities of heroin prescribed and then started to substitute methadone. (They stopped prescribing cocaine altogether).

However, control of prescribing to addicts extended only to heroin and cocaine. Thus, over the decade, there was a steady growth in the supply of other opioids (such as methadone or Diconal) which were not controlled in the same fashion. In the mid 1970 s, synthetic opiates accounted for a substantial part of the 'opioid problem'.

Meanwhile, a small market in illicitly imported heroin had developed involving so-called 'Chinese' heroin imported from Hong Kong. In the mid 70s, this was replaced by higher purity, white heroin from the 'Golden Triangle' in South East Asia. During the mid 70s, partly because of poor harvests, the supply of South East Asian heroin was restricted and prices rose steadily. In 1979, however, following events in Iran, heroin from South West Asia became available, the market expanded and prices fell.

Barbiturate and multiple drug use appeared to increase, particularly though not only amongst young people who could not afford heroin. In the late 60 s/early 70 s, Mandrax (containing methaqualone) was popular amongst a relatively wide range of drug users. Over the decade, it steadily became less available as prescribing dwindled.

By the early 1970 s, the prescribing of amphetamines had greatly diminished. However, the supply of other stimulants increased. This included the development of the illicit manufacture of amphetamine sulphate, increased prescribing of Ritalin (methylphenidate), and, in the mid 1970 s, the appearance of an illicit market in cocaine. In most cases, these stimulants were used intermittently rather than continuously, and were usually sniffed rather than injected.

Throughout the decade, cannabis became accepted and used by a broader cross-section of the youthful and relatively youthful population. LSD, however, after a peak of popularity in the early 1970 s, steadily declined thereafter. Towards the end of the decade, glue sniffing by adolescents started to attract attention.

The 1980 s

The major trend since 1980 has been the continued rise in the supply and use of heroin. In 1980, 'Turkish' heroin became more available as supplies from Iran dwindled. From 1961/82, this in turn was replaced by heroin from the Pakistan/Afghanistan border area. Much of the recent rise in heroin is accounted for by increases in sniffing and smoking heroin rather than by increases in injecting. Field research and informed observers confirm that the illicit market is 'buoyant', though it appears that the rate of increase of new users has now slowed down. Other trends include an increase in amphetamines and cocaine.

There are no precise figures for the true prevalence of opioid use. A tentative estimate (based on three methods), suggests that between 20,000 and 30,000 people in Greater London used opioids on a regular basis (daily/almost daily for at least one month) at some stage during 1985. This is a 12 month period prevalence of about 10 per 1,000 of the population aged 15-39, a fourfold increase over 1977. The rate is higher in Inner London, perhaps 20 per 1,000 aged 15-39, and lower in Outer London. It is very likely that the number of 'occasional' users exceeded the number of regular users. The principle drug is heroin.

The age range of regular opioid users is wide – no more than one in ten is under the age of 20. The majority, around two thirds, are in their twenties, but a significant proportion, about one quarter, are in their thirties. About one third are female. There is no 'typical' social background, nor are there clear factors which distinguish people who use from those who do not. About three quarters are unemployed. Traditionally, the various ethnic minorities have been underrepresented amongst opioid users. There are now indications that this is changing.

The recent growth of heroin use in London is a consequence of converging domestic and international factors. These include:

1. Increased supply of heroin of high purity and a fail in price.

2. Use of heroin by sniffing or smoking. (Users could distance themselves from the stereotype of the 'junkie' and use heroin in the belief that it was not possible to become addicted.)

3. Increased 'social acceptability' of heroin as a recreational drug and the breakdown of many of the subcultural boundaries that previously had helped to limit heroin use.

4. Wider distribution of heroin throughout local communities and drug using circles.

5. Changes in treatment policy away from maintaining addicts on prescriptions towards abstinence oriented approaches.

6. Wider social changes, and sense of futility associated with poor living conditions, rising unemployment and crime.

It is not currently possible to estimate the extent of stimulant use in London, regular or otherwise. However, it seems that cocaine is readily available, and amphetamine sulphate even more so, in many parts of London. Without suggesting a figure, it is likely that more people take cocaine on occasion than take heroin, though it is also probable that fewer people take cocaine on a regular basis. Amphetamines are probably more widely and more frequently used than cocaine.

It appears that amphetamines remain somewhat more of a working class drug and cocaine a middle class drug, as they were in the 1970's. There is, however, a considerable overlap and the choice of stimulant is as likely to be affected by financial as by social factors. Thus amphetamine use is more apparent than cocaine amongst adolescent drug users. The age range of those who use amphetamines and/or cocaine is, like that for heroin, broad – it is not uncommon to encounter middle aged users – though it is impossible to quantify this.

Whereas the barbiturates were the drug of choice some years ago, it appears that minor tranquillizers and non barbiturate hypnotics are now more common. The extent of this pattern of drug use is not known. It is likely that the extent of 'medical misuse', that is regular or excessive use of prescribed sedatives is substantially more extensive than that of illicit drugs such as heroin or cocaine.

There is little firm information concerning either the real extent of solvent use or how it has changed, though it appears that over the past year, solvent users have switched from glue to butane gas, possibly as a result of pressure to reduce sales of glue to 'suspicious adolescents'. Solvent use tends to increase for a few months in particular areas and then diminish again. The same pattern may be repeated in neighbouring areas or subsequently in the same area. At such times, it seems that a relatively substantial minority of adolescents may try solvents. A recent survey reported that in some schools, 25% of adolescents had sniffed solvents at some point. However, only a few continue and develop a serious problem. Those few may well create the impression of a much larger problem, partly because they are highly visible and partly because they can pose considerable problems to agencies. Most solvent users are in early to mid adolescence, though a minority persist into their early twenties.

Cannabis continues to be widely available and the most commonly used of the illicit drugs. Except as a result of arrest, it only rarely manifests as a problem at local agencies. Following an apparent decline over the 1970 s. LSD has become somewhat more available over the past two or three years, but is not often found as the primary drug amongst those presenting to agencies.

Comment on illegal supply

Much illegal distribution occurs in private, ie in people's homes or behind the scenes. Some takes place in semi-public places such as clubs, discos, pubs, amusement arcades etc.. Only in the West End, and in a few other locations such as Earl's Court can a 'street market' be found where drugs are bought or exchanged in public. Thus, although drugs such as heroin, cocaine, LSD, cannabis are available throughout most parts of the capital, many users, and in particular first time and 'occasional' users, obtain the drug through their existing circles of friends, acquaintances and friends of friends. Larger scale distribution is more likely to involve professional crime, though the structure is more at the level of separate entrepreneurial groups rather than monolopy control by large syndicates.

Summary – 1960s to the present

The major changes observed over the past two decades thus include a broadening of the range of drugs used for nonmedical or recreational purposes, a trend towards multiple drug use, a blurring of the social and subcultural differences associated with different patterns of drug use, an increase in the number of people involved in some form of illicit drug use, a large expansion in illicit importation and distribution of drugs and increased involvement of professional crime. In some inner city areas, the use of a variety of drugs is no longer restricted to separate subcultures, but is part of the everyday environment in which many ordinary young people live. It should be added, however, that this is not uniform in all parts of London. It should also be emphasised that although most public concern focuses on heroin, it is less commonly used than most other drugs.

A. 2 General policy; legislation

Background

Drug misuse was not seen as an issue of great social or political significance until the 1960 s. Several Dangerous Drugs Acts were introduced from 1920 on, but these were responses to international treaties rather than to domestic problems. Addiction itself was often seen as a chronic, relapsing neurotic condition found in individuals of 'nervous disposition', in people whose occupations were highly stressful or amongst medics and paramedics who had ready access to drugs. Treatment was provided, largely by general practitioners, within the traditional (and confidential) doctor-patient relationship.

In 1926, a Government appointed committee (the Rolleston Committee) concluded that it was appropriate to prescribe heroin or morphine to addicts either (a) if the person was being gradually withdrawn, ' or (b) if, after attempts at cure had failed, the patient could live a relatively normal and useful life when provided with a regular supply, but ceased to be able to do so when the supply was withdrawn. The principle that it was acceptable to maintain addicts, if this enabled them to stablise their lives (the "Rolleston approach") remained a major theme which underpinned UK policy for 40 years and still exerts a significant influence today.

The practice of maintaining addicts continued without controversy until the 1960 s, when the increase in youthful drug misuse led to rising public concern, to a new perception of drug taking as a threat to the social order, and thence to shifts in policy. These shifts occurred in two main areas: (a) increased criminal sanctions against the supply and possession of drugs, and (b) changes in the treatment of addiction to heroin and cocaine.

Criminal sanctions

Amphetamines were controlled in 1964, LSD in 1966 and methaqualone in 1971. Controls on supply and possession of drugs were accompanied by the formation of special drug squads. During the 1970 s, most enforcement activity concerned cannabis and, to a lesser extent amphetamines and LSD. Conversely, policy on these drugs was largely confined to criminal sanctions. These Acts, and the 1967 Dangerous Drugs Act (see below), were later replaced in 1971 by the Misuse of Drugs Act.

Treatment of addiction

Whilst the unauthorised sale or possession of heroin (and cocaine) also rendered offenders liable to arrest, the more significant policy changes concerned modifications to the 'Rolleston' approach to the treatment of addicts. This was extensively examined by an Interdepartmental Committee (the second Brain Committee, named after its chairman) which reported in 1965. Most of its recommendations were implemented in the Dangerous Drugs Act of 1967.

The major effects of the 1967 Dangerous Drugs Act were that doctors were prohibited from prescribing heroin or cocaine to addicts unless they (the doctors) were specially licensed; special drug treatment centres were set up, usually attached to hospital departments of psychiatry (most of the licensed doctors were based in these clinics); and compulsory notification of addicts was introduced. It should be noted that compulsory treatment was not included in the Act, even though it was one of the recommendations made by the Brain Committee.

By 1967, the image of addiction had changed from that of a chronically relapsing condition in individuals of 'nervous disposition' to one in which addicts were perceived as 'junkies' – young, hedonistic, socially deviant, and potentially 'contagious'. Because of the fear of a continuing 'epidemic', the aim of the new system was to contain the spread of addiction. It was hoped that this could be achieved through:

– reduced overprescribing to curtail the surplus supply;

– continued prescribing sufficient to prevent a black market;

– management of people who were already addicted (This, in effect, was a continuation of the Rolleston concept of the 'stabilised' addict, since methadone was often prescribed in the hope that it would minimise criminal activity, reduce the use of adulterated drugs and enable addicts to function more 'normally');

– last of all, encouraging addicts to consider abstinence.

Thus the 'British system' had changed from a model based on the medical management of an individual, chronic condition to an epidemiological public health model based on an analogy with infectious diseases. However, the strains between the various measures are self-evident, and were later to contribute to further shifts in policy.

Up to the mid 1970 s, most drug clinics prescribed methadone (usually injectable, sometimes oral) or, occasionally heroin, and offered other services such as counselling and referral. Over the latter 1970 s, there was a steady move away from maintenance or prescribing of any injectable drugs such as heroin, towards more abstinence oriented treatment, in particular, reducing prescriptions of oral methadone. The reasons for this change included doubts about the relevance of the Rolleston concept of 'stabilisation' to the youthful addicts of the 1970 s, and professional concern that appearing to condone and perpetuate addiction for the sake of minimising the illicit market and associated crime conflicted with the goal of discouraging drug misuse.

Whilst the treatment centres were moving away from maintenance prescribing, there was a steady growth in prescribing by GPs and private physicians of other opioids such as methadone or dipipanone (whose prescribing was not controlled).

At the same time, a number of voluntary organisations developed, notably 'street agencies', which grew out of the wider drug subculture, and therapeutic communities, based on the Synanon/Daytop model. There was often tension and mistrust between the voluntary and statutory sectors. At this stage, there were very few private facilities specialising in the treatment of drug dependence.

By the early 1980 s, the treatment centres (which had developed on the basis of the stereotype of the socially marginal, heroin injecting ‘junkie’) were dealing with only a small proportion of all addicts, and with a negligible proportion of the larger number of people who were experiencing problems with a wide variety of other drugs. At the same time, the illicit supply of various drugs, including heroin, amphetamines and cocaine, was growing, and the range of multiple drug use was becoming more apparent. Thus by the 1980 s, the policies that had evolved in the late 1960 s were becoming increasingly strained. At least five sources of strain can be identified.

(1) The large increase in the illicit market and the concomitant involvement of professional criminals pointed to a failure of criminal sanctions.

(2) The abandonment of maintenance prescribing by the treatment centres shifted the epidemiological model of containment towards the periphery.

(3) The increased involvement of generic professionals (not just GPs but also probation officers, youth workers and so on) aroused considerable anxiety and pointed to a serious lack of training and guidelines as to how they should respond.

(4) The limitations of a treatment policy based on pharmacological categories had become abundantly clear.

(5) The pervasiveness and apparent acceptability of drug taking amongst young people in some areas highlighted the inadequacies of preventive strategies.

Current Policy

As well as the historical background described above, current policy should be understood in the context of the division of responsibilities between central government and local authorities. Central government is responsible for legislation, broad policy guidelines and the overseeing of control, treatment and prevention. On occasion it may support special initiatives. The development and delivery of services (health, education, social aid, policing) is the responsibility of local authorities and Regional and District Health Authorities. The relationship between central government and local bodies is complex. However, two key points are that (a) central government has a degree of control over local expenditure, and (b) the priorities of central government and local bodies are not always identical.

Over recent years, official reports. Parliamentary Committees and Ministerial statements have pointed to a number of changes in British policy regarding drug misuse. The report which is often taken to mark this transition is the Report of the Advisory Council on the Misuse of Drugs on Treatment and Rehabilitation (ACMD) published in 1982. This is discussed below. Other significant events include an ACMD Report on Prevention (1984), the Report of the House of Commons Social Services Committee on the Misuse of Drugs (1985), and the Report of the House of Commons Home Affairs Committee on the Misuse of Hard Drugs (1986).

In July 1984, the Government established an interdepartmental Ministerial Group on the Misuse of Drugs under the chairmanship of the Under-Secretary for State at the Home Office with special responsibility for drugs matters. The other major Departments involved are Health and Social Services, Education and Science, and the Board of HM Customs and Excise, as well as the Scottish, Welsh and Northern Ireland Offices. In March 1985, this Group published a document (updated in March 1986) summarising the five objectives of the Government.

(1) Reduction of the importation of illicit drugs.
(2) Improved policing within the country.
(3) Improved control of prescribed drugs.
(4) Strengthened deterrence
(5) Improved treatment, rehabilitation and prevention.

In formulating policy, the Government is assisted by the Advisory Council on the Misuse of Drugs, a body of experts with the task of keeping under review the misuse of drugs and of advising Ministers on appropriate measures.

Legislation

The principle legislation controlling drug use is the 1971 Misuse of Drugs Act (with subsequent amendments). This replaced and rationalised previous legislation. It regulates the import and export of drugs and defines the offences of production, cultivation of cannabis, supply, intent to supply and possess specified drugs. A distinction is made between possession for personal use, and more serious offences involving supply. The Act also deals with legitimate possession, supply and prescribing of controlled drugs, the notification of addicts, restrictions on the right to prescribe to addicts and various other administrative requirements regarding record keeping and so on.

The 1971 Act places controlled drugs into three categories, based on the perceived relative dangers of misuse. Class A includes most opioids (heroin, methadone etc.), cocaine and LSD; Class B the amphetamines, barbiturates, codeine and cannabis; and Class C methaqualone and certain amphetamine-type drugs. The maximum prison sentences are shown below. In all cases, fines can be imposed instead of, or in addition to, imprisonment. Alternative sentences include conditional discharge or a probation order. Imprisonment may be suspended.

Maximum prison sentences under 1971 Misuse of Drugs Act

	Possession		Supply/Intent to supply	
	Magistrates Court	Crown Court	Magistrates Court	Crown Court
Class A	6 months	7 years	6 months	life
Class B	3 months	5 years	6 months	14 years
Class C	3 months	2 years	3 months	5 years

The maximum sentences for importation of controlled drugs are the same as for trafficking offences under the Misuse of Drugs Act 1971.

The major changes since the 1971 Act was passed have been that the maximum sentence for trafficking in Class A drugs has been increased to life imprisonment. Parole has been severely restricted for people sentenced to more than five years for drug trafficking. In addition, measures are being introduced to allow courts to order the seizures of all assets of someone convicted of trafficking unless they can prove that those assets were not obtained through trafficking. The Lord Chief Justice has issued sentencing guidelines recommending that judges impose longer sentences of imprisonment than have been usual for supply of drugs. Thus sentencing policy has become more severe.

Control of supply

Since 1983/84, illicit drugs, especially heroin, and more recently cocaine and amphetamines, have become an enforcement priority. Increased resources have been allocated to both Customs and Police. Over the past two years, there has been a tendency to caution rather than charge people found in possession of small amounts of cannabis. Controls have also been strengthened on various drugs of misuse, including barbiturates, dipipanone (an opioid) and diethylproprion. Doctors prescribing controlled drugs to addicts have become subject to greater surveillance. The Department of Health and Social Security has drawn up "Guidelines for Good Clinical practice in the Treatment of Drug Misuse" and circulated them to doctors.

Prevention

The main activities of central government in this field have been: a high profile, anti-heroin media campaign, aimed at young people, with the slogan "Heroin screws you up"; distribution of information leaflets for parents; production of educational material such as videos and teaching packages for use in schools and youth centres; initiatives to identify and respond to training needs for professionals such as nurses or teachers; and allocation of £22 million pounds, over three years, to help local authorities expand or set up treatment and prevention services. At the end of three years, local authorities have to take over most of the financial responsibility and will then have to decide whether to continue to fund drug projects at the expense of services for other groups (eg mentally ill, the elderly, children etc.)

Treatment and Rehabilitation

In 1982, an important report, 'Treatment and Rehabilitation' by the Advisory Council on the Misuse of Drugs recommended that the concept of the 'problem drug taker' should replace that of the 'addict'. A 'problem drug taker' was defined as ".. any person who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his/her own use of drugs or other chemical substances".

The report also recommended the establishment of multi-disciplinary teams in each local authority to be responsible for monitoring local drug problems and for coordinating appropriate responses. Such teams should include doctors, nurses, social workers, voluntary bodies, probation officers, educationalists, youth workers etc.

The implications of this approach are as follows.

(1) A shift of model from the medical clinical/epidemiological to the multi-disciplinary (though psychiatrists still seem to predominate in some areas). Arising from this is a growing concern with coordination between different agencies.

(2) A shift away from an approach based on pharmacological classifications towards a problem-centred approach. Linked to this is a perspective in which drugs are seen as one part of a broader matrix of personal and social difficulties.

(3) A shift away from the legal/illegal classification of drug problems. Although the public profile highlights illegal drugs, many local services are increasingly recognising needs regarding psychotropic drugs such as the tranquillizers.

The development of this approach is still in the very early stages. Many local authorities are following this lead. However, since policy implementation and service development rest largely with local authorities, there is no consistent, national pattern as regards the treatment and rehabilitation of addicts or other people with drug problems. The government recently directed all health and local authorities to assess the extent of the problem in their area, to form coordinating committees and to draw up strategic plans regarding what they intend to do concerning the treatment and prevention of drug problems. The response so far indicates considerable diversity, large gaps and even greater uncertainty.

In terms of prescribing to addicts, at present, any doctor may still, if he or she considers it appropriate, prescribe to any addict any of the drugs of addiction controlled under the Misuse of Drugs Act, with the exception of heroin, dipipanone and cocaine. There is considerable variation between doctors in the policies they adopt. In practice, many doctors choose not to treat or prescribe to addicts. Those who do are generally conservative in their prescribing. A minority prescribe liberally, but only a few of the more blatant “script” doctors are brought before a Tribunal. Most treatment centres in London prescribe low or moderate dose oral methadone for a limited period of time only.

A.3 Demographic information

London is the capital of the United Kingdom. Greater London covers 1,580 square kms, (46 km. from north to south, and 58km. from east to West). Greater London is divided into 32 boroughs plus the City of London. A borough is the basic unit of local government in London. These boroughs may be grouped into Inner and Outer London. There are significant demographic, cultural and economic differences between the Inner and Outer areas. It is in the inner city that most “social problems” are concentrated. For example, the unemployment rate of young people under 25 is about 30% in Inner London compared to about 15% in Outer London.

Until this year a second tier of local government existed in the shape of the Greater London Council. The GLC had London-wide responsibility for certain administrative areas (e.g. transport planning). The GLC was abolished with effect from April 1986. There is now no London-wide administrative structure.

The Health Service in London is administratively divided into four Regional Health Authorities, which all extend to include areas outside Greater London. Each Region is divided into between 13 and 16 District Health Authorities. In this report Health Service data usually refer to residents of Greater London.

The Metropolitan Police District (MPD) also extends beyond the Greater London Area, though to a lesser extent than do the Health Regions. In this report data on arrests include both arrests of non-London residents, and arrests made outside the Greater London Area (but within the MPD). Administratively the Metropolitan Police is divided into 24 geographical districts. The City of London force is separate, and police data in this report refer solely to the Metropolitan Police, unless otherwise specified.

Unfortunately for the epidemiologist, the geographical boundaries used by the Health Service and by the Metropolitan Police sometimes differ from each other, and from the boundaries demarcating the London boroughs.

During the period 1974 to 1983 London's population declined steadily, from 7,263,600 to 6,754,500 and then rose again by some 15,000 to the 1984 figure above (an overall decrease over the period of nearly 7%).

The respective populations of Inner and Outer London declined over this period at roughly the same rate until 1983. Then, while the Outer London population continued to decrease, the Inner London population increased by some 57,000 (accounting for the overall increase in London's population mentioned above).

A.4 Research on drug misuse

There have been two epidemics of drug research in the United Kingdom, the first in the late 1960 s and early 1970 s, the second in the 1980 s.

Studies of addicts at institutions have mainly concentrated on describing the characteristics of narcotic addicts at London treatment centres or, in fewer cases, in prisons or therapeutic communities. Blumberg (1981) has reviewed over 50 of these studies. Of particular note is the ten year follow up of 128 addicts receiving heroin from London clinics in 1969 (Stimson and Oppenheimer, 1981). After 10 years, 15% were dead, 38% were drug free, and the rest were still using opiates and mostly still attending clinics. Longitudinal studies of drug users in Britain have been reviewed by Thorley (1981).

A few investigators have conducted ethnographic studies of drug takers outside treatment or other institutional settings. Such studies provide ‘naturalistic’ accounts of patterns of drug use in certain communities and offer qualitative insights into the significance of drug taking to drug takers themselves.

Other studies have examined in depth the functioning of certain agencies, such as a crisis centre for drug takers (City Roads), three ‘street agencies’, and a residential project (ROMA). A somewhat different study in the mid 1970 s was a controlled trial comparing heroin maintenance with the offer of oral methadone (Mitcheson and Hartnoll). The results indicated that whilst heroin maintenance reduced illicit opiate use and criminal activity to some degree, it did not lead to improved social functioning. Refusal to prescribe heroin was associated with a higher abstinence rate (32% withing 12 months), but also with a higher level of illicit drug use and crime amongst those who did not abstain.

Studies of morbidity and mortality associated with drug use, and especially with narcotic addiction have been based on follow-up studies of clinical populations, searches of Coroners’ records, special surveys of casualty departments. Some of these are reviewed by Ghodse (1981). It appears that there is some evidence that the mortality rate has declined over recent years, from about 20 per 1,000 addicts per year to nearer 10 per 1,000 addicts per year.

Various epidemiological studies have been undertaken. An early and notable example is the paper of Spear (1969) who traced the case by case growth of heroin addiction in London. Later studies have relied on variations of multiple agency studies in particular boroughs or health districts, indirect indicator measures, and statistical projections from a combination of methods (Hartnoll 1985). Little use has been made of population surveys, except amongst selected student populations

A number of studies have examined the criminality of addicts, the relationship between drug misuse and crime, and various aspects of sentencing. These studies have been reviewed by Mott (1975 and 1981).

Current Research

Current or recent research on drug misuse in London includes: the processes of help-seeking and service utilisation by problem drug takers; factors associated with higher or lower likelihood of relapse following detoxification; patterns of adolescent drugtaking in the community; epidemiological study of indicators of drug misuse in London; the role of voluntary agencies in providing services for drug misusers; a survey of general practitioners in regard to opiate addicts; several local multi-agency surveys in parts of London (Southwark, Tower Hamlets, Waltham Forest, Earls’ Court); studies of drug-related mortalities (amongst cohorts of notified addicts, and from Coroners’ records); and a comparison of drug clinic treatment (methadone) versus domiciliary support plus clonidine.

A.5 Treatment and social care systems/facilities

Medical treatment

The treatment of addicts is carried out within several different types of medical settings, mostly within the National Health Service.

Drug Treatment Centres (drug clinics)

There are 13 specialised units in London, all attached to hospital psychiatric departments. The most common treatment is out-patient withdrawal on a reducing prescription, usually oral methadone. This may take between four weeks and six months, depending on the treatment centre. Typically, patients attend once a week for a prescription, and/or counselling or therapy. The drugs are usually collected daily from a retail pharmacist and taken home for self-administration.

It is rare for addicts to be maintained indefinitely or to receive heroin on prescription, though in principle these remain treatment options. The minority of addicts who do receive heroin on prescription are in most cases older, long-term clients who have been maintained on heroin for many years, in a few cases since the 1960 s.

In-patient detoxification units

These are specialised units within psychiatric hospitals. Length of stay varies from two weeks to six months. There are four such units in the London area. In-patient treatment, in London at least, is not widely used and may in general be considered one of several ‘second-line’ options rather than a major part of treatment policy.

Non-specialised medical services

Outside specialist treatment services, the picture is more confused. General psychiatric and non-psychiatric hospitals may offer a limited service, particularly in areas that are not covered by special facilities. Little is known about the treatment they provide, save that it is likely to be variable. In each health district, there is a hospital with a casualty department that provides emergency treatment.

General practitioners (most of whom work within the National Health Service) may, if they wish, provide treatment to addicts as they think best. Treatment may or may not, include the prescription of drugs such as methadone, dihydrocodeine etc.. Alternatively, they may refer addicts to hospital-based facilities or refuse to accept any responsibility for addicts at all. The attitudes of G P s towards addicts varies widely. Generally, there is little specialised support, though in some areas, drug clinics do provide assistance in the form of advice regarding the management of such patients.

Private medical practitioners may, like G P s in the NHS, accept addicts for treatment and may prescribe any of the drugs of addiction (with the exception of heroin, cocaine and dipipanone). Private clinics, unlike clinics in the National Health Service, are residential and provide detoxification and various forms of therapy.

Some general practioners and, in particular, certain private practioners, still prescribe substantial quantities of opioids to addicts on a non-reducing basis. The prescribing practices of these (relatively few) general and private practioners have been the focus of bitter controversy over the past two years. To date, however, such prescribing remains perfectly legal and within the broad historical framework of acceptable medical practice.

Treatment in prison

Prison Medical Officers are responsible for the treatment of addicts received into custody. There are a few special facilities for addicts. Otherwise treatment is generally limited to detoxification, either by “cold turkey” or by reducing doses of methadone or sedatives.

Police surgeons are general practioners who have agreed to be “on call” to police stations whenever medical assistance is required (not just for addicts). They are sometime called to attend addicts and may provide immediate medication.

Nonmedical services

Most nonmedical agencies involved in the treatment and rehabilitation of drug misuse are nonstatutory. An umbrella organisation, the Standing Conference on Drug Abuse (SCODA), is the coordinating body, but has little direct input into the policies of each individual agency. Thus the policies they adopt vary considerably.

Nonresidential voluntary agencies

These provide advice, practical assistance, counselling, referral and so on to a variety of people. Some focus on providing services for drug users, others at providing advice and information to parents, youth workers etc.. They aim to fulfil needs that are not met by statutory bodies. They tend to be easily non-bureaucratic and easily accessible, often operating an informal drop-in and self-referral system. They rarely have any medical personnel on their staff.

In inner London, there are three specialist drug projects (‘street agencies’) and at least a further six general advice/counselling agencies that see people with drug problems. In outer London, there are at least six local nonstatutory advice and information agencies primarily concerned with drug problems.

Residential programmes

There are three therapeutic communities in or near London that resemble the Synanon/Daytop models. There are also at least eight other residential communities and hostels that adopt various approaches to supporting and rehabilitating problem drug takers- One of particular interest is City Roads, which offers short-term (three week) crisis intervention. It is aimed at more chaotic, multiple drug-users who do not readily fit into the regimes available at the treatment centres. It offers detoxification, medical care, rest, time to reflect and, if possible, referral to longer term treatment. Another is Elizabeth House, a small family style community where half of the residents are ex-addicts, and half are ordinary young people. Entry to most programmes, except CityRoads, is by referral through other agencies.

Self-help groups

In the past three years, there has been a rapid growth in self-help groups. The two main organisations are Narcotics Anonymous (NA), based on the model of Alcoholic Anonymous, and Families Anonymous (FA), for the parents of addicts. There is a close relationship between some of the private clinics and these two organisations. Participation in NA groups is encouraged as an important support following inpatient detoxification and treatment in the private clinics.

Nonmedical statutory services

The Probation Service see substantial numbers of drug users through their contact with courts and prisons. Social workers, youth workers, teachers and educational welfare officers have generally played a small part in the 'treatment' of drug problems.

A.6 Control systems (law enforcement)

Customs

HM Customs and Excise are responsible for controlling imports of illegal drugs. They are administratively separate from the police.

There are two principal aspects of import control. The first is static preventive control by staff on passengers, vehicles and freight entering ports and airports. The second is investigative control by the Investigation Division, who are responsible for intelligence gathering and for targeting and investigating organised smuggling.

There were reductions in overall staffing levels over 1980-84, followed by increases from 1985. Since 1984, there has been an increase in the number of staff specialising in drug investigations. Over the past few years, the target drugs have been heroin and, more recently, cocaine. Resources have been diverted away from cannabis investigations.

Police

The police are responsible for enforcing the law once illegal drugs have entered the country. Enforcement of the drug laws in London is organised at two levels. The Scotland Yard drug squad covers the whole of the Metropolitan area and focuses on major traffickers. The strength of the central drug squad has increased substantially since 1980. Local police focus on lower level distribution and intelligence gathering, though most arrests are still for the offence of simple possession. Since 1984, following changes in police priorities, most of the 24 local divisions in London have formed drug squads.

Over the past few years, the target drugs have been heroin and to a lesser extent cocaine, and recently, amphetamines. Over the past 18 months, there has been a tendency to caution rather than charge people found in possession of small amounts of cannabis.

Based at Scotland Yard is the Central Drugs Intelligence Unit. This is a non-operational unit staffed by police forces and Customs officers from across the United Kingdom. It collates, analyses and disseminates intelligence information on illegal drugs for the whole country.

Prosecution

In most cases, the decision whether or not to prosecute is made by the police, sometimes in consultation with legal advisers. In practice, most arrests do lead to prosecutions which are dealt with in court. Subsequently, most prosecutions result in conviction.

There are two levels of courts. All cases are intitially heard in a lower court (Magistrates' court). Less serious offences (including most possession cases) are dealt with at the magistrates' court, usually within a few weeks of arrest. More serious offences are referred on ('committed') to a higher court (Crown court) for trial. These are presided over by a judge. If the plea is 'not guilty' then a jury decides the question of guilt.

Three further points should be stressed about the judicial system in England and Wales (Scotland and Northern Ireland are different). It is an adversory system; and there is no legal provision for pretrial diversion nor for laying aside a conviction if a person enters treatment; and there is technically no compulsory treatment for drug dependence per se.

Penal institutions

There are four main adult prisons serving London, and a variety of institutions for young offenders (under 21 years). These contain both remand prisoners (before trial, and after trial but before sentence) and sentenced prisoners. People serving longer sentences (over six months) may be transferred to other prisons outside London. Sentenced prisoners are eligible for remission of one third of their sentence for good behaviour. Prisoners serving longer than six months are eligible for parole after serving one third of their sentence.

A.7 Monitoring systems

The major monitoring system is notification of narcotic addicts to the Home Office. This is supplemented by enforcement data and intelligence.

Notifications of narcotic addicts to the Home Office

The Home Office Index (register) of known narcotic addicts has been in operation since the 1930 s. Before 1968, it operated through voluntary reporting by physicians and through scrutiny of people convicted for offences involving opiates (or cocaine). It is likely that it was in fact relatively comprehensive, even though reporting was voluntary. Since the 1967 Dangerous Drugs Act (later replaced by the 1971 Misuse of Drugs Act) there has been a statutory requirement for any doctor to notify any addict they see to the Chief Medical officer at the Home Office. This requirement to notify applies to any doctor, not just "those working in special treatment centres, and refers to any addict (in the restricted medico-legal sense) seen for any medical reason, not just those treated for their addiction. (This excludes patients treated with opiates for organic disease or terminal illness).

However, the Act restricts the term "addict" to dependence on specified controlled drugs, principally certain opioids. For practical purposes, this means:- heroin, morphine, methadone, dipipanone (Diconal), pethidine, dextromoramide (Palfium), hydrocodone, and cocaine. Many compound medicines containing codeine are NOT included, and in most cases are available without a prescription. A person who is dependent on other drugs (barbiturates, amphetamines, alcohol etc.) is not counted as an addict within this medico-legal framework.

Description of Home Office statistics

The Home Office maintains a master card index on all addicts who are notified to them. This is a cumulative index which records details of all notifications concerning every addict who has ever been recorded since the Index began in the 1930 s. This Index is subdivided into three files – "dead", "suspended" (ie not known to be actively addicted in current year) and "active".

Notifications are collated centrally and statistics are published annually in a Home Office Statistical Bulletin. Of particular interest is the number of new notifications, that is, people who have never been on the Index before. Basic information, for the whole of the UK, is usually made public within two months of the end of the calendar year. More detailed figures, including a geographical breakdown are published in the summer (for the previous year). Currently there are problems of computerisation and the 1985 figures will not be available so quickly. Information is recorded on age, sex, principal drug of addiction, source of notification and drugs prescribed, but this is only analysed for the country as a whole. A provisional, unpublished running total is maintained throughout the year. This refers only to basic numbers for the whole of the UK.

The more detailed data are only available at a national level. They show that new notifications were starting to indicate an increasing incidence rate during the latter 1970 s, though the sharp rise in new cases did not occur until the 1980 s. The national figures indicate other important trends.

(1) From 1978, the increase in new notifications is accounted for by an increase in heroin as the primary drug of addiction. In contrast, the major issue in the medical press in the early 1980 s was the excessive prescribing of synthetic opiates by a few independent practitioners.

(2) From 1978, general practitioners have become increasingly important as sources of first notification. Given that they are less likely to notify addicts than are the treatment centres, this suggests that they play an even greater role than the figures indicate.

(3) Over the 1970 s, the age range broadened and the average age increased. In the 1980s, the age range remained broad but the proportion under 20 increased.

Seizures and convictions and other routine statistics

The Home Office also publishes annual statistics on seizures and convictions involving illegal drugs. These are for the United Kingdom as a whole and are not routinely made available for smaller areas such as London. Similar considerations hold for other routine statistics such as drug-related deaths. These indicators are discussed in section B of this report.

B. INDICATORS

B.1 First treatment demand

The only routine data on treatment demand available for the whole of the London area are "narcotic addicts notified to the Home Office by medical practitioners" (see Section A.7). First treatment demand refers to notified narcotic addicts who have never previously been notified (new notifications). It should be remembered that the data refer to people addicted to specified controlled drugs, principally the opioids and, in a few cases, cocaine. The data are similar to ICD code 304.0 (drug dependence, morphine type). Other drugs, or problems apart from dependence, are not included. Notifications are derived from treatment centres, hospitals, general practitioners, and prison medical officers. They exclude counselling agencies and therapeutic communities.

At a London level, data are available for (a) the total number of people notified during each calendar year, broken down into new and previously known cases, and (b) the total number receiving notifiable drugs at the 31st December each year. The data for London are presented in Tables 2a and 2b. In particular, they show the sharp rise following 1980.

In principle, notifications should include all addicts who are seen by a doctor, regardless of whether they receive treatment. In practice, it is likely that the data refer mainly to addicts who are taken on for treatment, especially if they are prescribed drugs such as methadone. Thus, notifications are likely to understate the total number of addicts who request treatment, but are a more reliable guide to the numbers who actually enter treatment.

Notifications, and in particular new notifications, are a reasonably valid indicator of trends in opioid dependence in the community, but are not a valid measure of absolute prevalence. Research in inner north London suggests that total notifications understate true prevalence by a factor of about five. Elsewhere, the factor may be different.

A limitation of first treatment demand as an indicator is that there is a delay between the time when people start to use drugs such as heroin, and the time when they first seek treatment. Thus data from one treatment centre showed that over 50% of narcotic addicts who were seeking treatment for the first time had been using heroin for over four years. The implication is that the sharp increase in new notifications from 1983 reflects a rise in new heroin use that actually occurred during the late 1970 s and earlier 1980 s.

A major gap in information on treatment demand, especially first demand, is the lack of accessible data from nonmedical services such as street agencies, advice and counselling services or therapeutic communities. Further, whilst all agencies collect data, the items recorded, the time periods and the definitions vary so much as to make direct comparison impossible. Table 2(c) suggests that nonmedical agencies see large numbers of drug users.

B.2 Hospital admissions

"Hospital admission" is the WHO definition; "a stay in hospital lasting one night or more, irrespective of whether the patient is admitted to hospital for the first time, re-admitted... or transferred from another hospital". Diagnostic data are based on ICD 9 (ICD 8 before 1979).

The data for general (nonpsychiatric) hospitals refer to discharge diagnoses. The data for psychiatric hospitals refer to admission diagnoses, except that where discharges are linked to admissions, then discharge diagnoses supercede admission diagnoses. Data from casualty departments are not included unless patients are subsequently admitted to hospital wards from the casualty department. The data refer to discharges or admissions, not to individuals. Some indication of the relationship between the figures is given below.

Basic data are presented in Table 3. The data refer to any mention of the specified diagnoses (primary and secondary diagnoses together).

The data are kept on computer by each Regional Health Authority. In London, it is necessary to request a special printout of the relevant ICD codes from each Region. General hospital data are recorded in one system and psychiatric hospital data in another. In addition, each Region extends beyond Greater London. Thus it is necessary to request data only for patients with an area residence code in London (but who were treated in a hospital anywhere in the Region). Since we have analysed the data by geographical area within London, it has taken a lot of time, and much help and goodwill from the information officers at the four Regional Statistical Units, to produce data that might be of epidemiological value. If hospital data are to be used to monitor drug misuse in London, then administrative and programming changes are needed to facilitate retrieval of the relevant information.

The reliability of the data is unknown. It is likely that recorded diagnoses under-represent the number of drug dependants etc. who enter hospital. They may be more reliable as indicators of broad trends in hospitalisation.

The data cannot be used as direct measures of the real prevalence of drug misuse in London. They may, however, provide an indirect indicator of certain trends in drug misuse. Thus, both sets of data show an increase in the 1980 s of drug dependence of the morphine type (consistent with other evidence). However, data from psychiatric hospitals do not show a sharp increase until after 1983, two year later than general hospital data. This suggests that general hospital data, in which drug dependence is usually a secondary diagnosis, reflect changes in drug dependence more rapidly than psychiatric data (in which drug dependence is usually a primary diagnosis). This would be consistent with the reluctance to use inpatient detoxification as a first option in the treatment of drug dependence, so that people who are admitted as inpatients are more likely to be at a relatively advanced stage in their addiction career.

Other patterns of interest are; that rate of inpatient diagnoses for drug dependence per 1,000 population is four times greater for residents of inner London compared to outer London; the increase in diagnoses of morphine type dependence occurred earlier in inner London (1979), and was not apparent in outer London until 1981/82; and hospital admissions for drugs other than morphine have remained relatively constant over the past ten years, and account for about one quarter of the total. Within the 'not morphine' category the main trends are a decrease in barbiturates and a slight increase in stimulants (mainly amphetamines) and "other* (mainly solvents).

B.3 Viral Hepatitis

Two sets of data are presented in Tables 4a and 4b.

Inpatient discharge diagnoses are derived from general hospital inpatient records as described in Section B.2 on hospital admissions. These use ICD 9 codes for hepatitis B (070.2S3). Data refer to any mention of hepatitis B amongst diagnoses of Greater London residents.

Cases of acute hepatitis B are derived from the central public health laboratory and are based on routine case reporting by local laboratories. The data are available only for all the Thames Health Regions and therefore cover a larger area than Greater London.

A third source, notifications under public health legislation, do not distinguish types of hepatitis.

All data refer to calendar years. Inpatient data are available about one year or more later. Data from laboratories are collated more rapidly, but are available by Health Region only on request.

The reliability is not known. It is likely that the data are unreliable as a measure of the number of cases of hepatitis B seen by doctors.

This is partly because clinical diagnoses are not always supported by laboratory tests, and largely because of failures in reporting systems.

It is not known to what extent the data reflect variations in the level of intravenous drug use. Only the laboratory data indicate the number of cases known to be drug-related. In 1984, this was 22% of all cases of hepatitis B. However this cannot be considered reliable since information on risk factors is likely to be incomplete or missing. (Information on risk factors is derived from local laboratories, which in turn rely on information from the doctors who saw the patient.)

A detailed case review of patients admitted to a hospital for infectious diseases in north London between 1977 and 1985 (with hepatitis B and hepatitis NonA-nonB) suggested that the proportion who had a known history of intravenous drug use varied between 31% and 50%. Assuming concealment of drug use by some patients, it is likely that

these figures represent a lower limit to the proportion of intravenous users amongst hospitalised cases of hepatitis. The next most common risk factors were homosexuality, followed by transfusions, tattooing and unknown events. One interesting point to emerge was that in 1985, intravenous use of amphetamines emerged as a significant element.

The data in Tables 4a and 4b show an increase in 1983 and 1984, though this is small for hospital discharge diagnoses. This would be consistent with a moderate rise in intravenous drug use, but it would be unwise to draw such a conclusion from this indicator alone, especially as much of the increase in heroin use since 1978 has involved modes of administration other than by injection.

B.4 Drug-related deaths

There are three national routine sources of data. Only the third provides any data on London alone.

Coroners' verdicts of death dye to drug addiction Individual coroners vary in their use of this verdict, and the drugs involved are not specified. Long term national trends show an increase since the 1960 s.

Deaths of notified narcotic addicts refer to "Addicts removed from the Index on account of death". There is no requirement or system for notifying the Home Office of deaths of addicts. The figures are of unknown reliability, incomplete coverage and are relevant only to the minority addicts who have been notified. Long term trends show little consistent pattern.

Deaths dye to poisoning These are published annually by the Office of Population Censuses and Surveys. The information is derived from death certificates and is classified according to ICD 9 (ICD 8 before 1979). At a national level, data are available broken down both by type of drug and by individual substance. These data are also classified by external cause (accidental death, suicide, undetermined, violence from others). Long term trends show an increase and, in the differential patterns observed for different drugs, may be more a reliable indicator of national trends than the previous two sources, despite serious under-recording. However the data are not readily available in this form for London alone, and the numbers would probably be too small if they were.

The data for London refer only to deaths by poisoning from all substances (TCD 960-989), broken down by external cause. The data given in Table 5 are of little relevance to monitoring drug misuse.

Non-routine sources – deaths of addicts

More useful data are available from a continuing study of addict deaths carried out by Mr. John Harvey at three inner London coroners' courts. The data are presented in Table 6. The data are obtained by a thorough search of the coroners' records (not the verdicts). The criteria for death of addicts are as follows.

> Overdose on illicit drugs (specified) Overdose on other drugs where there is evidence of dependence on illicit drugs (clinical history, toxicology etc) Suicidal or accidental deaths from other causes where there is evidence of drug dependence

These are closer to the 'ideal' criteria agreed by the expert group. However, the data are only available because of the continuing research. We are greatly indebted to Mr. Harvey for giving us access to his data. They are usually available within two months of the end of each year. It is likely that the data are as reliable as information available to the coroners' inquests permit there to be.

As they stand, the data cannot easily be used as a direct indicator of prevalence. When examined more closely, however, they can be a useful indicator of certain trends in drug misuse. Table 6 shows the numbers of deaths of narcotic addicts in inner North London from 1977 to 1985. It can be seen that the number of deaths increases up to 1982/83 and then falls. (This pattern was also found, after 1983 in a national study of addict deaths). A simplistic interpretation would suggest that this reflects a rise and subsequent fall in prevalence. However, the following suggests that this may not be correct.

Cohort studies suggest that the annual death rate for addicts has been decreasing over recent years. This could be because (a) the reduced

availability and use of barbiturates and of Diconal (an oral opioid that was associated with high risk when injected); (b) the increased use of heroin by sniffing or smoking; (c) the heroin using population may now include a higher proportion of more psychologically and socially 'normal' individuals; (d) there is a possibility that the likelihood of death is higher in the early stages of addiction. If so, the falling death rate reflects a lower incidence rate of addiction in the 1980 s, not a lower prevalence. This is speculative, however.

If, as some evidence suggests, the death rate has fallen from about 2% per year in the latter 1970 s to 1% or possibly less in the mid 1980 s, then Table 6 suggests that whereas the increase in deaths up to 1982 does indicate a rising prevalence, the subsequent fall in deaths does not reflect a fall in prevalence.

Further evidence is needed before any firm conclusions can be drawn regarding prevalence. However, more detailed analysis does show, for example, that reduced availablity of barbiturates and Diconal was effective in reducing mortalities from those drugs, and that few addicts die from heroin alone, but more commonly from drug combinations.

B.5 Police arrests

An arrest is the first formal action taken by the police. Arrests refer only to offences under the 1971 Misuse of Drugs Act (mainly possession and supply of illegal drugs). No data are available regarding drug users who are arrested for other offences that do not contravene the drug laws. Most arrests for importing drugs are made by Customs and are therefore not included. The data refer to the number of arrests per year, not the number of individuals arrested.

Arrest data are routinely recorded by the Metropolitan Police on computer and are collated monthly, tabulated by main drug, age and sex of the arrestee/type of offence, and police division. The data are available, on special request, within two months.

The data are a reliable record of the number of arrests made by the police. If an arrest involves more than one drug, then only the drug that is considered more serious is recorded. The main effect appears to be to understate the number of arrests in which amphetamines are found. It is likely that an arrest is made in most cases where class A drugs (heroin, cocaine, LSD) are discovered. Forensic analysis is carried out on all drugs seized. Comparison between laboratory data and arrest data suggests that arrest data is broadly reliable, subject to understating amphetamine arrests.

The validity of arrests as an indicator of trends in drug misuse in London needs closer examination. For several years before 1984, there was little change in police priorities regarding drugs. Other evidence (treatment data and various research studies) suggest that the large increase in heroin use occurred between 1978 and 1983. This is partly reflected in police data, suggesting that arrests were reflecting real trends. From 1984, greater priority was given to drugs and police resources increased considerably. Other evidence suggests that the rate of increase in heroin use had slowed down by 1985. This would imply that the large increase in arrests since 1984 is partly an indication of increased police activity. A rise in the price of heroin during 1985 and 1986 would support this.

More detailed analysis suggests further uses of police data

(1) In 1.985, arrests for heroin and other opioids in inner London police divisions were about seven times higher (per 1,000 population) than in outer London. For all drugs, including cannabis, the difference was lower (about three times higher in inner London).

(2) The increase in arrests for heroin and other opioids occurred earlier in inner London (during the latter 1970 s, and then from 1984 on). In outer London, increases are not found until 1983.

Even allowing for the more visible illicit opioid market in the West End, which attracts addicts from many parts of London, these patterns

are consistent with inner/outer London differences found in hospital data. Thus as long as allowance is made for changes in police activity, arrest data provides a useful indicator, at least as regards opioids.

The position is less clear regarding stimulants, especially cocaine. Field research and anecdotal evidence suggest that intermittent, recreational use of amphetamines and cocaine is rather more common (relative to heroin, for example) than the arrest figures suggest. It is likely that data do not reflect the full extent of cannabis use.

B.6 Imprisonment

There are two sources of information on drug misuse and imprisonment.

Narcotic addicts notified to the Home Office by Prison Medical Officers (The definition of "addict" is as stated in Section A.7.) This information is routinely available for the United Kingdom. It can be obtained for London prisons only, but is not available at time of writing due to difficulties over computerisation. In any case, it is likely that notifications by prison medical officers are an unreliable measure of the number of addicts in prison, and, further, that the data should not be used as an indicator of trends in drug misuse.

If notifications (or some alternative measure of addicts received into prison) were more reliable and comprehensive, then the data might be a more useful indicator. Thus anecdotal reports from probation officers and others involved in the penal system suggest that addicts constitute a significant minority in some prisons, a marked change from the 1970 s.

People sentenced to imprisonment for offences against the drug laws This information refers only to offences involving illegal possession, supply etc. There is no information concerning whether any of the people concerned are dependent or not.

Detailed data on sentencing for drug offences are routinely available for the United Kingdom. The only information on London available at time of writing was the total number of people convicted for drug offences (Table 8). The decrease in 1984 reflects a fall in cannabis. Some examples of sentences, including imprisonment, are provided for the United Kingdom (Table 9). Data on sentences of imprisonment (and other sentences for drug offences) are reliable records of sentencing decisions. However, they cannot be used as an indicator of trends in drug misuse, since they reflect sentencing policy.

Thus, neither measure can be taken as a valid measure of trends in drug misuse. The major value of data on people with drug problems in the penal system is not as an epidemiological indicator, but as a tool for planning treatment and other appropriate services. The major value of sentencing data is for monitoring and analysing sentencing policy.

B.7 Seizures of illicit drugs

Seizures refer to illegal drugs confiscated by law enforcement authorities. Police seizures are reported separately from those made by Customs. Data for London refer only to police seizures.

There are two sources of information on police seizures in London. The Home Office obtains information from the police, who collate information from each police station about individuals arrested for drug offences. The Metropolitan Police Forensic Laboratory analyses all drugs seized by the police (and a few from other police forces). The two sets of data are similar, but not identical, due to differences in counting procedures. Separate data are reported for each type of drug (Table 10), for the number of seizures of particular drugs (Table 11), and for the total quantities of each drug (Table 12).

Provisional national data on customs seizures are published within weeks of the end of the year. More detailed police (and Customs) figures are published later in the year (summer). It is possible to obtain provisional data on both Customs and Metropolitan Police seizures more rapidly, and at intervals during the year.

The figures are broadly reliable as measures of illegal drugs seized, though there are some discrepancies between the different sources. It is not likely that the same seizures are counted twice by different authorities, though further enquiry is needed on this. The data are backed by forensic analysis. It is usually possible to ascertain whether large seizures made by Customs were ‘in transit’ to another country or destined for domestic distribution. In the case of London, it is more difficult to tell if drugs were to be distributed in London or moved to other parts of the country, though seizures made at Heathrow Airport are not included in the London data.

The question of whether seizures reflect trends in drug misuse or enforcement activity raises many of the same issues as arrest data. In London, as elsewhere in the UK, resources devoted to drug enforcement have increased, especially from 1984, in response to concern over heroin and, to a lesser extent, cocaine. However, both the number of seizures of these drugs, and the total quantified seized, had been increasing since the latter half of the 1970 s. Over this time, the price of heroin fell sharply (the price of cocaine fell slightly) and other indicators pointed to a substantial growth in heroin, and, less certainly, to a moderate increase for cocaine. Most of the increase in the number of seizures is for small ‘user’ quantities, consistent with increased availability at user level. When set against falling prices, relatively high (and rising) purity, and increases in other indicators, it is more likely that seizures, especially the number of seizures of ‘user’ amounts, reflect a real increase in supply and availability rather than a dramatic Improvement in the interception rate. Whilst variations in the quantities seized cannot be assumed to be directly proportional to the total market, it appears that even seizures of very large amounts have little effect on availability or Price at street level. Seizures are thus considered a useful indicator of trends in the supply and availability of illicit drugs, as long as they are interpreted in the light of other information.

B.8 Price/purity of illicit drugs

Prices are quoted in sterling and relate to the cost per gramme or per kilogramme purchased (they are not converted to equivalent price per mg pure). Where possible, 'user' prices are distinguished from 'dealer' or 'trafficker' prices. Purity is based on forensic analysis of drugs seized by the Metropolitan Police.

Some data on illicit drug prices are collated by the Central Drugs Intelligence Unit. They are based on reports from police forces around the country, including London. The data are not generally available, but can be obtained on special request. The data reported here are based on a series of field research studies and were obtained directly through interviews with drug users. Supplementary information comes from other individuals in contact with drug users. Data on purity are not generally available except on special request. The research data on prices and the forensic data on purity are considered reliable.

Table 13 provides data on the trends in the retail ('street') price of heroin and cocaine. Allowing for inflation, the price of heroin has fallen significantly since 1979, though there are signs that it is now rising again. Trends in the price of 'dealer' quantities (not shown) follow the same pattern. The price of heroin when bought in amounts of 20 grammes or more is almost half the street price.

Table 14 provides data on the purity of heroin and cocaine in 1984. Forensic evidence also suggests that the average purity of street heroin in London (quantities less than 1 gramme) has tended to increase from just under 40% in 1980 to nearer 50% in 1985.

These data on heroin, in the context of increasing seizures and treatment demand, suggest that price/rising purity can be used as an indicator of the supply and availability of drugs relative to the demand for drugs. There are inevitably local variations that reflect circumstances not directly related to changes in drug misuse.

B.9 Survey data

Few surveys have been conducted on drug misuse amongst samples of the general population in London. Those few have concentrated mainly on cannabis use amongst selected student populations. Recently, a number of surveys have been, or are still being, carried out, mostly on small and selective samples such as youngsters attending youth clubs in certain areas or in particular schools. There is little consistency between the criteria used in the various surveys, nor are the results of recent studies complete, so it is difficult to report any data which can contribute to the multi-city study.

There are a few ethnographic studies of groups of drug takers in London. These have provided accounts of trends in drug taking in certain areas, in terms of what is observed and reported within the drug scene itself, which have helped to cast light on the significance of more formal indicators. Of greater value, perhaps, is the information such studies contribute regarding qualitative aspects of drug taking, information that statistical indicators cannot provide.

One epidemiological study in the boroughs of Camden and Islington employed a multiple-indicator approach at three levels – official statistics, surveys of agencies and ethnographic fieldwork. This provided information on trends in drug misuse; generated several prevalence estimates (using statistical techniques such as capture-recapture and nomination); and indicated various reasons for changing patterns of drug misuse. This work provided the basis for a short guide and longer technical manual on methods for assessing the nature and extent of problem drug taking in a local community (Hartnoll et al., 1985 & 1986).

B.10 Other indicators; comments on AIDS

There are no other indicators that regularly provide information on patterns of drug misuse. Data from casualty departments are not available, apart from a survey conducted in 1975. Surveys of drug users known to various agencies such as probation officers or GPs have been carried out on an ad hoc basis. There are at present no data on drug-related cases of AIDS, though current research on AIDS generally may generate some in the future.

C. ASSESSMENT OF THE USE AND VALUE OF INDICATORS

C.1 Use of indicators in London

On a London-wide basis, a distinction must be made between the use that is currently made of various indicators, and their potential value if the data were more consistently and easily available. A major reason for the failure to make full use of the indicators considered here is that there is no overall body responsible for the government or administration of Greater London. Thus information tends to be collected by individual organisations for their own purposes (for example, data on arrests, seizures and price/purity by 1”he police). Treatment demand data is used by certain individual agencies to monitor their workloads rather than for epidemiological purposes. Conversely, the Home Office Index of notified addicts, which has an explicit epidemiological function, is geared towards providing national rather than local information.

Within London, a number of local data gathering exercises are in progress or have recently been completed. These have been carried out by Local Authorities, Health Districts or Regions in response to a directive from the Department of Health and Social Security to local Health Authorities to assess the extent of drug misuse and to draw up a long-range strategy. These local studies have made use of many of the indicators described in this paper. However, there are inconsistencies in how indicators have been covered, in how they have been used, in the criteria that have been employed or in the ways in which the results have been presented. Thus it is difficult to combine these data to produce a coherent picture of drug misuse in London, though they are useful for local planning and service development.

Monitoring in the future

If drug misuse in London is to be monitored in the future, there is a need for a structure which allows information to be collated in a continuous, systematic and consistent fashion. After abolition of the Greater London Council, there is no obvious body to do this. If drug ‘misuse in London is to be monitored effectively, the ideal indicators which it would be useful to cover include the following:

(1) Notifications of narcotic addicts, broken down into the detail given in the statistics for the whole country.

(2) Arrests for drug offences

(3) Drug-related deaths, based on information available to Coroners and classified according to the criteria specified in the Methodological Analysis and Synthesis of the Technical Report on indicators (Section 2 of this publication).

(4) Basic data on requests for help regarding drug problems from non-statutory specialist agencies.

(5) Basic data on clients with drug-related problems seen by the Probation Service.

(6) Seizures of illicit drugs by the police, broken down by drug, number of seizures and quantities seized.

(7) Price/purity of illicit drugs

(8) Easier extraction of relevant data for inpatient diagnoses

Most, but not all of these data are collected in some form at the moment. The issue is how to modify existing administrative arrangements so as to collate the data more easily and consistently.

It is probably not worth including hepatitis unless the quality of the original data improves and their value as an indicator is more clearly established. Although data from casualty departments might be useful, the problems (and cost) of obtaining reliable data may prove prohibitive. School or population surveys are only of value if repeated regularly and in standard form. Additionally, they are of little use for monitoring the more serious and deviant patterns of drug use.

One example of a localised monitoring system is that which has developed out of the research in Camden and Islington described earlier at the end of Section B.9. This monitors requests for treatment from a drug treatment centre, a day programme and outreach project linked to the treatment centre, CityRoads crisis centre, a casualty department, and a hospital for infectious diseases (hepatitis). Additional data are obtained from others on police arrests, drug-related deaths, requests for help at a street agency, hospital discharge diagnoses and, through associated field research, drug price.

C.2 Relationship between indicators

Relative visibility of different indicators

Figure 1 is an attempt to show the relative visibility of some of the indicators described in Section B. The term ‘visibility’ is used deliberately to suggest that the very existence of an indicator and its quantitative value are strongly influenced by (a) whether the data are collected and reported, and (b) how those who record and report data actually fulfil the task. Thus in Figure 1, indicators 1 to 4 are routinely collected. Relying on those alone would fail to reveal that street agencies might be as valuable as sources of information as notifications from doctors. Similarly, data on admissions to City Roads may be as useful as inpatient statistics.

It is not intended that Figure 1 should be taken as a literal 'to-scale' comparison of different agencies. There are two reasons for this. (1) The comprehensiveness of the data varies between agencies. Thus all arrests are included/ whereas notifications reflect only a minority of drug users seen by doctors. (2) The indicators are in any case recording different events. Thus admission to a therapeutic community involves much more than a brief enquiry about a practical matter at a street agency. The point of Figure 1 is to emphasise the importance of covering a wider range of indicators than are currently monitored on a routine basis.

Relationship between indicators over time

Figure 2 shows, for Greater London, the relative variations between certain indicators of opioid misuse over time. The year 1979 is taken as base 100. Prior and subsequent variations are thus measured in percentage change compared to 1979.

It can be seen that there is a very close relationship between police arrests and police seizures involving heroin and other opioids. The curve for new notifications of narcotic addicts (first treatment demand) also shows the same patterns, except that new notifications fell temporarily in 1980 and arrests fell temporarily in 1982/3. Inpatient discharge diagnoses (general hospitals only) show a similar pattern, to notifications, but do not increase so much in 1983. Both Hepatitis B indicators increase after 1982. The street price of heroin shows a sharp fail after 1978. Deaths of narcotic addicts increased up to 1982 and fell after 1983. Major points arising from Figure 2 are as follows.

(1) Changes from one year to the next in a single indicator cannot be taken as a reliable sign of change. Trends over five years or more are much more reliable.

(2) The relationship between different indicators is not always consistent at different times or between different areas.

(3) With some short-lived exceptions, there is a broad agreement between police indicators, price and treatment indicators.

(4) The number of drug-related deaths should not be taken as direct measure of prevalence (though it can be useful when interpreted – see B.4)

(5) Taken as a package, these indicators point to a substantial increase in opioid misuse over the past eight years.

(6) Finally, the data presented in these figures and elsewhere in this paper are much more significant when interpreted in the context of direct knowledge of the situations which they reflect, both at agencies and in the drug scene.

Comparison of profiles of clients at different agencies

There is considerable variation in the percentage of women in selected indicators. In inpatient diagnoses they account for about 40%; in police arrests, less than 20%. Most research studies suggest that the 'real' ratios of males to females amongst opioid addicts has been about 2:1 in recent years, ie that women account for 30 to 35%. If this is the case, then it appears that women are more likely to be inpatients and less likely to be arrested.

Figure 3 shows the age distribution found in selected indicators. As with sex, there are substantial variations, though it can be seen that I in all indicators there is a wide spread of ages. (It should be noted I that the age categories for arrests are different and that visual I impressions are misleading).

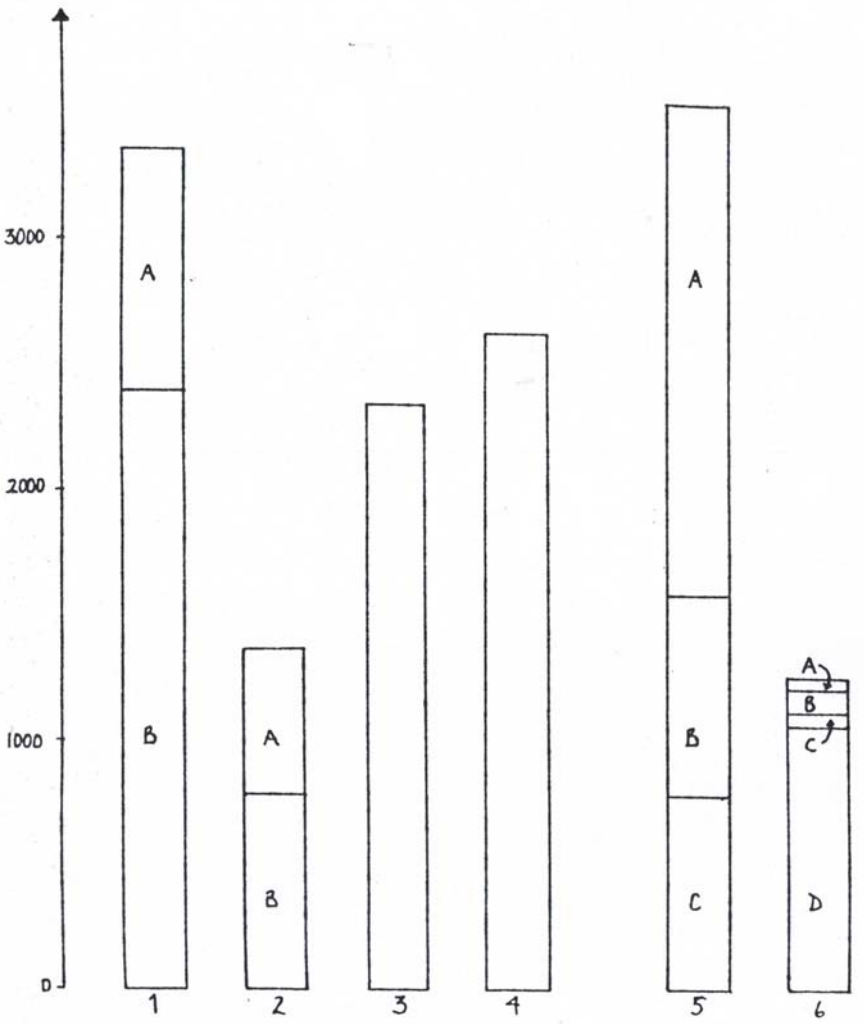
D. CONCLUSIONS

This report describes the history of drug misuse in London, the development of policy, and the treatment, control and monitoring of drug misuse. Data regarding drug misuse are presented and the various possible indicators of drug misuse examined. Some suggestions are put forward regarding possible ways of looking at the relationship between indicators and at how indicators are used to assess and monitor drug misuse.

The major conclusion is that, on the one hand, it is possible to glean a picture of drug misuse across London, from the various indicators, from research studies and from the rich but not easily quantified perceptions of agencies, drug users and knowledgeable others. However, on the other hand, this task would be much easier if there were a basic, consistent and reliable set of routine data, drawn from a range of sources, on which to base an assessment of drug misuse in London.

If monitoring drug misuse is to proceed more efficiently and more usefully, then there is a need for a structure for collating information from different sources in a continuing, consistent fashion.

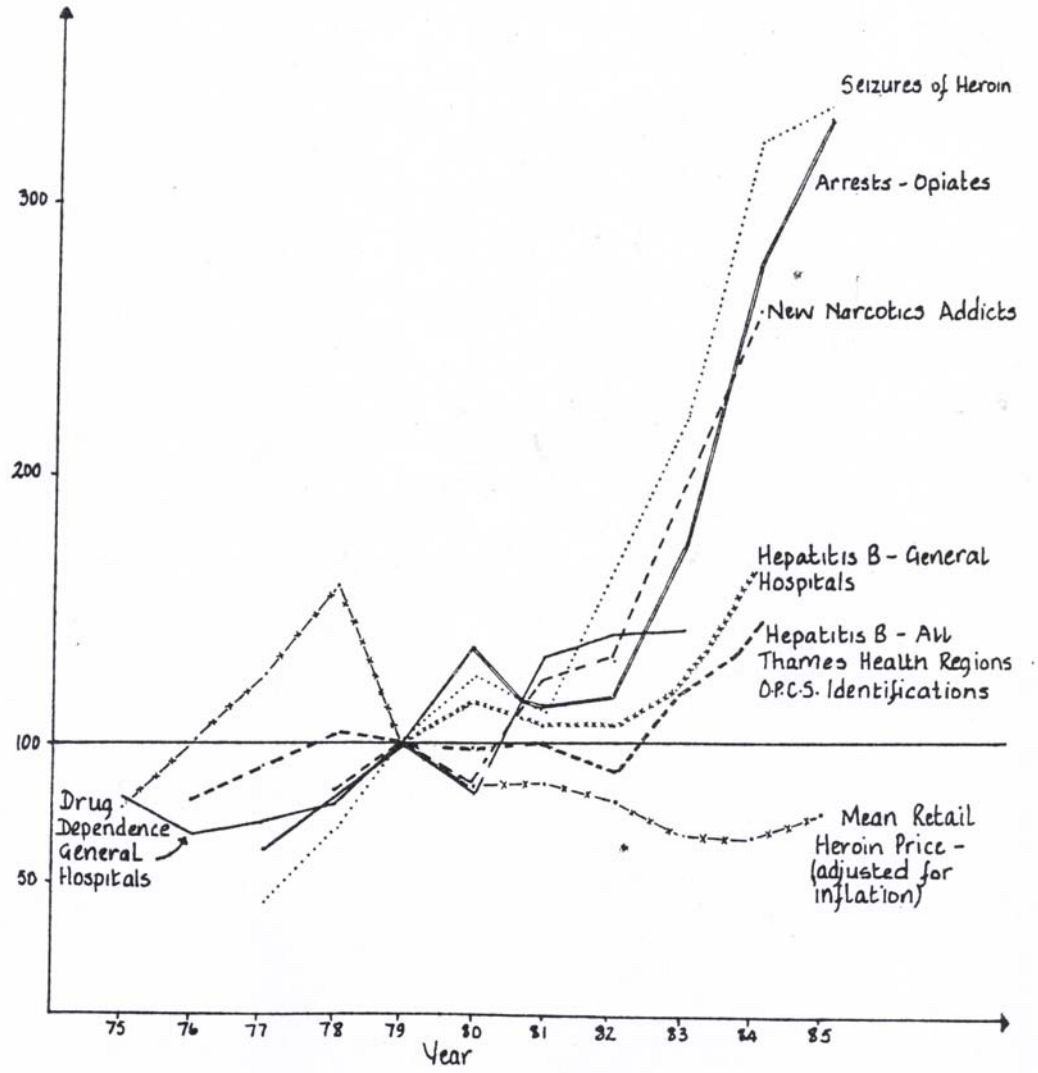
Figure 1: Relative Visibility of Different Indicators



1. Home Office Notifications - London - 1984 A: New Addicts B: Former Addicts.
2. Hospital Admissions - Drug Dependence - London
   A: Psychiatric Hospitals 1984
   B: General Hospitals 1983
3. Arrests for Drug Offences - London - 1984 - excl. Cannabis
4. Seizures of Heroin, Cocaine and Amphetamines - London 1984
5. Street Agencies:
   A: Blenheim Project - Enquiries on drugs - 1983/84
   B: Community Drug Project - Contacts from problem drug takers - 1984
   C: Hungerford Drug Project - contacts 1984
6. Residential Agencies:
   A: Cranstoon Projects (3 houses) Admissions 1984
   B: Phoenix House - Admissions - 1984
   C: Suffolk House - Admissions - 1984
   D: City Roads - Referrals - 1984
7. Addict Deaths
   Inner London Coroners Courts 1984

NOTE: 1-4 Routinely Available
5-7 Not Routinely Available

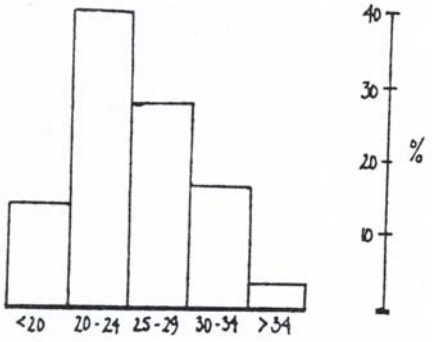
Figure 2 : Relative Variations in Selected Indicators of Opioid Misuse over Time (Greater London).



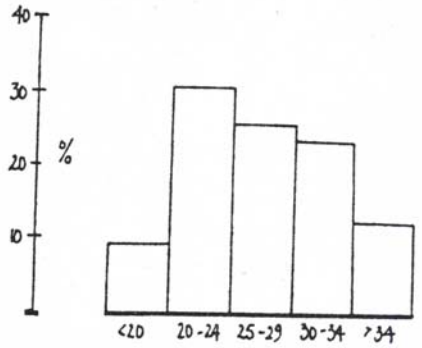
Opioids : London

* OPCS: Office of Population Censuses and Surveys

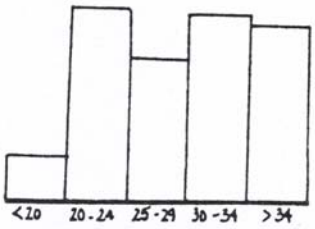
Figure 3 : Age Distribution in Selected Indicators



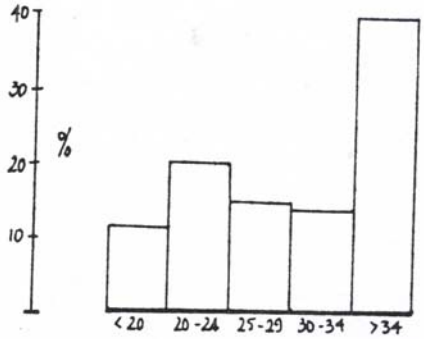
City Roads - Referrals 1985



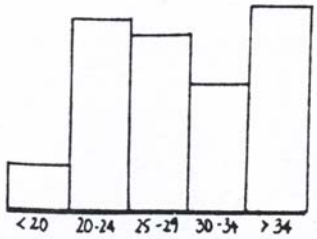
University College Hospital Drug Clinic - Front Sheets 1984



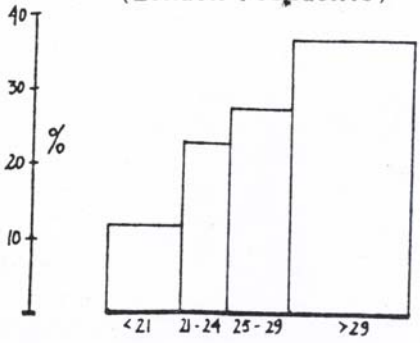
Drug Dependence - Morphine Type General Hospitals in the N.E. Thames Health Region 1984 (London Residents)



Hepatitis B - General Hospitals in the N.E. Thames Region 1984. (London Residents)



Addict Deaths - Inner London Coroners Court. 1984



Arrests for Drug Offences Involving Opiates - London - 1984

APPENDIX I

DATA

LIST OF TABLES

Table contents

Table 1 Population of Greater London by age and sex, 1981

Age	Males	Females	Total %	%
<15	624,016	595,136	1,219,152	18.4
15-19	265,546	262,787	528,333	8.0
20-29	539,207	549,990	1,089,197	16.5
30-39	453,759	457,548	911,307	13.8
40-49	366,992	370,034	737,026	11.2
50 +	933,042	1,190,541	2,123,583	32.1
Total	3,182,562	3,426,036	6,608,598	100.0

Source: OPCS (Office of Population Censuses and Surveys) (1981 Census)

Table 2a Narcotic Addicts notified to the Home Office: London

	Total addicts known to be in treatment at 1st Jan. each year (1) No.	Total addicts Notified during year (2) No.	Total addicts Known during year (3) No.	Rate(*)
1975		746		
1976		843		
1977		907		
1978		1196		
1979	1333	1371	2704	1.00
1980	1418	1231	2649	0.97
1981	1441	1688	3129	1.14
1982	1945	1860	3805	1.38
1983	2000	2693	4693	1.70
1984	2262	3375	5673	2.03

(1) Point known prevalence in treatment
(2) See Table 2(b) for breakdown of notifications during year
(3) (1) + (2) = 12 month period known prevalence in treatment

Table 2b Narcotic Addicts Notified to the Home Office each year: London

	New Addicts		Former Addicts	Total Addicts	
	No	Rate (*)	No.	No.	London % of UK
1975				746	51
1976				843	55
1977				907	52
1978	763	0.28	433	1196	57
1979	926	0.34	445	1371	57
1980	778	0.29	453	1231	50
1981	1152	0.42	536	1688	51
1982	1202	0.44	658	1860	45
1983	1813	0.66	880	2693	46
1984	2407	0.86	968	3375	46

2a: Numbers of addicts known by the Home Office each year, and

2b: Numbers of addicts notified to the Home Office during each year; London as % of U.K. notifications.

2a and 2b: Rate (*) of cases aged 15 – 39 per 1,000 of the population aged 15 39 each year.

Source: Home Office

Table 2c London voluntary (nonmedical) agencies: number of contacts/preferrals/enquiries by problem drug takers

Residential agencies

City Roads Crisis Centre (12 months, 1985)	888 referrals
Suffolk House (6 months, 1985)	157 referrals
Roma (6 months, 1985)	78 referrals
Oak. Lodge (8 months, 84/85)	152 referrals
235 Project (12 months, 84/85)	68 referrals
Phoenix House (12 months, 84/85)	698 referrals
Cranstoon Projects (11 months, 85/86)	206 referrals
Alwyn House (12 months, 1984)	132 referrals
Elizabeth House (12 months, 1984)	126 referrals

Street agencies/advice and counselling services

Blenheim Project (12 months, 1983/84)	1,934	customers
Hungerford (12 months, 1985)	750	contacts
Community Drug Project (12 months, 1984/85)	810	clients
Drug Concern Barnet (11 months, 84/85)	117	referrals
Basement Youth Project (12 months 1985)	144	drug users

Source: the above named agencies

Table 3 Hospital Inpatient Diagnoses

(a) Psychiatric Hospital Admissions:

	Drug Dependence -all drugs (ICD9 304.0-9)		Morphine type (adjusted total) (ICD9 304.0)	Other Drugs (adjusted total) (ICD9 304.1-8)
	No.	Rate (*)	No.	No.
1979	304	0.10	196	108
1980	381	0.12	249	132
1981	452	0.14	275	177
1982	465	0.14	329	136
1983	424	0.12	328	96
1984	588	0.16	430	158

Number of admissions to psychiatric hospitals, per year, involving residents of Greater London with any mention of drug dependence, and rate (*) of cases aged 15 – 39 per 1,000 of London's population aged 15 – 39 for each year.

Note: 1. No data included for Bethlem Royal and Maudsley Hospitals: admissions for drug dependence to these hospitals including non-Londoners were as follows – 1979: 83; 1980: 84; 1981: 55 (Primary diagnoses only).

2. The figures for 1979 and 1980 include an estimated total for one of the four Health Regions.

3. Sub-totals adjusted by redistributing total for 304.9 (drug dependence- drug unspecified) pro rata.

Source: Thames Regional Health Authorities

(Table 3 continues…)

Table 3 continued...

(b) General Hospital Admissions:

	----------DEPENDENCE----------				
	Ali drugs (304.0-9)		Morphine type (adjusted) (304.0)	Other drugs (adjusted) (304.1-8)	Non-Dependent Abuse of drugs (305.2-9)
	No.	Rate (*)	No.	No.	No.
1975	573	0.16	320	253	
1976	457	0.14	320	253	
1977	524	0.17	320	253	
1978	570	0.19	320	253	
1979	584	0.20	320	253	67
1980	524	0.16	320	253	84
1981	818	0.25	320	253	115
1982	790	0.24	320	253	162
1983	779	0.22	320	253	131
1984(1)	795	0.22	320	253	113

Number of general hospital discharges, per year, involving residents of Greater London with any mention of drug dependence or non-dependent abuse of drugs (excluding alcohol and tobacco), and rate (*) of cases aged 15 – 39 per 1,000 of London's population aged 15 – 39 each year.

Note:

(1) Sub-totals adjusted by redistributing total for 304.9 (drug dependence- drug unspecified) pro rata.
(2) 1984 figures are projections based on data from 2 of the 4 Regional Health Authorities

Source: Thames Regional Health Authorities

Table 4a Hepatitis B – Greater London residents

	No.	Rate
1979	261	0.061
1980	299	0.067
1981	280	0.069
1982	279	0.068
1983	309	0.064

Number of general hospital discharges, per year, involving residents of Inner, Outer and Greater London with any mention of Hepatitis B (ICD9 070.2 – 3); rate of cases aged 15 – 39 per 1,000 of London's population aged 15 – 39 each year.

Note: where Greater London figure > Inner + Outer, difference = discharges where patients' precise address not known.

Source: Thames Regional Health Authorities

Table 4b Cases of acute hepatitis B – Thames Health Regions

	----------Thames Health Regions----------									
	NE		NW		SE		SW		Total	
	No.	C	No.	C	No.	C	No.	C	Mo.	C
1980	70	10	163	74	62	11	83	14	378	59
1981	65	7	221	37	82	15	111	28	479	87
1982	65	14	150	17	70	13	107	26	392	70
1983	100	21	126	17	102	29	87	23	415	90
1984	113	35	185	28	168	39	142	29	608	131

Number of cases (No.) of acute hepatitis B & number of cases (C) with a known history of drug abuse in the Thames Health Regions (including areas outside Greater London) identified, per year, in the Central Public Health Laboratory.

Source: Central Public Health Laboratory

Table 5 Deaths by certain causes – Greater London

	(1) No.	(2) No.	(3) No.
1980	178	273	158
1981	374	285	252
1982	336	270	174
1983	278	270	143
1984	236	253	165

Number of deaths, per year, by certain causes in Greater London.

(1) Poisoning and toxic effects (ICD9 960-989)
(2) Suicide and self-inflicted injury (ICD9 E950-959)
(3) Injury undetermined whether accidentally or purposely inflicted (ICD9 E980-989)

Source: O.P.C.S. Series DH5 "Mortality Statistics – Area" Table 4

Table 6 Addict Deaths in Inner and Inner North London

	Inner London (1)				Inner North London (2)	
	Addicts (3)		Total Drug-related Deaths (4)		Addicts (3)	Total Drug-related Deaths (4)
	No.	Rate (*)	No.	Rate (*)	No.	No.
1977					11	15
1978					22	31
1979					25	36
1980					26	36
1981	78	0.008	92	0.009	33	39
1982	107	0.011	137	0.014	34	50
1983	96	0.010	118	0.012	34	42
1984	87	0.009	102	0.011	29	37
1985	73	0.007	87	0.008	22	32

Number of addict deaths, per year, identified through search of coroners' records for Inner North London, and rate (*) of cases aged 15 – 39 per 1,000 of Inner London population aged 15 – 39 each year.

(1) Inducing Greenwich and Merton, but excluding Hammersmith.
(2) Camden, Hackney, Islington and Tower Hamlets.
(3) Evidence of parenteral drug use, or use of narcotics by any means.
(4) As for (3) above, plus evidence of: predominantly oral forms of drug use (e.g. barbiturates); mature dependence on tranquillizers use of solvents, hallucinogens and cannabis.
(5) N.B. – Figures under (4) are inclusive of figures under (3).

Source: John Harvey, Stirling Winthrop Ltd.

Table 7 Police Arrests, by drug type

	All Drugs		Cannabis	Opioids (l)		Stimulants (2)	Other (3)
	No.	Rate (*)	No.	No.	Rate (*)	No.	No.
1977	4049	1.52	3053	290	0.11	289	417
1978	4865	1.80	3805	372	0.14	246	442
1979	5241	1.92	4190	487	0.17	183	381
1980	6582	2.38	5299	656	0.24	212	415
1981	6624	2.38	5346	556	0.20	266	456
1982	8110	2.92	6853	567	0.20	229	461
1983	9167	3.29	7393	838	0.29	468	468
1984	9928	3.44	7573	1339	0.47	614	402
1985	10335	3.73	7610	1565	0.53	772	388
1986	9608		7012	1356		814	426

Number of arrests for drug offences, per year, by the Metropolitan Police, and rates (*) of cases aged 15 – 39 per 1.000 of London's 15–39 population for each year.

Note: 1986 figures are projections based on data for Jan. – May

(1) Heroin + opium + other opiates
(2) Cocaine + amphetamine
(3) L.S.D. + multiple drug groups + other drugs

Source: Metropolitan Police

Table 8 Persons Convicted of Drug Offences – U.K. and London

	LONDON (1)		U.K.
	Number	Rate	Number
1978	4121	59.6	13394
1979	4315	62.7	14054
1980	5608	81.9	16919
1981	6033	88.7	17668
1982	7485	110.6	19833
1983	8469	125.4	22158
1984	7925	117.3	22882

Number of persons found guilty, per year, of offences under drugs legislation and other offences where controlled drugs were involved: London and U.K.; London figures as rates per 1,000 of London's population for each year.

(1) Metropolitan Police District and City of London.

Source: Home Office

Table 9 Sentences for Drug Offences – U.K. 1982

	(1) Number	(2) %	(3) %	(4) %	(5) %	(6)
Cocaine	425	7	8	38	12	37
Heroin	963	SF	15	26	13	39
Methadone	402	14	19	20	19	28
Dipipanone	564	10	22	21	16	31
L.S.D.	460	5	9	54	11	20
Cannabis	16958	11	6	70	4	9
Amphetamine	1500	9	12	53	9	18
ALL DRUGS	19833	11	7	65	5	12

Number of persons found guilty of drugs offences and percentage receiving different sentences, by drug type, U.K. 1982.

(1) Total number found guilty
(2) Absolute or conditional discharge
(3) Probation, supervision order, community service order etc
(4) Fine
(5) Fully suspended sentence of imprisonment
(6) Custodial sentence: unsuspended or partly suspended prison sentence, detention centre, borstal training

Source: Home Office

Table l0 Seizures of Controlled Drugs, London l984

Drug Type	Number
Cocaine	442
Dipipanone	56
Heroin	1146
Methadone	325
L.S.D.	113
Other Class A Drugs	76
Total Class A Drugs	1935
Cannabis	7395
Amphetamines	775
Other Class B Drugs	83
Total Class B Drugs	7949
Total Class C Drugs	56
TOTAL ALL DRUGS	9412

Number of seizures of controlled drugs made by the Metropolitan and City of London Police Forces, by drug type, 1984.

Note: One seizure can involve more than one drug type.

Source: Home Office

Table 11 Seizures of Heroin, Cocaine and Amphetamine

	Heroin	Cocaine	Amphetamine
	No.	No.	No.
1977	152	91	
1978	259	178	
1979	371	143	324
1980	463	249	324
1981	419	240	440
1982	489	238	589
1983	830	411	753
1984	1198	519	909
1985	1242	383	1076

Number of seizures, per year, by the Metropolitan Police of heroin, cocaine and amphetamine.

Note: 1985 figures are projections based on data for Jan. – Aug.

Source: Metropolitan Police

Table 12 Quantities of Heroin, Cocaine and Amphetamine analysed by Metropolitan Police Laboratory

	Heroin	Cocaine	Amphetamine
	Kg.	Kg.	Kg.
1980	5.78	3.76	
1981	4.41	2.89	
1982	3.81	2.58	3.17
1983	7.63	12.88	3.73
1984	24.92	3.71	12.95
1985	14.41	11.50	14.10
1st 1/4 1986	13.66	2.27	3.41

Number of Kilos of powder including heroin, cocaine and amphetamine received, per year, in the Metropolitan Police Laboratory.

Source: Metropolitan Police Laboratory

Table 13 Street Price of Heroine and Cocaine

	HEROIN £ per gramme		COCAINE £ per gramme	
	Price paid	Converted to price as at 1975	Price paid	Converted to price as at 1975
1974	20 - 30	25 - 37	15 - 25	19 - 31
1975	25 - 40	25 - 40	25 - 30	25 - 30
1976	40 - 60	34 - 52	30 - 40	26 - 34
1977	60 - 80	45 - 60	40 - 45	30 - 33
1978	75 - 120	51 - 82	40 - 50	27 - 34
1979	60 - 80	36 - 48	45 - 50	27 - 36
1980	60 - 80	31 - 41	50 - 60	26 - 31
1981	75 - 85	34 - 39	50 - 65	23 - 30
1982	75 - 90	32 - 38	55 - 70	23 - 30
1983	65 - 80	26 - 32	55 - 70	22 - 28
1984	65 - 85	25 - 33	45 - 65	17 - 25
1985	80 – 95	29 - 34	50 - 60	18 - 24
1986	80 - 100		55 - 65	

Street price (£ per gramme) of small amounts of illicit heroin and cocaine bought by users, London, 1974 – 1986.

Note: converted prices = street price converted to 1975 equivalent using the Retail Price Index (all items) to remove the effects of inflation on price variations.

Source: Fieldwork/Police

Table 4 Percentage purity of samples of Heroin and Cocaine examined in the Metropolitan Police laboratory, 1984

	---------Number of samples---------	
Percentage Purity	Heroin	Cocaine
10	3	6
11-20	1	2
21-30	5	16
31-40	15	19
41-50	26	37
51-6-	39	47
61-70	22	22
71-80	12	37
81-90	1	29
91-100	1	25

Number of samples of Herein and Cocaine tested by the Metropolitan Police Laboratory, by percentage purity, 1984

Source: Metropolitan Police

APPENDIX II

GLOSSARY OF TERMS AND DEFINITIONS

1. Addict

There are two Meanings of this term.

(a) The Misuse of Drugs Act, 1971, defines a narcotic addict as someone who "if, and only if, he has as a result of repeated administration become so dependent on the drug that he has an overpowering desire for the administration of it to be continued."

This Act restricts the term "addict" to dependence on certain drugs, notably heroin, morphine, methadone, dipipanone (Diconal), pethidine, dextromoramide (Palfium), hydrocodone and cocaine.

(b) Persons medically diagnosed as drug dependent under ICD code 304.

Notified addict

A narcotic addict as defined in (a) above who has been notified to the Hone office by a doctor.

2. Hospital admission

The World Health Organisation's definition is:
"A stay in hospital lasting one night or more, irrespective of whether the patient is admitted to hospital for the first time, readmitted...or transferred from another hospital."

Inpatient diagnoses refer to diagnoses made under the International Classification of Diseases (ICD). 9th revision since 1979, 8th revision prior to 1979.

There are two sources of data on hospital admissions:

General hospitals – the Hospital Activity Analysis, detailing discharge diagnoses.

Psychiatric hospitals – the Mental Health Enquiry, detailing admission diagnoses.

3. Treatment demand

There are two sources of data on this indicator:

(a) Notified addicts – see 1. above.

(b) Requests for some form of help Bade to statutory or non-statutory (including non-medical) agencies regarding use of drugs. It is not always clear whether data refer strictly to requests or merely to persons seen.

First treatment demand

(a) New notifications – narcotic addicts as defined above who have been notified to the Home Office for the first time.

(b) Mew clients – persons requesting help from an agency for the first time (strictly speaking, from any agency).

4. Arrest

The first formal action taken by the police in relation to a person suspected of having broken the law. An arrested person is taken into police custody with consequent though often temporary restrictions on their civil rights while it is decided what further actions will be taken.

5. Seizure

The confiscation of (at the tine, suspected) illicit drugs by law enforcement agencies – usually police or customs.

6. Viral Hepatitis

Hepatitis B – used as an indicator of intravenous drug use, injecting being one of a number of associated risk factors.

There are three sources of data:

(a) Inpatient discharge diagnoses under ICD 9 code 070.2 & 070.3

(b) Collated cases of acute hepatitis B identified from tests carried out by the Central Public Health Laboratory.

(c) Identifications of hepatitis B collated centrally by the Office of Population Censuses and Surveys from notifications of hepatitis under public health legislation on infectious diseases.

Cases identified under (a) and (c) above may or may not have been supported by laboratory tests.

7. Imprisonment

As an indicator this term may refer either to

(a) persons convicted of drugs offences and sentenced to a term of imprisonment, irrespective of their use or non-use of drugs, and, if a drug user, irrespective of whether they are dependent or not; or

(b) persons identified as drug users (including those notified to the Home Office as narcotic addicts) as a result of serving a term of imprisonment, irrespective of whether their offence was drug-related.

8. Price

This refers to the retail price paid per gramme by the consumer for a small amount of an illicitly supplied drug.

9. Purity

The percentage of any substance supplied as a “drug” which is the active ingredient as opposed to a “cutting agent”.

10. Deaths

There are four definitions of drug-related deaths:

(a) Coroners’ verdicts of death due to drug addiction, for which there are no criteria as to case definition, and in which the drugs involved are not specified.

(b) Deaths of notified narcotic addicts, which refer to deaths by any cause.

(c) Deaths due to poisoning – published annually by the Office of Population Censuses and Surveys, derived from death certificates and classified under ICD.

(d) Research carried out in Inner London by Mr. John Harvey on Coroners’ records (not just verdicts) which identifies cases where there is evidence on the part of the deceased of parenteral drug use; use of narcotics by any means; predominantly oral forms of drug use; mature dependence on tranquillizers; use of solvents, hallucinogens and cannabis.

11. Convictions

This tern refers to persons found guilty by a court of having broken the law. Some official data include persons receiving cautions.

APPENDIX III

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