



European Monitoring Centre  
for Drugs and Drug Addiction



Centre for Public Health

## 2004 NATIONAL REPORT TO THE EMCDDA by the Reitox National Focal Point

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

REITOX



UK Focal Point

## **United Kingdom Drug Situation. Annual Report to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2004**

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## The United Kingdom Focal Point on Drugs

The UK Focal Point on Drugs is based at the Department of Health and the North West Public Health Observatory at the Centre for Public Health, Liverpool John Moores University. Along with equivalent organisations in other EU Member States, the Focal Point provides detailed information to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) on the drug situation in England, Northern Ireland, Scotland and Wales. It works closely with the Home Office, other Government Departments and the devolved administrations. In addition to this annual report, it collates an extensive range of data in the form of standard tables and responses to structured questionnaires, which are submitted regularly to the EMCDDA. It also contributes to other elements of the EMCDDA's work such as the development of its five key epidemiological indicators, the Exchange on Drug Demand Reduction Action (EDDRA) and the implementation of the Joint Action on New Synthetic Drugs.

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

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

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The report largely describes the situation in 2003 and was submitted to the EMCDDA in 2004. It, and the reports from the other EU Member States, will be used in the compilation of the EMCDDA's annual report to be published in 2005.

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## SUMMARY

### Main Findings

#### 1. National policies and context

The United Kingdom (UK) Drug Strategy was updated in December 2002. There is a particular focus on Class A drugs and there is a renewed emphasis on reducing drug-related harm and helping drug users access treatment, including through the Criminal Justice System.

The year 2003 saw changes in legislation, as well as new legislation:

- Cannabinol and its derivatives (previously Class A), and cannabis (previously Class B) are reclassified as Class C drugs.
- GHB has been classified as a Class C drug.
- Legislation allows the provision of injecting paraphernalia (other than needles and syringes) by health service providers with the aim of reducing the sharing of such equipment.
- The *Anti-Social Behaviour Act 2003* introduces provisions to assist in closing crack-houses.
- The *Proceeds of Crime Act 2002* and the *Money Laundering Regulations 2003* implement the *Second EU Money Laundering Directive*. The Assets Recovery Agency also became operational.

Direct expenditure for tackling drugs in 2003/04 was £1,244 million (€1766<sup>1</sup> million); this was made up of:

- protecting young people                      £149 million (€211.5 million);
- safeguarding communities                      £212 million (€301 million);
- drug treatment                                      £503 million (€714.2 million); and
- reducing supply                                      £380 million (€539.6 million).

#### 2. Drug use in the population

Prevalence in the general population of use of any illegal drug remains stable with lifetime prevalence being over a third; between 7 and 12 per cent of adults have used in the last year.

Young adults under 30 continue to be significantly more likely to use illicit drugs; lifetime prevalence is around 50 per cent. However, throughout most of the UK, the gradual decline in prevalence amongst 16 to 24 year olds continues.

Prevalence amongst school children (11 to 16 year olds) is stabilising with last year prevalence at around 25%.

Prevalence continues to be particularly high amongst vulnerable young people.

Males are over twice as likely to use; though this is less marked amongst those in their teens. Drug use is greatest amongst the white population, irrespective of age.

Cannabis continues to be the most commonly used drug. Prevalence of all other drugs remains low, though there has been an increase in the use of crack, cocaine and ecstasy.

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<sup>1</sup> All conversions used in this report will use the exchange rate of 1.42 as of May 2003 unless otherwise stated.

Although some sources suggest a rise in the use of magic mushrooms and an interest in licit 'herbal highs', such as types of salvia, this is yet to be confirmed.

### *3. Prevention*

Drugs education is a key component of UK drug strategy; guidance for schools has been, or is being, developed throughout the UK.

Vulnerable young people are targeted through a number of specialist interventions.

A National Collaborating Centre for the Drug Prevention has been established.

National public information campaigns, as part of action to reduce the use of Class A drugs, have been launched throughout the UK.

### *4. Problem drug use*

Latest UK estimates of problem drug use are 9.35 per thousand of the population aged 15 to 64 years (360,811) and for injecting drug use, 3.2 per thousand (123,498). Males continue to represent over 70 per cent of new presentations to treatment. Opiates continue to be the most commonly used drug by those seeking treatment (80%). There is some evidence of an increase in the number of individual presenting for treatment whose main drug of use is crack or cocaine, but it remains low (4% to 6%). Approximately a quarter of problematic drug users inject.

### *5. Treatment*

Treatment provision has increased substantially and standards and national guidance have been introduced. Most treatment continues to be through specialist drug services (outpatients) with increasing GP involvement. Medically assisted methadone maintenance is the preferred treatment, with still low, but increasing, use of buprenorphine (see 11). Services for crack users are being piloted. Referral into treatment through the Criminal Justice System is a key component of UK Drug Strategy (see 12).

### *6. Health correlates and consequences*

The number of drug-related deaths continue to fall, as does average age of death. Opiates continue to account for a large majority of deaths. While still rare, cocaine deaths are rising. Deaths involving ecstasy and volatile substances are unchanged. The decline in the number of deaths due to HIV contracted through injecting drug use victims has levelled off.

Prevalence of HIV amongst injecting drug users remains at less than or around one per cent. Incidence of hepatitis C (HCV) continues to increase; current prevalence is approximately 45 per cent. Prevalence of hepatitis B (HBc) has levelled off at 20 per cent. Outbreaks of hepatitis A and other infections are increasing.

Information from Scotland suggests pregnancies involving women who use drugs have risen.

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

#### *Prevention of drug related deaths*

UK strategy is to reduce drug-related deaths by 20 per cent by 2004, to be achieved through information campaigns, treatment initiatives, and better surveillance, monitoring and research.

Prison services are developing interventions to reduce the risk of fatal overdose upon release from custody.



To reduce deaths from volatile substances there are a number of awareness campaigns aimed at parents and at retailers. The Department of Health is drafting an action plan on volatile substance abuse.

*Prevention and treatment of drug-related infectious diseases*

The Hepatitis C Action Plan for England was launched in June 2004 prioritising the prevention of infection and disease progression. An action plan for Scotland is due in autumn 2004. A range of services to promote the uptake of HCV testing has been funded. Legislation allowing for the provision of injecting paraphernalia aims to reduce the spread of infections by reducing sharing.

*Interventions related to psychiatric comorbidity*

The Scottish Executive plans to improve education and awareness, and is looking towards more effective planning and delivery of care and treatment services.

*Interventions related to other health correlates and consequences*

The Scottish Executive is implementing recommendations to make services more flexible, accessible and appropriate in meeting the needs of pregnant drug users and the children of drug users.

The Home Office has developed a toolkit on drugs and driving; information campaigns are to begin in England, Wales and Scotland, including a website aimed at young people.

*8. Social correlates and consequences*

There was a 10 per cent fall in drug offences; this applies to most drugs, though numbers found guilty of unlawful supply of heroin are stable and there has been a significant rise in cocaine offences and possession with intent to supply crack. The number of offences for unlawful production of cannabis rose.

Newly published research evidence suggests that there is a strong association between drug use and offending: 69 per cent of arrestees tested positive for drugs.

A programme has been established to improve measures of drug related crime. As part of the latter, a new continuous arrest survey began in 2003.

It is suggested that over half those entering custody in England and Wales and two thirds in Scotland are problematic drug users.

*9. Responses to social correlates and consequences*

The Supporting People programme was introduced in 2003, funding supported accommodation for marginalised groups (not only drug users). Progress2Work, supporting drug users into employment, will be initiated in all areas during 2004.

Healthcare services in all non-private prisons in England will become part of the National Health Service by 2006. Clinical services (detoxification and maintenance-prescribing programmes) remain available in all local and remand prisons. Programmes for drug users continue to expand and include intensive drug rehabilitation programmes, therapeutic communities; withdrawal management units; and low-intensity short duration programmes.

The Drugs Intervention Programme (DIP)<sup>2</sup> was launched in 2003 with the aim of more effectively channelling problematic drug users, particularly persistent offenders, from the Criminal Justice System into treatment.

All Youth Offending Teams, from April 2004, must ensure young offenders are screened for substance misuse.

*The Railways and Transport Safety Act 2003* gives police the power to undertake preliminary tests of impairment and screening for drugs at the roadside.

#### *10. Drug markets*

Overall, seizures have continued to rise, including for cannabis, crack and benzodiazepines. However, seizures of cocaine, ecstasy and heroin have fallen back slightly. Seizures of amphetamines have stabilised.

The prices of all substances have continued to fall. The purity of brown heroin and amphetamines fell, cocaine purity has risen and that of crack has stayed the same.

#### *Selected issues*

##### *11. Buprenorphine, treatment, misuse and prescription practices*

Buprenorphine, under the brand name Subutex, was licensed for use for the management of drug dependence in the UK in 1999, though restricting it to Schedule 3. No other product containing buprenorphine is licensed for the management of opiate dependence.

Clinical guidelines provide an outline of indications, contraindications and precautions, dosage regimens, maintenance treatment and prescribing, detoxification and shared care.

Since 2001, there has been a considerable increase in the use of buprenorphine, indicated by in the number of prescribed items; from 5,000 items in 1999 to 310,000 in 2003.

Research and reviews undertaken in the UK suggest buprenorphine and methadone are of similar efficacy in retaining clients in treatment and reducing heroin use.

In the late 1980s and early 1990s, a wave of buprenorphine misuse (Temgesic), in the form of injecting, was reported in several parts of the UK. Recording of abuse of buprenorphine is not routinely undertaken through current information systems.

##### *12. Alternatives to prison targeting to drug using offenders*

In the UK, drug treatment cannot be strictly defined as an alternative to custody; if a custodial sentence is required offenders will enter custody; however a key component of national drug policy is to increase the number of drug using offenders in treatment.

There are a number of interventions aimed at drug using offenders. For those in police custody, these include help with referral into treatment for arrestees (Arrest Referral), drug testing on charge, and Conditional Cautioning. Arrest Referral and testing on charge is being piloted for those under the age of 18 years. A restriction on bail pilot was also introduced in 2004 giving new powers to courts to order drug treatment and assessment as conditions of bail.

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<sup>2</sup> The Drugs Intervention Programme was originally launched as the Criminal Justice Interventions Programme but was re-named in October 2004.

There are presently a number of community sentencing options many of which include a commitment to undergo treatment.

The Criminal Justice Interventions Programme, launched in 2003, seeks to develop and integrate measures for directing adult drug-misusing offenders out of crime and into treatment, taking advantage of all opportunities within the Criminal Justice System (police custody, the courts and probation, and prison).

### *13. Public nuisance definitions, trends in policies, legal issues and intervention strategies*

Surveys on crime and policing in the United Kingdom show that the public place a high priority on tackling incidents described as anti-social behaviour, minor disorder or 'quality of life issues'. These include using and selling drugs.

The Drugs Strategy Directorate works with the Anti-social Behaviour Unit to tackle drug related anti-social behaviour and public nuisance. Measures target street drug taking, using drugs in public, discarded needles, public intoxication as well as begging, rough sleeping and sex work. They also target street drug dealing and the problem of crack houses.

The Home Office has published a number of guidance manuals to local partnerships who are charged with managing problems.

A new Police Plan defines the way that police forces should take account of drug related nuisance.

The *Anti-Social Behaviour Act 2003* is designed to tackle the serious nuisance associated with properties used for the sale and use of crack and other drugs.

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

- The reclassification of cannabis.
- The implementation of the *Proceeds of Crime Act 2003* and the accompanying Assets Recovery Agency, seeking to prevent money laundering.
- The *Anti-Social Behaviour Act 2003* introduced provision to assist in tackling the public nuisance issue of property used for the sale of drugs such as crack (crack houses).
- Prevention remains high on the agenda with new guidance for schools, continued emphasis on prevention activities outside school for vulnerable young people, and the establishment of a National Collaborating Centre for the Drug Prevention.
- Prevalence in the general adult population of use of any illegal drug remains stable, and there are indications of a decrease in prevalence amongst those aged 16 to 24 years. Prevalence amongst 11 to 16 year olds of use of any illegal drug, which doubled over the last decade, is stabilising.
- Nevertheless, there are indications of a continued increase in cocaine, accompanied by a rise in the mention of cocaine in deaths and a rise in cocaine drug offences. Continued increase in the use of crack has also been accompanied by a rise in possession offences. There are also increasing indications of an increase in the use of magic mushrooms.
- There are indications that the incidence of hepatitis C continues to increase.
- Treatment provision has increased substantially, with the Criminal Justice Intervention Programme designed to increase the number of offenders in treatment and other services.
- The use of buprenorphine is steadily increasing for the treatment of drug misuse.

### Overall analyses and interpretation of development and trends

While drug use, on the whole, is stabilising there are indications of a rise in Class A drug use; cocaine, crack, ecstasy and, possibly, magic mushrooms. It is however of note that this increase is based on information about prevalence obtained prior to the updated Drug Strategy with its emphasis on reducing Class A drug use. Evidence of the effectiveness of this will not be available for some time.

The reclassification of cannabis, undertaken as part of the emphasis placed on Class A drugs, is an important development in the UK. Its impacts, however, are yet to be evaluated.

With prevalence estimates of problematic drug use being rarely undertaken, it is difficult to accurately gauge any changes.

### Consistency between indicators

Seizures of drugs, on the whole, had begun to decrease since the late 1990s, but are now rising, including those for cannabis, the most seized drug (and most used drug), crack and benzodiazepines. The continued increase in cocaine use, within the general population and problematically, has been accompanied by a rise in mentions of cocaine in deaths and a rise in drug offences for cocaine, though seizures of cocaine have fallen. The fall in seizures of cocaine is not consistent with the reduced price and increased purity of cocaine. Indications of increases in crack use have been accompanied by an increasing public nuisance problem of property used for the sale of crack (and other Class A drugs); it is of note that there has been an increase in crack seizures and of offences for possession with intent to supply crack.

The decrease in seizures of LSD, and the stabilisation in seizures of amphetamines is reflected in the decrease in their use in the general population. Reduced seizures of ecstasy may reflect the stabilisation of its use in the general population.

Map of the United Kingdom, its constituent countries and selected cities



# PART A

New developments and trends

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# PART A: NEW DEVELOPMENTS AND TRENDS

## 1. National policies and context

### 1.1 Overview

The *Misuse of Drugs Act 1971* is the foremost piece of drug legislation in the UK, dividing controlled drugs into three classifications (A, B and C) depending on their potential for harm. These classifications correspond to a graded scale of penalties for possession and supply, with Class A drugs carrying the highest penalties. Use of controlled drugs *per se* is not an offence in the UK; however, since 1995, it is contrary to prison rules (HM Prison Service 1995; HM Prison Service 2004a).

The UK population is 58.8 million, spread across the four administrations (2001 census). Eighty-four per cent (49 million) live in England, 8.6 per cent (5 million) in Scotland, 4.9 per cent (2.9 million) in Wales and 3 per cent (1.7 million) in Northern Ireland<sup>3</sup>. Since 1999, a number of institutions have been devolved to the administrations of Northern Ireland, Scotland and Wales; each has its own parliament or assembly, which have health, education and some criminal justice functions.

There is, however, a UK Drug Strategy, *Tackling drugs together to build a better Britain*, launched in 1998 (UKADCU 1998) and updated in 2002 (Drugs Strategy Directorate 2002a). The Strategy seeks to balance the needs of individual users with those of the wider community. There are four principal aims: prevention of drug use amongst young people, safeguarding communities, the provision of treatment and reducing availability. These are to be achieved through education, prevention programmes, expanded treatment, legal sanctions and the expansion of legal opportunities. The devolved authorities in Northern Ireland, Scotland and Wales have developed their own strategies that reflect the aims of the UK Strategy, but include specific objectives and priorities tailored to their individual concerns and circumstances of each country. *Tackling drugs in Scotland: action in partnership* (Scottish Office 1999) and the *Drug strategy for Northern Ireland* (Northern Ireland Office 1999) were launched in 1999 (since 2000 the Department of Health, Social Services and Public Safety (DHSSPSNI) has taken lead responsibility), and *Tackling substance misuse in Wales: a partnership approach* (National Assembly for Wales 2000) was launched in 2000, the latter also including alcohol and solvent misuse.

Delivering the Strategy is a cross-government initiative. Since 2001, the Home Secretary has taken lead responsibility as Chair of the Cabinet Ministerial Sub-Committee on Drugs Policy; this includes ministers from the Department of Health, the Department for Education and Skills, the Office of the Deputy Prime Minister, the Cabinet Office, the Treasury and the Foreign and Commonwealth Office. The Drug Strategy Delivery Group supports this structure at civil service senior official level. Membership reflects that of the Cabinet Sub-Committee, with additional members drawn from the devolved administrations, the English regions and departments and agencies responsible for delivery. In addition, there are cross-departmental groups focusing on individual strategy aims; for example, the Concerted Inter-departmental Action Group (chaired by HM Customs and Excise) reviews supply reduction. These delivery groups include representatives from a wide range of agencies and stakeholders.

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<sup>3</sup> For more information on the results from England and Wales' census, please see [www.statistics.gov.uk/census2001/profiles/uk.asp](http://www.statistics.gov.uk/census2001/profiles/uk.asp). For Northern Ireland, please see [www.scrol.gov.uk](http://www.scrol.gov.uk) and for Scotland, please refer to [www.nicensus2001.gov.uk](http://www.nicensus2001.gov.uk).

The Drugs Strategy Directorate of the Home Office is responsible for co-ordinating the Drug Strategy and ensuring its delivery. In England, delivery is through 149 local drug partnerships and nine regional Government Offices, who support and monitor the work of local partnerships. They provide a vital link between local delivery and central government. Drug and Alcohol Action Teams (D(A)ATs) bring together local agencies involved in tackling the misuse of drugs, including health and local authorities, police, probation, social services, education, youth and voluntary services. Crime and Disorder Reduction Partnerships in England and Community Safety Partnerships in Wales work with the police and communities to tackle local drug problems and associated crime. It is of note that in Wales, in 2003, D(A)ATs<sup>4</sup> were disbanded and in each of the four police authority areas, Regional Advisory Teams were put in place; the 22 Community Safety Partnerships were asked to establish Local Substance Misuse Action Teams to undertake executive actions on behalf of their respective partnerships. In Northern Ireland, a Regional Drug and Alcohol Strategy Co-ordinator is responsible for driving forward delivery across eight government departments, agencies and the voluntary and community sector. Four Drug and Alcohol Co-ordination Teams bring together local agencies involved in tackling the misuse of drugs, including services similar to those involved in England.

Representation of the Drug Strategy and its delivery has been generally positive in the media (IMPACON 2003). Although, there is widespread public concern about drug-related crime and its effect on communities (Fraser 2002; Simmons and Dodd 2003). As such, drugs still retain a high profile and remain a controversial topic.

## 1.2 Legal framework

### 1.2.1 Reclassification of cannabis

The *Misuse of Drugs Act 1971 (Modification) (No. 2) Order 2003*<sup>5</sup> reclassified cannabinol and cannabinol derivatives (previously Class A drugs), and cannabis and cannabis resin (previously Class B) as Class C drugs; effective from January 2004. This followed an assessment of their relative harmfulness (ACMD 2002), and should enable a more effective message to be conveyed about the graded scale of danger of different types of drugs, according to their classification. In addition, it reinforces Government's priority to tackle those drugs that cause the most harm: Class A drugs.

With reclassification, the maximum sentence for possession has been reduced from five to two years imprisonment. However, penalties for drug-related offences have been increased; the maximum penalty for trafficking Class C drugs has increased from five to 14 years imprisonment. Under the *Cannabis Enforcement Guidance* issued by the Association of Chief Police Officers (ACPO 2003) to police forces in September 2003, there is a presumption against arrest for those aged 18 or over found in possession of cannabis<sup>6</sup>. Guidance is directed at ensuring that certain individual offenders are dealt with appropriately. Guidance relates to:

- those repeatedly dealt with for possession of cannabis (repeat offenders);
- those whose cannabis use causes or threatens to cause public disorder; and
- those in possession of cannabis in or near premises where young people are present and vulnerable (e.g. schools, youth clubs and play areas).

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<sup>4</sup> In Wales local action teams have been concerned with alcohol since devolution.

<sup>5</sup> The *Misuse of Drugs Act 1971 (Modification) (No. 2) Order 2003* can be found at <http://www.legislation.hmsso.gov.uk/acts.htm>.

<sup>6</sup> Cannabis Enforcement Guidance can be found on <http://www.drugs.gov.uk/NationalStrategy/CannabisReclassification/ACPO/cannabisenforcem entguidance-formal-5sep03.doc>



It is expected that for most possession offences, a police warning and confiscation of the drug will be sufficient. The subsequent time saved is intended to allow the police to focus greater resources on priority areas such as tackling Class A drug supply offences.

However, young people under 18 in England and Wales arrested for cannabis offences will continue to be dealt with under the provisions of the *Crime and Disorder Act 1998*. Police enforcement will be consistent with the more structured framework for early juvenile offending established under this Act: a young offender can receive a reprimand, final warning or charge depending on the seriousness of the offence. Following one reprimand, any offence will lead to a final warning or charge, and any further offence will result in a charge. After a final warning, the young offender will be referred to the Youth Offending Team (YOT) where their substance use will be assessed, and arrangements will be made for treatment or other support as required.

This reclassification has been dealt with in various ways by the different administrations. In Northern Ireland, there are similar arrangements to those in England and Wales, whereas in Scotland, ACPO guidance does not apply. Here, there are existing conditional powers of arrest as prescribed by the *Misuse of Drugs Act 1971* and the *Criminal Procedure (Scotland) Act 1995*. These state that arrest for cannabis possession is not automatic and depends on the individual circumstances. It is the responsibility of the Lord Advocate<sup>7</sup> to issue guidance to Scottish police forces, and the Procurator Fiscal<sup>8</sup> (rather than the police) to decide whether to institute criminal proceedings. At present, police forces are not instructed to issue cautions to those in possession of cannabis, and all cases are reported to Procurators Fiscal.

The continuing illegal status and harmfulness of cannabis is being publicised through the FRANK campaign<sup>9</sup>, and in Scotland, through the “Know the Score” Drugs Communications Strategy campaigns<sup>10</sup>. In Northern Ireland, the Health Promotion Agency is running similar campaigns<sup>11</sup> (see Chapter 3).

### 1.2.2 Classification of GHB

Following a decision by the United Nations to add GHB (gamma hydroxybutyrate) to Schedule IV of the 1971 Convention on Psychotropic Drugs, from July 2003 GHB became a Class C controlled drug under the *Misuse of Drugs Act 1971*.

### 1.2.3 Supply of drug injecting paraphernalia

An amendment to the *Misuse of Drugs Act 1971* was made in 2003 to allow doctors, pharmacists and drug workers to legally supply swabs, sterile water, certain mixing utensils (e.g. spoons, bowls, cups and dishes) and citric acid to drug users who obtained controlled drugs without a prescription came into force in August 2003 (see UK Focal Point Report 2003).

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<sup>7</sup> The Lord Advocate is the chief law officer of the crown who has ultimate responsibility for criminal prosecutions in Scotland. The Lord Advocate does not usually act in inferior courts, where prosecution is carried out by procurators-fiscal acting under their instructions.

<sup>8</sup> The Procurator Fiscal is an officer of the Scottish court who inquires into suspicious deaths and carries out the preliminary questioning of witnesses to crime.

<sup>9</sup> For more information, please see <http://www.talktofrank.com>

<sup>10</sup> Please see <http://www.knowthescore.info> for more information.

<sup>11</sup> For further information, see <http://www.healthpromotionagency.org.uk>

#### 1.2.4 Anti-Social Behaviour Act 2003

The *Anti-Social Behaviour Act 2003* introduced provisions to assist in closing crack-houses (see Chapter 13).

#### 1.2.5 Money laundering

The *Proceeds of Crime Act 2002* and the *Money Laundering Regulations 2003* implemented the *Second EU Money Laundering Directive*<sup>12</sup>. Laundering now relates to the proceeds of any crime, as does the obligation on the regulated sector to report it. The latter was extended from March 2004 to encompass not just financial institutions, but also the “gatekeepers to the financial system” such as lawyers, accountants, casinos, estate agents and certain dealers in High Value Goods. This reporting obligation extends not just to actual suspicion or knowledge of money laundering, but also to when there are reasonable grounds to know or suspect money laundering.<sup>13</sup> Legislative change has been complemented by a review of the reporting system, and substantial reforms have been made to improve the quality and speed of the dissemination of the intelligence provided to law enforcement agencies by the National Criminal Intelligence Service (NCIS). The Assets Recovery Agency also became operational in February 2003<sup>14</sup>.

### 1.3 Institutional framework, strategies and policies

#### 1.3.1 Co-ordination arrangements

Each administration has or is developing its own performance management arrangements. These will rationalise the bureaucratic burdens on local partnerships. This reflects the central government principle of local responsibility for delivery, set in a framework of national standards and supported by a strategic approach to performance indicators. In England the nine Government Offices will be the key mechanism for negotiating local priorities, targets and milestones with local partnerships, and for monitoring progress against these.

#### 1.3.2 National plan and/or strategies

NO INFORMATION AVAILABLE.

Please refer to Chapter 1.1 of this report or UK Focal Point (2003) Chapter 1.1.

#### 1.3.3 Implementation of policies and strategies

There are a number of new initiatives and programmes to facilitate the implementation of UK Drug Strategy, such as the Drugs Intervention Programme<sup>15</sup> (DIP - see Chapter 12). There has been variety of guidelines and toolkits devolved in 2003, including those helping increase the number of those who are hard to reach accessing treatment services. Local partnerships and agencies are charged with local implementation, and to complement this, funding arrangements have been rationalised in many areas during 2003/04.

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<sup>12</sup> For more information, please see

[http://europa.eu.int/comm/justice\\_home/fsj/crime/laundrying/wai/fsj\\_crime\\_laundrying\\_en.htm](http://europa.eu.int/comm/justice_home/fsj/crime/laundrying/wai/fsj_crime_laundrying_en.htm)

<sup>13</sup> See <http://www.renewal.net/Documents/RNET/Policy%20Guidance/Reportpateight.pdf>

<sup>14</sup> For more information, please see <http://www.assetsrecovery.gov.uk>

<sup>15</sup> The Drugs Intervention Programme was originally launched as the Criminal Justice Interventions Programme but was re-named in October 2004.

### 1.3.4 Impact of policies and strategies

The impact of the Drug Strategy is measured predominantly by performance against Public Service Agreements (PSAs)<sup>16</sup>. Current performance is shown in Table 1.

*Table 1: The current status of the Public Service Agreements*

Public Service Agreement	Government Department Responsible	Performance
To reduce the use of illicit drugs among all young people under the age of 25 years.	Home Office	The use of Class A drugs among young people under 25 has been broadly stable since 1996, with downward trends in some drugs such as ecstasy.
To reduce drug-related crime.	Home Office	An interim proxy measure shows a 2 per cent reduction in drug-related acquisitive crime convictions for the year ending June 2003, from the previous year.
To reduce the availability of illegal drugs.	HM Customs and Excise	In the first nine months of 2003, 1.67 tonnes of heroin and 16.8 tonnes of cocaine were taken out of the supply chain and 121 significant trafficking groups were disrupted. Also, £19.7 million <sup>17</sup> (€28 million) of drug-related criminal assets were confiscated.
To increase the number of problematic drug users in drug treatment programmes.	Department of Health	During 2002/03, there were 140,900 drug users in treatment, a 41 per cent increase since 1998. Fifty seven per cent successfully completed or sustained treatment.

## 1.4 Budget and public expenditure

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

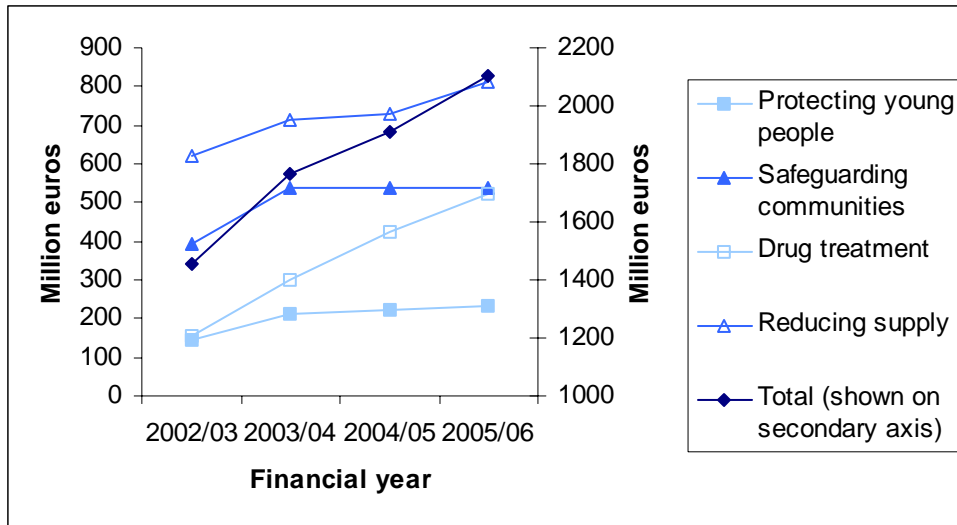
Direct expenditure for tackling drugs in 2003/04<sup>18</sup> was £1,244 million (€1,766 million), a rise of £18 million (€25 million) from 2002/03 (Drugs Strategy Directorate 2002a). The budget was then divided up to target specific areas in of the Strategy (see Figure 1).

<sup>16</sup> These can be found on <http://www.hm-treasury.gov.uk>

<sup>17</sup> All conversions used in this report will use the exchange rate of 1.42 as of May 2003 unless otherwise stated.

<sup>18</sup> This refers to the financial year from 1<sup>st</sup> April 2003 to 31<sup>st</sup> March 2004.

Figure 1: Direct expenditure for tackling drugs in the United Kingdom



Source: Drugs Strategy Directorate 2002a.

#### 1.4.2 Funding arrangements

The various funding streams from central Government departments to local partnerships have also been rationalised into the pooled drug misuse treatment budget (2001), the young people’s substance misuse pooled budget (2004) and the Building Safer Communities Fund (2004).

### 1.5 Social and cultural context

#### 1.5.1 Public opinion of drug issues

The associated campaigns following the reclassification of cannabis provided the ideal opportunity to highlight its continuing illegal status and to inform the public of its related harms. LVQ Research evaluated the effectiveness of such a campaign, assessing the attitudes of 14 to 17 year olds before the reclassification of cannabis, then again after the reclassification and after the campaign (see Table 2).

Table 2: Attitudes of 14 to 17 year olds regarding cannabis

Attitudes	Pre-reclassification	Post-reclassification and the campaign
Believe cannabis to be illegal	88%	93%
Believe smoking cannabis could be harmful	74%	81%
Aware of a change in the law	38%	61%
Believe that under the new law, you will always/are likely to be arrested if found in possession of cannabis	24% of those aware of a change in the law	41% of those aware of a change in the law
Believe they would definitely or probably take cannabis if offered	17%	12%

Source: LVQ Research 2004.

The research’s findings will inform longer-term educational campaigns.

### 1.5.2 Debates and initiatives in parliament and civil society

Debate concerning the legalisation of drugs continues, but this has been low key despite a senior member of the North Wales police force stating that this could be a valid way forward (Bunyan 2004).

### 1.5.3 Media representations

Media analysis reports suggest representation of the Government's Drug Strategy has been generally positive, particularly in respect of the expansion of CJIP (see Chapter 12). There has been widespread coverage of the reclassification of cannabis and the results of the latest British Crime Survey (IMPACON 2003).

## 2. Drug use in the population

### 2.1 Overview

In the UK, the primary sources of information about prevalence of drug use amongst the adult population are from representative household surveys.

- In England and Wales, the *British Crime Survey* (BCS) questions respondents, aged 16 to 59, about a number of crime-related topics including their experience of illicit drugs<sup>19</sup>. Since 2002 it has become a continuous survey reporting quarterly.
- The *Scottish Crime Survey* (SCS) is undertaken less frequently, the latest survey being in 2003 (although this has not yet been published, so the latest available data is from 2000). It asks comparable questions to those in the BCS.
- In Northern Ireland, a *Drug Prevalence Survey*, using the EMCDDA model questionnaire and recommended methodology, was conducted for the first time in 2002/03 in association with the Republic of Ireland. This survey will be repeated in 2005/06 subject to funding.

Amongst the school age population, surveys of drug use prevalence are:

- in England, a survey of the prevalence of smoking, drinking and drug use amongst young people (11 to 15 year old school children), undertaken annually since 1998;
- the *Young Person's Behaviour and Attitudes Survey*, which was undertaken in Northern Ireland in 2000 for the first time, repeated in 2003 and will run every three years thereafter;
- in Scotland, the *Scottish Schools Adolescent Lifestyle and Substance Use Survey* (SALSUS)<sup>20</sup>; and
- the *Health Behaviour in School Age Children Survey* (HBSC), which provides Welsh data; this is undertaken every four years with a two-year interim survey. The most recent survey, the sixth in the series, was conducted in 2001/02<sup>21</sup>.

In addition, the *European School Survey Project on Alcohol and Other Drugs* (ESPAD) surveys children aged 15 and 16 in a representative sample of private and state secondary schools every four years. The survey was undertaken in 2003 but results are not available for the UK as yet.

While such surveys offer estimates of prevalence of illicit drug use in the general population, they do not provide useful estimates of problem drug use; these are provided in Chapter 4.

Prevalence of use of any drug has remained stable over the last few years (based on last year prevalence), though use of Class A drugs is increasing (Fraser 2002; Condon and Smith 2003; NACD and DAIRU 2003). Amongst adults, drug use is highest in England and Wales where around a third have ever used. In Northern Ireland, prevalence of drugs remained exceptionally low (House of Commons Northern Ireland Affairs Committee 2003), with no definable drug culture until the 1990s. However, by 2003 one fifth (20%) of the adult population reported lifetime use (NACD and DAIRU 2003). Young adults under 30 are significantly more likely to use illegal drugs; in most of the UK lifetime prevalence for this age group is around 50 per cent (31% in Northern Ireland for those aged 15 to 34 years). Throughout most of the UK, there appears to have been a significant and gradual decline in the

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<sup>19</sup> The BCS and SCS do not provide information on all the drugs asked for by the EMCDDA (alcohol, tobacco, barbiturates and benzodiazepines).

<sup>20</sup> In Scotland, a similar survey to England was run until 2002 when SALSUS was introduced.

<sup>21</sup> England, Scotland and Northern Ireland have taken part in this survey until recently.

use of any drug amongst 16 to 24 year olds in the last five years (though use of Class A drugs in this age group has remained stable since the late 1990s). Of note is that the age band with the highest prevalence is widening as young people continue to use into their thirties.

Increase over time is most pronounced amongst school children; doubling in the last decade. Data for England suggest that over the last few years use of any illicit drug by 11 to 15 year olds has nearly doubled to approximately 20 per cent. Data for England and Wales suggest that over the last few years use of any illicit drug by 11 to 15 year olds has nearly doubled to 20 per cent. Much of this may be due to the change in the question format of the survey in 2001, which resulted in a higher proportion of pupils reporting that they had 'tried sniffing glue, gas, aerosols or solvents' compared with previous surveys. Therefore, estimates of taking drugs from 2001 onwards are not strictly comparable with previous years.

Males are more than twice as likely to use; though the difference is less marked amongst those in their teens. Drug use is greatest amongst the white or mixed population, irrespective of age.

Cannabis continues to be the most commonly used drug amongst all age groups across the UK and prevalence is increasing; last year use in England and Wales was approximately 11 per cent, six per cent in Scotland and in Northern Ireland, five per cent. Prevalence of all other drugs is considerably lower; no more than two per cent for last year use. There has been an increase in the use of cocaine and crack (accounting for increased use of Class A drugs). There has been a decrease in the use of amphetamines and LSD.

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

## **2.2 Drug use in the general population**

The BCS for 2003/04 sampled over 37,000 adults (24,422 completed the drugs component) aged 16 to 59 years living in households in England and Wales. Results from this survey are not yet in the public domain and therefore cannot be included in this report. Similarly, in Scotland, information from the SCS 2003, which had a sample size of approximately 5,000, have not yet been fully analysed. No new information is therefore available for reporting from these countries.

New information on prevalence, however, is available for Northern Ireland through the 2002/03 Drug Prevalence Survey (NACD and DAIRU 2003), which sampled over 3,500 15 to 64 year olds. Lifetime prevalence of any drug was 20 per cent (Table 3), the lowest in the UK<sup>22</sup>, reflecting the fact that use of illicit drugs has been less prevalent in Northern Ireland over the last decade. However, as elsewhere in the UK, use among younger adults is higher and growing: 29 per cent of those aged 15 to 24 years reported lifetime prevalence. Similar prevalence rates can be seen among those aged 15 to 34 years in Table 3.

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<sup>22</sup> When compared to earlier data from England, Scotland and Wales.

Table 3: Prevalence of illegal drug use in Northern Ireland by age (%): 2002/03

Prevalence	Age (years)		
	15-24	15-34	15-64
Lifetime	29.1	31.1	20.4
Last year	14.2	11.3	6.2
Last month	8.9	6.1	3.3

Source: National Advisory Committee on Drugs and Drug and Alcohol Information Research Unit 2003.

Prevalence amongst males was shown to be higher than amongst females (Table 4).

Table 4: Prevalence of illegal drug use in Northern Ireland by gender (%): 2002/03

Prevalence	Age (years)					
	15-24		15-34		15-64	
	Male	Female	Male	Female	Male	Female
Lifetime	36.0	22.1	38.5	23.6	27.0	13.9
Last year	20.6	7.7	16.6	6.1	9.5	3.1
Last month	14.3	3.4	9.9	2.4	5.7	1.1

Source: National Advisory Committee on Drugs and Drug and Alcohol Information Research Unit 2003.

In Northern Ireland, 17 per cent of respondents reported ever having used cannabis, five per cent in the last year and three per cent reported recent use.

### 2.3 Drug use in the school and youth population

Amongst school age children, the latest available information for England (headline figures only; NatCen/NFER 2004), and Northern Ireland (DHSSPNI 2004a) is for 2003; Scottish data are from SALSUS 2002 (CAHRU 2003), and Wales is only able to provide information on cannabis use for 2002 (Clements *et al.* 2004). The English survey has a sample size of approximately 10,000 pupils aged 11 to 15 years. In Northern Ireland, over 7,000 individuals aged 12 to 16 years were sampled, and in Scotland, there were approximately 23,000 13 to 15 year olds (see Table 5).

In 2003, headline figures for England (NatCen/NFER 2004) suggest that drug use among young people has begun to stabilise:

- 21 per cent had taken drugs in the last year (20% in 2001 and 2002);
- 12 per cent had taken drugs in the last month (as in 2002 and 2001); and
- 8 per cent of 11 year olds and 38 per cent of 15 year olds had taken drugs in the last year (6% and 36% respectively in 2001, UK Focal Point 2003).

Figures for Scotland are from SALSUS 2002 and were reported by the UK Focal Point (2003). There has been no change since 1998 in the proportion of 13 year olds reporting having taken drugs, and amongst 15 year olds, while there was an increase, this was not significant.



Table 5: Prevalence of illegal drug use amongst the school age population in the United Kingdom

Prevalence (%)	England	Northern Ireland	Scotland
Last month prevalence	12	7	14
Last year prevalence	21	14	22
Lifetime prevalence	27 <sup>23</sup>	22	24

Source: Child and Adolescent Health Research Unit 2003; National Centre for Social Research/National Foundation for Educational Research 2003; Department of Health, Social Services and Public Safety Northern Ireland 2004a; National Centre for Social Research/National Foundation for Educational Research 2004.

There are of course methodological issues<sup>24</sup> around using data from different surveys to make comparisons between the administrations within the UK; problems here are exacerbated by the fact that surveys were not completed in the same time period. Nevertheless, given this caveat, Table 5 shows the differences between England, Scotland and Northern Ireland amongst young people aged 15 years. The only available data for Wales is amongst 15 year olds from the HBCS for 2001/02, which suggest that 26 per cent of boys and 24 per cent of girls had used cannabis in the last year (Clements *et al.* 2004).

Table 6: Prevalence of illegal drug use amongst 15 year olds in the United Kingdom<sup>25</sup>

Prevalence (%)	England	Northern Ireland <sup>26</sup>	Scotland
Last year prevalence	38	22	33
Last month prevalence	23 <sup>27</sup>	10	23

Source: Child and Adolescent Health Research Unit 2003; National Centre for Social Research/National Foundation for Educational Research 2003; Department of Health, Social Services and Public Safety Northern Ireland 2004a; National Centre for Social Research/National Foundation for Educational Research 2004.

Drug use is more prevalent in the older age groups than in the younger age groups, and more prevalent amongst males than females.

Cannabis, as in the adult population, is the most commonly reported drug in school surveys: in England, 13 per cent of 11 to 15 year olds had taken cannabis in the last year; 14 per cent in Northern Ireland; and 21 per cent in Scotland. In Northern Ireland's previous survey (2000, see UK Focal Point 2003), volatile substances were reported as the most commonly used drug by 12 to 16 year olds (15% reported lifetime prevalence) and lifetime prevalence of cannabis was 12 per cent. In comparison, the latest survey results for Northern Ireland suggest ten per cent for volatile substances and 17 per cent for cannabis. However, the most recent available data also shows that the situation is different for younger pupils. In England, amongst 11 year olds, use of volatile substances was more common than cannabis in the last year (6% and 1% respectively) (NatCen/NFER 2004). The picture is the same in Northern Ireland with 1.8 per cent of 12 year olds reporting

<sup>23</sup> The corresponding figure for this cell has not yet been published, and as such the 2002 figure has been used instead (so that an idea can be given of the situation).

<sup>24</sup> The surveys cited here have different bases in terms of the age range included, the timing of the survey within the calendar year, and the methodology.

<sup>25</sup> There are no new data for Wales.

<sup>26</sup> Northern Ireland data are for 15 to 16 year olds.

<sup>27</sup> The corresponding figure for this cell has not yet been published, and as such the 2002 figure has been used instead (so that an idea can be given of the situation).

cannabis use in the last year compared to 3.9 per cent reporting solvent use (DHSSPNI 2004a).

## 2.4 Drug use among specific groups

Research into substance use among specific groups, who tend not to be included in general population surveys, has been undertaken as part of the Vulnerable Groups Research Programme funded by the Home Office. The aim was to investigate patterns of drug use and access to services through researching: people leaving care; homeless young people; young people in contact with youth offending teams; young drug users who are in contact with drugs services; and young people involved in sex work. Results of the first four studies were reported in 2003.

### 2.4.1 Care leavers

Research was conducted on 200 young people (with an average age of 18 years) who was in the process of leaving or having recently left care and on young people who had left home at a young age ('runaways') (Ward *et al.* 2003). There were high levels of self-reported drug use compared with general population surveys:

- Almost three-quarters (73%) have used cannabis during their lifetime, a third (34%) on a daily basis;
- 10 per cent had used cocaine within the last month;
- 15 per cent had used ecstasy within the last month;
- lifetime prevalence of heroin and crack cocaine was around 10 per cent.

Of note is that steadily lower levels of consumption were reported as young people assumed or approached independent living status. The research suggested that practical responsibilities (such as household management) when well planned as part of the care leaving transition, encourage more responsible levels of drug consumption.

### 2.4.2 Young offenders

Research into drug use amongst 293 Youth Offending Team (YOT) clients aged 14 to 18 years show prevalence of any illegal drug to be extremely high (Hammersley *et al.* 2003). Eighteen per cent had used crack cocaine and 11 per cent, heroin; but use of these drugs was infrequent. It was suggested that drug use and offending in this cohort may represent a period of intense misbehaviour, which may or may not be temporary. There was no evidence that age of first use of drugs has dropped (although progression to more serious substances has speeded up) or that heroin and cocaine dependence have become commonplace (few reported dependence though 15 per cent were rated by an Assessment of Substance Misuse in Adolescents (ASMA; see Willner 2000) as at high risk of substance abuse problems). Forty per cent or more of the cohort felt there was some relationship between their substance use and their offending.

### 2.4.3 Homeless young people

A study into substance use amongst 160 homeless young people aged 25 years and under in England and Wales found 95 per cent of them had used drugs (typically beginning experimentation aged 14 years). Cannabis, amphetamine and ecstasy use were particularly high: used in the last month by 68 per cent, 12 per cent and 21 per cent respectively. A substantial minority had used heroin (21%) and crack cocaine (18%) in the last month. There was evidence of unsafe injecting practices and 23 per cent had accidentally overdosed on drugs or alcohol (Wincup *et al.* 2003).

#### 2.4.4 Sex workers

Research has also been conducted amongst participants with experience of both sex work and drug use (Cusick *et al.* 2003). Cusick *et al.* surveyed and interviewed 125 participants, with an age range of 16 to 64 years and a mean age of 26.7 years. They found that the experiences of sex work and drug use may be mutually reinforcing, and that the relationship between the two is potentially strengthened when individuals are exposed to the following 'trapping factors':

- involvement in prostitution and/or 'hard drug' use before age 18;
- sex working 'outdoors' or as an 'independent drifter'; and
- experience of at least one additional vulnerability indicator such as being 'looked after' in local authority care or being homeless.

The most vulnerable and most damaged participants were exposed to all three 'trapping factors'. They shared the following characteristics:

- they were young. The mean age of first prostitution for this group was 13.8 years;
- they were likely to have been 'looked after' (78% of this group); and
- they had supported at least one 'boyfriend's' problematic drug use.

#### 2.5 Attitudes to drugs and drug users

NO NEW INFORMATION AVAILABLE.

Please see Chapter 1.5.1 of this report for details of young people's attitudes to cannabis and Chapter 1.4 (UK Focal Point 2003) for further details regarding attitudes and debates.

## 3. Prevention

### 3.1 Overview

Within current UK drug strategy there are three main strands of prevention activities:

- preventing young people from using drugs;
- preventing young people, particularly the vulnerable, from becoming problematic drug users; and
- preventing the use of Class A drugs (UKADCU 1998; Northern Ireland Office 1999; Scottish Office 1999; National Assembly for Wales 2000; Drugs Strategy Directorate 2002a).

Drug education is a key component of prevention. In England and Northern Ireland, it is a statutory part of the national curriculum. The aim is to develop their knowledge, skills, attitudes and understanding about drugs in order to resist them. In Scotland, while there is no statutory curriculum, the majority of schools provide drug education (Scottish Executive 2003a). The Welsh Assembly is developing guidance.

Information campaigns focused particularly on the young and their parents are also part of the prevention strategy<sup>28</sup>.

Vulnerable young people and those living in high crime areas are known to be at risk of using drugs and of making the transition into problem drug use and there is concern that the vulnerable may not be reached in the school setting. Drug prevention in areas of social disadvantage is seen as part of a wider need to address social deprivation (Drugs Strategy Directorate 2002a). Positive Futures uses sport and arts to engage the most vulnerable young people and encourage them to develop the skills to help them resist drugs and, if required, re-enter education and training as well (Drugs Strategy Directorate 2003a). In areas of social disadvantage, Health Action Zones have initiated drug prevention projects working with vulnerable young people (DH 2002a).

#### 3.1.1 Drug prevention in community and outreach settings

In England, Wales and Northern Ireland, the Communities Against Drugs (CAD) programme<sup>29</sup> supports action at a local level (Home Office 2004a). In addition, the Scottish Drugs Forum (SDF)<sup>30</sup> works to develop the capacity of communities whilst Scotland Against Drugs (SAD)<sup>31</sup> provides support to community-based initiatives aimed at drug prevention in local communities.

There are a number of local initiatives aimed at prevention in recreational settings including peer education (Shiner 2000), outreach and information campaigns (Henderson 2002). Particular concern is with drugs and driving (Scottish Executive 2000; Tunbridge *et al.* 2001).

### 3.2 Universal prevention

In 2003, the Health Development Agency (HDA) published a review of reviews of drug use prevention initiatives (Canning *et al.* 2003). This considered evidence from

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<sup>28</sup> See <http://www.talktofrank.com> and <http://www.knowthescore.info> for more details.

<sup>29</sup> In England and Wales, CAD has now been subsumed under the Building Safer Communities programme (BSC).

<sup>30</sup> For more information, please see <http://www.sdf.org.uk>

<sup>31</sup> For more information, please see <http://www.sad.org.uk>

selected systematic reviews, other reviews and meta-analyses published since 1996 with the aim of identifying interventions shown to be effective in preventing or reducing drug use. The review concluded the following:

- the impact of prevention programmes has not been adequately reviewed.
- school-based interventions can delay for a short time the onset of drug use by non-users, and temporarily reduce use by some current users, although the effects decrease with time.
- universal prevention programmes are most effective for lower-risk adolescents.
- effective programmes include those that modify attitudes, normative beliefs and/or impact on behaviour such as preventing or reducing drug use. They require booster sessions; intensity does not equate to effectiveness.
- neither Life Skill Training (LST) nor other prevention programmes have a major impact on drug use and drug problems; though LST has a positive impact on use.
- interactive education programmes using peers are more effective than non-interactive programmes; though peer leaders benefit most.
- parent-orientated programmes are poorly attended and not adequately evaluated.
- information based programmes such as DARE (Drug Abuse Resistance Education)<sup>32</sup> have had little impact.
- teacher-led programmes require more research evidence.
- most British programmes are not properly evaluated in terms of outcome.

The National Collaborating Centre for Drug Prevention (NCCDP) was established by the HDA (HDA) and the Centre for Public Health, Liverpool John Moores University in 2004<sup>33</sup>. Initially it will focus on 7 to 25 year olds, and will be examining evidence at all levels from local to international. The Centre will update the work of Canning *et al.* (2003), as well as produce an Effective Action Briefing and an Evidence Review of the grey literature of drug prevention in young people, and associated topics, including a health economic evaluation.

In England, FRANK<sup>34</sup> was launched in 2003, jointly funded by the Home Office and Department of Health, and supported by the Department for Education and Skills. It aims to prevent 11 to 21 year olds from becoming problematic drug users, discouraging involvement with Class A drugs, and encouraging both parents and young people to become better informed. The campaign delivers its messages using a 24-hour helpline, TV, radio, press and specifically targeted information and stickers. Promotion of the campaign has involved supporting stakeholders to deliver the message locally. Preliminary findings are that 84 per cent of young people and 70 per cent of parents are aware of FRANK. Each element of the campaign has been researched and tested to ensure that all the public information is acceptable to the target audiences. By June 2004, the campaign had had over 1.5 million visits to its website and received over 425,000 calls to the helpline. Research among 15 to 18 year olds and parents of 11 to 17 year olds showed that FRANK was welcoming, helpful, and non-judgmental for those with a problem; and there was strong recognition of the campaign among teenagers. Users of the FRANK service reported:

- those who sell hard drugs should be punished (85%);
- those with a drug problem should be offered treatment (86%) (LVQ Research 2004).

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<sup>32</sup> For more information, please see [www.dare.uk.com](http://www.dare.uk.com)

<sup>33</sup> For more information, please go to <http://www.cph.org.uk/nccdp>

<sup>34</sup> More information on this national public information campaign can be found at: <http://www.talktofrank.com>

In Scotland, the Know the Score communications strategy<sup>35</sup> provided information about the risks of drug use to young people, adults (who may be parents) and professionals. In 2003, their campaigns concentrated on providing advice about drug-assisted sexual assault, volatile substance abuse and cannabis re-classification. The Health Protection Agency runs similar campaigns in Northern Ireland (HPA 2003a).

### 3.2.1 Schools

In 2004 in England, the Department for Education and Skills issued guidance on drugs (DfES 2004). This sets out the school's role in relation to all drug matters, providing guidance on both the content and organisation of drug education, and the management of drugs within school boundaries. The document defines drugs as including alcohol, tobacco and illegal drugs, as well as medicines and volatile substances, as these are of particular significance to pupils. It states that:

- schools have a drug education programme which is developmental and appropriate to the age, maturity and ability of pupils. It should cover, as a minimum, the statutory elements included in the National Curriculum Science Order for each Key Stage;
- drug education should be delivered as part of Personal, Social and Health Education (PSHE) and citizenship;
- the programme should be based on pupils' views, building on their existing knowledge and understanding; and
- drug education should be taught by skilled and confident teachers.

In addition:

- schools should develop a range of procedures for managing drug incidents, understood by all members of the school and documented within the drug policy;
- schools should make clear that the possession, use or supply of illegal and other unauthorised drugs within school boundaries is unacceptable; and
- schools and police should establish an agreed policy which clarifies roles and mutual expectations.

Within these guidelines, the DfES has also addressed which issues need to be considered before implementing drug testing. These include gaining appropriate consent from parents (and pupils where they are deemed competent), whether testing is consistent with their pastoral responsibility, whether there is appropriate support and whether it is an effective use of resources. Where schools decide to test their pupils, it must be accounted for in the school's drug policy.

Schools are also expected to ensure that pupils vulnerable to drugs are identified and receive appropriate support either from within the school or through referral to other services, with clear referral protocols. All staff are expected to receive drug awareness training, understand the school's drug policy and their role in its implementation.

In 2003, schools were provided with a self-evaluation tool within the series, *How Good is our School*, to help assessment of programmes (HM Inspectorate of Education 2002). Her Majesty's Inspectorate of Education is to undertake a focused inspection of drug education in schools.

In Northern Ireland, new guidance was issued in 2004 (DENI 2004). This states that schools have a duty in law to:

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<sup>35</sup> For more details on their campaign, please see <http://www.knowthescore.info>.

- teach drug education, as part of the Health Education cross-curricular theme;
- have a drug education policy, and publicise it in their prospectus;
- inform the police if they suspect a pupil to be in possession of a controlled drug;
- have their drug education monitored for effectiveness by the Education and Training Inspectorate; and
- train teachers as a priority to enable them to deliver drug education programmes effectively and to deal with drug related issues as they arise.

In Scotland, while there is no statutory curriculum, 99 per cent of schools (out of nearly 3,000 publicly funded schools) provide drug education (Scottish Executive 2003a). Guidance is available to assist with content, and advice to teachers (Scottish Executive 2003b). Scotland Against Drugs (SAD) aims to: provide teachers with the necessary training and resources; make young people aware of the latest information on drugs; and empower them to make informed choices. SAD also supplies a range of drug education materials<sup>36</sup>.

Guidance for schools is currently being developed in Wales, through an *All Wales Schools Programme*<sup>37</sup>.

Schools in the North West of England and the East Midlands began to pilot the Blueprint Drug Education Programme amongst 11 to 13 year olds during 2003 (Home Office 2003; see UK Focal Point 2003). This programme seeks to determine how international research on effective drug prevention can be adapted within the English system, and is based upon evidence that suggests that combining school-based education on drugs with parental involvement, media campaigns, local health initiatives and community partnerships is more effective than school interventions alone. Six million pounds (£8.5 million) has been allocated to this programme, which will be assessed over two years<sup>38</sup>.

### 3.2.2 Families

Following work by the Scottish Executive's Effective Interventions Unit (EIU) to review the impact of drug use on families and carers, and the role of family support groups, 2003 saw the establishment of the Scottish Network of Families Affected by Drugs, using funding from recovered criminal assets. The Network aims to address the needs of families affected by drugs (EIU 2004a).

### 3.2.3 Communities

Engaging communities in drugs prevention remains a priority of UK drug policy (see Chapter 3.1).

## 3.3 Selective/indicated prevention

### 3.3.1 Recreational settings

A survey of 760 club-goers alongside 26 in-depth interviews in the South East of England confirmed that drug prevalence is far higher among this group than among other young people; lifetime prevalence was 79 per cent (as opposed to 50%). They used a wide range of drugs, increasingly synthetic drugs such as ketamine (35% had used) and GHB (13%). Clubbers were aware of health and legal risks; they had

<sup>36</sup> See <http://www.sad.org.uk>.

<sup>37</sup> For more information, please see <http://www.wales.gov.uk/subicsu/content/substance/sub-misuse-team-e.htm>.

<sup>38</sup> For more information see <http://www.drugs.gov.uk/WorkPages/YoungPeople/Blueprint/EvidenceBase>

adopted strategies to minimise risks such as avoiding unknown dealers (Deehan and Saville 2003).

In Scotland, Crew 2000 has organised a coalition of young people, club goers and others to produce information about how to reduce the risks involved in drug use<sup>39</sup>.

The Health Promotion Agency for Northern Ireland launched a range of posters for pubs and nightclubs targeting 18 to 30 year olds about the dangers of drugs (HPA 2003a).

### 3.3.2 At-risk groups

In England, guidance was published in 2003 for professionals working in the statutory or voluntary sectors who provide a service to children and young people, most of whom are vulnerable (Britton and Noo 2003). The guidance discusses their responsibilities of identifying the young people's substance-related needs, and provides a framework for doing so within existing procedures.

Research into key elements of the Positive Futures projects suggested that there appear to be many factors<sup>40</sup> that help projects work effectively (MORI 2003) (see Chapter 9.2.2). An impact study is due to report in 2004.

In Scotland, the Partnership Drugs Initiative (PDI) issued grants to support voluntary sector work targeted at: families where parents use drugs; pre-teen children at high risk of developing patterns of problem substance use; and young problematic drug users. By the end of 2003, 52 projects were funded. An evaluation of 17 has been completed (EIU 2004b). Findings suggest that many of the projects are making a significant input with a range of factors contributing to their success: careful planning of projects that are well integrated with their host agency or agencies; clarity of purpose; having a flexible, holistic client-centred approach; a clear model of care and support with well-defined boundaries; in-house expertise; and training. One area in which many of the projects needed to address was how to define criteria for the closure of cases.

The second stage in the national evaluation of the pump priming drug prevention initiative reported in January 2004. Seven million (£10 million) pounds was distributed to Health Action Zones (HAZs) in deprived areas of England in order to develop services targeted at vulnerable young people (Bauld *et al.* 2003). The report concluded that although the initiative did facilitate the development of interventions, it was felt that the services were too small, too localised, and in some cases, too short-term to do so effectively. Subsequently, this raises questions about the merits of distributing relatively limited amounts of very short-term funding.

### 3.3.3 At-risk families

In Scotland, services for children and families suffering from the effects of drug use are being improved through the Changing Children's Services Fund<sup>41</sup>.

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<sup>39</sup> See [www.crew2000.co.uk](http://www.crew2000.co.uk) for further details.

<sup>40</sup> Including flexibility, good relationships with partners and referral agencies, sessional staff, and the community itself.

<sup>41</sup> See [http://www.childrenscotland.org.uk/html/poly\\_c\\_cr.htm](http://www.childrenscotland.org.uk/html/poly_c_cr.htm).



## 4. Problem drug use

### 4.1 Overview

Population-based surveys, because of the often hidden nature of problem drug use, are considered to be of limited use in estimating its full extent. Instead, national prevalence estimates can be derived from a range of methods, with the multivariate indicator method being the favoured approach. This combines local prevalence estimates along with routinely available indicator data. Local estimates are usually derived from specific research studies that employ slightly different definitions of what constitutes problem drug use. In this instance, it is the capture-recapture method that is the most widely used to provide local prevalence estimates. At present, these are only available for Scotland and parts of England. Table 7 shows the national prevalence rates for the UK, although Wales has not been included as their last national prevalence rate was derived in 1994 and so is now thought to be obsolete.

Table 7: National prevalence estimates for problem drug use in the United Kingdom

Administration	Year	Problem drug use		Injecting use	
		Number	Rate per thousand population	Number	Rate per thousand population
England	2000/01	287,670	8.91 95% CI= 8.53 to 9.29	93,185	2.89 95% CI= 2.87 to 2.91
Northern Ireland	2000	828	0.76 95% CI= 0.63-0.93	No estimate	No estimate
Scotland	2000	55,800	16.65 95% CI= 16.45 to 17.53	24,696	7.737 95% CI= 5.87 to 8.58

Source: Information Statistics Division, Scotland 2002<sup>42</sup>; McElrath 2002<sup>43</sup>; Frischer *et al.* 2004<sup>44</sup>.

Local prevalence estimates of problem drug use in Scotland range from 2.9 in the Orkney Isles to 30.8 per thousand (confidence interval (CI) = 26.6-36.7) in Glasgow (ISD 2002). In comparison, local estimates of injecting in Scotland range from 1.9 in the Highlands (CI = 0.5-30.5) to 14.4 per thousand (CI = 10.2-26.1; Bird *et al.* 2003). In Greater Manchester, estimates of local prevalence of problem drug use are 13.9 per thousand of the population aged 16 to 54 years old (19,255, 95% CI of 18,731-21,853; Millar *et al.* 2004).

Information on clients presenting to treatment is collected from the Drug Misuse Databases<sup>45</sup> (DMDs) in each administration, which gather data on all presentations

<sup>42</sup> ISD (2002) derived their national estimate through using the sum of the 32 local prevalence estimates. Here, problem drug use is defined as opiate and/or benzodiazepine use.

<sup>43</sup> McElrath (2002) used the capture-recapture method for Northern Ireland. Here, problem prevalence is defined as heroin use.

<sup>44</sup> Frischer *et al.* (2004) used information gathering to collect the data for England.

<sup>45</sup> In England, the National Drug Treatment Monitoring System (NDTMS) replaced the DMD in April 2001.

from those seeking treatment from specialist drug services (outpatients), inpatient services and general practitioners. For those presenting for treatment in Great Britain, the main drug is heroin (varying between 49% and 67% of treatment presentations). In Scotland, diazepam continues to be the second most commonly used drug after heroin as it is reported by 37 per cent of those making presentations (not necessarily as main drug). Elsewhere in the UK, diazepam use is less common. In Northern Ireland, just over a third use opiates and nearly half use cannabis as their main drug. Lifetime prevalence of injecting varies between 27 and 59 per cent. For all presentations, a third are under 24 years of age and a quarter are aged between 25 and 29 years; approximately three quarters are male.

## 4.2 Prevalence and incidence estimates

### 4.2.1 National prevalence

Using the available estimates of national prevalence for England, Northern Ireland and Scotland, an estimate of national prevalence has been calculated. This assumes that the prevalence rate for England (8.91 per thousand) applies to Wales. The estimate for problematic drug users is 9.35 per thousand (360,811 with a CI of 8.99 to 9.79 per thousand). For injecting drug use, the estimate is 3.2 per thousand (123,498 with a CI of 3.07 to 3.34 per thousand population aged 15 to 64 years).

More recent estimates of problem drug use and drug injecting prevalence for 2003 have just been derived for the whole of Scotland; these estimates are not due to be in the public domain until late 2004.

### 4.2.2 Local estimates

Local prevalence estimates<sup>46</sup> are available for 14 areas covering 24 of the 149 Drug and Alcohol Action Teams (D(A)ATs) in England (published in 2004). Estimates for prevalence of problem drug use varied from 0.2 per cent to 1.5 per cent of the resident population. Estimates for injecting drug use varied from nought to one per cent (Frischer *et al.* 2004).

Studies in Brighton, Liverpool and London considered the age range 15 to 44 years. The prevalence of problem opiate use was estimated to be 11.0 per thousand in 12 London boroughs (N=2,623,362; CI= 8.53-16.40). The prevalence of injecting drug use was estimated to be 6.4 per thousand in the London boroughs (N=2,623,362; CI=5.26-8.24), 9.3 per thousand in Brighton (N=2,304; CI=6.11-15.08), and 6.6 per thousand in Liverpool (N=2,910, CI= 8.78-17.15) (Hickman *et al.* 2004).

## 4.3 Profile of clients in treatment

Table 8 shows the latest available data on clients in treatment for the UK.

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<sup>46</sup> Derived from capture-recapture studies in 2000/01.

Table 8: New presentations for treatment in the UK

Administration	Year	Number of new presentations
England <sup>47</sup>	2003/04	81,547
Northern Ireland <sup>48</sup>	2002/03	1,368
Scotland <sup>49</sup>	2002/03	11,433
Wales <sup>50</sup>	2000/01	3,730
TOTAL		98,078

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

#### 4.3.1 By substance used

Opiates continue to be the most common main drug at approximately 67 per cent of those newly presenting for treatment, cannabis accounts for nine per cent, crack, five per cent, cocaine, four per cent and benzodiazepines at two per cent. Males represent 72 per cent of presentations. Approximately 27 per cent of those presenting for treatment have ever injected, and 21 per cent currently inject. In Northern Ireland, nearly half (47%) of new treatments concern cannabis as the main drug involved. This is far higher than elsewhere in the UK. In addition, the Northern Ireland percentage of new presentations reporting injecting is also much lower at 9.3 per cent, although amongst opiate users, 53 per cent inject (DHSSPSNI 2004b).

For the UK as a whole, it is difficult to describe trends as the relevant information for England, by far the largest of the countries, is for 2000/01. However, figures for Scotland are available and despite concerns about lack of treatment for stimulant users, and therefore, a lack of incentive to present to treatment services, the percentage of individuals reporting use of cocaine has increased from two per cent in 1998/99 to seven per cent in 2002/03. The use of crack has increased from one to three per cent. The proportion of new clients reporting the use of diazepam in Scotland has remained broadly similar over the past five years (reported by 37% of those making presentations, although not necessarily as their main drug of use); ecstasy use has also remained reasonably constant at around five per cent over recent years (ISD 2004). These data also indicate an increase in injecting as 42 per cent reported that they had injected in the past month. This is an increase from the relative stability of previous years (in 1998/99, 39%; in 2001/02, 38%). The rise in new individuals reporting injecting in the last month was reflected in all age groups but particularly so in the 20 to 24 age group. However, there was a fall from previous years in the number of current injectors reporting that they had shared needles or syringes in the previous month (32% of current injectors; 34% in 1998/99; 36% in 2001/02).

#### 4.3.2 By centre types

See Chapter 5.3

#### 4.3.3 Other specific sub-populations

##### *Preteen drug use*

Research in Glasgow and Newcastle suggests that among the 2,000 participants aged 10 to 12 year, 4 per cent had used drugs (McKeganey *et al.* 2003). Whilst

<sup>47</sup> These data are from NDTMS returns for 2003/04 as supplied by NDTMS 1<sup>st</sup> September 2004. the Drug Misuse Research Unit compiled these data for UK Focal Point.

<sup>48</sup> Data for 2002/03 were provided by the NIDMD.

<sup>49</sup> Data for 2002/03 were provided by the ISD.

<sup>50</sup> These data were extracted from the DMD by the Department of Health.

principally confined to cannabis, a very small number had used heroin. Early age of onset was often combined with a wide range of problem behaviours, deprivation, and/or with having a family member who used drugs.

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

NO NEW INFORMATION AVAILABLE

Please see UK Focal Point (2003) for details of after-care and reintegration.

## 5. Drug-related treatment

### 5.1 Overview

UK Drug Strategies identifies treatment as being effective in tackling drug use and, therefore, indicate a need to increase its availability and quality (Northern Ireland Office 1999; Scottish Office 1999; National Assembly for Wales 2000; Drugs Strategy Directorate 2002a). As such:

- in 2000, the Effective Intervention Unit (EIU) was established to identify and disseminate effective practice in Scotland.
- in 2001, the National Treatment Agency for Substance Misuse (NTA) was established in England to: increase the availability, capacity and effectiveness of drug treatment; develop a range of quality standards and guidelines; double the number in treatment over 10 years from a baseline of 100,000 in 1998; and to increase the proportion who successfully complete or, if appropriate, continue treatment.
- the Department of Health, Social Services and Public Safety (DHSSPSNI) in Northern Ireland, and the Welsh Assembly are responsible for similar arrangements.

This emphasis on treatment is also replicated for those in the Criminal Justice System, and is a key component of UK Drug Strategy (see Chapters 9 and 12).

The *Updated Drug Strategy* clarified that while treatment services should continue to seek abstinence, reducing the harms associated with problem drug use is a key objective (Drugs Strategy Directorate 2002a). Treatment providers are to offer prescribed treatment, advice and information, needle exchange, care planned counselling, structured day care programmes, community prescribing, inpatient drug treatment and residential rehabilitation. In addition, drug users are to be offered relapse prevention and aftercare programmes, hepatitis B vaccinations, and testing and counselling for hepatitis B and C, and HIV (DH 2002b). With regards to prescribed treatment, oral methadone maintenance is common in treating heroin addiction, although recently buprenorphine has been introduced as an alternative (see Chapter 11). Specialist treatment for crack users is being developed as part of the National Crack Plan (Drugs Strategy Directorate 2002b). Such services are provided by specialist agencies in the statutory and voluntary sector, and increasingly by general practitioners.

Young people do not benefit from treatment services directed at adults. They need separate services which address their specific needs as, for example, their drug use is not entrenched and may often reflect other personal and social problems, which are best met by mainstream children and adolescent services (Drugs Strategy Directorate 2002a).

Referral into treatment through the Criminal Justice System and whilst in prison, is a component of UK Drug Strategy (see Chapters 9 and 12).

There has been considerable investment into research into treatment over the last few years. NTA funds a number of initiatives and the Department of Health has provided £1.4 million (€2 million) over 3 to 4 years for research through the Drug Misuse Research Initiative (see Chapter 7.2).

## 5.2 Treatment systems

The Scottish Executive has recently undertaken a review of drug treatment and rehabilitation services (Scottish Executive 2003c), the report is not yet published. A review of Welsh Substance Misuse Services in 2002/03 has also been undertaken (National Assembly for Wales 2003). This found many of the problems encountered within treatment services elsewhere in the UK prior to the development of strategies for improvement; a complex service structure, a plethora of planning structures, commissioners and funding streams, too many short term initiatives, and under resourcing. A number of initiatives are currently underway to rectify these problems. Community Safety Partnerships replaced D(A)ATs in Wales in taking responsibility for improving drug treatment, and are developing Substance Misuse Action Plans locally<sup>51</sup>. Substance Misuse Regional Teams provide advice at the local level and a Substance Misuse Treatment Framework is currently being developed.

Expenditure available for treatment in the UK has risen to £503 million (€714 million) in 2003/04. By 2004/05, this will be £573 million (€814 million) (Drugs Strategy Directorate 2002a; see Chapter 1.4).

### 5.2.1 Treatment presentations

Recent figures show that the number of people receiving treatment for their drug problem in England has increased by 41 per cent since 1998, and waiting times have been cut by two-thirds since December 2001. In 2003, 141,000 people received treatment, suggesting that the target of doubling the number in treatment over ten years to 200,000 in 2008 may be met (NTA 2003a). Table 9 gives further information for the UK on the number of new treatment presentations.

*Table 9: The number of new treatment presentations in the United Kingdom*

Administration	Year	Number of new presentations
England	2003/04	81,547 <sup>52</sup>
Northern Ireland	2002/03	1,368
Scotland	2002/03	11,433
Wales	2000/01	3,730

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

### 5.2.2 Service standards

The NTA has been involved in a number of projects including the production of guidance and standards for the commissioning and provision of drug treatment services, and working to build capacity to ensure services are developed in England (see Chapter 7.2)<sup>53</sup>. In 2003, the agency also took over responsibility for the National Drug Treatment Monitoring System (NDTMS), which collects and analyses information on treatment presentations.

### 5.2.3 Under-representation in services

The Diversity Team in the Home Office continues to address the under-representation of certain population groups (such as women and minority ethnic groups) in services. To tackle this issue, drug services are expected to be more flexible and willing to develop methods for attracting and maintaining these groups

<sup>51</sup> These concern both alcohol and drugs.

<sup>52</sup> Identified by 1<sup>st</sup> September 2004.

<sup>53</sup> For more information, please see <http://www.nta.nhs.uk>.

into treatment. Consultation on how to access them began in 2004. A number of pieces of research have been undertaken in this area and guidance has been issued. This includes: street homelessness (Randall *et al.* 2002) and begging (Drugs Strategy Directorate 2004a) and those involved in street prostitution (Hester and Westmarland 2004; Hunter and May 2004).

#### 5.2.4 Research into treatment

A programme co-ordinator has been appointed to help with overall co-ordination, communication and dissemination of the Drug Misuse Research Initiative programme. As such, a number of research projects were completed in 2003/04<sup>54</sup>.

1. A step-by-step epidemiological needs assessment of dual diagnosis, and the design of a training and service response model (Strathdee *et al.* 2002) (see Chapter 6.4).
2. Research into the nature and extent of comorbidity in England and Wales (Frischer *et al.* 2003) (see Chapter 6.4).
3. A pilot feasibility study for a multi-centre randomised controlled trial to compare the outcomes and costs of offering and prescribing injectable versus oral methadone (Metrebian *et al.* 2003). However, the study was unable to recruit a sufficient number of opiate dependent injecting users presenting for treatment, suggesting that the target population does not appear to be presenting to treatment.
4. Research into preteen drug use (McKeganey *et al.* 2003) (see Chapter 4).
5. Research into the effect of waiting times (Donmall *et al.* 2003). This found that agencies define and measure their 'waiting times' in a variety of ways and stress the importance of clear guidance on this. It was also suggested that waiting times should not be used on their own as a measure of quality, at least in terms of uptake and retention, as other factors influence these outcomes. Most consistent is the highly significant effect that the agency itself has on whether clients are taken on and retained; some agencies are better at engaging clients and retaining them.
6. An evaluation of a brief intervention model for use with young non-injecting stimulant users (Marsden *et al.* 2003) concluded that such interventions are valuable for use with this group and can be successfully delivered by trained and well-supported workers. There was evidence that such interventions were significantly better than a basic assessment of drug use and lifestyle in encouraging young people to reduce risky stimulant use. However, this evidence was not sufficient enough to say that brief motivational interventions should be delivered in practice without further development.

#### 5.3 Drug free treatment

In England, a new approach to treating crack/cocaine use is being piloted, focusing training on new occupational standards and piloting a range of new materials and tools for drug workers to use (NTA 2003b). The pilot along with eight existing crack treatment services is to be evaluated. The NTA suggests that this will constitute the largest study of crack/cocaine treatment ever carried out in Europe (NTA 2003c). The EIU is supporting the development and evaluation of a pilot psycho-stimulant service in Aberdeen (EIU 2004c). While services for crack users are under consideration in Northern Ireland, to date there have been only four reports of individuals presenting to services with crack problems (DHSSPSNI 2004b).

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<sup>54</sup> Summaries can be found on. <http://www.mdx.ac.uk/www/drugsmisuse/execsummary.html>

### 5.3.1 Inpatient treatments

Available information for England (2003/04), Scotland (2002/03) and Northern Ireland (2002/3) suggest that just over four per cent of new treatments for drug problems involved inpatient care (4,099).

### 5.3.2 Outpatient treatments

Available information for England (2003/04), Scotland (2002/03) and Northern Ireland (2002/03) suggest that just over 91 per cent of new treatments for drug problems involved specialised drug services (outpatients) (86,264).

A further four per cent (3,987, n= 94,350) involved general practitioners.

## 5.4 Medically assisted treatment

### 5.4.1 Withdrawal treatment

Information on this is not currently monitored.

### 5.4.2 Substitution treatment

Northern Ireland has not seen the same level of problem drug use as elsewhere in the UK until the last few years (House of Commons Northern Ireland Affairs Committee 2003), though prevalence is increasing (see Chapter 4), and so substitute prescribing has been rare. However, in 2004 in Northern Ireland, guidelines for substitution treatment for opiate dependence were introduced (DHSSPSNI 2004c).

Injectable heroin and methadone, while long prescribed in the treatment of opiate addiction, albeit rarely in the UK, are to be extended in England (NTA 2003d). Three per cent, or 2,500 methadone and 450 heroin users, currently receive this treatment. It is estimated that between five and 10 per cent of patients may benefit from this. As such, new guidance has been developed on prescribing injectable drugs (NTA 2003d). It is not the intention of the guidance to expand the number of drug users being prescribed heroin, but to improve the quality of prescribing practice. There are no plans to make heroin or injectable methadone available elsewhere in the UK.

### 5.4.3 Other medically assisted treatment

Only prescribed treatments are offered with medical assistance.



## 6. Health correlates and consequences

### 6.1 Overview

There are a number of risks to health associated with drug use, in particular use of opiates and cocaine-based drugs. These include the potential for overdose and death, infectious diseases, mental illness, other physical health problems and health problems for children born to mothers who used drugs during pregnancy.

#### 6.1.1 Drug-related deaths

There are two main types of source in the UK for information on 'acute' deaths: three General Mortality Registers (GMRs), the General Register Offices for England and Wales, Scotland, and Northern Ireland and one Special Mortality Register (SMR), compiled through the National Programme on Substance Abuse Deaths (np-SAD) based at St George's Hospital Medical School.

Since 2000, when drug-related deaths (DRDs) reached nearly 2,000, the numbers have fallen. While males are still more likely to be involved, the male to female ratio is at 4.24:1. The average age at death has also begun to fall to around 34 years, with males tending to be five years younger. Overall, most deaths occurred in the 25 to 29 age group. Over seventy per cent of deaths are associated with opiates (chiefly heroin/morphine and methadone), often in combination with other drugs, including alcohol. Large numbers of deaths also involve benzodiazepines such as temazepam and diazepam. Cocaine-related deaths, while still low in numbers, have increased substantially over the last few years (mentioned in 9% of cases in 2002). There has been a steady increase in the number of deaths associated with ecstasy, with 202 occurring between 1996 and 2002.

#### 6.1.2 Blood borne infectious diseases

Data on the prevalence of blood borne infectious diseases amongst injecting drug users (IDUs) are provided by a number of sources:

- the Unlinked Anonymous Prevalence Monitoring Programme's (UAPMP) surveys of IDUs in contact with drug services in England, Wales and Northern Ireland (Hope *et al.* 2001; Unlinked Anonymous Steering Group 2002);
- the Centre for Research on Drugs and Health Behaviour's surveys of IDUs recruited from community settings in England (Hunter *et al.* 2000); and
- the Scottish Centre for Infection and Environmental Health's (SCIEH) surveys of IDUs attending both community and drug agency settings in Glasgow (Taylor *et al.* 2000). SCIEH also holds anonymous epidemiological data on all those who have had a named HIV antibody test in Scotland since 1989 (on the HIV Denominator Database).

All collect behavioural data and oral fluid for testing for antibodies to hepatitis C (anti-HCV).

The main sources of information on newly diagnosed HIV/AIDS infections are from voluntary cases reporting from laboratory reports of newly diagnosed infections by microbiologists and clinicians<sup>55</sup>. For England, Wales and Northern Ireland, reports are made to the Health Protection Agency's Communicable Disease Surveillance Centre (CDSC) whilst new diagnoses in Scotland are reported to SCIEH.

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<sup>55</sup> Laboratory report data for England and Wales, Scotland, and Northern Ireland are available from the following websites: <http://www.hpa.org.uk> for England and Wales, <http://www.show.scot.nhs.uk/scieh> for Scotland and <http://www.cdscni.org.uk> for Northern Ireland.

HIV prevalence among IDUs in the UK has remained at less than or around one per cent since the mid-1990s, though in London it has been higher at or near four per cent. At the end of 2002, there were an estimated 1,400 people living with HIV infection acquired through injecting drug use, of whom 300 were thought to be undiagnosed.

The prevalence of hepatitis C (HCV) amongst IDUs has been much higher at around 45 per cent, and there is evidence of increased incidence (Health Protection Agency 2003). Prevalence of antibodies for hepatitis B (anti-HBc) has declined, levelling off at 20 per cent. Outbreaks of hepatitis A and increasing occurrence of other infections among IDUs have been increasingly reported; methicillin resistant *Staphylococcus Aureus* (MRSA) as a cause of IDU-related sepsis (Anon 2003a) and other serious Clostridial infections acquired through contaminated drugs (Jones *et al.* 2002; McGuigan *et al.* 2002). This has followed reported increases in injecting risk behaviour among IDUs (Hope *et al.* 2002).

### 6.1.3 Dual diagnosis

Prevalence and attribution of dual diagnosis remain difficult to estimate. Depression, anxiety disorders, personality and psychotic disorders are commonly reported, although prevalence varies with setting and specific sub-populations. There is also increasing information regarding the attribution of mental health issues to the use of cannabis (Patton *et al.* 2002; Zammit *et al.* 2002) and ecstasy (MacInnes *et al.* 2001), although this needs further investigation.

### 6.1.4 Other health correlates and consequences

Other physical health problems associated with problem drug use include thrombosis, blood clots and gangrene (Scottish Advisory Committee on Drug Misuse 2002).

In addition, maternal drug use can have a significant impact on unborn children. There is evidence of high rates of early pregnancy loss and placental disruptions associated with cocaine use, and evidence is now emerging that children whose mothers used cocaine whilst they were pregnant are at risk of haemorrhaging as they grow older (DH *et al.* 1999).

Maternal heroin use is associated with low birth weight babies (DH *et al.* 1999). There is concern about birth defects linked to ecstasy use (Ho *et al.* 2001). Benzodiazepines can cause “floppy infant syndrome” and evidence suggests it may also be linked to major malformations such as cleft palate. Babies born to mothers exposed to long-term benzodiazepine use risk deviation in neurological development during their first 18 months, which can result in behavioural problems, dyslexia and attention-deficit disorder. These problems may not come to light until puberty (Bibby 2000). Cleft palate is also associated with amphetamine use (Bibby 2000).

Withdrawal from maternal drug use can also be problematic for babies. Withdrawal from opiates and stimulants is not predictable and withdrawal from maternal benzodiazepines can be severe and prolonged; there may be a link with Sudden Infant Death Syndrome (Bibby 2000).

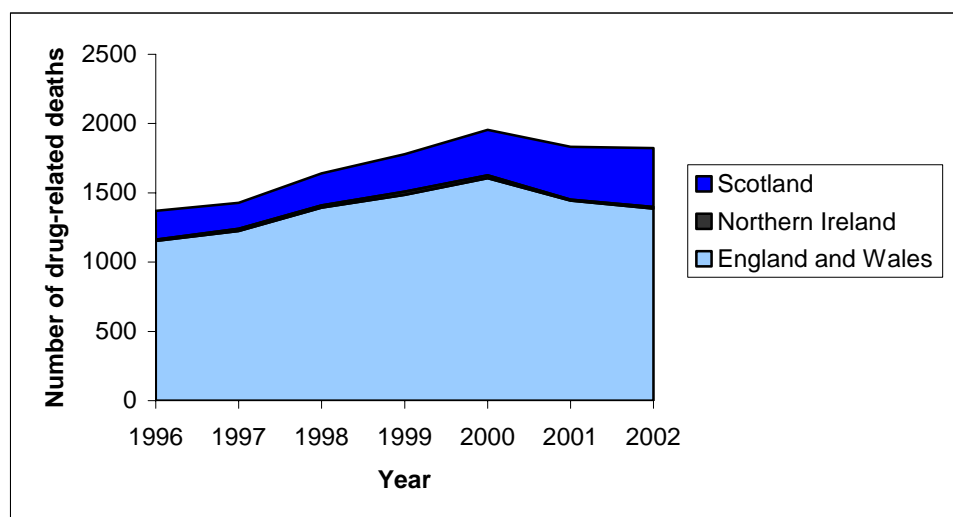
There is no evidence of HIV transmission to babies in the UK through maternal infection associated with drugs, but there is a risk of hepatitis transmission, particularly hepatitis C, where the risk of transmission amongst babies whose mothers test positive is six per cent (DH 2002c; Siney 2002).

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

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

The latest information on DRDs is for 2002. The total number of deaths has continued to fall from its peak in 2000 by 4.9 per cent to 1,824 in 2002 (Figure 2). The male to female ratio continues to reduce; 4.24 males to 1 female (Table 10 and Figure 3). The overall average age fell back to 34.0 years (SD 11.4) in 2002, though the average age of death for females remains much higher than for men, ranging from over four to nine years higher.

Figure 2: Number of deaths using European Monitoring Centre for Drugs and Drug Addiction drug-related deaths standard definition



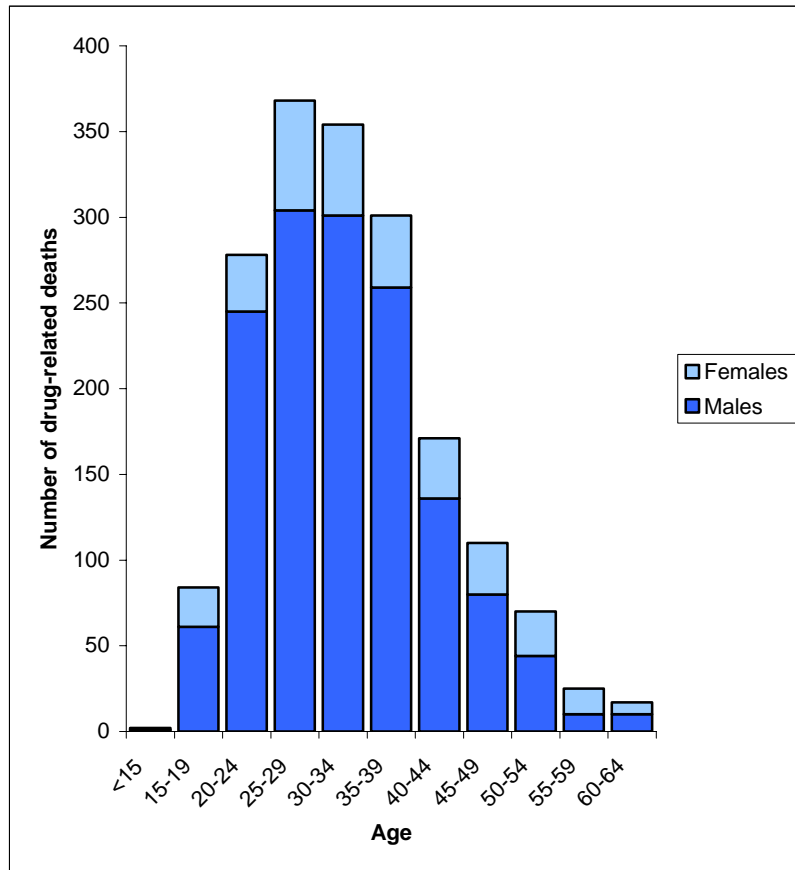
Source: compiled by John M. Corkery from published data from the Office for National Statistics, the General Register Office for Scotland (2003), and from unpublished data provided by the General Register Office for Northern Ireland. 2004.

Table 10: Death by age, gender and administration in the United Kingdom using the European Monitoring Centre for Drugs and Drug Addiction drug-related deaths standard definition, 2002

Age	England and Wales		Northern Ireland		Scotland		UK	
	Males	Females	Males	Females	Males	Females	Males	Females
<15	1	1	0	0	0	0	1	1
15-19	45	12	16	11	0	0	61	23
20-24	177	25	67	8	1	0	245	33
25-29	227	46	75	18	2	0	304	64
30-34	239	45	62	8	0	0	301	53
35-39	205	34	51	8	3	0	259	42
40-44	104	23	31	12	1	0	136	35
45-49	61	20	19	7	0	3	80	30
50-54	38	21	5	5	1	0	44	26
55-59	3	10	7	6	0	0	10	15
60-64	7	5	3	2	0	0	10	7

Source: compiled by John M. Corkery from published data from the Office for National Statistics, the General Register Office for Scotland (2003), and from unpublished data provided by the General Register Office for Northern Ireland. 2004.

Figure 3: Death by age and gender using European Monitoring Centre for Drugs and Drug Addiction drug-related deaths standard definition, 2002

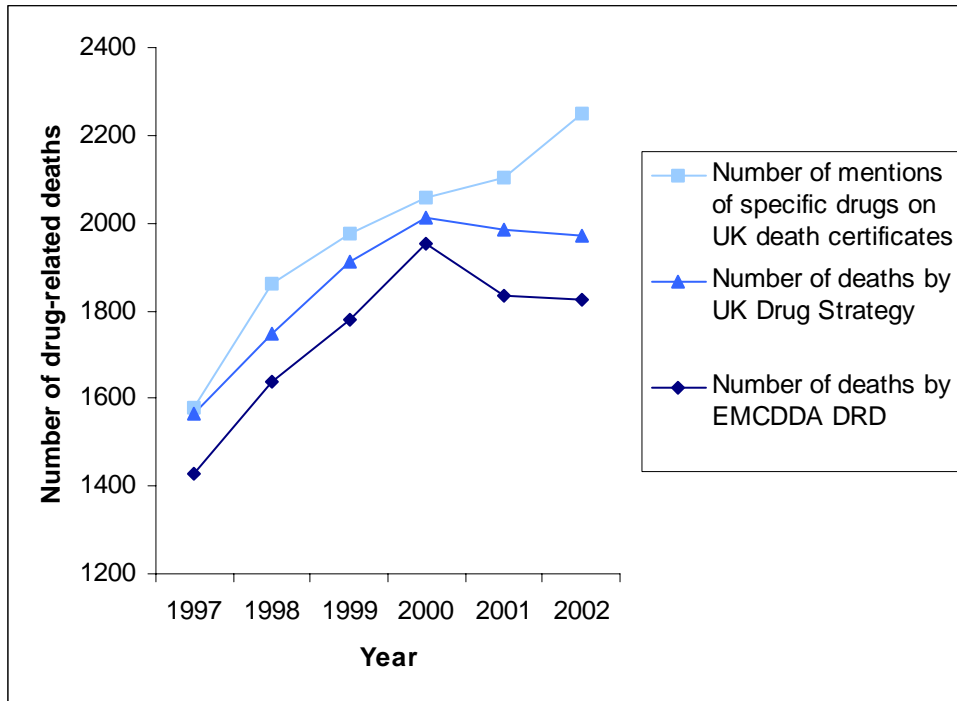


Source: compiled by John M. Corkery from published data from the Office for National Statistics, and General Register Office for Scotland (2003), and from unpublished data provided by the General Register Office for Northern Ireland. 2004.

The number of deaths per 100,000 of the population is different between the UK administrations. In 2002, the rate in Scotland was 8.42 compared to 2.64 in England and Wales, and 0.71 in Northern Ireland. The UK average was 3.08.

Differences also emerge when looking at the various definitions used for DRDs. Figure 5 demonstrates that although the three definitions displayed show similarities in terms of numbers and trends, there are still noteworthy differences between them (see UK Focal Point 2003 for further details).

Figure 4: Comparison of total number of deaths using three definitions (United Kingdom)



Source: Office of National Statistics 2004, General Register Office for Scotland 2003, General Register Office for Northern Ireland.

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

Overall, deaths in England and Wales in 2002 were described as being due to:

- mental and behavioural disorders (54%);
- accidental poisoning (27%);
- intentional or undetermined poisoning (18%); and
- assaults by poisoning or drug psychoses (5 cases).

Heroin/morphine continued to account for the highest number of deaths according to all three definitions discussed (see Tables 11 and 12). Using the EMCDDA standard, this is 63 per cent. In addition, mentions of cocaine and ecstasy are increasing (see Tables 11 and 12).

Table 11: Mentions of specific drugs on United Kingdom death certificates

Drug	2000	2001	2002
Heroin/morphine	1204	1192	1146
Methadone	373	362	418
Cocaine	85	115	171
Ecstasy	49	76	75
Diazepam	231	278	345
Temazepam	116	82	95

Source: Office of National Statistics 2004, General Register Office for Scotland 2003, General Register Office for Northern Ireland.

Table 12: Drugs as a proportion of drug poisoning deaths by definition<sup>56</sup>

Drug	1999		2000		2001		2002	
	EMCDDA	UK	EMCDDA	UK	EMCDDA	UK	EMCDDA	UK
Heroin/morphine	56.3	52.5	61.6	59.9	65.0	60.1	62.8	58.1
Methadone	24.4	22.8	19.1	18.5	19.7	18.3	22.9	21.2
Cocaine	5.6	5.2	4.3	4.2	6.3	5.8	9.4	8.7
Ecstasy	2.0	1.8	2.5	2.4	4.1	3.8	4.1	3.8
Diazepam	14.6	13.5	11.8	11.5	15.2	14.0	18.9	17.5
Temazepam	8.0	7.4	5.9	5.8	4.5	4.1	5.2	4.8
Total number of deaths	1780	1912	1955	2011	1833	1983	1824	1972

Source: Office of National Statistics 2004, General Register Office for Scotland 2003, General Register Office for Northern Ireland.

There were 63 deaths associated with volatile substance abuse in 2002 (the same as in 2001). The figures for 2001 and 2002 are the lowest since 1982, and can be compared with 1990's peak of 152 (Field-Smith *et al.* 2003).

Deaths of IDU AIDS victims accounted for 5.3% of the total number of AIDS deaths in England And Wales up to the end of March 2004. In Northern Ireland the figure was 4.7%, but in Scotland was 42.0%. The decline in the number of deaths of IDU AIDS victims seen in recent years has levelled off. The UK figure of 23 for 2003 (21 in 2002) is about 14% of the peak level in 1995 (159).

### 6.2.3 Research into drug-related deaths

A number of studies touching on DRDs in the UK were published in the last year. Unfortunately, these did not include any cohort mortality studies.

A study of 221 coroners' cases, for males aged 15 to 39 years in 1995 for which toxicology reports were available, found post mortem evidence of drugs in 90 cases, alcohol in 102, and both in 46. Overdose verdicts were given in 74 cases. There was evidence of significant alcohol problems in 18 cases and drug misuse in 74 cases. The presence of drugs at post mortem was significantly related to a verdict of accidental or undetermined death rather than suicide. Whilst coroners determined drugs to be related to death in 90 cases, the figure would have been recorded as 60 using the ONS definition or 40 using the EMCDDA DRD standard (Stanistreet *et al.* 2004).

Observed DRDs (n=332) in Scotland in 2001 fitted better with expectations based on regional estimates of current IDUs (n=22,805) than those based on related estimates of problematic drug users. DRDs were significantly lower in female than in male drug users. DRDs were between two and six times more frequent amongst those older than 34 than those younger than 25 years (Bird *et al.* 2003).

Deaths associated with ecstasy have continued to increase. In 17 per cent of cases, ecstasy was the sole drug implicated in death and in the remainder, a number of other drugs (mostly alcohol, cocaine, amphetamines and opiates) were found. MDMA 3,4-(methylenedioxy-n-methylamphetamine) accounted for 86 per cent and MDA (methylenedioxyamphetamine) for 13 per cent; single deaths were associated with MDEA (methylenedioxyethylamphetamine) and PMA (para-metoxamphetamine).

<sup>56</sup> Definitions used are the EMCDDA drug-related death standard definition (under those columns marked 'EMCDDA') and UK Drug Strategy definition (under those marked 'UK').

This is the largest sample of ecstasy-related deaths so far examined (Schifano *et al.* 2003).

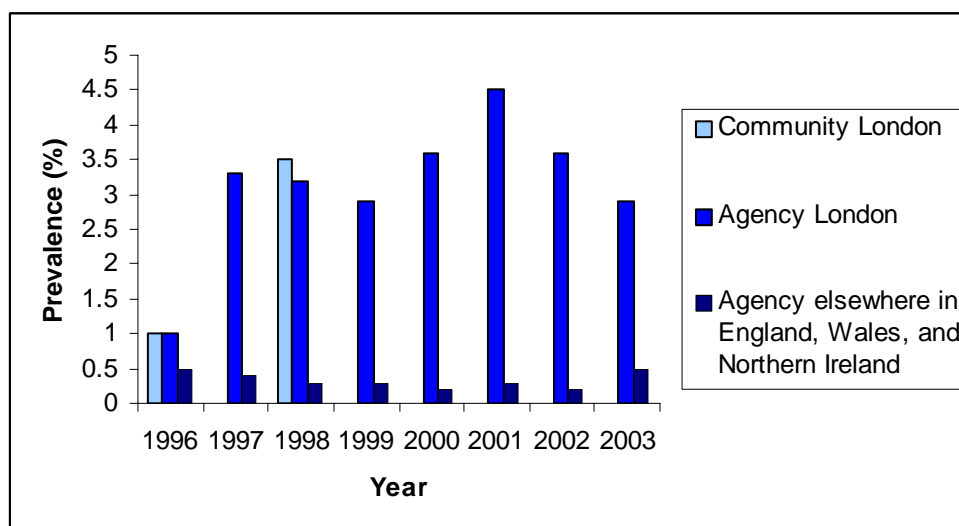
An important development was the publication of two studies addressing antidepressants. The first was a study of deaths involving antidepressants which reported to the SMR in 1998-2000 (468 out of 4,167 drug-related deaths in that period; Cheeta *et al.* 2004). The study found that most were suicides (80%). Tricyclic antidepressants accounted for more drug mentions than any other antidepressants (12 per million prescriptions). SSRIs (selective serotonin reuptake inhibitors) were associated with a significantly lower risk of toxicity but 93 per cent of deaths from SSRIs occurred in combination with other drugs, especially tricyclics (24.5%). In 'combination' deaths, patients were significantly more likely to have had a history of drug use.

Between 1993 and 2002, a second study looked at the 4,767 deaths that occurred in that time involving antidepressants in England and Wales (18% of all poisonings). Research found that over the period, age-standardised mortality rates for antidepressants in England and Wales decreased from about nine to seven per million of the population for both genders. However, unlike females, rates in males rose to a peak of 12 per million in 1997 before falling. The number of antidepressant prescription items during the study period rose 2.5 times to 26 million prescriptions, largely due to increased use of SSRIs and other antidepressants. Overall, death rates in England per million antidepressant prescription items declined, with falls in the rates for dothiepin, amitriptyline and all tricyclics. There was no change in the SSRI rate while rates for other antidepressants rose. Despite these trends, throughout the study period, rates were highest for tricyclics and lowest for SSRIs (Morgan *et al.* 2004).

### 6.3 Drug-related infectious diseases

#### 6.3.1 HIV/AIDS

Figure 5: HIV prevalence among injecting drug users in the UK<sup>57</sup>



Source: Communicable Disease Surveillance Centre, Health Protection Agency; Centre for Research on Drugs and Health Behaviour, Imperial College London

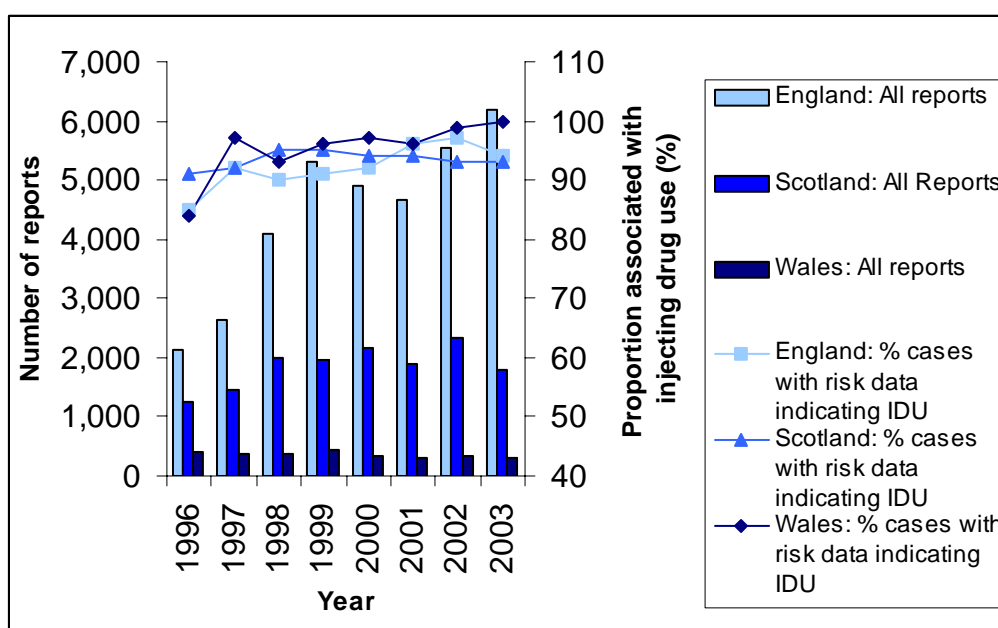
<sup>57</sup> The figure includes information for Northern Ireland from 2002.

Prevalence data presented here have not been adjusted for assay sensitivity. In 2003, HIV infections were found in the UAPMP agency survey amongst those who had begun injecting in the past three years (0.8%, 3 of 849); this was the highest prevalence seen in this group since 1990 and is a marker of current incidence, suggesting that transmission continues and may even have increased recently (see Figure 5).

### 6.3.2 Viral hepatitis

Prevalence of hepatitis C among injectors increased to 41 per cent (1,081 of 2,615) in 2003, from 36% in 1998 in England and Wales (1,151 of 3,188; Hope *et al.* 2001). Prevalence among recent initiates (those who began injecting in the last three years) has also increased from 8 per cent in 1998 to 17 per cent in 2003 in England, Wales and Northern Ireland (Health Protection Agency 2004)<sup>58</sup>. (See Figure 6.)

Figure 6: Hepatitis C laboratory reports in the United Kingdom<sup>59</sup>



Source: Communicable Disease Surveillance Centre, Health Protection Agency; Scottish Centre for Infection and Environmental Health.

Prevalence of hepatitis B remains the same (20%).

### 6.3.3 Sexually transmitted diseases

NO INFORMATION AVAILABLE

### 6.3.4 Tuberculosis

NO INFORMATION AVAILABLE

<sup>58</sup> The anti-HCV assay for England and Wales has 83 per cent sensitivity (Judd *et al.* 2003). More recent work suggests that this can be improved if a different cut-off point is used and work is in progress to revise the data appropriately. The Glasgow anti-HCV assay has 85 per cent sensitivity (Cameron *et al.* 2003) and the anti-HBc assay for England and Wales has 75 per cent sensitivity (Judd *et al.* 2002).

<sup>59</sup> England and Wales, and Scotland have different case definitions. Data for Scotland for 2002 are not presented as they relate only up to 30 June 2002.



### 6.3.5 Other infectious morbidity

While tetanus has rarely been reported in IDUs (Rushdy *et al.* 2003), an outbreak occurred in 2003 and is ongoing: 14 cases were reported between July 2003 and January 2004 (Hahné *et al.* 2004). The majority of cases had generalised tetanus and one case is known to have died. Seven out of nine cases for whom information on the method of injection was available, reported subcutaneous injection of heroin ('skin popping'). This outbreak was probably due to contamination of heroin with tetanus spores. During 2003, there were also five cases of reports of *Clostridium histolyticum* infection among IDUs from December 2003 (Anon 2003b) and 27 cases of wound botulism from January to August in 2004 (Anon 2004).

### 6.3.6 Research

A community survey of at least 800 IDUs is underway at four sites (Devon, Bristol, Greater Manchester, and Middlesbrough and Teeside). This survey of blood borne viruses and injecting risk behaviour has been designed to aid the interpretation of routine data collected by the UAPMP's survey of IDUs attending drug agencies, and is a collaborative project between CDSC and Imperial College, London.

## 6.4 Psychiatric comorbidity (dual diagnosis)

Research published in 2003 estimated that from 1993 to 1998, there were at least 195,000 comorbid patients and 3.5 million general practitioner (GP) consultations involving such patients in England and Wales (Frischer *et al.* 2003). Eighty to 90 per cent of patients consulting for both drug abuse and mental illness do so for the first time. The level of comorbidity is increasing at a higher rate among younger patients, which indicates that comorbidity may increase in future years. Approximately one-third of psychiatric discharges involve a supplementary rather than a main diagnosis of drug use. In these cases, the most common diagnoses were: schizophrenia, mood (affective) disorders, and alcohol misuse.

### 6.4.1 Personality disorders

NO NEW INFORMATION AVAILABLE

Please refer to UK Focal Point (2003) Chapter 16.1 for further information.

### 6.4.2 Depression

NO NEW INFORMATION AVAILABLE

Please refer to UK Focal Point (2003) Chapter 16.1 for further information.

### 6.4.3 Anxiety

NO NEW INFORMATION AVAILABLE

Please refer to UK Focal Point (2003) Chapter 16.1 for further information.

### 6.4.4 Affective disorders

NO NEW INFORMATION AVAILABLE

## 6.5 Other drug-related health correlates and consequences

NO NEW INFORMATION AVAILABLE

### 6.5.1 Maternal Drug Use

There is little reliable information about the numbers of pregnant females who use drugs, though in Scotland, it is reported that the number of pregnancies involving female drug users has risen over recent years from 2.4 in 1997/98 to 4.8 per 1,000 in 2003. This is set against an underlying decrease in the total number of maternities. Over two-thirds of the babies born to women known to be using drugs were full-term and of normal birth weight, compared to 90 per cent of all live births (ISD 2004).

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

NO NEW INFORMATION AVAILABLE

### 6.5.3 Non-fatal drug emergencies

NO NEW INFORMATION AVAILABLE

### 6.5.4 Other health consequences

NO NEW INFORMATION AVAILABLE

### 6.5.5 Driving and other accidents

With regards to driving, results from a recent study show that at least one medicinal or illicit drug was detected in 24.1% of the sample of 1,184 fatal road accident casualties (Tunbridge *et al.* 2001). In the earlier study carried out between 1985 and 1987, comparable drugs were detected in 7.4% of the sample (Everest *et al.* 1989). Of the 1,184 fatal casualties 17.7% tested positive for a single drug and 6.3% tested positive for multiple drug presence. Thus, one quarter of the drug incidence involved multiple drug use. This contrasts sharply with the previous survey in which only 5.3% of those who had consumed drugs had used multiple drugs. This suggests a significant increase in multiple-drug use.

## 7. Responses to health correlates and consequences

### 7.1 Overview

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

#### 7.1.1 Drug-related deaths

Government plans are to reduce DRDs by 20 per cent by 2004, from a national baseline of 1,568 deaths, set in 1999. This is to be achieved through a number of campaigns, treatment initiatives, better surveillance and monitoring, and research (DH 2001a).

#### 7.1.2 Drug-related infectious diseases

In the 1980s, UK drug policy was led by a public health approach aiming to contain HIV transmission. The subsequent action is regarded as having been successful in containing HIV amongst injecting drug users (IDUs) by harm reduction approaches such as providing free needles and syringes, and promoting the safe disposal of used equipment (Stimson 1995; McVeigh *et al.* 2003). Syringe and needle exchange is now offered through a range of services: specialist syringe exchanges, specialist drug services, detached outreach, mobile syringe exchanges, pharmacy-based syringe exchanges, and Accident & Emergency services. There are no national data currently available; however, it has been estimated that 27 million syringes were distributed from approximately 2,000 sites in 1997, of which 25 million were distributed in England, and a million each in Wales and Scotland (Parsons *et al.* 2002). Scotland has ongoing data on the extent and level of provision<sup>60</sup>. In 2000, funding was made available to develop a free needle and syringe exchange scheme in community pharmacies in Northern Ireland. With input from community pharmacists and other expert advisors, and taking account of models of best practice developed elsewhere, the Northern Ireland Needle and Syringe Exchange Scheme (NSES) was introduced in April 2001. Initially five pharmacies were involved in the scheme but by the end of 2003/04, there were nine. Pharmacies were chosen based on their willingness to participate, their location, and the assessed need for needle exchange in the locality. In 2002/03, 67,516 syringes were issued.

Other actions to reduce infection include: information campaigns on safer sex and safer injecting; and HIV/AIDS, hepatitis B and C counselling, support and testing. The *Hepatitis C Strategy for England* recommends, as a national standard of good practice, that all those attending specialist drug treatment services are offered HCV testing, and immunisation against hepatitis B (DH 2002d). Treatment for infectious diseases is provided as part of the NHS, including the provision of anti-retroviral treatment for HIV and treatment for hepatitis C; both are included in national guidelines (NICE 2004). Treatment for wound infections is available through primary care, and Accident & Emergency departments. In some areas, wound care is also available from needle exchange schemes and through some specialist drug services. Those in prison have access to HIV and hepatitis testing, and vaccination against hepatitis B.

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<sup>60</sup> See <http://www.drugmisuse.isdscotland.org>

### 7.1.3 Psychiatric comorbidity (dual diagnosis)

In 2001, the Health Advisory Service published the standards on caring for patients with substance use and psychiatric problems (comorbidity or dual diagnosis) for England and Wales (HAS 2001b). *Models of care* provides detailed guidance on the provision of services (DH 2002b), cross-referencing the *Dual diagnosis good practice guide* (DH 2002e). These set out policy and good practice in the provision of mental health services for people with severe mental health problems who are also experiencing difficulties with any drug, including alcohol, reaffirming dual diagnosis as 'core business' and a priority for mainstream mental health services, and emphasises the need for mainstream mental health services to work in partnership with other agencies, such as substance misuse services and Drug and Alcohol Action Teams (D(A)ATs). Local Implementation Teams (LITs) are charged with implementing the policy requirements described in the guide, working in partnership with (D(A)ATs).

### 7.1.4 Interventions related to other health correlates and consequences

Maternity services are expected to provide appropriate facilities for the needs of pregnant women and their babies, though the approach is inconsistent across the country.

## 7.2 Prevention of drug-related deaths

Using the definition of the UK Drug Strategy for drug-related deaths, the figure of 1,952 deaths is about 430 above the target figure for 2004 (that of 1,254). To try to reduce the number different strategies are being adopted. In England, the National Treatment Agency for Substance Misuse (NTA)<sup>61</sup> has developed a range of programmes including:

- new guidance and information for generic services;
- guidance for all drug treatment providers and commissioners on overdose and delayed death due to blood-borne viruses (NTA 2003e);
- a range of materials for drug users awaiting structured drug treatment on how to reduce the risk of overdose and blood-borne infections;
- various materials, posters, credit card-sized leaflets etc. targeting under-served drug users such as young people leaving care, those leaving prison, drug treatment detoxification and rehabilitation, the homeless, crack or stimulant users in police custody suites; and
- funding fund ten black and minority ethnic communities, who had previously undertaken a drug needs assessment for their local groups, to produce materials specifically in their own language.

The Department of Health has published guidance for Drug and Alcohol Action Teams (D(A)ATs) on providing resuscitation training for drug users<sup>62</sup>.

Funding has also been provided for work in the following areas:

- the use of naloxone to prevent overdose by the ambulance service and the National Patients Safety Agency (NPSA);
- the use of "take home" naloxone; and
- an evaluation of supervised consumption of methadone administration by pharmacists.

<sup>61</sup> See <http://www.nta.nhs.uk/programme/drd3.htm>

<sup>62</sup> See <http://www.doh.gov.uk/drugs/polguide.htm>

### 7.2.1 Prison service

With reportedly high rates of overdose amongst prisoners released from custody (ONS and National Addiction Centre 2003), the Prison Service for England and Wales is drafting a new clinical standard, not only to combat the risk of suicide during drug withdrawal, but the also risk of fatal overdose upon release from prison.

The Scottish Prison Service (SPS) has undertaken a number of initiatives including:

- participation in D(A)AT DRD Steering Groups;
- an analysis of prison health care records and addiction case management files of all prisoners who were victims of DRDs within six months of release (2002);
- a review of clinical prescribing practices in order to reduce the risk of fatal overdose upon release (this will report in the near future);
- a review of the National Induction Process; SPS have introduced a harm reduction awareness session for all prisoners on admission;
- with the Scottish Executive Know the Score Campaign, SPS have produced a range of harm reduction material for all offenders, including young offenders; and
- a new addictions policy advocating a treatment and integrated care focus, with the aim to reduce DRDs amongst prisoners on release.

### 7.2.2 Volatile substances

In 2003, the Scottish Executive piloted an awareness campaign on the law governing the sale of volatile substances, which is to be rolled out across Scotland. In Northern Ireland, a review of effective interventions has been undertaken by the Health Promotion Agency, with an information pack being distributed to retailers (HPA 2003b) and parents (HPA 2003c). The Department of Health is currently developing an action plan for England and Wales.

### 7.2.3 Safer use training

Safer drug use training has been instigated as part of NTA guidance to reduce DRDs.

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

### 7.3.1 Prevention

In 2003, funding was provided through the Scottish Executive's Drug Misuse Research Programme to undertake an in-depth observational study of the injecting practices of IDUs in Glasgow focusing on practices that could potentially facilitate the transmission of HCV infection (EIU 2004d). This showed there are multiple ways in which IDUs put themselves at risk including: reusing needles and syringes, knowingly or unknowingly used by others; preparing or drawing up drug solute for more than one injector; and sharing cookers, filters and water. The findings emphasise the importance of:

- having the means to use sterile equipment for each injecting episode;
- ensuring IDUs understand the importance of distinguishing each other's equipment; and
- ensuring IDUs understand how injecting equipment can become contaminated.

The report suggested the provision of safe injecting rooms would help address the needs of those who have to inject outdoors. The importance of such issues in preventing drug-related infectious diseases has meant that legislation in the UK now allows the legal provision of injecting equipment other than needles and syringes by health services, with the aim of reducing the sharing of this equipment (see Chapter 1.2.3).

In addition, the Hepatitis C Action Plan for England was launched in June 2004 (DH 2004). It prioritises prevention of infection and disease progression. Actions include:

- monitoring trends in infection;
- evaluating the effectiveness of prevention measures;
- increasing awareness and reducing the number of undiagnosed infections;
- the provision of high-quality health and social care services; and
- co-ordinating assessment and treatment.

For drug users specifically, new action will include:

- health promotion information explaining the risks of injecting and how to avoid blood borne viruses to be given to all young people entering the Criminal Justice System;
- information about how to avoid infection while abroad; and
- an audit of needle exchange schemes.

Its launch was accompanied by a professional awareness campaign with an information pack being sent out to primary care professionals. Also being launched is the NHS hepatitis C awareness website<sup>63</sup>. In autumn 2004, a publicity campaign will continue to raise awareness by addressing how to avoid the risk of infection, testing and treatment. In addition, national standards for commissioning, delivery and monitoring of the syringe exchange services are being established (NTA 2003f).

The Scottish Executive is currently developing their Action Plan, due to be launched in autumn 2004. They have already introduced a range of measures, these include:

- revising guidelines to permit a substantial increase in the number of needles and syringes which can be supplied to drug users;
- a range of information materials to drug services and prisons across Scotland;
- issuing hepatitis C materials for professionals and patients;
- establishing a national database of patients diagnosed with hepatitis to help evaluate the effectiveness of treatment; and
- the Scottish Centre for Infection and Environmental Health (SCIEH) is developing a two-tiered HCV awareness campaign, aimed at the general population and at high risk groups, and in particular ex and current IDUs.

### Research

A community-wide survey of 500 injectors is being conducted in Glasgow. The survey aims to determine whether increasing the supply of sterile needles and syringes to IDUs will decrease the frequency of equipment sharing. It will collect oral fluid specimens for anti-HCV testing, and measure injecting risk behaviour.

A study addressing injecting drug use in areas of England (Brighton, Liverpool and London) has suggested that the coverage of needle and syringe exchange services may be insufficient to prevent infection (Hickman *et al.* 2004; see Chapter 4.2.2).

### 7.3.2 Counselling and testing

In 2003, with £1 million (€1.4 million euros) Department of Health funding, the NTA commissioned a range of services to promote the uptake of hepatitis C (HCV) testing. Proposals were required to clearly demonstrate good project planning and the expected impact on the target population. Projects included:

- the production and distribution of hepatitis C related literature;
- community and outreach initiatives;
- pre-test counselling;

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<sup>63</sup> See <http://www.hepc.nhs.uk>

- blood testing;
- post-test counselling and support;
- work to develop and define the HCV testing care pathways; and
- training to support delivery of this care pathway.

A cluster trial examining whether the introduction of dried blood spot collection at drug agencies and prisons increases the uptake of hepatitis C testing among IDUs is being conducted by Imperial College, London.

### 7.3.3 Infectious disease treatment

The Hepatitis Action Plan for England, published in 2004, will prioritise treatment.

## 7.4 Interventions related to psychiatric comorbidity

Implementation of this guidance (see Chapter 7.1.3) is on-going. The Scottish Executive has published similar guidance (SACDM and SACAM 2003). The Scottish Executive plans to improve education and awareness, and is looking towards more effective planning and delivery of care and treatment services (Scottish Executive 2003c).

### *Research*

A multi-method needs assessment of dual diagnosis in primary care will develop a screening and assessment tool to identify dual diagnosis. It will assess the prevalence of dual diagnosis and related health, social and lifestyle needs across a range of treatment services (Strathdee *et al.* 2003). A two-tier assessment process was developed for the project: a brief screen to identify at-risk dual diagnosis cases (taking 7 to 10 minutes); and for clients screening positive, a comprehensive 45 to 60 minute assessment. This will be used in routine clinical practice through an educational outreach training model.

## 7.5 Interventions related to other health correlates and consequences

The Drugs Strategy Directorate is developing a maternity module within a new Children's National Service Framework, setting standards for pregnant drug users and making services more flexible and accessible. The Scottish Executive published information on working with pregnant drug users in its guidance on working with families (Scottish Executive 2003b).

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

The Home Office has developed a toolkit on drugs and driving<sup>64</sup>, and information campaigns are to begin in England, Wales and Scotland, including a website aimed at young people<sup>65</sup>. The Scottish Executive and the Scottish Road Safety Campaign evaluation of a recent TV advert aimed at discouraging people from driving under the influence of drugs found awareness of the campaign to be high (76%) and their understanding to be good. However, the overall impact was undermined by doubts about the credibility of the enforcement message, in particular that actors appeared to be drunk rather than on drugs (Ormston 2003).

### 7.5.2 Other health consequences reduction activities

NO NEW INFORMATION AVAILABLE

<sup>64</sup> For more information see <http://www.drugs.gov.uk>

<sup>65</sup> See <http://www.drugs.gov.uk/News/1017067613>

## 8. Social correlates and consequences

### 8.1 Overview

Evidence suggests that there is a strong relationship between drug use and certain characteristics of social exclusion. These correlates include: street homelessness (Randall and Britton 2002); begging (Jowett *et al.* 2001); selling sex on the street (Hester and Westmarland 2004); unemployment (Klee *et al.* 2002); and lack of educational achievement, truancy and school exclusion (NatCen/NFER 2003).

The number of cases dealt with under the law for drug offences (possession and supply<sup>66</sup>) has generally increased since 1990 (Ahmad and Mwenda 2004). Furthermore, although drug users commit a significant amount of crime, a causal relationship cannot be firmly established (Coid *et al.* 2000). However, between a half and two thirds of those in custody are reported to be problematic drug users (HM Prison Service 2004b; ISD 2004), less so in Northern Ireland (House of Commons Northern Ireland Affairs Committee 2003).

Drug use can also give rise to dangers associated with safety in the workplace, and productivity (Drugs Strategy Directorate 2004b).

Latest cost estimates are based on the study by Godfrey *et al.* (2002) and are for 2000. It was estimated that drugs cost UK society between £11.1 and £20 billion (€15.8 billion and €28.2 billion) a year.

### 8.2 Social exclusion

#### 8.2.1 Homelessness

See Chapter 2.4.3 for research concerning homeless young people and drug use and UK Focal Point (2003) Chapter 4.1.

#### 8.2.2 Unemployment

NO NEW INFORMATION AVAILABLE

Please refer to UK Focal Point (2003) Chapter 4.1.

#### 8.2.3 School drop out

NO NEW INFORMATION AVAILABLE

#### 8.2.4 Financial problems

NO NEW INFORMATION AVAILABLE

#### 8.2.5 Social networks

NO NEW INFORMATION AVAILABLE

### 8.3 Drug-related crime

#### 8.3.1 Drug offences

Latest figures for drug offences (Ahmad and Mwenda 2004) show that over 113,000 persons were found guilty, cautioned or fined for drug offences in 2002; a 10 per cent rise from the previous year (102,610). The majority (90%) were male and 40 per

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<sup>66</sup> Drug use *per se* is not an offence, though it is against prison rules.



cent were aged under 21. It is of note that in Northern Ireland, there were 1,924 drugs offences recorded in 2002/03, a 74 per cent increase on the previous year.

#### *Possession and supply*

Having fallen in recent years, unlawful possession offences rose by 11% between 2001 and 2002 to 102,160. This accounted for 90% of drug offences in the UK. The majority were cannabis offences (76%, 72,850), a rise of 15 percent from 2001. However, there was a fall in the possession of heroin (7% to 8,430), ecstasy (13% to 4,530), LSD (one third to 70) and methadone (19% to 302). Crack offenders rose to over a 1,000. Cocaine offenders rose by 21 per cent to 4,030.

The numbers convicted for unlawful supply continued to fall, albeit by less than one per cent to 4,830. Heroin accounted for the highest number of these offences (1,500) - the same as the previous year. Cannabis accounted for 1,150 (34% of supply convictions) - a fall of five per cent from 2001. Ecstasy offences also fell (by 4% to 520). There was a 25 per cent rise in convictions for the supply of cocaine: up to 440.

The number charged with possession with intent to supply continued to fall (5,980); cannabis accounted for 1,860 (31%; 38% in 2001 of possession offences - see Table 15).

After a fall in 2001, the number of convictions for the unlawful production of illicit substances rose 17 per cent to 2,060. The majority of these offences were cannabis-related – with 1,940 convictions for production.

#### *Trafficking*

Unlawful import or export offences have continued to decline in 2002 to 1,740.

### 8.3.2 Other drug related crime

#### *Acquisitive crime*

The New English and Welsh Arrestee Drug Abuse Monitoring (NEW-ADAM) programme took place between 1999 and 2002 (see UK Focal Point 2003). A final evaluation has now been completed, after interviewing 3,064 arrestees in custody suites in England (Holloway *et al.* 2004). Data from the first two years of the survey showed a strong association between drug use and acquisitive offending: 69 per cent of arrestees tested positive for any drug, 48 per cent for cannabis and over a third (38%) for opiates and/or cocaine. There was a strong association between self-reported drug use, particularly heroin and cocaine, and self-reported acquisitive offending in the year before interview.

Drug-using arrestees reported significantly higher levels of illegal income than those who did not use drugs; those reporting use of heroin, cocaine and crack in the last 12 months reported a mean annual illegal income of more than £24,000 (€34,000), four times greater than those who had not used illicit drugs (£5,763 or €8,200). Drug using repeat offenders, 18 per cent of the sample, were responsible for 70 per cent of the total number of acquisitive offences reported.

The NEW-ADAM programme has been reviewed as part of a programme to improve measures of drug-related crime. As part of these measures a new continuous Arrestee Survey commenced in September 2003 in a representative sample of 60 custody suites in England and Wales. This involves computer assisted self-interviewing, covering: self-reported offending, self-reported drug use, information on

sources of illegal drugs, past experience of drug treatment and arrest referral, other aspects of the Drugs Intervention Programme (DIP)<sup>67</sup> and drug testing arrestees. The target sample size was 9,000 arrestees.

In addition to the Arrestee Survey, a number of other information tools are being developed, for example, the Offenders Index (a register of all people convicted of a 'standard list' offence in courts in England and Wales) and Recorded Crime Statistics.

*Property crimes, illegal prostitution, prescription offences, violence under the influence, driving offences*

NO NEW INFORMATION AVAILABLE

#### **8.4 Drug use in prison**

In 2003, it was reported that 55 per cent of those entering prison in England and Wales were problematic drug users (HM Prison Service 2004b).

More detailed information is available only for Scotland who undertake a Reception Study each year; during one month a random sample of prisoners are tested on admission to some prisons. The Reception Study was only expanded to cover all Scottish Prison Service establishments in 2003; information from this extended study is not currently available. Due to the period between last drug use and testing after entry to prison, urine test results may under report drugs such as heroin. In 2003, 66 per cent of urine tests were positive for drugs, though this is a fall from 73 per cent in 1998/99. This fall was reflected in detections of all drugs types apart from methadone and Temgesic. Cannabis (34%), benzodiazepines (30%) and opiates (excluding methadone) (24%) were most commonly detected (ISD 2004).

Since the introduction of Mandatory Drug Testing (MDT) in prisons in England and Wales numbers testing positive for drugs have reduced from 24.4 per cent in 1996/97 to 11.7 per cent in 2003 (HM Prison Service 2004b). In 2002/03, in Scotland, 17 per cent of tests were positive, which has remained unchanged over that past five years. In Scotland, the drugs most frequently detected were cannabis and opiates, both 12 per cent (ISD 2004).

Research into substance use has been conducted among 301 women in both remand and sentenced populations across England (Borrill *et al.* 2003). Eighty-one per cent of the participants reported having ever used drugs, 77 per cent having ever used cannabis, and half having used crack, heroin, tranquillisers and amphetamine at some time. Forty-nine per cent, according to the Severity Dependence Scale (SDS), were rated as dependent while 31 per cent had injected at some time. White women were more likely to have a substance misuse problem.

#### **8.5 Social costs**

NO NEW INFORMATION AVAILABLE

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<sup>67</sup> The Drugs Intervention Programme was originally launched as the Criminal Justice Interventions Programme but was re-named in October 2004.

## 9. Responses to social correlates and consequences

### 9.1 Overview

As was discussed in Chapter 8.1, drug use can be linked to the characteristics of social exclusion. The Government set up the Social Exclusion Unit in 1997 and, in addition, UK Drug Strategy aims to improve the country's most deprived neighbourhoods by raising standards of employment, educational attainment, housing and health, and by lowering crime rates (Drugs Strategy Directorate 2002a). These are also Government objectives for UK society in general, so there is a close link between the Strategy and other central Government initiatives. Several initiatives have come into force that tackle the issues associated with social exclusion.

The Communities Against Drugs (CAD)<sup>68</sup> initiative, which ran from 2001/02 to 2003/04 provided funding to build communities that are resistant to drugs. The work of this initiative has now been subsumed into a larger generic funding programme, the Building Safer Communities Programme, administered by the Crime Reduction teams within the Regional Government Offices to reduce bureaucracy, and give flexibility to local partnerships to deliver their priorities on crime and drugs.

The Homelessness Directorate, set up in 2002, coordinates homelessness policy nationally (DTLR 2002), but homelessness issues are also addressed in the UK Drug Strategy and the Strategy on Rough Sleepers. There has been joint work between the Homelessness Directorate and the National Treatment Agency for Substance Misuse (NTA) to build treatment services that are responsive to the needs of the homeless (Randall *et al.* 2002). In Scotland, the Homelessness Task Force has responsibility for improving interventions.

Progress2Work, initiated in 2002, provides support for clients who have made sufficient progress in their recovery to be drug free or stabilised, but whose history of drug misuse is likely to be a significant factor in preventing them from getting or keeping a job. Led by the Department of Work and Pensions, it is a cross Government initiative advised by an inter-departmental group. Representation on the group includes officials from the Home Office, Prison Service, NTA, Welsh Assembly and Scottish Executive (see UK Focal Point 2003).

The updated Prison Service Drug Strategy for England and Wales aims to reduce the supply of illegal drugs into prison through a range of practical initiatives, and at reducing the demand for drugs amongst prisoners through effective treatment (HM Prison Service 2002). Initiatives include (HM Prison Service 2004c):

- mandatory drug testing;
- clinical help with withdrawal, which is available at all local and remand prisons;
- substitution treatment, which is offered in all female and some male prisons (for those on remand or serving a short sentence who have been being maintained on methadone in the community, with evidence of current engagement in a community programme having been beneficial; for those who are HIV positive and/or terminally ill and who are already on methadone maintenance);
- low threshold counselling, assessment, referral, advice and through-care services (CARATs); and

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<sup>68</sup> Communities Against Drugs has now been absorbed into a larger generic programme aimed at tackling crime (the Building Safer Communities Fund).

- intensive drug treatment programmes, which are available in some prisons and include cognitive-behavioural treatment, 12-Step, and Therapeutic Communities (TCs).

## 9.2 Social re-integration

### 9.2.1 Housing

Local Authorities introduced the Supporting People Programme in April 2003 as a new way of funding supported accommodation. It is funded by more than £25 million (€35.3 million) each year, and is aimed at marginalised groups generally, encompassing drug users within that client group.

### 9.2.2 Education and training

Positive Futures, the national sports-based social inclusion programme for young people aged 10 to 19 years, offers opportunities to engage in employment, education and training (see Chapter 3). Research shows that Positive Futures, which operates on a voluntary basis, has so far attracted nearly 35,000 young people (mostly aged 10 to 16 years). Just under 85 per cent are reported to develop a meaningful relationship with the project and have shown encouraging signs of progression. In the past year, nearly 14,000 young people achieved at least one of the following:

- improving their educational performance;
- undertaking training;
- joining the labour market;
- joining local sports clubs;
- improving their social relations; or
- making personal development progress (Drugs Strategy Directorate 2004c).

### 9.2.3 Employment

Progress2Work (p2w) will be rolled out to all districts during 2004. The scheme has already been subject to an external evaluation by York Consulting<sup>69</sup>. This initial qualitative study examined the start up phase of the first pathfinder services and has been used to inform the roll-out to subsequent districts. A full impact evaluation was planned to begin in 2004 involving tracking a sample of clients through the whole p2w process. However, because of competing priorities, the bid for funding this work has been suspended due to competing analytical priorities and therefore analysts are considering a smaller restructure evaluation programme. In the meantime, p2w will be subject to regular (quarterly) performance review drawing on the regular management information collected from providers by Jobcentre Plus.

Early indications from Jobcentre Plus (2004), who are responsible for the programme, suggest that interest has been high and that it is successfully helping people recovering from drug use to get back into the labour market and overcome additional barriers to work such as a lack of stable accommodation and a criminal record.

### 9.2.4 School drop out

NO NEW INFORMATION AVAILABLE

### 9.2.5 Financial Problems

NO NEW INFORMATION AVAILABLE

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<sup>69</sup> Please see

[http://www.yorkconsulting.co.uk/areas\\_of\\_expertise\\_9\\_employment\\_progress2work\\_evaluation.htm](http://www.yorkconsulting.co.uk/areas_of_expertise_9_employment_progress2work_evaluation.htm) for further information.

## 9.2.6 Social networks

NO NEW INFORMATION AVAILABLE

## 9.3 Prevention of drug-related crime

### 9.3.1 Assistance to drug users in prisons

#### *Prevention*

1. *Drug testing and drug free units.* The target for reducing the proportion of positive results from random mandatory drug tests (MDTs) in England and Wales for 2003/04 (10%) was not achieved: 11.7 per cent tested positive, although the overall rate has halved since 1997 when 24.4 tested positive (HM Prison Service 2004b). Over 28,000 prisoners signed a compact during 2003/04 for Voluntary Drug Testing (VDT) (HM Prison Service 2004b, 2004c). The *Prison (Amendment) (Northern Ireland) Order 2004, Statutory Instrument 2004 No. 704 (N.I. 5)* will allow for mandatory testing of both drugs and alcohol for the first time in Northern Ireland.
2. *Supply reduction.* A visitor's ban policy remains in place (banning those who have attempted to bring drugs into prison); increased numbers of drug dogs have been made available, as has provision for closed circuit television (CCTV) in visitor areas. Ongoing work includes a project on the supply routes and research into electronic drug detection equipment. New guidance on supply reduction was circulated in November 2003 for England and Wales, ensuring successful anti-smuggling and detection initiatives are replicated in all prisons, as well as helping prisons to review performance and develop improvement plans (HM Prison Service 2004c).

#### *Harm reduction measures.*

CARATs is to extend pre-release interventions to include overdose awareness cards and videos depicting the risks of restarting opiate use.

The Prison Service is exploring ways of making the policy on condom provision clearer and more uniformly applied. However, at the moment prison health care staff in England and Wales have been reminded that they should prescribe condoms, in their clinical judgement, there is a known risk of HIV infection (CDSC 2003).

There are no present plans to introduce a needle exchange scheme.

Blood-borne virus testing is provided and a programme of hepatitis B vaccination will be available in 71 of 137 prisons by the end of 2003 (including all prisons accommodating young persons). Between January and June 2003, over 6,800 prisoners received at least one dose of hepatitis B vaccine and 3,200 completed a vaccination course.

#### *Treatment*

There are a number of programmes providing assistance to drug users in prisons:

A CARATs review, in England and Wales aimed at delivering a more 'rounded' service began in 2003; the final report is not yet published. The target for CARATs was to have performed 25,000 assessments in 2004, and this was more than met with 2003/04 figures equalling 49,770 (HM Prison Service 2004c).

Between 2003 and 2006, healthcare services in all non-private prisons in England will become part of the National Health Service (NHS). This will mean prison health care is financially administered by local health trusts (Primary Care Trusts) and will

enhance the opportunity for linking with a full range of community health service provision.

During 2003/04, prisons offered 60 intensive drug rehabilitation programmes and Therapeutic Communities (40 cognitive behavioural therapy programmes, 15 '12-Step' programmes and 5 TCs). All drug programmes are to be accredited by the independent Correctional Services Accreditation Panel by March 2004. However, although the number of programmes being run has increased considerably, the number of drug users successfully completing programmes remains small.

In England and Wales, clinical services (detoxification and maintenance-prescribing programmes) remain available in all local and remand prisons. Clinical management has continued to grow with nearly 58,000 treatments in 2003/04, 14 per cent more than the previous year. The majority of interventions were prescribed detoxification regimes. The Prison Health Department (England and Wales) reviewed its policy towards clinical management of substance use in light of a number of factors (HM Prison Service, personal communication):

- a growing problem of suicide and self-harm during drug withdrawal;
- management problems during drug withdrawal, including drug smuggling and acts of violence toward staff and other prisoners;
- risk of fatal overdose in the first few days following release from prison;
- the need to provide clinical services in line with the NHS and international good practice; and
- in line with DIP<sup>70</sup>, to facilitate continuity of treatment for individuals entering prison on a community methadone or buprenorphine prescription.

This review has resulted in the drafting of a new clinical model, the principal elements of which are (HM Prison Service, personal communication):

- prescribed management of withdrawal on the night of custody, informed by the reception health-screen and assessment;
- where possible, location of prisoners within a unit that offers access to unrestricted 24-hour observation;
- for opiate-dependent patients, stabilisation on medication for at least five days prior to progression to one of the following treatments: standard detoxification (minimum duration of 14 days); extended detoxification (21+ days) and maintenance (up to 13 weeks or beyond, depending on individual need);
- good quality joint working between clinical and CARAT teams;
- joint management and care planning by mental health in-reach services, and substance use problems where appropriate;
- ongoing reviews of all extended prescribing regimes, informed by random drug tests;
- provision of a 28 day psychosocial programme for all prisoners with problematic drug use; and
- all prescribed regimes are to be evidence-based, conforming to Prison Service Order 3550 (HM Prison Service 2001) and Department of Health *et al.* (1999) guidelines, and in accordance with the principles of clinical governance.

This model, due for publication in 2004, will bring prison clinical practice in line with *Models of Care* (DH 2002b).

Withdrawal management units were opened in four prisons (Leeds, Feltham, Birmingham and Eastwood Park) during 2003. Their enhanced services are to be

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<sup>70</sup>The Drugs Intervention Programme was originally launched as the Criminal Justice Interventions Programme but was re-named in October 2004.

evaluated to determine their influence on suicide and self-harm among vulnerable patient groups.

A national programme of clinical training has been completed, delivered jointly by St George's Hospital Medical School in London and Prison Health, across 12 locations to 270 clinicians working in prisons. To build further clinical competence, 30 doctors, nurses and pharmacists working in prisons were funded for entry into the Royal College of General Practitioners certificate course in substance misuse. A new phase of competence-based education, related to the training needs associated with the current clinical model, will be introduced in 2005/06.

A low-intensity Short Duration Programme (SDP) delivered to short-term and remand prisoners will be piloted in 2004. The SDP will provide intensive treatment to adults and young offenders whose time in prison would previously have precluded them from accessing intensive drug rehabilitation treatment. It is expected that this programme will reduce the 'revolving door' process (with many short-term prisoners return to custody without the opportunity to engage in intensive treatment).

In Scotland, over 9,000 (67%) new receptions were offered an assessment for help with substance misuse; 7,271 (50%) of prisoners undertook such an assessment (ISD 2004).

#### *Social re-integration*

The Criminal Justice Intervention Programme has initiated measures to establish links with services in the community and help drug using offenders reintegrate (see Chapter 12).

#### *Community links*

See paragraph above

### 9.3.2 Alternatives to prison for drug users

In the UK, alternatives to prison for drug users are referred to as non-custodial responses. DIP was launched in 2003 with the aim of more effectively channelling problematic drug users from the Criminal Justice System into treatment programmes. Its key target group is drug using persistent offenders (See Chapter 12).

#### 9.3.3 Other interventions for prevention of drug-related crime

##### *Interventions for drug using young offenders*

All Youth Offending Teams (YOTs)<sup>71</sup> will, from April 2004, have to ensure all young offenders are screened for drug use. Those identified with treatment needs will receive appropriate specialist assessment within five working days, and following assessment, will receive access to the required early intervention and treatment services within ten working days.

##### *Driving Offences*

The *Railways and Transport Safety Act 2003* gives police the power to undertake preliminary tests of impairment and screening for drugs at the roadside.

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<sup>71</sup> Youth Offending Teams are locally-based multi-agency teams set up in every local authority area in England and Wales to respond to the needs of the young offender in a comprehensive way.

## 10. Drug markets

### 10.1 Overview

The latest data into the value of the UK drug market are for 1998 (Bramley-Harker 2001), suggesting a value around £6.6 billion (€10.4bn). However, this is thought to be an underestimate; the margins of error being very large. The methodology is currently being revisited in the light of newly available data.

It remains difficult to provide reliable information about the availability and supply of drugs. Quantities can only be inferred from seizures and other law enforcement interventions, treatment figures and other data such as deaths. The exact relationship between supply and demand remains unclear at the macro level; however, widespread poly-drug use (SWPHO 2002) provides an incentive for traffickers to engage in multi-drug trafficking, rather than limiting themselves to one commodity (NCIS 2003). Nevertheless, the largest importers of heroin and cocaine tend to concentrate on a single commodity (NCIS 2003). A key factor in multi-drug trafficking is the convergence of the various drug trades, in the Netherlands and Spain, for a number of logistical reasons. Both countries play reluctant host to major foreign and British traffickers, or their representatives and criminal associates, who broker deals for UK-based groups. These drugs then enter the UK market through a variety of different routes (Table 13).

*Table 13: Importation routes of some illegal drugs entering the United Kingdom*

Drug	Origin	Importation route	Further details
Cocaine	Mainly Columbia, Peru and Bolivia.	Shipped across the Atlantic to the Iberian Peninsula, the Netherlands or increasingly to Central and Eastern Europe. Shipments are concealed in heavy goods vehicles and routed overland to the Channel and North Sea ports.	It is also smuggled into the UK by air couriers, arriving from South and Central America, and from the Caribbean.
Crack cocaine	It was thought that it was produced in the UK in small street-level quantities but there is now intelligence that it is being imported from the West Indies.	Evidence suggests the involvement of British Caucasians, West Africans and South Asians working both independently and collaboratively.	Intelligence indicates that the UK crack trade is becoming complex and dynamic, and that crack is often sold with heroin.
Ecstasy-type substances	Some ecstasy and other synthetic drugs are produced in the UK.	Ecstasy enters the UK market from Holland and Belgium through the ferry ports and Channel Tunnel.	Ecstasy is exported to Australia, Malaysia, South Africa and locations popular with British clubbers e.g. Ibiza.
Heroin	Mainly Afghanistan and the 'Golden Triangle'.	Much arrives via Northern Cyprus and Turkey in freight and passenger vehicles. The Channel Tunnel and air couriers are also used <sup>72</sup> .	

Source: National Criminal Intelligence Service 2003.

<sup>72</sup> See the National Criminal Intelligence Service website: <http://www.ncis.co.uk>



Information about seizures is provided by the Home Office Research and Statistics Directorate who collate figures provided by Customs and Excise and the police. In general, seizures of amphetamines, cannabis, and crack are increasing. Seizures of cocaine, ecstasy-type drugs, heroin and LSD are falling (Ahmad and Mwenda 2004).

Information on the average purity at street level of certain drugs and the content of tablets is provided by the Forensic Science Service (FSS). The purity of cocaine has fluctuated over the last few years. Purity of crack is falling. In general, brown heroin and amphetamines have shown an increase in purity.

Information on the average price of drugs is provided by the National Criminal Intelligence Service (NCIS). The prices of ecstasy, heroin and cocaine have been falling since 1998 although prices of cannabis leaves and resin, amphetamines and crack have remained largely similar.

Ease of access is often tied closely to patterns and levels of use, where the most commonly used drugs are usually also the most accessible (Condon and Smith 2003).

## 10.2 Availability and supply

### 10.2.1 Availability of drugs (perceived availability/access in population, other indicators)

NO NEW INFORMATION AVAILABLE

### 10.2.2 Production, sources of supply and trafficking patterns within countries as well as from and towards other countries

There has been no change in sources of supply and trafficking.

## 10.3 Seizures

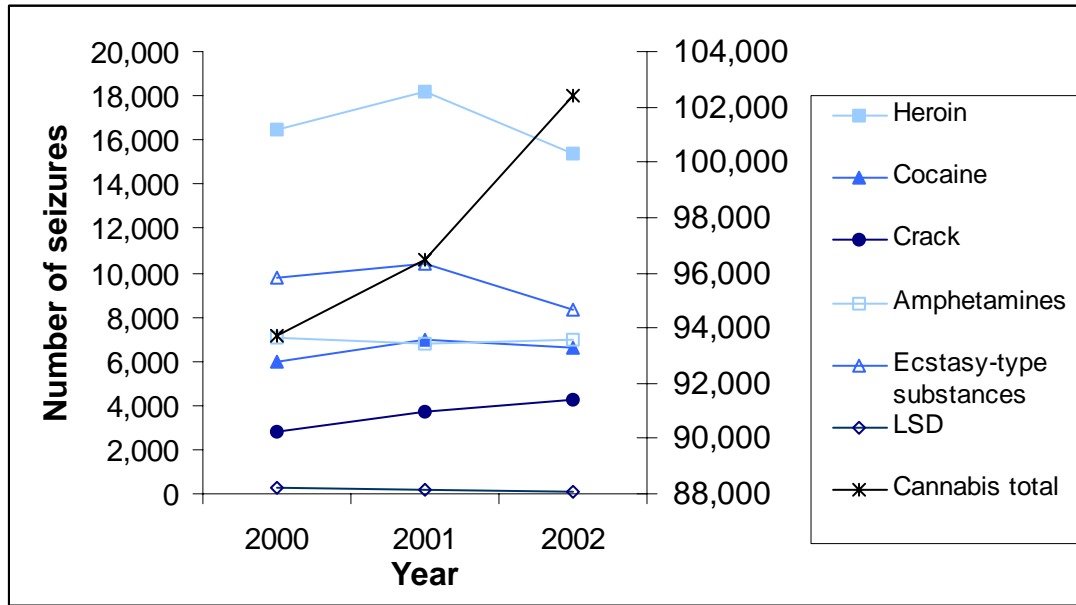
Latest available information on seizures in the UK is for 2002 (Ahmad and Mwenda 2004). Seizures continued to rise in 2002, by 5 per cent to 137,304 and are detailed for each drug in Figure 7 and Table 14.

*Table 14: Number of seizures of illicit drugs made by all law enforcement agencies, United Kingdom*

Drug	2000	2001	2002
Cannabis (total)	93,750	96,460	102,390
Heroin	16,450	18,170	15,360
Cocaine	6,010	6,980	6,630
Crack	2,770	3,690	4,260
Amphetamines	7,080	6,830	6,990
Ecstasy-type substances	9,790	10,410	8,300
LSD	300	170	50

Source: Corkery and Airs 2001; Ahmad and Mwenda 2004.

Figure 7: Number of seizures of illicit drugs made by all law enforcement agencies, United Kingdom



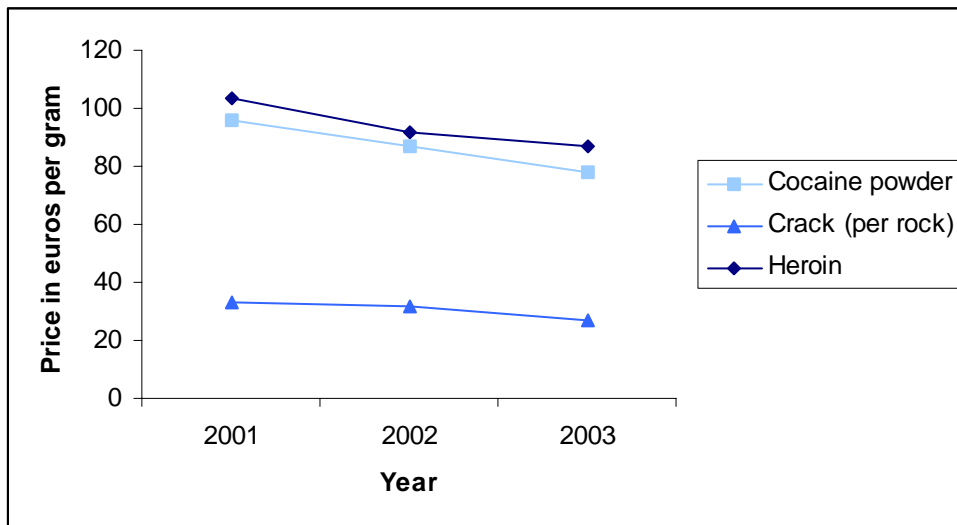
Total seizures for cannabis are plotted against the secondary axis.  
 Source: Corkery and Airs 2001; Ahmad and Mwenda 2004.

## 10.4 Price/purity

### 10.4.1 Price of drugs at street level

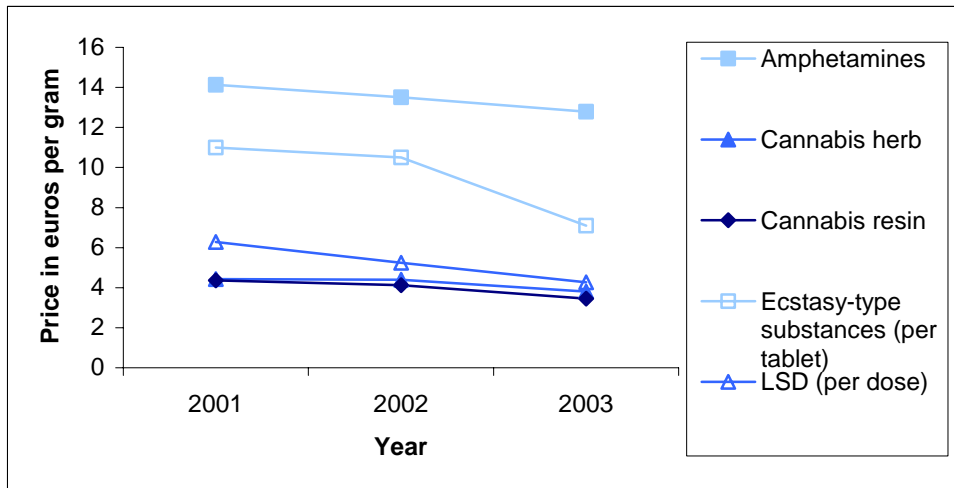
Generally, in 2003, the average price of illegal drugs continued to fall with, a gram of cocaine powder costing €78.10 (£55) (Figure 5) and a rock of crack cost at €27 (£19). Cannabis leaves cost €3.80 (£2.7) per gram and cannabis resin cost €4.45 (£3.1) per gram. The average price of an ecstasy tablet was €7.51 (£5.3). (see Figures 8 and 9). However, although heroin's price lowered cost €91.50 in 2001 and fell to €86.62 in 2002, the equivalent costs in pounds sterling have remained the same (£61 – the change conversion rate has altered the price in euros).

Figure 8: Price in euros at street level of heroin, crack and powder cocaine, United Kingdom



Source: National Crime Intelligence Service (unpublished data).

Figure 9: Price in euros at street level of some illegal substances, United Kingdom

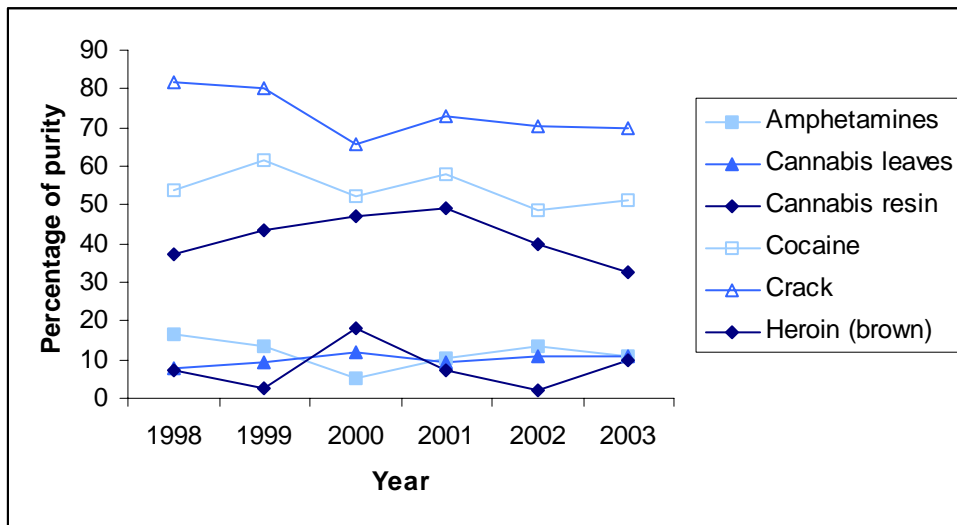


Source: National Crime Intelligence Service (unpublished data).

#### 10.4.2 Purity of drugs at street level and composition of drugs/tablets

The latest data are for 2003 and show that the purity of brown heroin fell to 33 per cent. Cocaine purity was 51 per cent (higher than previously); crack stayed the same (70%). Purity of amphetamines fell to 10 per cent (Figure 10).

Figure 10: Street level average purity of illegal substances in England and Wales<sup>73</sup>



Source: Forensic Science Service (unpublished data).

<sup>73</sup> Note: for cannabis products, the % THC content is shown; for other illicit drugs, the % of pure substance is shown.

# PART B

Selected issues

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## PART B: SELECTED ISSUES

### 11. Buprenorphine, treatment, misuse and prescription practices

#### 11.1. Introduction

Buprenorphine, an analgesic, is a semi-synthetic derivative of opium, and acts as a partial agonist (agonist/antagonist) at opiate receptor sites in the brain. Methadone and heroin are pure agonists; they bind to receptors in the nervous system and produce effects such as euphoria and analgesia, as well as side-effects such as respiratory depression. Antagonists, such as naltrexone and naloxone, can displace agonists and cause withdrawal symptoms or block the effect of the opiate when taken so that there is no immediate effect of the opiate. Partial agonists such as buprenorphine can display properties of both; one effect of which is to give buprenorphine a more favourable safety profile in terms of minimizing respiratory depression and as such, a potential advantage in the prevention of drug related deaths due to overdose. However, it can precipitate opiate withdrawals and can be injected (with associated risks).

#### 11.2 Treatment with buprenorphine

##### 11.2.1 Use of buprenorphine

As a pain reliever, buprenorphine has a long history of use in the United Kingdom. Under the brand name Temgesic it has been available since 1978, initially in injectable form; sublingual tablets were introduced in 1982. There is some evidence of its use in the treatment of dependence for a number of years in the UK (Donmall *et al.* 1995). Buprenorphine is increasingly used for substitution purposes in other countries, both in Europe and elsewhere (Gilvarry and Schifano 2002), and use in the UK has been increasing from a low base recently.

##### 11.2.2 Licensing

Buprenorphine was not licensed for use for the management of drug dependence in the UK until 1999 when the Medicines Control Agency granted a license for the marketing of it under the brand name Subutex (a higher dose form than Temgesic), though restricting it to a Schedule 3 list drug under the *Misuse of Drugs Regulations 1985*<sup>74</sup>. Such scheduling requires that relevant restrictions on import, export, production, supply, possession prescribing and record keeping apply, but all medical practitioners can prescribe this for the purposes of treatment. No other product containing buprenorphine is licensed for the management of opiate dependence.

Buprenorphine remains a Class C controlled drug under the *Misuse of Drugs Act 1971* and therefore there are legal penalties for possession and supply.

##### 11.2.3 Guidance

National 'Clinical Guidelines' for the management of drug misuse and dependence, revised in 1999, referred to and offered guidance about the use of buprenorphine in

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<sup>74</sup> These regulations define the categories of people authorised to possess or supply those drugs controlled under the *Misuse of Drugs Act 1971*. Drugs are categorised under a graded scale with drugs such as raw opium, cocaine leaves and LSD residing in Schedule 1. See <http://www.legislation.hms.gov.uk/si/si2001/20013998.htm> for more details.

the management of withdrawal (DH *et al.* 1999); maintenance treatment (substitution) with buprenorphine was referred to but little specific guidance on its use was issued.

Due to concerns about the possibility of buprenorphine being diverted or misused by injection<sup>75</sup>, from 2001 the National Health Service (General Medical Services) Regulations 1992<sup>76</sup> were amended to allow doctors to prescribe buprenorphine to be dispensed by instalments from one prescription (DH 2001b). The product is available in three strengths, 400 microgrammes, 2mg and 8mg and each strength is supplied in packs of either 7 or 28 tablets.

New guidance stated that the only licensed product containing buprenorphine for use in managing of drug dependence is marketed under the brand name "Subutex Sublingual Tablets" (DH 2001b). It is to be used for substitution treatment for opioid dependence in those aged 16 years and over. It states that supervised consumption should be inherent to any well-delivered buprenorphine substitution programme and that Temgesic should not be supplied for substitution treatment of opioid dependence. It is also suggested that buprenorphine treatment be instigated by specialist practitioners. The Department of Health is providing the appropriate training England. The National Assembly for Wales has introduced a similar change (DH 2001b).

The 'Clinical Guidelines' on drug use (DH *et al.* 1999) advised that locally approved guidelines for treating drug addiction should be developed for general practitioners (GPs). As such, a number of health authorities have developed appropriate protocols and guidance (such as NHS Berkshire 2001). Also, in February 2003, the Royal College of General Practitioners published guidance and developed a training programme (Ford *et al.* 2003). The guidance outlines the indications, contraindications and precautions for buprenorphine, and examines topics such as dosage regimens, maintenance treatment, prescribing, detoxification and shared care. It recommends that, initially, buprenorphine should be dispensed daily and, if possible its consumption should be supervised by a pharmacist for at least three months. In addition, it emphasises the importance of patient education. However, the guidance also states that patients who are responding well to existing treatment (whether buprenorphine or methadone) should remain on their current treatment.

Further, the Ford *et al.* (2003) state that there appears to be increasing consensus among clinicians experienced in using both buprenorphine and methadone that:

- Buprenorphine may be better suited to those who wish to cease using heroin, as the blockade effects of even moderate dose buprenorphine interfere with the subjective effects of additional heroin use. To achieve the same effect with methadone, a much higher dose is required. So, those patients who wish to continue to use heroin may prefer low dose buprenorphine treatment.
- Withdrawal from buprenorphine appears to be milder than from methadone, and as such may be preferred for those considering a detoxification program.
- The transition from buprenorphine to naltrexone can be accomplished much earlier than that from methadone to naltrexone, and consequently, those considering naltrexone treatment may be better suited to buprenorphine.

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<sup>75</sup> This is a long-recognised problem which had been reported with the prescribing of Temgesic (Anon 1989).

<sup>76</sup> These regulate the terms under which doctors provide General Medical Services under the National Health Service Act 1977.

Ford *et al.* (2003) then go on to compare buprenorphine to methadone, suggesting that:

- it is less dangerous in overdose;
- with maintenance doses between eight and 32mcgs the effects of other opioids used 'on top' are markedly reduced, with optimal effect at a dosage of between 12 to 24 mcg daily;
- it is useful in maintenance and detoxification, being easier to withdraw from; and
- patients report that they remain clearer headed with less 'clouding' effect (this may be positive or negative for different patients).

Disadvantages are that:

- it is highly soluble leading to potential for injection;
- it can precipitate acute opiate withdrawal if used incorrectly;
- it is more expensive than methadone.

#### 11.2.4 Increased use

Since 2001, with regulations enabling GPs to prescribe buprenorphine more easily, there has been a considerable increase in its number of prescribed items for buprenorphine both in the management of withdrawal and as a substitute opiate. However, although use of buprenorphine has significantly increased in recent years (see Table 15), it is still used much less often than methadone (with 1,614,200 prescriptions being dispensed in 2003)

*Table 15: Total prescription items dispensed for Subutex in England*

Prescriptions dispensed	Year				
	1999	2000	2001	2002	2003
Subutex (thousands)	5.132	36.673	75.602	164.27	310.65

Source: Table compiled by Department of Health 2003.

#### 11.2.5 Cost

At current prices, the cost of treatment for one year is:

- £1,051 (€1,500) with buprenorphine at 8mcg daily;
- £318 (€450) with methadone mixture at 60mcg daily;

Given the lack of UK studies and experience, the cost effectiveness of buprenorphine compared with methadone has not been determined.

#### 11.2.6 Research and reviews in the UK

Recent UK research and reviews suggest that buprenorphine and methadone are of similar efficacy in retaining clients in treatment and reducing heroin use:

- Myles *et al.* (2001), following a randomised control trial of buprenorphine/naloxone and methadone/lofexidine for detoxification, found no significant differences in retention, illicit opiate use or symptoms of withdrawal.
- A Cochrane review of buprenorphine maintenance for opioid dependence concluded that, 'Buprenorphine is an effective intervention for use in the maintenance treatment of heroin dependence, but it is not more effective than methadone at adequate dosages' (Mattick *et al.* 2004).
- It has also been suggested that buprenorphine has potential as a medication to ameliorate the signs and symptoms of withdrawal from heroin and possibly methadone, but treatment protocol and relative effectiveness need to be investigated further. It is therefore suggested that there is limited evidence of superiority of either medication, and the decision as to which medication to use should be made in consultation with each patient after consideration of the relative merits of each (Gowing *et al.* 2004).

In addition, Schering-Plough has recently started the Sirius project. This is a safety assessment study. The design is observational and it is expected that Subutex and methadone will be compared in approximately 5,000 patients from 200 treatment centres (Quartey 2000).

### 11.3 Misuse of buprenorphine

Gilvarry and Schifano (2003) point out that the very properties, which make buprenorphine an attractive treatment option (lower dependence, milder withdrawal symptoms and longer action), also make it attractive to the street market. As a drug of abuse, buprenorphine has been sniffed, snorted, inhaled, smoked and injected (see Ghodse 1987). In the late 1980s and early 1990s, a wave of buprenorphine misuse through injecting was reported in Scotland (Sakol *et al.* 1989; Morrison 1989; Hammersley 1990; Lavelle *et al.* 1991) and to a lesser extent, in the North of England (Strang 1985; Strang 1991). Abuse of buprenorphine was also reported in many European countries and so in 1989, it became a controlled drug under Schedule 2 of the *Misuse of Drugs Act 1971*, following the UN Convention on Narcotic Drugs (UNCND) requirement in 1989 that stricter controls be imposed on its use. Subsequently, a significant drop in abuse was reported (Stewart 1991; Forsyth *et al.* 1993), although abuse continued in Glasgow until a voluntary ban on its prescribing to known users by Glasgow GPs in 1992 (Hutchinson *et al.* 2000).

The recording of buprenorphine abuse is not routinely undertaken in the UK. If it is recorded, it is listed under the category of 'other opiates', except in Scotland, where it can be recorded separately. As a controlled drug, information on seizures by police and HM Customs has been recorded since 1989, however such information is not routinely published. However, buprenorphine use has been reported in Scottish prisons through mandatory drug testing (MDT), although since testing began in 1996/97 this has been rare (Table 16).

*Table 16: Mandatory drug testing in Scottish prisons: positive tests for buprenorphine*

Year	Number of tests	Positive buprenorphine results	
1996 to 1997	2,364	71	3
1997 to 1998	7,070	141	2
1998 to 1999	7,162	72	1
1999 to 2000	6,605	66	1

Source: Gilvarry and Schifano 2003.

In England, MDT screening for buprenorphine was introduced in prisons in Yorkshire and the North East. Corkery reports that between 1 April 2000 and 31 March 2001, 0.2 per cent of all random samples tested positive for buprenorphine (Gilvarry and Schifano 2003).



## 12. Alternatives to prison targeting to drug using offenders

### 12.1 Political, organisational and structural information

In the UK drug treatment cannot be strictly defined as an alternative to custody as if a custodial sentence is required offenders will enter custody. However there is a range of interventions that seek to increase the number of drug using offenders accessing treatment, a key tenant of national drug policy (Drugs Strategy Directorate 2002a).

Policy on this is coordinated through the Drugs Strategy Directorate in the Home Office. Although treatment is not an alternative to custody, the UK continues to consider ways in which to get more drug using offenders into treatment. A wide range of agencies, nationally and locally cooperate in making treatment accessible to drug using offenders (see Chapter 12.2).

### 12.2 Intervention

Over recent years a number of interventions have been established to provide treatment of drug using offenders.

#### *Arrest Referral*

Arrest referral involves specialist workers seeing drug using offenders, usually in police custody suites and, increasingly, in court, to provide information and, where appropriate, referral to treatment or other assistance. Involvement is voluntary and it is not an alternative to prosecution or due process. Schemes have been available across all police force areas in England and Wales since April 2002. Since 2003 the scheme has been enhanced in some areas (Enhanced Arrest Referral), extending the role of the drug worker beyond assessment and referral to include case management (Drugs Strategy Directorate 2002a).

#### *Drug testing*

The *Criminal Justice and Court Services Act 2000* included provision drug test on charge, that is to do Class A drug tests (specifically for heroin and crack/cocaine) on:

- those in police detention charged with trigger offences (theft, burglary, robbery and other offences under the *Theft Act 1968*);
- those in police detention charged with drug offences such as possession and supply, if committed in respect of the specified Class A drugs;
- those at pre-sentence where the court is considering imposing a community sentence;
- offenders under probation supervision; or
- as a condition of release from custody on licence.

These provisions apply to those aged 18 and over. Drug testing on charge while in police custody was introduced on a pilot basis in 2001, and is now operational in 114 custody suites in the 66 police areas with the highest levels of acquisitive crime in England and Wales. From July 2004, the list of trigger offences set out in Schedule 6 of the *Criminal Justice and Court Services Act 2000* was extended to include: handling stolen goods (under section 22 of the *Theft Act 1968*); "attempted offences" (under section 1(1) of the *Criminal Attempts Act 1981*, if committed in respect of the offences of theft, robbery, burglary, obtaining property by deception and handling stolen goods); and offences in relation to begging under sections three and four of the *Vagrancy Act 1824*. Those charged with non-trigger offences may also be tested, where a police officer of at least Inspector rank has reasonable grounds to

suspect that misuse of any specified Class A drug caused or contributed to the offence and authorises the taking of a sample.

#### *Conditional cautioning*

Conditional Cautioning targets offenders who admit a first-time minor offence. A caution can be issued with a condition conducive to restoration or rehabilitation, and the offender may be prosecuted for the original offence if the condition is not met.

#### *Restrictions on bail pilot*

Restriction on bail pilot was introduced on in May 2004 in Nottingham, Salford and Manchester. This has given new powers to courts to order drug treatment and assessment as conditions of bail.

#### *Interventions for drug users under probation supervision*

There are a number of interventions with drug users under probation supervision.

#### *Drug Treatment and Testing Orders (DTTOs)*

DTTOs were rolled out to courts in England and Wales in 2000 and in parts of Scotland in 2002. These orders target persistent offenders who have committed significant numbers of crimes to fund their drug misuse. They require the offender to undergo treatment, either in a residential centre or in the community, for between six months and three years. Offenders subject to the Drug Treatment and Testing Order are required to undertake treatment and testing as laid down by a National Standard. Failure to comply results in enforcement measures which can lead to breach and subsequently revocation of the order and re-sentencing; treatment providers report on how well the offender is responding to treatment. Additionally, in English and Welsh law, the courts have a formal role in the reviewing process. Under the *Criminal Justice Act 2003*, DTTOs will be replaced with a number of community sentencing options which will be easier to match to the individual circumstances of an offender.

#### *General rehabilitation interventions*

These are largely provided as part of a Community Rehabilitation Order (CRO) or Community Punishment and Rehabilitation Order (CPRO). Interventions include support into detoxification and therapeutic "lifestyle" services such as acupuncture and counselling. They are voluntary on the part of the offender.

#### *Accredited substance misuse programmes*

Addressing Substance Related Offending (ASRO) and the Programme for Reducing Individual Substance Misuse (PRISM) provide a structured environment for the delivery of group or one to one programmes aimed at assisting offenders to address their drug misuse but do not include any element of clinical intervention. These are most commonly delivered as a requirement of a CRO or CPRO or a DTTO.

CROs or CPROs with ASRO are targeted at offenders for whom both drug misuse and offending is an issue, but who are fairly stable and have no clinical treatment needs. ASRO and PRISM have currently been adopted by around half of the 42 probation areas in England and Wales. The theoretical basis and evidence base for the ASRO and PRISM programmes can be found in their respective theory manuals (McMurrin and Priestly 2000; Priestly and McMurrin 2000). Results of a research evaluation are due to be reported in October 2004.

#### *The Offender Substance Abuse Prevention Programme (OSAPP)*

OSAPP was piloted in 2003 (National Probation Service for England and Wales 2003) and is being rolled out to the remaining probation areas. The programme is based on a cognitive behavioural model.

### *Drug Abstinence Orders (DAOs)*

DAOs are aimed at those whose offending is at a fairly low level, who do not have additional offending behaviour problems, and whose drug use is of a low level.

### *Drug Abstinence Requirements (DARs)*

DARs target offenders who are dependent on or have a propensity to use drugs, and where there is no immediate need or willingness for treatment although they are assessed as requiring some form of behavioural intervention to address their offending behaviour.

Generic Community Sentencing is being established, which will allow magistrates to select from a range of options, including a drug rehabilitation requirement (which will supersede DTTOs, DAOs and DARs) and to tailor community sentencing to the needs and profiles of individual offenders.

### *The Drug Intervention Programme*

In 2003 the Drug Intervention Programme (DIP)<sup>77</sup> was launched as a critical part of the Government's strategy for tackling drugs. It is a three-year programme to develop and integrate measures for directing adult drug-misusing offenders out of crime and in treatment. The programme seeks to take advantage of all opportunities to identify drug-misusing offenders within the Criminal Justice System (that is those in police custody; with the courts, on probation and in prison), not only engaging them treatment, but using a case management approach to integrate and co-ordinate treatment and care. Beyond the initial programme, it is envisaged that these processes will become the normal way of working with drug using offenders across England and Wales. The £447 million (€630 million) programme draws together and builds on the best existing solutions available (identified above) and introduces new elements, such as throughcare and aftercare. Key partners to the Home Office are the criminal justice agencies such as the police, prisons, probation officers and the courts, along with the Department of Health, the National Treatment Agency for Substance Misuse, treatment service providers and those who provide linked services such as housing and job-seeker support.

Delivery of the programme at the local level is through Criminal Justice Integrated Teams (CJITs). The CJIT allocates a worker after a drug using offender has been assessed and it has been agreed that he/she will be taken onto the CJIT caseload. This can occur at any point in the Criminal Justice System or on leaving treatment. The CJIT worker will develop a care plan with the offender and link with appropriate interventions. Where a CJIT client is remanded into custody, CARATs (see Chapter 9) take responsibility for managing drug treatment whilst the offender is in prison and liaise with the CJIT in preparing release plans at the end of the sentence.

Aftercare arrangements will also be made, providing support after the offender reaches the end of a prison based treatment programme, completes a community sentence or leaves treatment. These will include access to additional support such as housing, managing finance, family issues, learning new skills and employment.

A national framework has been developed to manage the transfer of information between community services (CJIT) and the Prison Service, and between the community and the probation service.

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<sup>77</sup> The Drugs Intervention Programme was originally launched as the Criminal Justice Interventions Programme but was re-named in October 2004.

In the first year, 2003/04, the programme rolled out its various components in 25 Drug Action Team areas across England which cover 30 police Basic Command Units<sup>78</sup> with high levels of acquisitive crime. From April 2004, funding for throughcare and aftercare has been available to all Drug and Alcohol Action Teams (D(A)ATs) and partnerships across England and Wales, ensuring access to, and co-ordination of, appropriate aftercare arrangements to provide those leaving the Criminal Justice System or treatment programmes with continuity and vital support at the time when they are most vulnerable. In April 2004, the intensive programme was extended to a further 36 Basic Command Units, and a further expansion is planned for 2005/06.

### Young offenders

DIP is currently implementing special measures for those under 18 years to reduce the risk of continued offending behaviour. Key partners to this work are the Youth Justice Board, the police, D(A)ATs, Youth Services, Connexions, the National Treatment Agency for Substance Misuse, voluntary agencies, and other child-centred services. (See Chapter 1 for details regarding the national co-ordination of drugs policy.)

Arrest referral schemes and drug testing on charge (see Chapter 1.1), which are dedicated to targeting drug using offenders who are under 18 years, have been established in ten pilot areas for the first time. Each stage of the schemes provides an opportunity to identify children and young people who have or are at risk of developing problems with drugs, assess their needs and direct them to appropriate support and treatment services (Home Office 2004b). Taken together and with other services outside the scope of the Drugs Interventions Programme, they deliver an end-to-end programme of support to young people at each stage of the criminal justice system.

## 12.3 Quality assurance

### 12.3.1 Guidelines

Guidance is available for the interventions (DPAS 1999a; DPAS 1999b; Drugs Strategy Directorate 2003b).

### 12.3.2 Evaluation and research

The majority of evaluation programmes on Criminal Justice System interventions with drug using offenders use the following indicators to evaluate success (such as Home Office 2004c):

- levels of treatment uptake and retention;
- levels of drug consumption;
- rates of re-offending (measured variously through levels of re-arrest, reconviction or self-reported re-offending, depending on the individual evaluation); and
- where possible, whether there have been any improvements in health and social welfare.

Data systems for analysing activity and outcomes are still under development. However, some information is available. By April 2004 approximately 5,000 offenders (25% being persistent offenders) per month were being drug tested of whom half were testing positive for Class A drugs (Home Office 2004c). Evidence

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<sup>78</sup> This refers to a specific part of the police force in England and Wales. Basic Command Units are headed by a police superintendent and serve an average population of 166,000 people. Most are coterminous with the boundaries of one or more local authority area. For further details, please see <http://www.policereform.gov.uk/whitepaper/chapter4/4.3.html>.

from pilots suggests wide variation in the extent and nature of drug use among the population charged for acquisitive crime

A number of factors critical to the successful implementation of drug testing on charge were identified. These included strong leadership; good working relations across different stakeholders; a clear vision; clear accountability mechanisms and structures to monitor and improve performance as required (Nacro and DrugScope 2003).

The number of drug using offenders in treatment is increasing; there has been a 47 per cent increase in numbers starting treatment in DIP areas in 2003, while waiting times for treatment in the 'intensive' DIP areas have fallen significantly (Home Office, personal communication).

Cluster analysis identified two main groups among the population receiving Drug Abstinence Orders and Drug Abstinence Requirements attached to a Community Rehabilitation Order:

- individuals with recent multiple drug use (mainly both heroin and crack), high levels of recent and previous offending, high incidence of previous links with treatment and high levels of drug related problems. Most had strong social networks with other drug users and the vast majority believed that their offending was linked to their drug use; and
- individuals with lower levels of recent drug use and considerably lower rates of previous offending. Though they also commonly reported drug-related problems, they were far less likely than to link their offending with their drug use. (Matrix Research and Consultancy and NACRO 2004).

Some, albeit limited, comparisons have been made between those entering treatment through conventional routes and those entering through arrest referral. They suggest that those entering through arrest referral are likely to be a 'harder to help' group of more chaotic drug users with considerably higher levels of offending. There were also lower levels of retention and completion among the arrest-referred group than those conventionally referred (Sondhi *et al.* 2002). This suggests a need for greater support during and after treatment for the criminal justice-referred group. The Home Office is currently considering research into variations of treatment outcomes, which among other things would examine outcomes by referral source.

Evidence from the evaluations of arrest referral, DTTOs and drug testing in the CJS has identified substantial reductions in the extent of offending, illegal drugs spend and drug consumption. Among the DTTO client group:

- the number of crimes committed by offenders fell from an average of 137 offences in the month before arrest to around 34 per month (a reduction of 75%) after only six weeks on the order; and
- the average amount spent on drugs fell from £400 (€568) per week in the four weeks before arrest to £25 (€35) per week in the first four to six weeks of the Order (Turnbull *et al.* 2000).

The follow-up two-year reconviction study found that 53 per cent of those who completed their order (30% did this) were convicted of a crime within two years of the start of their sentence, compared with 91 per cent of those whose orders were revoked. The report concluded that the key to success in DTTOs lies in retention, as well as: strong inter-agency and partnership working; appropriate staffing at all levels; improved referral and assessment; effective monitoring and review of offenders (through testing and court reviews); and streamlining breach procedures (Turnbull *et al.* 2003).

Among arrest referral clients, 67 per cent were arrested less often following referral and self-reported offending was substantially reduced. Factors identified as contributing to the success of schemes include: reduced waiting times for treatment, catering for the different needs of clients, and a good relationship between arrest referral and treatment providers (Sondhi *et al.* 2002).

Among those receiving a DAO or DAR, arrests, convictions and imprisonment were all lower for the pilot group in contrast to the comparison group who received standard community sentences. However, this was not statistically significant.

Individuals tested on licence or under notice of supervision, at around four months after testing started, were less likely to have been arrested (38%) or convicted of an offence (20%, both with a sample size of 829) than those in the comparison group on licence without a drug testing condition (65% and 39% respectively, with a sample size of 198) (Matrix Research and Consultancy and NACRO 2004).

### 12.3.3 Training for staff

See Chapters 5.2.4, 5.3 and 9.2.2.

## 13. Public nuisance: definitions, trends in policies, legal issues and intervention strategies

### 13.1 Definition

Public nuisance is a matter of perception and it is not easy to categorise nationally what all citizens consider to be nuisance behaviour. The *Crime and Disorder Act, 1998* formally defines it as acting “in a manner that caused or was likely to cause harassment, alarm or distress to one or more persons not of the same household as [the defendant]”.

Public surveys on crime and policing in the UK suggest the public place a high priority on tackling incidents described as anti-social behaviour, minor disorder or ‘quality of life issues’. The following types of behaviour, incidents and complaints are examples (Lupton *et al.* 2002; Thorpe *et al.* 2004):

- noise;
- using & selling drugs;
- unkempt gardens (e.g. those which attract dumping of goods, creating ‘eyesores’);
- alcohol and solvent abuse;
- criminal behaviour;
- prostitution;
- verbal abuse;
- uncontrolled pets and animals;
- intimidating gatherings of young people in public places;
- harassment (including racist & homophobic incidents);
- damage to property (including graffiti & vandalism);
- intimidation;
- nuisance from vehicles (including parking & abandonment);
- nuisance from business use;
- rubbish dumping and misuse of communal areas;
- riding/cycling on footpaths; and
- aggressive begging.

Some are criminal, whilst others are not. They highlight the fact that such types of behaviour do not fall into the ambit solely of one agency, illustrating the need to work constructively with local communities to identify local problems of anti-social behaviour and develop appropriate strategies to tackle them.

At one level, all drug problems can be considered to be public nuisance. However, the Home Office suggest the following constitute public drug-related nuisance as they involve an aspect of visible, or street based disturbance that has negative impacts beyond users and their immediate families, and which can blight locations:

- public drug taking and visible drug-related intoxication;
- drug-related litter;
- visible drug-related behaviour – sex workers, begging, street homelessness;
- the sale of drugs in public settings, especially to young people;
- the sale of drugs from residential or other property; and
- drug-related street crime, where it is clear that drugs are the cause of the crime.

This categorisation is indicative rather than definitive, but it highlights the priorities for action in the UK. All illegal substances would be covered by this categorisation.

With European partners, through the Pompidou group, the UK has been working to develop a consensus opinion on what constitutes public nuisance about drugs and to share practice between states on effective forms of intervention that could minimise the harm from such settings.

### **13.2 Tackling 'Public Nuisance'**

As the problem of nuisance includes so many different types of behaviours, the range of responses is equally broad.

UK policy seeks to help persons who cause street problems and community disorder through their drug use by directing them into treatment and to safer methods of using whilst they develop control (see Chapter 12). Criminal justice and situational control methods take a different approach through controlling unacceptable behaviour, street management systems, criminal justice responses and control strategies for the public space, as it is about offering treatment. Tackling 'public nuisance' involves a variety of specialists including drug specialists and police working in partnerships.

### **13.2 Genesis**

The Drugs Strategy Directorate works with the Anti-social Behaviour Unit to tackle drug-related anti-social behaviour and public nuisance<sup>79</sup>. A combined programme of work between the Home Office and the Office of the Deputy Prime Minister, and involving the Department of Health, focuses on the most manifest forms of drug use as they affect British communities. A number of research initiatives have been funded concerned with local drug markets and how they affect local communities (Lupton *et al.* 2002).

### **13.3 Measures taken**

Building 'bottom-up' community responses to drugs is a major strand in drug policy (Drugs Strategy Directorate 2002a). As such, local Drug and Alcohol Action Teams (D(A)ATs), working with Crime Reduction Partnerships, seek to provide a balance between treatment and enforcement. As part of this, Communities Against Drugs (CAD) (2001-2003) enabled many community groups and organisations to engage in developing innovative responses to their local problems (see Chapter 3). Funding through the CAD programme has helped to focus the work of local partnerships on developing strategies to address street drug use problems.

The Home Office has published a number of guidance manuals to local partnerships who manage such problems<sup>80</sup>. These are concerned with: street homelessness (Randall *et al.* 2002); regeneration and deprived areas (Home Office 2002); dance clubs and venues (Webster *et al.* 2002); street crack markets (Burgess *et al.* 2003); housing management settings (Drugs Strategy Directorate 2004d); tackling street prostitution (Hester and Westmarland 2004; Hunter *et al.* May 2004); and begging (Drugs Strategy Directorate 2004a). All recommend an approach comprising a mixture of enforcement, treatment and support. Action also includes work to regulate street environments to stop such problems occurring in the future. For example, one project will tackle drug-related litter through educating the general public, users and those who supply needles.

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<sup>79</sup> The anti-social behaviour website can be found at <http://www.homeoffice.gov.uk/crime/antisocialbehaviour/index.html>.

<sup>80</sup> The crime reduction toolkit is available at <http://www.crimereduction.gov.uk/toolkits/as03.htm>.



The *Anti-Social Behaviour Act 2003* will tackle a problem which has emerged over the past few years: properties used for the sale and use of crack and other Class A drugs, which are associated with serious nuisance. The Act is part of both (a) the national strategy on anti-social behaviour, which extends more widely than drug-related behaviour<sup>81</sup> and (b) the national crack strategy (Drugs Strategy Directorate 2002b), a sub-set of the national drugs strategy. The Act makes an explicit link, for the first time, between penalties and powers to control drug-related behaviour with nuisance arising from them. Previously the only punishable act was that of possessing or supplying (or producing or trafficking etc.) of the drug itself. The new Act criminalises such offences' subsequent nuisance. Its powers are targeted against properties, not people, as the Act enables the closure of premises used in connection with the production, supply or use of Class A drugs and which are associated with disorder or serious nuisance. The Act also contains other powers against nuisance, none of which are defined as drug-related even though they may be caused by drug use. Guidance to the police and courts has been produced by the Drugs Strategy Directorate (2004e).

In addition, a new Police Plan published in the spring of 2004 defines the way police forces should take account of drug-related nuisance (Home Office 2004d). This requires the police to meet certain key objectives: to reduce crime, and to tackle criminality, anti-social behaviour and the fear of crime. In tackling anti-social behaviour and disorder, Chief Officers and police authorities are expected to include in their local plans a strategy for tackling youth nuisance and anti-social behaviour. In formulating and implementing this, forces are to work closely with Crime and Disorder Reduction Partnerships and to make best use of all the available tools including Anti-Social Behaviour Orders (ASBOs), Anti-Social Behaviour Contracts, fixed-penalty notices, the power to seize vehicles being used in a manner causing alarm and the power to take action against badly run pubs and clubs. In reducing the volume of crime, street crime, drug-related crime, violent crime and gun crime in line with local and national targets, local police plans are expected to identify how forces and authorities will contribute to crime reduction, both through their own efforts and by working in partnership with other agencies, and set appropriate local targets. Local plans must also include local three-year targets for reducing vehicle crime, burglary and robbery.

### **13.4 Results / evaluation**

Policy is always kept under review. The Home Office is developing recording systems to measure the use of the closure powers for 'crack' houses.

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<sup>81</sup> For further information see <http://www.together.gov.uk>

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**List of websites used in the text**

Adfam

[www.adfam.org.uk](http://www.adfam.org.uk)

Changing Children's Services Fund

[www.childreninscotland.org.uk](http://www.childreninscotland.org.uk)

Communicable Disease Surveillance  
Centre Northern Ireland

[www.cdscni.org.uk](http://www.cdscni.org.uk)

Connexions

[www.connexions.gov.uk](http://www.connexions.gov.uk)

Crime Reduction

[www.crimereduction.gov.uk](http://www.crimereduction.gov.uk)

Department for Education and Skills

[www.dfes.gov.uk](http://www.dfes.gov.uk)

Department for Transport, Local  
Government and the Regions

[www.dtlr.gov.uk](http://www.dtlr.gov.uk)

Department of Education Northern  
Ireland

[www.deni.gov.uk](http://www.deni.gov.uk)

Department of Health

[www.doh.gov.uk](http://www.doh.gov.uk)

Department of Health, Social Services  
and Public Safety Northern Ireland

[www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk)

Drug Abuse Resistant Education

[www.dare.uk.com](http://www.dare.uk.com)

Drugs Strategy Directorate, Home  
Office

[www.drugs.gov.uk](http://www.drugs.gov.uk)

EMCDDA

[www.emcdda.eu.int](http://www.emcdda.eu.int)

Eurosurveillance

[www.eurosurveillance.org](http://www.eurosurveillance.org)

FRANK

[www.talktofrank.com](http://www.talktofrank.com)

Forensic Science Service

[www.forensic.gov.uk](http://www.forensic.gov.uk)

General Register Office for Scotland

[www.gro-scotland.gov](http://www.gro-scotland.gov)

Health Promotion Agency

[www.healthpromotionagency.org.uk](http://www.healthpromotionagency.org.uk)

Health Protection Agency

[www.hpa.org.uk](http://www.hpa.org.uk)

Her Majesty's Prison Service England  
and Wales

[www.hmprisonservice.gov.uk](http://www.hmprisonservice.gov.uk)

Her Majesty's Treasury

[www.hm-treasury.gov.uk](http://www.hm-treasury.gov.uk)

Home Office

[www.homeoffice.gov.uk](http://www.homeoffice.gov.uk)

Information and Statistics Division,  
Scottish Executive

[www.drugmisuse.isdscotland.org](http://www.drugmisuse.isdscotland.org)

Know the Score

[www.knowthescore.info](http://www.knowthescore.info)

Management Standards Consultancy

[www.themsc.org](http://www.themsc.org)

National Collaborating Centre for Drug  
Prevention

[www.cph.org.uk/nccdp](http://www.cph.org.uk/nccdp)

National Criminal Intelligence Service

[www.ncis.co.uk](http://www.ncis.co.uk)

National Health Service

[www.nhs.uk](http://www.nhs.uk)

National Health Service hepatitis C  
awareness website

[www.hepc.nhs.uk](http://www.hepc.nhs.uk)

National Treatment Agency for  
Substance Misuse

[www.nta.nhs.uk](http://www.nta.nhs.uk)

North West Public Health Observatory,  
Centre for Public Health

[www.cph.org.uk](http://www.cph.org.uk)

Northern Ireland Office  
[www.nio.gov.uk](http://www.nio.gov.uk)

Pricing Prescription Authority  
[www.ppa.org.uk](http://www.ppa.org.uk)

Research and Statistics Division,  
Home Office  
[www.homeoffice.gov.uk/rds](http://www.homeoffice.gov.uk/rds)

Scotland Against Drugs  
[www.sad.org.uk](http://www.sad.org.uk)

Scottish Executive  
[www.scotland.gov.uk](http://www.scotland.gov.uk)

Scottish Drugs Forum  
[www.sdf.org.uk](http://www.sdf.org.uk)

The Stationery Office  
[www.legislation.hmso.gov.uk](http://www.legislation.hmso.gov.uk)

Substance Misuse Management in  
General Practice  
[www.smmgp.demon.co.uk](http://www.smmgp.demon.co.uk)

Tackling Anti-Social Behaviour  
[www.together.gov.uk](http://www.together.gov.uk)

UK Focal Point  
[www.ukfocalpoint.org.uk](http://www.ukfocalpoint.org.uk)

Welsh Assembly  
[www.wales.gov.uk](http://www.wales.gov.uk)

**List of abbreviations used in the text**

ACMD	Advisory Council on the Misuse of Drugs, United Kingdom
ACPO	Association of Chief Police Officers, England, Wales and Northern Ireland
AIDS	Acquired Immunodeficiency Syndrome
Anti-HCV	Antibodies to hepatitis C virus
Anti-HBC	Antibodies to hepatitis B virus core
ASBO	Anti-Social Behaviour Orders
ASMA	Assessment of Substance Misuse in Adolescence
ASRO	Addressing Substance-Related Offending
BCS	British Crime Survey, England and Wales
BSC	Building Safer Communities
CAD	Communities Against Drugs
CAHRU	Child and Adolescent Health Research Unit, Scotland
CARATs	Counselling, assessment, referral, advice and through-care services
CCTV	Closed circuit television
CDR	Communicable disease report
CDSC	Communicable Disease Surveillance Centre, England
CI	Confidence interval
CJIT	Criminal Justice Intervention Team
CJS	Criminal Justice System
CPRO	Community Punishment and Rehabilitation Order
CRO	Community Rehabilitation Order
DAAT	Drug and Alcohol Action Team
DAIRU	Drug and Alcohol Information and Research Unit, Northern Ireland
DAO	Drug Abstinence Order
DAR	Drug Abstinence Requirement
DARE	Drug Abuse Resistance Education
DENI	Department of Education Northern Ireland
DfES	Department for Education and Skills, England
DH	Department of Health, England
DIP	Drugs Intervention Programme
DPAS	Drug Prevention Advisory Service
DHSSPSNI	Department of Health, Social Services and Public Safety Northern Ireland
DMD	Drug Misuse Database
DPAS	Drug Prevention Advisory Service
DRD	Drug-related death
DTLR	Department for Transport, Local Government and the Regions
DTTOs	Drug Treatment and Testing Orders
EIU	Effective Interventions Unit, Scotland
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESPAD	European School Survey Project on Alcohol and other Drugs
FSS	Forensic Science Service, England and Wales
GHB	Gamma hydroxybutyrate
GMR	General Mortality Register
GP	General practitioner
HAS	Health Advisory Service
HAZ	Health Action Zones
HBC	Hepatitis B
HCV	Hepatitis C

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HBSC	Health Behaviour in School Age Children Survey
HDA	Health Development Agency
HIV	Human Immunodeficiency Virus
HM Customs and Excise	Her Majesty's Customs and Excise, United Kingdom
HM Prison Service	Her Majesty's Prison Service, England and Wales
HPA	Health Promotion Agency, Northern Ireland
HPA	Health Protection Agency, England
IDU	Injecting drug user
ISD	Information and Statistics Division, Scotland
LSD	Lysergic dyethylamide acid
LST	Life Skill Training
mcg	Microgramme
MDA	Methylenedioxyamphetamine
MDEA	Methylenedioxyethylamphetamine
MDMA	3,4-Methylenedioxy-n-methylamphetamine
MDT	Mandatory drug testing
MRSA	Methicillin Resistant Staphylococcus Aureus
NACD	National Advisory Committee on Drugs
NatCen	National Centre for Social Research
NCCDP	National Collaborating Centre for Drug Prevention
NCIS	National Criminal Intelligence Service, United Kingdom
NDTMS	National Drug Treatment Monitoring System, England
NEW-ADAM	New English and Welsh Arrestee Drug Abuse Monitoring
NFER	National Foundation for Educational Research
NHS	National Health Service. United Kingdom
NICE	National Institute for Clinical Excellence
np-SAD	National Programme on Substance Abuse Deaths
NPSA	National Patients Safety Agency
NSES	Northern Ireland Needle and Syringe Exchange Scheme
NTA	National Treatment Agency for Substance Misuse, England
ONS	Office of National Statistics
OSAPP	Offending Substance Abuse Prevention Programme
p2w	Progress2Work
PDI	Partnership Drugs Initiative
PMA	Para-metoxamphetamine
PPA	Pricing Prescription Authority
PRISM	Programme for Reducing Individual Substance Misuse
PSA	Public Service Agreement
PSHE	Personal, Social and Health Education
RCGP	Royal College of General Practitioners
SACAM	Scottish Advisory Committee on Alcohol Misuse
SACDM	Scottish Advisory Committee on Drug Misuse
SAD	Scotland Against Drugs
SALSUS	Scottish Schools Adolescent Lifestyle and Substance Use Survey
SCIEH	Scottish Centre for Infection and Environmental Health
SCS	Scottish Crime Survey
SDF	Scottish Drugs Forum
SDP	Short duration programme
SDS	Severity Dependence Scale
SMMGP	Substance Misuse Management in General Practice
SMR	Special Mortality Register
SPS	Scottish Prison Service
SSRI	Selective Serotonin Reuptake Inhibitors

SWPHO	South West Public Health Observatory, England
TC	Therapeutic community
UAPMP	Unlinked Anonymous Prevalence Monitoring Programme
UK	United Kingdom
UKADCU	United Kingdom Anti-Drugs Coordination Unit
UNCND	United Nations Convention on Narcotic Drugs
VDT	Voluntary drug testing
YOT	Youth Offending Team