Annual Report

on the UK Drug Situation 2001

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Acknowledgements

The following people in the UK contributed to these sections:

Section 1: Stephane Aujean, Rachel Lohan, Rachel Murphy
Section 2: Martin Frischer
Section 3: Michael Donmall, John Corkery, Ali Judd, John Marsden
Section 4: Jill Britton, Trevor Bennett, Katy Holloway, Andrew Healey, Debra Jeffery
Section 5: Rachel Murphy
Section 6: Martin Frischer
Section 7: Martin Frischer, Ali Judd, Debra Jeffery, Michael Donmall
Sections 8-10: Jill Britton, Safia Noor, Rachel Lohan, Alison Stafford, Rachel Kirk, Felicity Stephens
Section 11: Jane Fountain
Section 12: John Marsden
Section 13: Tony Bullock, Malcolm Ramsay

Edited by Stephane Aujean, Rachel Murphy, Les King, Debra Jeffery. Managed by Nicholas Dorn

DrugScope, 32 Loman Street. London SE1 0EE, United Kingdom
www.drugscope.org.uk

Framework for report: staff of the EMCDDA in consultation with all Focal Points

European Monitoring Centre for Drugs and Drug Addiction, Rua Cruz de Santa Apólonia 23, P-1149-045 Lisbon, Portugal
www.emcdda.org
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INTRODUCTION

DrugScope is designated by Government as the United Kingdom focal point for drugs information. This role involves the collection and dissemination of information about illegal drugs from primary and Government information sources in England, Scotland, Wales and Northern Ireland. The UK focal point is one element of a European network of drugs information centres. The network is co-ordinated by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), a specialised agency for the European Union.

This report contains information on the situation in the United Kingdom up to 2001. In due course, some of this information will be selected for inclusion in the EMCDDA’s Annual report on the state of the drugs problem in the European Union 2002. The EMCDDA’s report for 2001 contains information collated in 2000. The format is common to all national focal points in the European Union.

Data sources are provided in the text. Contact DrugScope's library if you require any of these in detail.

Contact details for the EMCDDA in Lisbon, Portugal website: www.emcdda.org email: info@emcdda.org.uk Tel: 00 351 21 811 3000
SUMMARY: MAIN TRENDS AND DEVELOPMENTS

**Trends in drug use**

There has been a significant increase in cocaine use from 6% of 16-29 year olds having tried the drug in 1998 to 10% of the same age range having tried it in 2000. Studies in 2000 have found that cocaine was preferred more than amphetamine and ecstasy and young people appeared to have a less negative attitude towards cocaine than other drugs because they felt that it was more socially acceptable and easier to control. Furthermore, evidence from the British Crime Survey 2000 showed that use of this drug was as common among those who were employed as unemployed. This Survey also showed that there has been a growth in the use of cocaine in the North of England, but London still had consistently higher rates of ‘any’ drug use than other regions.

Heroin use for both sexes and all age ranges remained low in 2000 with no significant changes.

Cannabis was still the most widely consumed illicit drug in the UK in 2000 with 44% of 16-29 year olds having tried it. This was an increase from 42% in 1998.

Ecstasy use continued to be broadly stable with a small increase from 4% in 1998 of 16-59 years olds ever having tried the drug to 5% in 2000. There has been a decline in the use of amphetamines, poppers and LSD. There was some evidence that other drugs such as gammahydroxybutyrate, ketamine and flunitrazepan (rohypnol) were being misused.

On an inflation-corrected basis, all drug prices in the UK continued to fall. From 1999 to 2000, the purity of heroin increased whereas the purity of cocaine and amphetamine decreased. The purity of crack in 2000 was the lowest for many years.

**Trends in drug-related problems**

The most recent data (1998) showed that Government estimates of the social and economic costs of drug use in the UK amount to £4 billion with most of the money spent on drug-related crime victims. The drug retail market was estimated to be around the value of £6.6 billion.

Drug-related deaths continued to rise across the UK in 2000. Rates for England and Wales appeared to be slowing contrasting with rates for Scotland and Northern Ireland which were increasing. Opiates were one of the most common groups associated with drug-related deaths throughout the UK. In Scotland more than 23 heroin users were killed by necrotising fasciitis.
For the UK as a whole HIV infection remained low and stable, but the transmission of Hepatitis C and B became a major problem. In 2000, in England, Scotland and Wales combined 40,430 drug users sought treatment for their drug use in the six month period ending 30th September. This was an increase of 7% in relation to the same period in 1999 and a 45% increase in the same period from 1995. Heroin was the main drug of use in over half of the reported cases in 2000, a slight increase from 1999, but the proportion said to be injecting heroin as their main drug has remained stable from 1995 to 2000.

There was a strong association between problematic drug use such as heroin and/or crack addiction and criminality, with most offenders more likely to be consumers of prohibited drugs than was true of the rest of the general population. From 1996-1999 there were substantially more drug possession offences recorded than drug-trafficking offences for each type of drug; the majority in 1999 being recorded for cannabis-related offences. There was an overall decrease in 1999 in the total number of drug offences compared to previous years (1996-1998).

In the second developmental stage of the New English and Welsh Arrestee Drug Abuse Monitoring (NEW-ADAM) (1999/2000) a statistically significant correlation was found between those arrestees who tested positive for drug use and all four measures of criminal behaviour. Half the arrestees held for burglary in non-dwelling premises tested positive for cocaine (including crack) and more than two-thirds tested positive for opiates (including heroin). A large proportion of arrestees held for shoplifting offences also tested positive for these types of drugs but a small proportion tested positive in arrestees held for offences involving assaults. It was also found that there was a clear progression, with measures of involvement in crime increasing as the measure of drug use increased.

Trends in strategy and implementations

During the period 1999/2000 in the UK there was a shift of emphasis in the Government in relation to drugs from policy making to policy implementing. Developments in the implementation of the UK drugs strategy in the period under review included the growth of the anti-drugs strategy in Northern Ireland in 1999, the Scottish Executive’s Drug Action Plan and the Welsh Strategy in May 2000.

Within Scotland, the Executive’s Effective Intervention Unit was established in June 2000 with the responsibility of coordinating drugs research through identifying effective and cost effective practices in prevention, treatment, rehabilitation and availability and addressing the needs of both the individual and the community.

In Northern Ireland in 2000 the strategy for reducing alcohol related harm was produced and proposals were set forward for a Joint Implementation Model to be introduced in 2001 in which the anti-drugs strategy and the strategy for reducing alcohol related harm would proceed together.
A new unit in the Home Office was created in 2000: the Drugs Prevention Advisory Service (DPAS). This service provides support for all Drug Action Teams (DATs) in England. Also, in England, all prisons now provide counselling, assessment, referral, advice and throughcare (CARAT) services, and DTTOs (Drug Treatment and Testing Orders), an alternative to custody, were made available in courts in England and Wales to combat drug-driven crime.

The Criminal Justice and Court Services Act 2000 included a provision for persons aged 18 or over to be tested for specified Class A drugs, heroin and cocaine/crack. Testing is used in those cases where the person has been charged with a trigger offence such as property crime, robbery and/or Class A drug offences or are offenders under probation service supervision, for example, bail, community sentence or on licence from prison. This was to identify those who are misusing drugs and monitor their progress. The Act applies principally to England and Wales only.

In October 2001, the Home Secretary announced that subject to advice to be received from the Advisory Council on the Misuse of Drugs, the Government foresees moving cannabis from Class B to Class C of the Misuse of Drugs Act (1971). Re-classification of cannabis to Class C would not amount to either legalisation or decriminalisation of cannabis. The effect of this is that both possession and supply would remain criminal offences with a maximum penalty of 2 years imprisonment for possession and 5 years for supply. There is no power of arrest for possession of Class C drugs. Although there is a power of arrest for supply and trafficking, this will be discussed further with the police service. Offenders could be dealt with on the spot by the police officer and warned, cautioned or reported for summons.
1. DEVELOPMENTS IN DRUG POLICY AND RESPONSES

1.1 Political framework in the drug field

1.1(a) Objectives and priorities of the national drug policies

**UK (and English) Strategy**

The UK anti-drugs strategy, ‘Tackling Drugs to Build a Better Britain’ (1998), functions as the UK and English strategy. Scotland and Northern Ireland have each published their own strategies during 1999, and Wales in 2000, which broadly reflect the UK Strategy.

The UK anti-drugs strategy sets out the following four keys aims:

1. **Young people:** To help young people resist drug misuse in order to achieve their full potential in society.
2. **Communities:** To protect our communities from drug-related anti-social and criminal behaviour.
3. **Treatment:** To enable people with drugs problems to overcome them and live healthy and crime free lives.
4. **Availability:** To stifle the availability of illegal drugs on our streets.

To achieve these aims the government has introduced a number of initiatives such as the introduction of key performance targets (UK Anti-Drugs Coordinator, First Annual Report and National Plan, 1999).

**Scottish Strategy**

Scotland’s anti-drugs strategy ‘Tackling Drugs in Scotland: Action in Partnership’ (May 1999) contains the same four key aims as those of the UK strategy. Within the four UK aims, Scotland has set clear objectives and action priorities. The Scottish Executive’s Drugs Action Plan (2000) outlines progress to date and sets out a detailed plan for future action (Part 4, section 12).

The Scottish Executive has set national targets and standards to monitor progress in the implementation of its drugs strategy. These are founded on the four UK headline targets, but reflect the differing circumstances of the drugs problem in Scotland. Drug Action Teams (DATs) are required to set local targets where necessary.

DATs report progress in implementing the Scottish strategy through annual corporate planning arrangements, where they are required to report action and direct expenditure in support of the strategy’s objectives and targets.

The Drug Misuse Information Strategy (launched in 1998) is a vital part of the strategy in Scotland and establishes a coherent structure for the long term availability of appropriate information in support of evidence based decision making.

Drugs research co-ordination is the responsibility of the Executive’s Effective Interventions Unit (EIU), which was established in June 2000. EIU’s remit is to:

* identify what is effective-and cost effective-practice in prevention, treatment, rehabilitation and availability and in addressing the needs of both the individual and the community;

* disseminate effective practice based on sound evidence and evaluation to policy makers, DATs and practitioners;
* support DATs and agencies to deliver effective practice by developing good practice guidelines, evaluation tools, criteria for funding, models for service; and by contributing to the implementation of effective practice through the DAT corporate planning cycle.

**Welsh Strategy**

The Welsh Strategy, ‘Tackling Substance Misuse in Wales: A Partnership Approach’ (2000) has similar aims to those of the UK strategy with a key difference being that it also includes prescribed drugs, over-the-counter medicines, volatile substances and alcohol. The strategy emphasises a holistic approach to tackling drug problems in Wales. Partnerships between key agencies including health, social services, education and criminal justice agencies are seen as being crucial to the success of the strategy. The Welsh Drug and Alcohol Unit, now assimilated into the National Assembly for Wales as the Substance Misuse Intervention Branch, supports DAATs in strategy implementation. The strategy does not contain performance targets. However, these are currently being developed and will be published separately along with an information and research strategy which will outline arrangements for the monitoring of progress against the key targets.

**Northern Ireland Strategy**

The Northern Ireland Drugs Strategy (1999) is also based upon the four key aims of the UK drug strategy. In 2000 the Strategy for reducing Alcohol Related Harm was also produced. In May 2001 the Northern Ireland Executive endorsed a Joint Implementation Model. Through this structure both strategies will be taken forward together. A Ministerial Group provides a strategic focus while, at official level the Drugs and Alcohol Implementation Steering Group review progress and ensure a co-ordinated approach. The Joint Implementation Model includes the establishment of six working groups to develop action in specific areas including Communities, Treatment, Education and Prevention, Information and Research, Social Legislation and Criminal Justice. These groups comprise relevant representatives from all sectors including the statutory and voluntary/community sectors. A Drug and Alcohol Information Research Unit has been established to develop baselines from which performance against the targets set in both strategies can be more accurately measured.

1.1(b) **Basic elements of drug policy at national, regional, local level**

**Before the June 2001 Elections**

The UK Anti-Drugs Coordination Unit (UKADCU), based in the Cabinet Office, was responsible for the coordination and implementation of the UK anti-drugs strategy. Attached to this unit were the UK Anti-Drugs Coordinator and his deputy. These were high profile appointments created to give personal leadership to the UK anti-drugs strategy, and to drive forward its implementation to the satisfaction of Ministers.

When the Government’s 10-year strategy for tackling drug abuse was presented in 1998, the key to the new approach was the development of the concept of partnership. The strategy stresses this concept in order to avoid the possibility that partnership could be an ‘excuse for blurring responsibility and inactivity’. Joint action and accountability, objectives for real achievements and coordination of activities are conceived as crucial success factors of the UK strategy, guaranteed by the designation of a UK Anti-Drugs Coordinator.

The new Cabinet Sub-Committee on Drug Misuse is known as the Ministerial Steering Group on Drugs (MSGD). The UK Anti-Drugs Coordinator and his Deputy were members of, as well as reporting to, the MSGD. Their role on behalf of Ministers was to provide day-to-day leadership and focus on implementing and developing the Government’s strategy. The Coordinator, in particular, rigorously scrutinised the performance of departments and agencies, individually and collectively, against the actions, objectives and performance indicators set out in this report. He produced a report describing progress in implementation in each successive year.
Departments continued to be responsible for their own policies and resources, and accountable to their Ministers accordingly. But the Coordinator’s responsibility to the Government for the production of his Annual Report meant that progress across the board was co-ordinated and open to scrutiny.

There is a network of Committees that report to the Ministerial Group. At the top of this structure sits the Strategic Planning Board, whose membership consists of senior officials from all the government departments with an interest in the anti-drugs strategy. This committee co-ordinates all areas of activities, preparing papers for approval by the Ministerial Group.

A number of planning groups covering particular subjects feed in to the Strategic Planning Board: youth (prevention); communities (crime prevention and economic regeneration); treatment; availability (supply reduction); local delivery; research and information; communications; international; diversity (gender and ethnic minority issues).

These planning groups assess the situation in their area of concern, and propose future courses of action.

A feature of the UK structure is the strong links between the agreed national policy and programmes, and local delivery at municipal level. The regional and local structures are described below. In general, the central government department passes resources down to each of the 150 Drug Action Teams (DATs) to deliver the drugs strategy in their area. Their responsibility is to agree a local strategy that applies the national policy to the particular conditions in their area, and report annually on the progress achieved.

At regional level, a new ‘Drugs Prevention Advisory Service (DPAS)’, was created in 2000. It is based in the Home Office and has nine teams located in the Government Offices for the Regions, to provide support for all DATs in England. The DATs are local structures1 that were created by the previous drug strategy ‘Tackling Drugs Together’ (1995) and are located all over England, Scotland, Wales, and Northern Ireland. They are composed of all those involved in drugs issues at local level and vary according to the local situation (for example probation services, health services, police, treatment centres, communities, NGO’s)2. The DATs are the critical link in the chain for delivering the anti-drugs strategy on the ground.

After the June 2001 Elections
Responsibility for drugs within Government has been moved from the UKADCU in the Cabinet Office to the Home Office, under the responsibility of David Blunkett, the Secretary of State for Home Affairs (‘Home Secretary’). This change was announced in the Prime Minister’s cabinet reshuffle the day after Labour’s victory at the polls.

1.2 Policy Implementation, legal framework and prosecution

1.2(a) Law and regulations (drug-related issues about health, social affairs, youth, justice, drug control, etc.)

In relation to drug users, from 1 April 2001 doctors will be able to prescribe and pharmacists dispense buprenorphine (as Temgesic) by installments for the treatment of drug addiction. Until now only methadone has been prescribed in this way for drug replacement therapy. Buprenorphine has been used for some time in other countries to treat drug users. The risk of overdose is said to be less than methadone and some users prefer buprenorphine tablets to methadone liquid.

The Misuse of Drugs Act 1971 is the main law regulating drug control in the UK. It is through the Misuse of Drugs Act 1971 that the UK fulfils its obligations under the UN Single Convention of Narcotic Drugs and

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1 These comprise DATs in England and Scotland, Drug and Alcohol Action Teams (DAATs) in Wales, and Drug and Alcohol Coordination Teams (DCTs) in Northern Ireland.
2 The arrangements in Scotland are mixed, including DATs, DAATs, and some with smoking responsibilities also.
the 1971 Convention on Psychotropic Substances. In general drug use or consumption is not in itself an
offence under the Misuse of Drugs Act 1971 - it is the possession of the drug that constitutes an offence.
However, article 9 of the Misuse of Drugs Act of 1971 does criminalise the smoking of opium, although
prosecutions are rare, reflecting contemporary patterns of drug misuse.

The Misuse of Drugs Act divides controlled substances into 3 classes (A, B, C) with A being the most
dangerous. These classes provide a basis for attributing penalties for offences. Offences involving Class
A substances, such as heroin, attract the highest penalties - up to lifetime imprisonment for unlawful
production or supply. The same offences for Class B drugs and Class C drugs (such as temazepam)
attract maximum penalties of 14 years and 5 years respectively. Possession offences attract lesser
maximum penalties.

In October 2001, the Home Secretary announced that subject to advice to be received from the Advisory
Council on the Misuse of Drugs, the Government foresees moving cannabis from Class B to Class C of
the Misuse of Drugs Act (1971). Re-classification of cannabis to Class C would not amount to either
legalisation or decriminalisation of cannabis. The effect of this is that both possession and supply would
remain criminal offences with a maximum penalty of 2 years imprisonment for possession and 5 years for
supply. There is no power of arrest for possession of Class C drugs. Although there is a power of arrest
for supply and trafficking, this will be discussed further with the police service. Offenders could be dealt
with on the spot by the police officer and warned, cautioned or reported for summons.

In May 2001 new legislation was introduced that will extend the liability to prosecution of anyone
knowingly permitting the unlawful use of controlled drugs on their premises. It is already an offence to
knowingly allow the supply of any drug, or the use of cannabis or opium on premises: the law will now be
extended to cover the unlawful use of any controlled drug. This amendment reflects changing drug
misuse patterns, particularly the shift from “open” to “closed” drugs markets, such as crack houses. Many
of those working in the treatment and voluntary sectors have expressed concern at this change despite
the promise of guidelines for their protection. Nightclub owners are also said to be concerned by the new
legislation. However, an undertaking has been given to Parliament to consult with the police, other
Government departments and the treatment and voluntary sector before the changes come into force.

Since 1998 the Government has provided significant additional funding to increase the number of drug
using offenders engaged with treatment services, and has developed an innovative range of interventions
throughout the criminal justice system to identify drug misusing offenders and help them address their
problems earlier in their drug using career.

Arrest Referral schemes are partnership initiatives between the police and local agencies. They are not
alternative to prosecution or due process and use the point of arrest as a key opportunity to encourage
problem drug users who are arrested to take up appropriate treatment or other effective programmes of
help. A proactive model was found to be most effective and dedicated drug workers have been employed
to work in custody suites in police forces across England and Wales. The UK Anti-Drugs Strategy target
is that by the end of March 2002 all police forces in England and Wales to be operating a face to face
(dedicated worker) arrest referral schemes covering all custody suites.

Drug Treatment and Testing Orders were introduced in courts in England and Wales from the 1st October
2000 following successful piloting. DTTOs are a new form of disposal targeted at persistent offenders
who have committed a large amount of crime to fund their drug misuse and who might otherwise be sent
to prison. The Order can only be made if the offender consents and also requires the courts to continue
to be closely involved by regular reviews of the Orders made. Offenders will also be subject to frequent
drug testing.
The evaluation of the pilot schemes identified significant reductions in the amount of money spent on drugs (from £400 to £25 per week) and the number of offences committed (137 to 34 per month) while offenders were subject to the Order. For those who stayed on the programme these reductions were largely sustained over time.

New drug testing powers introduced by the Criminal Justice and Court Services Act 2000 to drug test persons aged 18 and over for specified Class A drugs (heroin/crack cocaine) charged with trigger offences (property crime, robbery and/or Class A drug offences); offenders under probation supervision (bail, community sentence and on licence from prison) to identify those misusing drugs and monitor their progress. They are being piloted in three sites; Nottingham, Staffordshire and Hackney from Summer 2001 for two years. Drug testing will use oral fluid samples. The pilots will be fully evaluated.

These powers will complement other initiatives such as Arrest Referral Schemes, Drug Treatment and Testing Orders and prison - based treatment which we have also piloted and evaluated before rolling out over the last few years.

The Powers of Criminal Courts (Sentencing) Act 2000 introduced a minimum sentence of 7 years imprisonment for a third conviction for trafficking in Class A drugs. The Criminal Justice and Police Act 2001 will give the courts the power to impose overseas travel banning orders on drug traffickers convicted of certain serious ‘trigger offences’, identified by virtue of a direct relationship with overseas travel and subject to a sentencing threshold of four years to distinguish serious cases. Passports of British nationals may be confiscated for the period of the travel ban. The aim of the legislation is to make it more difficult for convicted drug traffickers to travel overseas and thereby help to prevent and disrupt drug trafficking and reduce the availability of illegal drugs.

A draft Proceeds of Crime Bill was published in March 2001. It seeks to bring together under one Act updated and strengthened laws relating to money laundering and the confiscation of assets. It will remove the distinction between drug money laundering and that derived from other crimes, and will make failure to report suspected money laundering in the regulated sector an offence subject to a negligence test. The draft clauses contain proposals of a number of new measures outlined in the following paragraphs.

A Criminal Assets Recovery Agency (CARA) to be established next year or 2003 depending on the Parliamentary timetable. The Agency would have a Director accountable to the Home Secretary and a Centre of Excellence for training and accreditation of financial investigators.

A new civil recovery scheme, allowing the Director of CARA to sue in the High Court to recover the proceeds of criminal conduct.

New court-approved powers to help investigators working for the police, other law enforcement authorities and CARA, including in some cases accredited civilian financial investigators, to trace assets.

Giving the Director of CARA the ability to carry out tax functions, for example income tax, capital gains, corporation and inheritance taxes, where he has reasonable grounds to suspect that a person’s income or gains were derived from crime. This would apply to individuals, companies or partnerships.

Crown courts would hear all asset restraint and criminal confiscation hearings. Courts would have the ability to apply confiscation orders to all offences (all summary offences, i.e. those dealt with in a Magistrates Court, to be included rather than specified ones as now).

Restraint of assets would be brought forward from when a person is charged (or about to be charged) with an offence to the start of the criminal investigation.

Unifying money laundering legislation to remove loopholes, for example, distinctions between drug and non-drug offences.
Extending the offence of failing to report knowledge or suspicion of drug money laundering in two ways: by including any money laundering (instead of just drug money laundering) and by penalising negligent failure to report (i.e. where a person had reasonable grounds to suspect that another person was engaged in money laundering).

The new extended offence would apply to people working in the sectors covered by the Money Laundering Regulations. The maximum penalty is 5 years imprisonment and/or an unlimited fine. The Bill would apply UK-wide, with CARA operating in England, Wales and Northern Ireland. The Agency would not operate in Scotland. Instead, building on existing Scottish arrangements, criminal confiscation would remain the responsibility of the Lord Advocate while civil recovery would rest with Scottish Ministers. Funding to set up CARA was announced last July, giving a total of £54 million over the next three years.

However, according to a human rights lawyer, the powers in the government's crime bill to seize the ill-gotten gains of drug traffickers breach the Human Rights Act because it would destroy the presumption of innocence and place a burden of proof on a defendant.

1.2(b) Prosecution policy, priorities and objectives in relation to drug addicts, occasional users, drug related crime

The Scottish Executive decided to introduce drugs courts, with an announcement in the Scottish Parliament in November 2000. In February 2001 it was announced that Scotland's first drug court would be set up in Glasgow by Autumn 2001. A working group, headed by Sheriff Principal Bowen, was asked to produce a workable Scottish model, and its recommendations submitted in April 2001 were accepted by Ministers. The Glasgow Drug Court will commence its work in November.

In London, on an experimental basis, Lambeth police has implemented a policy for cannabis possession whereby the cannabis is confiscated and a formal warning is issued. The final decision followed a process of consultation with the local community, partner organisations and local leaders as well as soundings with senior officers at New Scotland Yard. The scheme is part of a wider strategy in Lambeth to free resources to fight the problems associated with other drugs such as crack and heroin. Lambeth police stress that the move will not legalise cannabis possession in the borough. Instead of spending hours of police time processing a full arrest the formal warning can be issued far more quickly. The result of the scheme in Lambeth will be evaluated and treated as a pilot in considering future decisions regarding policy in policing the rest of London. Following the launch of this scheme, the Home Secretary, David Blunkett, stated his interest in the pilot. Mr Blunkett visited Lambeth shortly after the election and felt that the intention behind the experiment was in line with the Government's crime and drugs prevention strategies.

1.2(c) Any other important project of law or other initiative with political relevance to drug related issues

The police have started to test motorists for drug use in the first nationwide concentrated effort against drug-driving. Police have new powers to force suspected drivers to perform a series of 'coordination' tests. Strathclyde Police in Scotland launched the scheme on March 2001, after which other police forces will roll it out across the country. Motorists can be asked to stand with feet together, eyes closed and head tilted back, and to estimate time periods of between 30 seconds and one minute. They can be told to walk in a straight line, turn around and walk back the same way. They can be asked to touch their nose with the index finger on one hand and then the other index finger. They can also be told to stand on one leg. Officers check for symptoms of drug consumption/taking, including dilated pupils, sweating and slurred speech. If they suspect a driver has taken drugs, he or she will be taken to the nearest police station for a blood test. Drivers who refuse to take the tests can be forced to give a blood sample.

The Prison Service continues to improve procedures for reducing the supply of drugs into prisons. Every closed prison is required to have CCTV in visits areas and, since April 1999, the Prison Service has introduced a more comprehensive and consistent framework for dealing with visitors attempting to smuggle drugs in to prisoners. In the period 1/4/00 to 31/3/01 2584 visitors were banned and 2076
prisoners were made subject to closed visits during the same period. These figures are comparable with
the previous year. In addition, every prison is required to have access to a passive drug dog.

All prisons are providing CARATs (Counselling, Assessment, Referral, Advice and Throughcare) services,
which is a package of support and advice services for drug misusers throughout their time in prison.
CARATs can refer prisoners to more intensive treatment programmes if applicable. CARAT drug workers
will ensure that information is gathered about a prisoner’s drug misuse prior to release and will take
responsibility for attempting to arrange throughcare. If a link cannot be made with a community agency, or
responsibility for the offender does not pass to a statutory body, the post release element of CARATs
ensures that support is, where possible, available for up to eight weeks. Current performance is well
ahead of target; 37,000 assessments were undertaken in 2000-01. There are also intensive treatment
programmes for prisoners with moderate to severe drug misuse problems and related offending
behaviour. There are currently 50 such programmes and 3,100 entrants onto these programmes in 2000-
01.

The Prison Service is committed to developing an alcohol strategy to complement the drug strategy. A
draft alcohol strategy is due to be presented to the Prison Service Management Board in spring 2002.

No community surveys of injectors have been undertaken in England since 1999 and in Scotland since
1997. Community surveys are thought to provide a more representative picture of prevalence of injectors
than treatment surveys alone, as they can measure prevalence of injecting among drug users both in and
out of treatment. However, in 2000, new community surveys were commissioned for London and
Glasgow, with recruitment for these studies beginning in 2001. No data on prevalence of infectious
diseases among injecting drug users are available from Northern Ireland (Smyth, Communicable Disease
Surveillance Centre (Northern Ireland), personal communication). However, in 2002 Northern Ireland are
due to commence unlinked anonymous testing of injecting drug users attending treatment services, following
the same approach as that already in place in England and Wales.

1.3 Developments in public attitudes and debates

1.3(a)(b) Public perception of the drug issues and public debates carried out by civil society, national
Parliament, organizations, NGO’s as well as Media presentation and imaging drug use

There has been widespread public debate on drugs in the UK in 2000. The publication of key reports and
a number of events have meant that drugs issues have been a central topic of debate and discussion and
fundamental questions have been raised by the media and in Parliament.

A debate around the UK drugs laws first began in 2000 after a court case in which a manager and a
deputy manager of a Cambridge day centre for the homeless were jailed for five and four years
respectively under laws relating to the use and supply of drugs on premises. The pair won an appeal
against their sentence (not their conviction) and were released. However, the initial sentence had lead to
various questions being asked in Parliament and in the media about the aim of helping consistency
between the Government trying to help the socially excluded and the laws’ treatment of the two (House of

Press coverage of issues around cannabis presented a variety of positions. On the one hand, one
government Minister and a number of other national politicians made statements, either about their own
previous (youthful) cannabis use or about their views on a need for legislative change, and some
newspapers gave the issue repeated coverage. On the other hand, a number journalists and drug
campaigners argued against any softening of controls: DARE Chairman Richard Goad was reported in a
number of local papers as saying that relaxing the law sent out the wrong message to drug users;
Melanie Philips (a journalist) in the Sunday Times was very opposed to any change in the law (see 25
November 2001 & 28 October- Sunday Times), again because it would send out ‘wrong signals’; Paul
Bettes (father of Leah, who died after taking ecstasy) was reported as saying that the Government should
not ‘go soft on drugs’ (Sunday Times, 28 October 2001); and Janet Bettes was reported in the Aberdeen
Press and Journal (26 October 2001) as saying that cannabis is a highly carcinogenic, high tar substance, hallucinogenic and psychoactive; Lorraine Kelly (in the Sun 27 October) also spoke against; and, on the TV programme Newsnight, Peter Stoker, Director of the National Drug Prevention Alliance, spoke against changing the law on cannabis.

The publication of a high profile and wide-ranging investigation into the current UK drugs legislation lent further public consideration to the drugs laws. From the independent inquiry into the Misuse of Drugs Act (published by The Police Foundation 2000) a committee made up of prominent public figures, including legal experts, academics, a police chief constable, a former national newspaper editor and chaired by Dame Ruth Runciman, recommended detailed reform of the drugs laws. The media, politicians and general public alike debated the recommendations that included downgrading ecstasy, LSD and cannabis and an end to prison sentences for possession of class B and C drugs. A key proposal was that society should concentrate on the drugs, which cause the most harm. The report's recommendations on reclassifying some drugs were rejected by the government although the government did accept a majority of the other recommendations from the independent inquiry. In late October 2001, the Home Secretary announced that subject to advice to be received from the Advisory Council on the Misuse of Drugs, the Government foresees moving cannabis from Class B to Class C of the Misuse of Drugs Act (1971).

The Government stimulated discussion over what concrete action is needed at ground level when it released £300 million to ‘tackle the evil of drugs in Britain’ (Labour Party 2001): most of the money was aimed at community-based policing strategies.

Cocaine use surged onto the front pages and became a major talking point across the country, mainly due to the publication of a bizarre photograph of a famous television actress who had part of her nose missing through snorting too much of the drug (Wingett 2000). The picture probably stimulated more debate on the down side of excess drug taking than any other single event. The serious and popular press told their readers that cocaine use was increasing and that it was currently a very fashionable drug (Bee, 2000). A leading style magazine maintained the momentum of the story by publishing a special cocaine supplement, where clubbers, dealers and long-term users were all interviewed (Braddock 2001).

There were warnings that people were being lured into using crack cocaine without realising it.

With a General Election called, the media and public were interested to find out what the three main UK parties planned to do on drugs. Labour promised to raise spending on treatment and set up a register for convicted drug dealers (The Labour Party 2001); the Conservatives pledged to introduce mandatory sentences to those convicted of selling drugs to under 16s (The Conservative Party 2001) and the Liberal Democrats backed effective community sentences that include drug treatment and promised a Royal Commission on drugs (The Liberal Democrats 2001).

The policy announcements came alongside an ecstasy death that captured a very large amount of media attention. A 19-year-old student died after taken ecstasy at a nightclub and her parents made the decision to publish a photograph of her shortly after her death to try to warn others of the dangers associated with the drug (Millward 2001). Questions were asked whether such photos did actually prevent other young people from trying ecstasy.

With a Labour victory in the UK election, drugs were back on the front pages with the reorganization of the UK ADCU (UK Anti-Drugs Coordination Unit). Commentators queried if moving the drugs strategy to the Home Office would mean the crime agenda taking precedence over treatment and education/prevention activity (Druglink 2001).

Heroin was the subject of a major television documentary (Davies 2001a) tied in with a series of features in a national broadsheet (Davies 2001b) that called for its complete legalisation. The journalist asked the public to question whether it is the drug causing most damage or the fact that the drug is illegal.

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3 Refer to government response.
The debate around cannabis was renewed by two former Home Secretaries and the UK’s Chief Inspector of Prisons who all called for the decriminalisation of the drug (Landale 2001) which was followed by media opinion polls showing a majority in favour of decriminalisation (Leader section 2001).

An inquiry into the drugs laws by a Government committee (Home Affairs Select Committee 2001), commencing autumn 2001 suggests that the issue will almost certainly continue to be debated. It remains to be seen if politicians will amend current legislation (see section 2.1(a)).

1.4 Budgets and Funding Arrangements

1.4(a) Funding (figures at national level)

The government’s comprehensive spending review in July 2000 was split into the four key aims of the anti-drugs strategy; drug treatment, young people, communities and availability (see table below). The review showed that the drug treatment section of the strategy would receive £234 million (374.4 million euros) (for financial year 2000/2001, rising to £401 million (641.6 million euros)) in 2003/2004, while the young people element would get £63 million (100.8 million euros) in year 2000/2001, rising to £120 million (192 million euros) in 2003/2004. The communities’ component of the strategy would receive £45 million (72 million euros) in 2000/2001, increasing to £95 million (152 million euros) in 2003/2004, while £353 million (564.8 million euros) would be attributed to the availability section of the strategy in 2000/2001, rising to £380 million (608 million euros) in 2003/2004. (This information is the same as presented in the previous report to the EMCDDA because broad spending plans have not changed.) It should be noted that some expenditure that occurs in other policy areas might also have implications for drug treatment, young people, communities, and availability etc.

Table 1: Government funding on drugs strategies

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Drug Treatment</td>
<td>£234m (374.4m e)</td>
<td>£328m (524.8m e)</td>
<td>£377m (603.2m e)</td>
<td>£401m (641.6m e)</td>
</tr>
<tr>
<td>Young People</td>
<td>£63m (100.8m e)</td>
<td>£90m (144m e)</td>
<td>£97m (155.2m e)</td>
<td>£120m (192m e)</td>
</tr>
<tr>
<td>Communities</td>
<td>£45m (72m e)</td>
<td>£79m (126.4m e)</td>
<td>£81m (129.6m e)</td>
<td>£95m (152m e)</td>
</tr>
<tr>
<td>Availability</td>
<td>£353m (564.8m e)</td>
<td>£373m (596.8m e)</td>
<td>£376m (601.6m e)</td>
<td>£380m (608m e)</td>
</tr>
</tbody>
</table>

Source: UKADCU

1.4(b) Geographical differences

The National Assembly for Wales, via the Drug & Alcohol Treatment Fund (DATF), allocates resources to DAATs. The DATF budget in 2001-02 is £2.0 million. Funding for each DAAT is Bro Taf, £492,336; Dyfed Powys £386,399; Gwent £381, 658; Morgannwg £347,700 and North Wales £441,907. HAs should spend at least 0.4% of their discretionary revenue allocations on substance misuse issues. Section 64 budget for substance misuse 2001-02 is £346K (Source: Personal communication with Michael Jones at the Welsh Assembly).

The UK focal point does not at the present time have similar breakdowns for DATs for other parts of the UK.
Notes on Part 1

Title: Criminal Justice and Court Services Act 2000
Date of adoption: 30th November 2000
Status: Law
Entry into force: This Act shall come into force on such day as the Lord Chancellor or the Secretary of State may by order appoint.
Main modifications: see text.

Title: Powers Of Criminal Courts (Sentencing) Act 2000
Date of adoption:
Status: Law
Main modifications: see text.

Title: Criminal Justice and Police Act 2001
Date of adoption:
Status: Law
Entry into force: Shall come into force on such day as the Secretary of State may by order made by statutory instrument appoint; and different days may be appointed under this subsection for different purposes.
Main modifications: see text.

Title: Proceeds of Crime Bill
Date of adoption: 18th October 2001
Status: Bill
Entry into force?
Main modifications: see text.

Title: The Crime and Disorder Act (Drug Treatment and Testing Orders)
Date of adoption: 1998
Status: Sentence
Entry into force: 1st October 2000
Main modifications: see text.
Electronic copy: http://www.homeoffice.gov.uk/cdact/cdaint1.htm
PART 2: EPIDEMIOLOGICAL SITUATION

2. PREVALENCE, PATTERNS AND DEVELOPMENTS IN DRUG USE

Introduction

The first task for drug epidemiology is to describe and explain the current epidemic in drug use (which has its roots in the 1960s) and consider whether drug epidemics are preventable and/or treatable. The second task is to determine why so few people who are exposed to drug use (about 1-3%, depending on definition) develop problems in relation to their drug use (in so far as these problems present to treatment agencies).

The study of, and response to, illicit drug use in the UK do not lend themselves to straightforward epidemiological methods or public health strategies. In other areas where there are standard definitions and data collection procedures, epidemiology has enabled greater understanding (e.g. the link between cigarette smoking and lung cancer). Primarily because of the illicit nature of drug use, the epidemiology is less robust. It is therefore easy to reach dubious or incorrect conclusions based on differing methodologies (e.g. between surveys in different localities), non-standardised data (drug related deaths in different countries) or lack of outcome measures (what impact do drug prevention initiatives in schools have on the prevalence of drug use among young people?).

Population survey trends can be interpreted as evidence that a particular policy has been successful or has failed. In fact, reports of changing trends may reflect a whole range of factors other than changes in prevalence. For example, responses to drug surveys are extremely sensitive to the settings in which the questions are asked (Davies 1992).

More fundamentally, the concept of drug epidemiology assumes an underlying entity, which behaves in a 'disease like' manner. This may not in fact be the case and the reasons (as distinct from the causes) for drug use may lie out with the medical (or even the psychosocial) model. In particular, it is widely assumed that drug dependence is an attribute which is (a) stable and (b) internal. A stable attribution is one which explains behaviour in terms of factors which are unlikely to change (for example a disease as opposed to a periodic impulse). An internal attribute (or locus of control) means that the cause of the behaviour originates within the person (e.g. addictive personality).

As Table 2 shows the public health or political consequences of different locus x stability explanations for drug use are far-reaching. The internal x unstable explanation poses particular difficulties for policy makers.

Table 2: Different attribution explanations of drug use

<table>
<thead>
<tr>
<th>Attribution (locus x stability)</th>
<th>Common sense Meaning</th>
<th>Public health or political measures implied</th>
</tr>
</thead>
<tbody>
<tr>
<td>internal x stable</td>
<td>disease (addiction)</td>
<td>medical treatment</td>
</tr>
<tr>
<td>internal x unstable</td>
<td>Periodic pleasure seeking</td>
<td>replace drugs with other rewards (reduce demand)</td>
</tr>
<tr>
<td>external x stable</td>
<td>poor environment</td>
<td>change environment</td>
</tr>
<tr>
<td>external x unstable</td>
<td>high drug availability</td>
<td>reduce supply</td>
</tr>
</tbody>
</table>
2.1 Main developments and emerging trends

2.1(a) Overview of most important characteristics and developments of drug situation

All drugs


Among people aged 16-29, 25% (2.3 million) reported using drugs in the previous year in the 2000 BCS and among 16-24 year olds 533,000 used Class A drugs in the last year and 275,000 in the last month (Ramsey et al., 2001)

Although the BCS does not contain information on licit drugs (alcohol and tobacco), similar data from the Dutch household survey indicate that continuation rates (lifetime use minus last month use) for illicit drugs are much lower; approximately 10-20% for illicit drugs compared to 50% for tobacco and 80% for alcohol (Abraham et al. 1997; Amsterdam and Centrum Voor Drugsonderzoek 1998)

The proportion of the population in England and Wales who have ever used illicit drugs increased from 28% in 1994 to 34% in 2000 but the proportion of monthly users has remained stable at 6% (Ramsey et al., 2001). Among people aged 16-29 in England and Wales the prevalence of reported drug use in the last year was 23% in 1994 and 25% in both 1998 and 2000 (Ramsey et al., 2001).

One of the key findings of the 2000 BCS is that use of ‘any drug’ in the last year by 16 to 19 year olds fell from around a third in 1994 to just over a quarter by 2000. (Ramsey et. al, 2001)

Use of Class A drugs remained fairly stable for 16-24 year olds between surveys, with use in the last year increasing slightly from eight per cent in 1998 to nine per cent in 2000; use in the last month increased from three per cent in 1998 to five per cent in 2000. Neither increase was statistically significant. Class A drugs include heroin, cocaine (both powder and ‘crack’, the latter being a ‘cooked’ form of cocaine), ecstasy, unprepared magic mushrooms, LSD and unprescribed use of Methadone (a synthetic form of opioid). [There are many other drugs also categorised as Class A but in practice their use is rarely reported].

In Wales, an increase in heroin as primary drug has become evident amongst those presenting for treatment; until the mid 1990s, amphetamines featured more significantly in many areas.

In Scotland, drug use in the general population increased between 1993 and 1996. Patterns of drug misuse may be changing, with evidence of increased use of ecstasy, valium and cocaine, but there is little evidence that the vast majority of drug users progress from ‘soft drugs’ (e.g. cannabis) to ‘hard drugs’ (e.g. heroin) (Anderson and Frischer 2000).

In Northern Ireland, the extent of drug misuse has increased significantly since 1992, up until which time it was considered that the problem in Northern Ireland was relatively limited (Northern Ireland Office 1999). There are now more young people experimenting with drugs.

9% of school pupils aged 11-15 in England used drugs in the last month in 2000 compared to 7% in 1998 (National Centre for Social Research and the National Foundation for Educational Research 2001). Last year use was 14% in 2000 compared to 11% in 1998. The most popular drug was cannabis (12%); other rates were 4% (cocaine, ecstasy, amphetamines), 1% heroin/methadone.

There is evidence of new outbreaks of heroin use among young users (Parker, Bury and Egginton 1998) and indications that other drugs such as gammahydroxybutyrate, ketamine and rohypnol are being misused (Calafat et al. 1999).

Although there are methodological problems in making cross-national comparisons, the UK appears to have high levels of illicit drug use compared to many other European countries (Calafat et al. 1999;
Drug use cannot be understood independently of the context in which drugs are taken. Qualitative research is necessary to understand the epidemiological data. The 'Nightlife' survey (Calafat et al. 1999), for example, provides insight into the role of recreational drugs in young people's lives.

**Cannabis**

In 2000 9% used cannabis in the previous year and lifetime cannabis use increased from 21% to 27% among those aged 16-59 in England and Wales (1994-2000) (Ramsey et. al., 2001). In 2000, 22% used cannabis in previous year and lifetime cannabis use increased from 34% to 44% among those aged 16-29, (1994-2000) (Ramsey et al., 2001).

**Hallucinogens, amphetamines, cocaine, ecstasy**

In the British Crime Survey (BCS), the percentage of respondents aged 16-29 who reported using cocaine in the last year was 1% in both 1994 and 1996, but increased to 3% in 1998 and 4.9% in 2000 (Ramsey et. al., 2001).

Amphetamine use in the last year decreased from 7.9% of 16-29 year olds in 1998 to 5.2% in 2001. Ecstasy use increased from 3.9% of 16-29 year olds in 1998 to 5.0% in 2001 (Ramsey et al., 2001).

**Opiates (heroin, methadone)**

Very few people report using illicit opiates in household population surveys; in the 1998 BCS among those aged 16-29, less than 0.5% reported opiates in previous year (Ramsey and Partridge 1998). By 2000, 1% of those aged 16-29 reported heroin use in the BCS (Ramsey et al., 2001).

**Problem drug users**

The reported number of new clients, people presenting to the services with problem drug misuse for the first time, or for the first time in six months or more, in England receiving treatment has risen to 33,093 in the six month period to September 2000, compared to 16,810 in the corresponding period to September 1993 (Department of Health 2001b). The figures for Scotland are 4,789 (2000) compared to 2,207 (1993). The figures for Wales are 1,776 (2000) compared to 1,204 (1993).

In the UK, the reported number of new clients receiving treatment has risen to 39,658 in the six month period to September 2000, compared to 20,221 in the corresponding period to September 1993 (Department of Health 2001b).

The multiple-indicator method suggests that the number of problem drug users in the UK in 1996 was 268,000 (Frischer et al. 2001). This contrasts to previous estimates of 100,000-200,000 (President of the Council 1998).

In England and Wales, 92,000 drug-dependent cases were diagnosed in general practice in England and Wales between 1993 and 1998 (Frischer et al., unpublished).

**Law enforcement indicators**

Customs succeeded in dismantling or significantly disrupting the activities of 138 organisations involved in the smuggling of Class A drugs in the financial year 1999/2000. This compares with 116 in the previous twelve months, an increase of 19 per cent (Corkery 2001).

The number of persons dealt with in Great Britain for supply offences (possession with intent to supply unlawfully, unlawful supply, and import/export) involving Class A drugs rose from 8,101 in 1998 to 9,517 in 1999 (an increase of 17.5 per cent) (Corkery 2001).

The number of doses (4.8 million) of ecstasy-type drugs seized by Customs rose nearly four-fold - 388 per cent - in 1999 (Corkery 2001).
Heroin remains the most frequently seized Class A drug, with cocaine and 'crack' the next most prevalent in 1999. Greater quantities of cocaine than of heroin have been seized in recent years (Corkery 2001).

The number of seizures within the UK involving Class A drugs increased by 4.3% from 28,795 in 1998 to 30,032 in 1999 (Corkery 2001).

In Scotland, the number of Class A seizures increased from 510 in 1985 to 3,231 in 1998, class B 3,000 to 15,124 and class C, 5 to 1,207 (Information and Statistics Division 2000).

In 1987 just over 26,000 people were found guilty in a court or given a caution for drug offences – typically drug possession offences - in the UK. This figure has risen sharply each year and peaked at 128,500 in 1998. This fell to 118,600 in 1999. In 1999 over 68,000 people were sentenced in court and about 50,000 were given a caution (Corkery 2001).

The number of people jailed for drugs offences – typically drug trafficking offences - has risen to a record level, according to figures from the Home Office. More than one in ten prison inmates was jailed for drug offences. 13% of criminals in custody were convicted of drugs offences - twice the proportion 10 years ago. One in five inmates regularly take drugs in prison (Walsh and Rose 2001). A decade ago, 2,845 of the 48,610 prisoners in England and Wales were in jail for drug related offences. The prison population has since risen by nearly 20,000 and last year 8,475 prisoners were jailed for drugs - twice the proportion of a decade ago (Walsh and Rose 2001).

**Health consequences**

**Human Immunodeficiency Virus (HIV)**

It is difficult to estimate the number of HIV infections acquired among injecting drug users. However, the best estimate is around 1,600 persons living with HIV at the end of 1998 in this group, most of whom will have had their infections diagnosed (Unlinked Anonymous Surveys Steering Group 2000).

Injecting drug use has made a larger contribution to the HIV epidemic in Scotland than elsewhere in the UK. In Scotland 36% of the AIDS cases have been attributed to HIV infection acquired through injecting drug use (IDU) compared with 5% for the rest of the UK (Unlinked Anonymous Surveys Steering Group 2001).

While there is little evidence for substantial recent transmission of HIV in the UK, numbers of new cases of AIDS attributed to injecting drug use have shown an upward trend in the UK as a whole as infections acquired in the mid to late 1980s have progressed (Unlinked Anonymous Surveys Steering Group 2001).

Since 1988 the number of new HIV diagnoses attributed to injecting drug use has remained about 150 per year in England, Wales and Northern Ireland. In Scotland the high number of diagnoses reported in the mid-1980s has decreased, from over 200 in 1986 to around 30 reports in 1996 (Unlinked Anonymous Surveys Steering Group 2001). Prevalence figures for Scotland will be available later in 2001.

The median age at HIV diagnosis has risen with time, which suggests that many of the more recent diagnoses are in individuals from an ageing cohort mainly infected some time ago (Unlinked Anonymous Surveys Steering Group 2001).

Diagnosed HIV infections among injecting drug users (IDUs) form about 5% of the current HIV related caseload in England and Wales (Unlinked Anonymous Surveys Steering Group 2001).

Experience in Scotland and elsewhere indicate the potential for sudden epidemics of HIV transmission among injecting drug users, especially in the prison setting (Unlinked Anonymous Surveys Steering Group 2001).

The risk of transmission through IDU remains. In 1998 around 32% of current IDUs in England and Wales and 28% of current IDUs in Scotland report direct sharing of needles and syringes. These are significant increases over preceding years. Three in five current injectors reported the recent sharing of items of
injecting equipment and this figure also increased in 1998 (Unlinked Anonymous Surveys Steering Group 2001).

Hepatitis
Transmission of hepatitis C and hepatitis B infection through injecting drug use is a major problem. There appears to have been an increase in sharing of injecting equipment which will facilitate hepatitis transmission (Unlinked Anonymous Surveys Steering Group 2001).

Since 1992, reports of acute hepatitis B in England and Wales have risen four-fold among injecting drug users, while in 1999 only 29% reported having been vaccinated against hepatitis B (Unlinked Anonymous Surveys Steering Group 2001).

One-third of injecting drug users attending specialist agencies in England and Wales had antibodies to hepatitis C as had 1 in 11 of those who began injecting in the past three years (Unlinked Anonymous Surveys Steering Group 2001). In Scotland, 386 cases of hepatitis B were reported in 1999, the highest annual total since 1986. It is likely that the majority acquired their infection through unsafe injecting practices (Information Statistics Division 2000).

By 1998, 8,075 people in Scotland had been diagnosed as having had hepatitis C (majority injectors). The likely overall figure is 20,000 to 40,000. Nearly 25% of those who began injecting drugs after 1996 in Glasgow were hepatitis C antibody positive when tested in 1999. The prevention of this infection among injectors is one of Scotland's greatest public health challenges (Information and Statistics Division 2000).

Drug related deaths
See section 3.2 drug-related mortality

2.1(b) Emerging trends (changing patterns or modes of use, new users groups, new drugs, new problems)

In 1998 80% of DAT networks and 81% of police forces making returns reported recent or new clusters or, in some cases, full scale outbreaks of heroin use among young people within their jurisdictions (Parker, Bury and Egginton 1998). These outbreaks are not currently occurring in the old heroin areas (e.g. North West England, London) nor in many rural areas but they are colonising in most regions of England, particularly North East England, Yorkshire, West Midlands, Avon and South West England (Parker, Bury and Egginton 1998). The first outbreaks began around 1993-4 primarily in large towns/small cities with a heroin 'footprint' from the past (e.g. established user/dealer networks). However heroin use is now occurring in completely new areas with no heroin history (Parker, Bury and Egginton 1998).

The outbreaks appear to be supply led. The UK has seen a major illegal importation of heroin from South West Asia brought primarily via the Balkan route on across the EU and into this country. A fall in price, strong availability, with purity remaining high, all indicate a sustained supply (Parker, Bury and Egginton 1998).

Local drug use: example of an emerging trend in one area
(Kate O'Brien, Newcastle, personal communication)

The use of bongs or ('buckets') is by far the most common way of smoking cannabis (known locally as 'tac'), amongst young people growing up in housing estates in and around Newcastle upon Tyne. This does not seem to be the case in nearby cities such as Middlesborough.

'Criminal' boys and young men (7-17) are using large quantities of cannabis. They appear to have replaced alcohol with the use of 'tac' as their drug of choice.
Heroin use does not seem to be as prevalent and has not had the same impact on housing estates and neighbourhoods in Newcastle upon Tyne as seen in Leeds, Glasgow, Manchester, Leicester, for example.

However, amongst homeless people and young people in housing need in the area, the use of heroin has increased dramatically during the last two years.

**New synthetic drugs**

There has been an increase in ketamine use, from 3.9 per cent in 1999 to 29.7 per cent in 2000, but most people who try it never touch it again. In most areas of the country ketamine costs £40-50 a gram. "At the moment it is selling on novelty value and it is freely available [http://news.bbc.co.uk/hi/english/health/newsid_744000/744067.stm](http://news.bbc.co.uk/hi/english/health/newsid_744000/744067.stm).

GHB use was up from 3.4 per cent in 1999 to 25.8 per cent in 2000. This despite most respondents thinking that ecstasy feels more pleasant, lasts longer and is better value for money than GHB [http://news.bbc.co.uk/hi/english/health/newsid_744000/744067.stm](http://news.bbc.co.uk/hi/english/health/newsid_744000/744067.stm).

The real surprise is the way ketamine and GHB (gammahydroxybutyrate) have both increased market share dramatically [http://news.bbc.co.uk/hi/english/health/newsid_744000/744067.stm](http://news.bbc.co.uk/hi/english/health/newsid_744000/744067.stm).

In *Mixmag's second annual survey of drug use in the dance club scene over 90 per cent of respondents had tried cannabis – not surprising considering the sample group. Only 3.4 per cent of respondents preferred to go clubbing without drugs [http://news.bbc.co.uk/hi/english/health/newsid_744000/744067.stm](http://news.bbc.co.uk/hi/english/health/newsid_744000/744067.stm).

2.1(c) **Analysis of drug trends in wider social context (youth culture, economic or demographic changes, social attitudes, supply...)**

**Roots of the current drug epidemic**

In 1961 the Interdepartmental Committee on Drug Addiction (Brain Committee) report noted that "on the evidence before us the incidence of addiction to dangerous drugs is very small...there seems no reason to think that any increase is occurring” (Lawrie 1978). The UK Addict population was thought to be about 400, mostly elderly people who contracted the habit through medical treatment. There were an estimated 70 doctors and nurses addicts and perhaps a dozen non medical addicts. In 1964 there was a sudden increase in the number of notified addicts (mainly young people) and the committee was reconvened in 1965.

By the late 1980s there was dissatisfaction with the limitations of the Home Office Addicts Index (HOAI) and so regional drug misuse databases (RDMDS) were established in 1989. By 1992 there were RDMDS in all areas of Great Britain. The main difference between the HOAI and RDMDS is that the latter cover a wider range of services and a wider range of drugs (Department of Health 2001b). Unlike the HOAI which recorded new and renotified addicts each year, the RDMDS record only new agency contacts and re-attenders after a six month gap. A new system in 2001 known as the National Drug Treatment Monitoring System (NDTMS) will compliment the existing information from the RDMDS.

Because of these differences, it is difficult to compare the most recent figures from the RDMDS and the HOAI. However the number of notified drug users has continued to increase throughout the 1990s and 2000 (at least in part due to improved surveillance) (Department of Health 2001b).

**Youth culture**

The 'Nightlife in Europe and recreative drug use survey' covered nine European cities (Athens, Berlin, Coimbra, Manchester, Modena, Nice, Palma de Mallorca, Utrecht and Vienna). Information was obtained from a wide range of young people and key informants associated with nightlife scene (Calafat et al. 1999). "Young Europeans of the third millennium are the inheritors of a society defined in terms of consumption and opulence. Leisure has been assimilated by the market and is being defined by consumption criteria which
have given rise to a very active leisure industry which is well-established and ever-expanding” (Calafat et al. 1999). Results indicate that the prevalence of drug use was higher in Manchester than other cities and drug users in Manchester tended to start using drugs at an earlier age than their European counterparts (Calafat et al. 1999). Increasingly, people in Manchester appear to go to bars and restaurants rather than clubs. This is partly because Manchester's once thriving night-club industry has been plagued by violence and intimidation from gangs (Calafat et al. 1999). Informants felt that drugs were being consumed in all such bars, although dance music in particular was associated with the use of dance drugs (e.g. amphetamines, ecstasy). Cocaine is seen to be very popular again, especially amongst more affluent local people. LSD appears to be used to a lesser extent and more amongst young people. House, garage, big beat and funk nights were also associated with the use of ecstasy and amphetamines, though some felt that cocaine was becoming increasingly important in these scenes (Calafet et al. 1999). Several main sub-groups were also identified, though there may be obvious overlap in the categories: students, Manchester/locals, gays and lesbians, oldheads, hippies and crusties (Calafet et al. 1999). Informants felt that drug taking amongst young people was very prevalent and that drugs were generally widely available. The bulk of drug users that they came across were in the 17-25 age group, but they felt that drugs were now taken by a wide range of people, with ages ranging from as young as 9 years old up to 60 years plus. It was also felt that the range of drugs available for people to choose from was getting wider (Calafet et al. 1999).

Although the extent of drug use was felt to be generally very high, informants made a distinction between ‘recreational’ drug users and ‘dependent’ or ‘chaotic’ drug users. ‘Recreational’ drug users were seen as those individuals who would often restrict their use to spare time and for the most part do not consider their use to be a problem (Calafet et al. 1999). Alternatively, the more ‘dependent’ or ‘chaotic’ drug users were those who were often addicted to and in many cases injecting drugs such as heroin, crack cocaine and amphetamine. These users were considered to be more problematic in terms of the likelihood they would run into difficulties either with their physical or mental health and the criminal justice system. They were considered to primarily consist of people who were more socially dislocated and often suffering multiple deprivation - unemployed, marginalised, poorly educated with poor family and social relationships (Calafet et al. 1999). The motivation for taking drugs in this population was described as "...not to feel good, but in order not to feel bad". Heroin and crack cocaine were considered very easily obtained by informants who worked with dependent, injecting drug users, but were considered to be less easily available to recreational users (Calafet et al. 1999).

The last 12 months have seen the introduction of a number of new drugs into the dance scene. Drugs such as ketamine and GHB (gamma-hydroxybutyrate) are much more popular than before. Ketamine seemed to be less popular as a drug of choice, however there were concerns that it was often being passed off as Ecstasy, causing fears as to its effect on an unsuspecting user (Calafet et al. 1999). GHB was mentioned as a new drug on both the recreational and more dependent use scenes, creating a significant cause for concern in most panel members. Several members has heard stories of people running into difficulties with this drug, mainly arising out of a lack of knowledge of the drug and its effects. In particular was the concern that this drug has a very small dose range in which the desired effect occurs and there had been several reports of people in clubs unknowingly taking too high a dose (Calafet et al. 1999). GHB must also never be mixed with alcohol, and some panel members had heard of this occurring. Others expressed concerns at its increased use in the injecting population (Calafet et al. 1999).

Recently, there has been concern regarding rohypnol. This drug is part of the benzodiazepine family of drugs and has been implicated in a number of 'date rape' cases in America. There was growing evidence that this drug may be becoming abused in England. This was a particular concern of the police who felt that in the wrong hands this drug could be used to force sexual advances on women. However, most 'nightlife' panel members had not heard of anyone who had actually experienced a sexual assault or had been attacked as a result of being 'spiked' with this drug, however, some members had heard of it being abused (Calafet et al. 1999).
2.2. Drug use in the population

2.2(a)(b) Main results of surveys and studies: General Population

The main source of information on drug use is the British Crime Survey, which despite its name covers only England and Wales (Ramsey et. al., 2001; Ramsey & Partridge 1999). The Scottish Crime Survey provides (comparable) Scottish data (Anderson & Frischer 2000). Northern Ireland has its own crime survey (Northern Ireland Office 1999).

**England and Wales**


The Government’s drugs strategy emphasises the importance of reducing the proportion of young people under 25 reporting use of Class A drugs in the last year and the last month (Ramsey et. al., 2001). 50% of adults aged 16-29 reported using any illicit drug (lifetime) in 2000, compared to 49% in 1998, 46% in 1996 and 43% in 1994 (Ramsey et. al., 2001). 25% of adults aged 16-29 reported using any illicit drug (last year) in 1998 and 2000 compared to 24% in 1996 and 23% in 1994 (Ramsey et. al., 2001).

Drug misuse largely remains an uncommon or a short - lived activity (see FIGURE 2). While a third of those aged 16 to 59 have tried illicit substances at some time in their lives, rates of drug use for the last year and last month are much lower, at 11 per cent and six per cent respectively. The vast majority of people in the UK who use drugs, even those in deprived areas, do so infrequently (see FIGURES 3 & 4) (Ramsey & Partridge 1999). Cannabis remains the most widely consumed prohibited substance, tried by almost half of 20- to 24- year-olds. Around half of all drug users restrict themselves simply to cannabis (Ramsey & Partridge 1999).

Drug use is related to drinking frequency. For instance, those young people regularly visiting pubs or bars in the evening were more likely to have used drugs in the last year compared to those who visited less frequently (42% compared to 20%) (Ramsey et al., 2001).

Patterns of both drug use and deprivation are probably more complex now than in the past. Income and employment status are undoubtedly of considerable importance, but to some extent the use even of comparatively damaging opiate+ (heroin, methadone, cocaine, crack) drugs transcends these traditional indicators (Ramsey & Partridge 1999).
Scotland
The most recent data relate to the 1996 sweep of the Scottish Crime Survey (SCS) (Anderson & Frischer 2000). Between the 1993 and 1996 SCS, there was an increase in levels of reported drug misuse (18.3% to 22.5% 'ever' and 6.8% to 9.0% 'last year'). The differences were greater for young people (e.g. among 16-19 year olds, 'ever' use increased from 29% to 39%). This indicates that the upward trend in drug misuse has not yet peaked (Anderson & Frischer 2000). Cannabis remains the most widely used drug, although there were statistically significant increases in use over the previous 12 months of cannabis, cocaine, ecstasy and (unprescribed) valium (Anderson & Frischer 2000). Use of heroin, crack cocaine and methadone remains rare, with fewer than 1 respondent in 100 reporting ever having used each of these substances (Anderson & Frischer 2000).

Gender differences indicate that while women may have a similar propensity to experiment with drugs, they are less likely to continue using drugs on a regular basis (Anderson & Frischer 2000).

Analysis of the two sweeps of the Scottish Crime Survey suggests that drug use has increased between 1993 and 1996. Patterns of drug misuse may be changing, with evidence of increased use of ecstasy, valium and cocaine, but there is little evidence that the vast majority of drug users progress from 'soft drugs' (e.g. cannabis) to 'hard drugs' (e.g. heroin) (Anderson & Frischer 2000).

In 1993 respondents living in larger towns were more likely to have recently used drugs; by 1996 respondents living in smaller towns or villages were equally likely to have used drugs. Stimulant use was stable in large towns but increased in rural areas. Conversely, cannabis use declined in rural areas, but increased in urban environments (Frischer et al. in press). In comparison to cannabis or stimulants, opiate use was more concentrated in cities in 1993, but by 1996 had diffused to suburban and rural areas (Frischer et al. in press).

**Table 3: Proportion of urban vs rural respondents' using drugs in year prior to interview.**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>8.5</td>
<td>11.4</td>
<td>9.9</td>
<td>9.8</td>
<td>2.0</td>
<td>3.5</td>
</tr>
<tr>
<td>Rural</td>
<td>8.7</td>
<td>4.3</td>
<td>3.3</td>
<td>11.5</td>
<td>0.0</td>
<td>2.4</td>
</tr>
</tbody>
</table>

**Northern Ireland**

The extent of drug misuse has increased since 1992, up until which time it was considered that the problem in Northern Ireland was relatively limited. There are now more young people experimenting with drugs. Many young people see using drugs as part of youth culture and as ‘normative behaviour’ (Northern Ireland Office 1999). In the 1994/95 Northern Ireland Crime Survey, 17% of 16-59 year olds indicated that had ever taken drugs. In 1996 the British Crime Survey indicated that the figure for other parts of the UK for the same age group was 28%. Further data published in the Northern Ireland Omnibus Surveys of September 1996 and February 1997 show that the figure for those who had ever taken drugs was around 28% (Northern Ireland Office 1999).

While the percentage of those using heroin and cocaine has not statistically increased, other evidence suggests that Northern Ireland has a growing problem with these drugs in some communities (Northern Ireland Office 1999). Evidence from the addiction treatment services has indicated that the use of heroin and cocaine is growing, particularly in certain parts of Northern Ireland (Northern Ireland Office 1999).

In respect of 18-30 year olds specifically, 46% reported ever using drugs, 13% using drugs in the last month and 20% using drugs in the last year. The most commonly used drugs were cannabis, amphetamines and magic mushrooms. In relation to the most addictive drugs (cocaine, crack, methadone and heroin), less than 2% admitted to ever having taken them (Northern Ireland Office 1999).

2.2 (a)(c) Main results of surveys and studies: School and youth population

**England**

Smoking, drinking and drugs misuse amongst young people increased between 1999-2000, according to a national survey of secondary schoolchildren aged 11-15 (National Centre for Social Research and the National Foundation for Educational Research 2001). The proportion of pupils who had used drugs in the last month increased from 7 per cent in 1998 to 9 per cent in 2000. The proportion who had used drugs in the last year increased from 11 per cent to 14 per cent over the same period (National Centre for Social Research and the National Foundation for Educational Research 2001).

In 2000, cannabis was by far the most likely drug to have been used - 12 per cent of pupils aged 11-15 had used cannabis in the last year. Use of cannabis in the last year was slightly higher among boys (13 per cent) than girls (11 per cent). Cannabis use increased sharply with age: 2 per cent of 11 year olds had used the drug in the last year compared with 28 per cent of 15 year olds (National Centre for Social Research and the National Foundation for Educational Research 2001).

The Government has expressed particular concern about the use of heroin and cocaine, as these are considered the drugs which cause the greatest harm. In 2000, 1 per cent of 11-15 year olds had used opiates (heroin or methadone) in the last year, and 4 per cent had used stimulants (a group of substances which includes cocaine and crack as well as ecstasy, amphetamines and poppers). The proportions of pupils using these types of drugs are small and the survey did not detect any differences between 1998 and 2000 (National Centre for Social Research and the National Foundation for Educational Research 2001).

According to figures in the European School Survey Project on Alcohol and Other Drugs (ESPAD), teenagers in Britain are more likely to have taken illegal drugs or drink than their counterparts anywhere else in Europe. They are also near the top of the league when it comes to smoking cigarettes (Swedish Council for Information on Alcohol and Other Drugs 2000).

**Scotland**

The proportion of pupils aged 12-15 drinking alcohol had increased, the proportion smoking had decreased, and there was no significant change in the proportion of pupils aged 12-15 using drugs in the last month from 1998 to 2000 (National Centre for Social Research and the National Foundation for Educational Research 2001). Measures of drug taking in the last month remained at the same level
between 1998 and 2000 (10 per cent). The proportion taking drugs in the last year seemed to decrease slightly from 15 per cent to 14 per cent and the proportion who had ever taken drugs decreased from 18% to 17% (National Centre for Social Research and the National Foundation for Educational Research 2001).

Northern Ireland
The 1992 and 1994 surveys indicated that the percentage of 5th formers who had been offered drugs rose steadily from 25.5% to 41.9%. By 1998 the figure had risen to 52%. Those 5th formers who had ever used drugs rose between 1992 and 1994 from 15.8% to 25.9%. The 1998 figure indicates a marginal increase to 27.7%. The current 'use' figure rose from 5.6% to 18.0% during the same period. By 1998 this had levelled to 18.1% (Northern Ireland Office 1999).

The 1994 survey for 1st, 3rd and 5th formers indicated that only 1.5% of 1st formers were currently using drugs, compared to 18% of 5th formers. The findings in the surveys conducted during 1995-98 indicated that the most popular drugs used were cannabis, LSD and Ecstasy. Solvents tended to be used by more young people than heroin and cocaine (Northern Ireland Office 1999).

2.2(d) Specific groups

Prisoners in England
Prison Service achievements include (Home Office 2001) undertaking 37,000 assessments as part of the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) process, introducing CARAT leaflets to inform prisoners of the dangers of drug misuse, ensuring over 3,000 prisoners entered an intensive drug rehabilitation programme in prison, introducing a new healthcare standard for detoxification services and ensuring that over 30,000 prisoners entered detoxification programmes. The number of random drug tests on prisoners which proved positive has halved since MDT was introduced in 1995 from 24.4% in 1996/97 to 12.4% in 2000/01 which demonstrates that the Prison Service’s anti-drug strategy has delivered a sharp reduction in drug taking by prisoners. Access to voluntary drug testing is also available in 93% of prisons and over 23,000 prisoners are now on compacts. (Home Office, personal communication 2001)(http://www.hmprisons.gov.uk/news/newstext.asp?111).

Prisoners in Scotland
In the course of the second and third Scottish prison surveys (1994,1998), prisoners were asked a number of questions about drug use. Forty four per cent of prisoners reported in the third survey that they had used drugs at some point during the previous six months in prison (Information and Statistics Division 2000). 39% of prisoners reported using cannabis (possible underestimate), heroin 31% (up from 9% in 1994), diazepam 16%, dihydrocodeine 14%, other opiates e.g. temgesic 23% (Information and Statistics Division 2000).

The finding of a rise in heroin misuse reflects the increased use and availability of heroin in the community and also its lower cost in relation to cannabis (Information and Statistics Division 2000).

In Scotland 282 urine samples taken at point of entry between April 1999-March 2000, 75% were positive for various drugs (Information and Statistics Division 2000).

Random testing of 10% of prison population in Scotland in 1999/2000, 22% positive (11% cannabis, 9% opiates) (Information and Statistics Division 2000).

Children of drug using parents in Scotland
A Study based on recovering heroin addicts who were interviewed about the effect drugs had on their children's upbringing found that an estimated 10,000 children in Glasgow (20,000 in Scotland) alone are living within homes where one or both parents have a serious drug problem (http://www.bbc.co.uk/hi/english/uk/scotland/newsid_1457000/1457040.stm). According to the report,
children were exposed to illegal drug use on an everyday basis and were taken with their parents to buy drugs (http://www.bbc.co.uk/hi/english/uk/scotland/newsid_1457000/1457040.stm).

**Homeless people in London**

(Fountain, personal communication)

In a recent study of homeless people in London (Fountain and Howes 2001), almost two-thirds of the sample reported that their drug or alcohol use was one of the reasons they first became homeless.

However, until they became homeless, almost three-quarters had not used crack cocaine or pharmaceutical drugs, and over half had not used heroin. 80% (310) had used at least one new substance since they had become homeless, most often in the first year and whilst sleeping rough. Drug and alcohol use, and injecting, increased with the length of time respondents had been homeless.

Two-thirds of respondents (66%) spent their time with other homeless people who used the same amount or more drugs than they did themselves.

Only 22% of respondents thought their drug use had decreased in the last year, as did 23% of alcohol users. More than this thought their substance use had increased. An increase in substance use was correlated with a worsening accommodation situation in the same period. Those who predicted an increase in substance use in the next year were also likely to perceive themselves as sleeping rough in the same period. In addition, use of drug (and alcohol) services was very low (except needle exchanges), although use of services for homeless people was high.

**Ethnic minorities**

Members of black and other minority groups have been significantly underrepresented among known populations of problem drug users. However, ethnic minorities in Britain experience a high degree of social exclusion in terms of poverty, housing deprivation and educational disadvantage. All of these factors are associated with problematic drug use (Leitner et al. 1993).

The 2000 British Crime Survey (Ramsay et al. 2001) included an ethnic booster sample to conduct sufficiently sensitive analyses of the variations of drug use across ethnic groups. Using this they found that irrespective of ethnicity, cannabis was the most commonly used drug in people’s lives.

Among those aged 16-59 lifetime use of any drug was the greatest in the white group at 34%, then the black group at 28%, followed by Indians at 15% and Pakistani/Bangladeshis at 10%. The white group also reported statistically significant higher lifetime rates of cannabis, amphetamine, ecstasy, Class A drugs and ‘any’ drug use than other ethnic groups. For Indian respondents aged 16-29, lifetime use of Class A drugs and amphetamines equated to, or surpassed, that of the black group.

For older respondents aged 30-59, lifetime drug use was slightly higher among the white group compared to the black group. Asian drug use was around a third of the level of the white group. High lifetime use was found among ‘mixed ethnicity’ people.

Among different ethnic groups there were no statistically significant changes in the use of heroin in any age group, but there were small increases in the Indian and white group. Also in the Indian group the proportion using crack, cocaine and ecstasy increased significantly.

In the Indian and white group, for those aged 16-59, a significant increase in lifetime use occurred. Pakistani/Bangladeshi use significantly declined during the same period. Last year use of any drug among respondents aged 16-29 increased significantly among Indians only.

However, it is possible that drug users from Britain’s black and ethnic communities are more likely to remain unknown to service agencies-reflecting other aspects of disadvantage in access to health care (Awiah et al. 1990).
The English and Welsh Regional Drug Misuse Databases collect information on ethnicity, but at the present time it is felt that analysis of these data might be misleading (Department of Health 2001b).

In Scotland, only 17 out of 11,123 people recorded on the Scottish Drug Misuse Database were reported to be of Indian-sub continent or Afro-Caribbean ethnic origin (Information and Statistics Division 2000).

In the 1993 Drug Use and Drug Prevention sample (based on a random sample of the UK population), lifetime usage patterns for ethnic minorities 'match more closely the broader European picture than that generally represented in the UK literature' (Leitner et al. 1993). While ethnic respondents in the DUDP were more likely to be of lower socio-economic status, their level of reported drug use did not exceed that of the white population (Leitner et al. 1993).

Panel members in the Nightlife study who had some knowledge of drug use patterns in ethnic minority groups felt that stimulants such as amphetamine and ecstasy were unpopular, with only very low levels of use in comparison to drugs such as cannabis and cocaine. It was felt that this trend had a lot to do with the image of these drugs as being 'a white man's drug' (Calafat et al. 1999). In the Nightlife study there was also growing evidence that heroin use was increasing amongst young people from ethnic minority backgrounds, predominantly from South East Asia. This was of particular concern to some panel members, who felt that the exploding Asian youth population could fall into very real difficulties if this trend continues (Calafat et al. 1999). Heavy cannabis use was also described in African-Caribbean, Asian and black British communities and this was generally thought to be more widespread than in white British or white Europeans on a national level. Cannabis was also believed to be the primary drug of choice for this population and its use far outweighed that of all the other drugs. One panel member whose main interest was prevalence and patterns of drug use in Asian young people felt that this may be attributed to the Afro-Caribbean/black American culture many young Asians identified with. Cannabis use is also harder for parents and family to detect than alcohol, a drug which is heavily frowned upon in Asian culture (Calafat et al. 1999).

Khat use among the Somali communities in the UK was described in a Home Office report in 1998 (Griffiths 1998).

**Vehicle drivers in England**

Between 1985 and 1987 the Transport Research Laboratory carried out a study to measure the incidence of drugs in fatal road accident casualties. This showed that the incidence of medicinal drugs (5.5%) and drugs of abuse (3%) was relatively low in comparison to alcohol, which was found in 35% of cases (Tunbridge et al. 2000). A follow up study was completed in June 2000. The results from 1,184 fatal RTAs show that illicit drug taking (mainly cannabis) has increased by a factor of six since the earlier study. Over the same period, the incidence of medicinal drugs and alcohol has remained very similar (Tunbridge et al. 2000).

**Vehicle drivers in Scotland**

Recreational Drugs and Driving: Prevalence Survey. This study looked at prevalence of driving whilst under the influence of recreational drugs among 17 to 39 year old drivers in Scotland. It was based on a probability survey of the general household population. The sample was stratified by geographical area (Ingram et al. 2000). The main findings were that 9% of all respondents reported ever having driven under the influence of illegal drugs and 5% reported having done so in the previous twelve months; that cannabis was the most common drug to have been used when drug driving; that men were significantly more likely than women to have driven under the influence of drugs; and that drug driving appeared to be most prevalent among the 20 to 24 age group with much lower levels in older age groups. The second most commonly reported drug on the last drug driving occasion was ecstasy, but only 4 people reported having done this. Three people reported having drug-driven under the influence of a combination of drugs (Ingram et al. 2000).
2.3. Problem drug use

2.3(a) National and local estimates, trends in prevalence and incidence, characteristics of users and groups involved, risk factors, possible reason for trends

Estimates of the prevalence of problematic drug use in the UK are a key piece of evidence for informing the monitoring of the drug strategy. The government’s strategy aims both to reduce drug use in the population and increase the number and proportion of problem drug users in treatment (President of the Council 1998).

What is ‘problem drug use’? A 1998 EMCDDA working group defined ‘problematic’ drug use as “intravenous drug use or long duration/regular use of opiates, cocaine and/or amphetamines. Ecstasy and cannabis are not included” (Kraus et al. 1999). This definition does not mention anything about the user’s perception of their drug use. In contrast, the current International Classification of Diseases (ICD-10) definition of drug dependence which, in part, consists of ‘a cluster of behavioural, cognitive and physiological phenomena that develop after repeated substance use’. In practice the latter definition is difficult to implement in national prevalence studies which tend to be based on routine data sources (Kraus et al. 1999).

In the UK, the most recently cited official national estimate is 100,000- 200,000 ‘severely dependent drug misusers’ in 1996 (President of the Council 1998). This estimate was derived by multiplying the number of drug misusers notified to the Regional Drug Misuse Databases in the UK by a factor of between 2.5 to 5 (Hartnoll et al. 1985). The rationale for the multiplier was based on the Home Office Addicts Index (HOAI) using a multiplier derived in the early 1980s and is not likely to be applicable now, or transferable to the Regional Drug Misuse Databases which superceded the HOAI as the primary source of routinely collected information about drug misuse in 1997 (Tregoning 1998).

Known ‘problematic’ users

Great Britain

In the six month period ending 30 September 2000, 39,658 people were reported to have started drug treatment episodes in England, Wales and Scotland (Department of Health 2001b).

England

The number of drug misusers reported by drug treatment agencies and General Practitioners (GPs) in England as presenting for treatment has increased steadily from 16,810 for the six-month period ending 30 September 1993 to 33,093 for the six-month period ending 30 September 2000 (Department of Health 2001b). Rates per 100,000 population differ widely across Health Authorities (Department of Health 2001b).

For the September 2000 data, the vast majority of users (93%) had only one episode reported (Department of Health 2001b). Heroin is the most frequency reported main drug of use (64%), followed by methadone (10%) cannabis (9%), cocaine (6%) and amphetamines (4%) (Department of Health 2001b). Of those whose injecting status is known, 66% had ever injected and 45% in the previous 4 weeks (Department of Health 2001). Of those who injected and whose sharing status was known, 50% had ever shared and 21% had shared in the previous 4 weeks (Department of Health 2001b).

Comparing 1993 to 2000. Heroin was the main drug used by 46% of cases in 1993 compared to 64% in 2000. Methadone was the main drug for 18% of cases in 1993, 10% in 2000; cocaine 3% in 1993, 6% in 2000 and cannabis 6% in 1993 and 9% in 2000 (Department of Health 2001b). In the six months ending September 2000, 45% of users presenting to drug misuse services (whose status was known) had injected in the last four weeks, compared to 54% in the comparable period ending September 1993.

The number of patients in England and Wales who are diagnosed as being drug dependent +/- psychiatric illness is shown in table 4 (Frischer et al. unpublished).
**Table 4: Number of drug diagnosed and comorbid cases diagnosed in primary care 1993-1998. Figures based on annual prevalent cases.**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of drug diagnosed cases</th>
<th>Number of comorbid cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>66,254</td>
<td>17,385</td>
</tr>
<tr>
<td>1994</td>
<td>73,392</td>
<td>21,625</td>
</tr>
<tr>
<td>1995</td>
<td>78,057</td>
<td>23,498</td>
</tr>
<tr>
<td>1996</td>
<td>85,618</td>
<td>24,806</td>
</tr>
<tr>
<td>1997</td>
<td>88,375</td>
<td>27,562</td>
</tr>
<tr>
<td>1998</td>
<td>95,265</td>
<td>30,813</td>
</tr>
</tbody>
</table>

Source: Frischer et al. unpublished

**Scotland**

11,123 individual users were reported as presenting to drug misuse services in the financial year 1999/2000. The number of drug misusers presenting to services has increased steadily from 7,694 in 1995/96 (Information and Statistics Division 2000).

Heroin is the most frequently reported main drug of use (54%), followed by methadone (19%). Heroin increased from 36% in 1995/96 to 54% in 1999/2000 (Information and Statistics Division 2000).

Of those whose injecting status is known, 39% had injected in the past month in 1999/2000 compared to 33% in 1995/96. Of those who injected and whose sharing status is known, 34% had shared in the previous month (a slight increase from the previous year) (Information and Statistics Division 2000).

**Northern Ireland**

Statistics from the referrals to the Community Addiction Teams would suggest that the number of people who have ‘problem’ drug use is increasing. For example, in 1992 there were 60 registered drug addicts, which increased to 96 in 1995, 120 in 1996, 163 in 1997 and 260 in 1998. The number of new notifications per annum has risen during the period 1995-98 from 25 to 126. During the period 1995-97, 4 out of 18 Health Trusts saw particularly significant increases in the number of new addicts (Northern Ireland Office 1999).

**Total number of problematic drug users**

The estimated total number of problem drug users has been estimated using the Multiple Indicator (MI) method and a variety of (single) multiplier methods (Kraus et al. 1999).

Table 6 shows estimates for 1996 based on individual multipliers. Each of these methods has a number of assumptions, which have not been evaluated. This data has been presented previously – the data is unchanged. An estimate for the year 2000 will be calculated on the basis of year 2000 data from the British Crime Survey and other household survey data only (not triangulated with other sources) and will be made available when other household survey data has been collected and estimates have been made.
Table 5: Summary of 1996 UK prevalence estimates for drug use based on the multiplier methods.

<table>
<thead>
<tr>
<th>METHOD</th>
<th>FORM OF DRUG USE</th>
<th>ESTIMATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment demographic method</td>
<td>Problematic opiate users</td>
<td>162,544</td>
</tr>
<tr>
<td>Treatment Coverage method</td>
<td>Problematic opiate users</td>
<td>243,820</td>
</tr>
<tr>
<td>HIV Multiplier</td>
<td>Injecting drug users</td>
<td>161,200</td>
</tr>
<tr>
<td>Mortality multiplier</td>
<td>Drug users at risk of overdose related death</td>
<td>161,133</td>
</tr>
<tr>
<td>Household Survey data</td>
<td>Opiates + users</td>
<td>251,000</td>
</tr>
<tr>
<td>Household Survey data</td>
<td>Injecting drug users</td>
<td>169,000</td>
</tr>
</tbody>
</table>

Source: Frischer et al. 2001

The aim of the Multiple Indicator method is to estimate the number of problem drug users in the population by combining information on prevalence, that is available only in a few areas (the calibration samples, or 'anchor points'), with 'indicators' or 'predictors' of drug use that are available in all areas (see TABLE 5). There are a group of potential multipliers for obtaining prevalence estimates. These all follow the same principle: deriving or estimating an appropriate multiplier and applying this to the relevant benchmark, usually a routine data set. For example, multiplying the number of drug users in treatment by the proportion of the population of drug users in treatment; or multiplying the number of drug related overdose deaths by the proportion of problem drug users who overdose and die. TABLE 6 presents regionalized Multiple Indicator estimates for 1996.

Table 6: Multiple Indicator (MI) Prevalence Estimation Method. Indicators, anchor points and prevalence estimates for the UK, 1996 (Frischer et al. 2001).

<table>
<thead>
<tr>
<th>UK REGIONS</th>
<th>DRUG USE INDICATORS (SEE KEY)</th>
<th>POPULATION</th>
<th>ANCHOR POINTS</th>
<th>PREVALENCE ESTIMATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>A 83,53 3</td>
<td>B 92,095</td>
<td>C 51,85 0</td>
<td>D 2,37 1</td>
</tr>
<tr>
<td>Northern and Yorkshire</td>
<td>11,35 6</td>
<td>13,285</td>
<td>9,722 37</td>
<td>344 6,600,626</td>
</tr>
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<td>5870</td>
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<tr>
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<td>13,452</td>
<td>8,614 267</td>
<td>5,134,105</td>
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<td>7,989</td>
<td>4,331 97</td>
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<td>140 2,850,434</td>
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<td>United Kingdom</td>
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<td>111417</td>
<td>62746 1489</td>
<td>2777 55,024,382</td>
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</tbody>
</table>
Key to Table
A Convictions for drug offences, 1996
B Seizures of controlled drugs, 1996
D Cases of HIV related to IDU England and Wales, 1996  Scotland, 1996
E Drug related deaths, UK 1995
F Population
G Estimated no of problematic drug users (anchor Points)
H Model Estimate based on Principal Component Analysis
Source: Frischer et al. 2001
The estimates based on multiplier techniques, do not enable an assessment of how many people would be categorised as ‘drug dependent’ under the ICD definition.

2.3(b) Risk behaviours and trends

After a period of declining sharing rates during the early 1990s there are indications that sharing of injecting equipment is again increasing.

In 1998 around 32% of current IDUs in England and Wales and 28% of current IDUs in Scotland report direct sharing of needles and syringes. These are significant increases over preceding years. Three in five current injectors reported the recent sharing of items of injecting equipment and this figure also increased in 1998 (Department of Health 2001b). In the six months ending September 2000, 45% of users presenting to drug misuse services (whose injecting status was known) had injected in the last 4 weeks: of those, 21% where known to have shared (of those whose sharing status was known) (Department of Health 2001b). Care is needed in interpreting this data as the injecting status in the last four weeks was not known for 17% of users, and the sharing status in the last four weeks was not known for 13% of users (Department of Health 2001b).

Among IDUS reported in the English RDMDs, sharing among recent injectors was 13% in 1993 and 21% in 2000; sharing among ever injectors 42% in 1993, 50% in 2000 (Department of Health 2001b).

Among IDUS reported in the Scottish DMD, of those whose injecting status is known, 39% had ever injected in 1999/2000 compared to 33% in 1995/6 (Information and Statistics Division 2000).

Among IDUS reported in the Scottish DMD; of those who injected and whose sharing status was known, 34% had shared in previous month (slight increase from previous years) (Information and Statistics Division 2000).

3. HEALTH CONSEQUENCES

3.1 Drug treatment demand

3.1(a) Characteristics of clients, patterns of use and trends

The Drug Treatment Monitoring System in the UK is organized regionally, with Regional Drug Misuse Databases in England and systems in Scotland, Wales and Northern Ireland. All are broadly compliant to the Treatment Demand Indicator protocol of the EMCDDA. Where there are exceptions to this, review processes are in place to ensure greater harmonization in the future. A major strategic review of drug treatment monitoring in England was implemented in April 2001. This review focuses both on national information needs and international obligations. A review of the Scottish Drug Misuse Database was undertaken by the Information and Statistics Division in Scotland in 2000/2001.
Drug Treatment Data for the UK (drug users presenting to treatment services and reported to the Regional Drug Misuse Databases) are collated by the Department of Health for policy purposes and for delivery to key stakeholders. <http://www.doh.gov.uk/public/hpssspub.htm> (RDMDs). Data are currently collated on a six-month basis; this will change with full implementation of the new system (see section 7.3).

For England, Scotland and Wales combined, a total of 40,430 drug users sought treatment for their drug use in the six months period ending 30 September 2000. This represents a 7% increase over the same period in 1999, and a 45% increase over the same period five years ago in 1995. Seventy three percent (29,429) of presenting users were men and 27% (11,001) were women. The gender ratio, at around 3:1 male: female, is relatively stable year on year. In terms of age, about 1 in 7 (14%) were under 19 years of age, but the majority (68%) were aged between 20 and 34 years. The age/ gender distribution shows that a greater proportion of young women (16%) than young men (11%) were between the ages 15-19 years.

About 40% (45% in 1999), reported that they were currently injecting drugs, and 16% (17% in 1999) reported that they were former injectors. Over a third (40% in 2000, 37% in 1999) were reported to be injecting their main drug of use. Most cases reported were opiate users and nearly eight out of ten (76%) reported that opiates were their main drug of use (71% in 1999). More than half of these (55%) were injectors (47% in 1999).

3.1(b) Comments on different client profiles in different types of treatment.

Current systems in the UK do not distinguish between different types of treatment and it is therefore not possible to comment on client profiles. Information will be available in 2002.

3.1(c) Comments on treatment demand for different drugs, including cannabis, cocaine, synthetic drugs...

Heroin was the main drug in 62% of reported cases, compared to 57% in 1999 and 48% in 1995. The proportion said to be injecting heroin as their main drug remains stable year on year at nearly 60% (58% in 2000, 1999 and 1995).

With the exception of cannabis, other drugs reported as the main drug of use each represented 5% or less of the presenting treatment population reported.

Cocaine decreased a little as a main drug of use (5% in 2000, 6% in 1999, 4% in 1995), but a greater proportion were reported to be injectors (12% in 2000, 4% in 1999). The proportion of main drug cocaine users injecting their cocaine has remained stable at around 5% (6% in 2000, 5% in 1999, 7% in 1995). These figures are indicative of the fact that most cocaine users are also users of other drugs. It should also be noted, that while cocaine as a main drug of use has stayed relatively stable, or even fallen a little, it has increased considerably as an adjunctive drug, as the figures for England show, (15% in 2000, 14% in 1999, 10% in 1995). Amphetamine as a main drug of use showed a continuing downward trend at 4% of cases in 2000 compared to 8% in 1999 and 10% in 1995. Of these, 38% were said to be injecting their amphetamine, a proportion that has also fallen in recent years (47% in 1999, 47% in 1995, 54% in 1993). Main drug cannabis use continues to account for around 1 in 10 of reported cases (9% in 2000, 10% in 1999, 8% in 1995).

There were only minor differences in the distribution of main drug of use between males and females particularly for cocaine (2% of males, 1% of females), amphetamines (3% or males, 4% of females), benzodiazepines (2% males, 3% females) and cannabis (10% males, 6% females).

3.2 Drug-related mortality

3.2(a) Drug-related deaths, direct and indirect, characteristics and trends, possible reasons for changes.

Under this heading it is necessary to consider three different classes of deaths:
(a) Direct/’acute’ drug-related deaths e.g. poisonings, overdoses;
(b) VSA deaths; and
(c) Indirect drug-related deaths including violent deaths, road traffic accidents (RTAs), and those of drug-users not covered in (a) i.e. HIV/AIDS.

For each of these types of death, information is presented on the current situation, based on the latest available data; key characteristics and trends; and, where possible, suggest possible reasons for them.

**Direct/’acute’ drug-related deaths**
This section considers deaths which are directly attributable to drugs, that is where death occurs as an immediate consequence of the use of illegal substances or the misuse/abuse of licit drugs. Typically such deaths will be from poisoning or overdose, and as such can be termed ‘acute’ deaths. Other types of (indirect) death are discussed below.

There are two main types of source in the UK for information on ‘acute’ deaths - three General Mortality Registers (GMRs) and one Special Mortality Registers (SMRs). These will be considered separately.

**GMRs**

**England and Wales**
The Office for National Statistics (ONS) has responsibility for the registration and compilation of official statistics on all deaths in England and Wales, including drug-related deaths (DRDs). They code all causes of death on the death registration forms to ICD 9. Their ‘standard’ definition for DRDs comprises the following codes:

- 292 Drug psychoses
- 304 Drug dependence
- 305.2 – 9 Non-dependent abuse of drugs
- E850 – E858 Accidental poisoning by solid or liquid substances – drugs, medicaments, and biologicals
- E950.0 – 5 Suicide and self-inflicted poisoning by solid or liquid substances – drugs and medicaments
- E980.0 – 5 Poisoning by solid or liquid substances, undetermined whether accidentally or purposely inflicted – drugs and medicaments
- E962.0 Assault by poisoning – drugs and medicaments

A database was developed by ONS in 1999 to facilitate research into deaths caused by drug poisoning, and to help in the identification of specific substances involved in such cases (Christophersen et al 1998). Information is taken from death certificates and Part V of the coroners’ inquisition forms. Data from 1993 to 2000 have been added to the database, although cleaning of the data for the latter year still remains to be completed. Figures for the period 1993-9 have now been published (ONS 2000a, 2000b, 2001). These and other data being submitted with this report to the EMCDDA are now examined.

Overall numbers of drug-related poisonings in England and Wales rose steadily from 2252 in 1993 to 2943 in 1999 (Table 7). However, there has been a slowing down in the rate of increase in recent years. For example, there was an increase of only 21 deaths between 1998 and 1999. Data compiled on a
slightly different and narrower definition for the EMCDDA’s DRD Standard indicates a fall between 1999 and 2000. It is understood that a fall will also be reflected in the ‘official’ ONS figures due to be released in the Spring 2002 issue of Health Statistics Quarterly.

The number of males who died in 1999 was 2043, an increase of 99 on the previous year. By contrast, the number of female deaths fell 78 to 900 in 1999. The male:female ratio has increased from 1.29:1 in 1990 to 2.27:1 in 1999.

Whilst the average age of those dying in 1999 was 39.9 years, there was a difference of nearly a decade in the average ages of males (37.0) and females (46.5). The distribution of ages is skewed to the younger age groups in the male population, in contrast to that of females which is more evenly distributed - except for a significant proportion in the 65 and over age group. The modal 5-year age group for both genders combined during the period 1990-8 was 25-29 years, whilst in 1999 it was 30-34 years. However, there is variation year to year in the absolute numbers comprising each age group. There have been falls in the number dying of those aged 15-19 and 20-24 in the period 1997-9. It has to be recognised that these figures may be underestimates, partly because toxicological analysis is not carried out in all cases.

During the period 1993-9 most deaths for both genders were given an underlying cause of suicide/undetermined poisoning (Table 8). This proportion was highest for females. More male deaths were ascribed to drug dependence/non-dependent abuse of drugs and also to accidental poisonings...
Table 7: Number of deaths where selected substances were mentioned on the death certificate, including with other drugs or alcohol, England and Wales, 1993-1999.

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>With other drug</td>
<td>with alcohol</td>
<td>Total</td>
<td>with other drug</td>
<td>with alcohol</td>
<td>Total</td>
</tr>
<tr>
<td>All Deaths</td>
<td>2252</td>
<td>469</td>
<td>445</td>
<td>2404</td>
<td>496</td>
<td>2563</td>
<td>529</td>
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<tr>
<td>All mentions of Heroin + Morphine</td>
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<td>61</td>
<td>39</td>
<td>276</td>
<td>78</td>
<td>61</td>
<td>355</td>
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<td>Heroin</td>
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<td>14</td>
<td>13</td>
<td>127</td>
<td>31</td>
<td>26</td>
<td>162</td>
</tr>
<tr>
<td>Morphine</td>
<td>129</td>
<td>48</td>
<td>28</td>
<td>176</td>
<td>51</td>
<td>40</td>
<td>231</td>
</tr>
<tr>
<td>Methadone</td>
<td>230</td>
<td>92</td>
<td>49</td>
<td>269</td>
<td>110</td>
<td>57</td>
<td>310</td>
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<td>Cocaine</td>
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<td>0</td>
<td>24</td>
<td>12</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td>All amphetamines</td>
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<td>17</td>
<td>6</td>
<td>46</td>
<td>21</td>
<td>6</td>
<td>48</td>
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<td>2</td>
<td>27</td>
<td>12</td>
<td>3</td>
<td>10</td>
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<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Cannabis</td>
<td>14</td>
<td>12</td>
<td>6</td>
<td>18</td>
<td>16</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>Temazepam</td>
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<td>115</td>
<td>66</td>
<td>163</td>
<td>95</td>
<td>50</td>
<td>138</td>
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<tr>
<td>Diazepam</td>
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<td>72</td>
<td>64</td>
<td>32</td>
<td>76</td>
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<tr>
<td>Nitraxepam</td>
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<td>14</td>
<td>9</td>
<td>18</td>
<td>12</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>44</td>
<td>11</td>
<td>10</td>
<td>46</td>
<td>10</td>
<td>4</td>
<td>46</td>
</tr>
<tr>
<td>All antidepressants</td>
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<td>138</td>
<td>75</td>
<td>476</td>
<td>135</td>
<td>79</td>
<td>489</td>
</tr>
<tr>
<td>Dothiepin</td>
<td>210</td>
<td>51</td>
<td>37</td>
<td>261</td>
<td>58</td>
<td>44</td>
<td>235</td>
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<tr>
<td>Amitriptyline</td>
<td>172</td>
<td>58</td>
<td>24</td>
<td>138</td>
<td>51</td>
<td>22</td>
<td>145</td>
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<tr>
<td>Paracetamol incl. Compounds</td>
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<td>147</td>
<td>96</td>
<td>468</td>
<td>146</td>
<td>100</td>
<td>526</td>
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<tr>
<td>Paracetamol</td>
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<td>128</td>
<td>56</td>
<td>284</td>
<td>106</td>
<td>49</td>
<td>323</td>
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<td>Co-proxamol</td>
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<td>36</td>
<td>187</td>
<td>40</td>
<td>49</td>
<td>189</td>
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<tr>
<td>Aspirin</td>
<td>65</td>
<td>22</td>
<td>5</td>
<td>53</td>
<td>19</td>
<td>10</td>
<td>50</td>
</tr>
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Notes: (1) Figures should not be added to give totals. (2) Heroin degrades in the body into morphine. Sources: ONS 2000a, 2000b and 2001.
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<tbody>
<tr>
<td>Drug dependence/non-dependent abuse</td>
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</tr>
<tr>
<td>Male</td>
<td>245</td>
<td>301</td>
<td>375</td>
<td>432</td>
<td>491</td>
<td>599</td>
<td>681</td>
<td>3,124</td>
<td>25.5</td>
</tr>
<tr>
<td>Female</td>
<td>45</td>
<td>48</td>
<td>70</td>
<td>96</td>
<td>84</td>
<td>120</td>
<td>85</td>
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<td>8.57</td>
</tr>
<tr>
<td>Accident</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Male</td>
<td>425</td>
<td>507</td>
<td>537</td>
<td>612</td>
<td>612</td>
<td>595</td>
<td>595</td>
<td>3,883</td>
<td>31.7</td>
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<tr>
<td>Female</td>
<td>209</td>
<td>215</td>
<td>187</td>
<td>225</td>
<td>209</td>
<td>246</td>
<td>217</td>
<td>1,508</td>
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<td>5,217</td>
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<td>661</td>
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<td>629</td>
<td>609</td>
<td>597</td>
<td>4,317</td>
<td>67.5</td>
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<tr>
<td>Drug psychoses/assault</td>
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<td></td>
<td></td>
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<tr>
<td>Male</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>10</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>43</td>
<td>0.4</td>
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<tr>
<td>Female</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>7</td>
<td>4</td>
<td>3</td>
<td>1</td>
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<tr>
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<td>1,643</td>
<td>1,811</td>
<td>1,932</td>
<td>1,944</td>
<td>2,043</td>
<td>12,267</td>
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</tr>
<tr>
<td></td>
<td>887</td>
<td>875</td>
<td>920</td>
<td>910</td>
<td>926</td>
<td>978</td>
<td>900</td>
<td>6,396</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Sources: ONS 2000a, 2001
An examination by ONS, for the Advisory Council on the Misuse of Drugs, of deaths for 1994-6 showed that men in their 20s and early 30s are more likely to die than men in other age groups and females (ACMD 2000). This peak is largely attributable to higher death rates from accidental overdoses. Death rates for females are more consistent and at a lower level than males. Deaths from drug dependence/non-dependent abuse in women occur most commonly amongst young adults. Both men and women in their 80s or older exhibit higher rates of suicidal poisonings.

From 1993 to 1999 more than one drug was mentioned on the death certificate in 20.9% of cases, and alcohol in 21.7% of drug-related deaths. Most deaths are associated with opiates (chiefly heroin/morphine and methadone), often in combination with other drugs and/or alcohol. Large numbers of deaths also involve benzodiazepines such as temazepam and diazepam. However, amongst the types of drug most often mentioned are antidepressants - especially dothiepin and amitriptyline - and paracetamol (which are not controlled drugs) - either on its own or in compound preparations such as distalgesic. By comparison, aspirin was implicated in only one-tenth of the number of cases involving paracetamol compounds. Deaths from antidepressants and analgesic drugs were mostly suicides.

The number of deaths where heroin/morphine was mentioned was 4 times higher in 1999 (at 754) than in 1993. The number of cases in which methadone was implicated rose steadily from 230 in 1993 to peak at 421 in 1997, since which time it has fallen (to 298 in 1999). Mentions of cocaine, although still comparatively low when compared to heroin/morphine, have risen more than 7-fold since 1993 (Corkery 2000).

Although much media attention has been given over recent years to deaths involving ecstasy they account for only 0.6% of drug-related deaths. Amphetamines generally are much less of a problem in England and Wales than in Nordic countries.

The involvement of temazepam had been falling since 1993, and this movement was assisted by the imposition of controls on jelly-filled capsules from 1 January 1996. However, temazepam is typically used in combination with other drugs. Diazepam, also prescribed for treating drug dependence, is often implicated in DRDs.

Antidepressants and prescribed analgesics feature very highly, as do non-controlled drugs such as paracetamol and aspirin. However, there are signs that the involvement of the latter two substances may be reducing following the introduction in September 1998 of tighter restrictions on the number of tablets which can be sold at any one time (Hawton et al 2001).

Nearly half the DRDs amongst young men in 1994-6 were accounted for by opiates. Between 1995 and 1999 the male death rate for heroin/morphine rose from 11 per million population to 25, the greatest increases occurring in 1997-9. Male deaths involving amphetamines doubled between 1995 and 1999, although numbers are still very low. By contrast, deaths mentioning methadone fell 30% in 1997-9. Death rates for opiates fall off at older ages. Amongst elderly men there has been an increase in deaths due to barbiturates and tranquillisers, and a decline in antidepressants.
Table 9: Age-standardised drug poisoning mortality rates per million population for selected substances by gender and Government Office Region, England and Wales, 1993-9

<table>
<thead>
<tr>
<th>Region</th>
<th>Heroin/ morphine</th>
<th>Methadone</th>
<th>Cocaine</th>
<th>Amphetamines</th>
<th>All substances</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Males</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>12.6</td>
<td>8.9</td>
<td>1.0</td>
<td>1.4</td>
<td>57.6</td>
</tr>
<tr>
<td>North East</td>
<td>7.1*</td>
<td>3.9+</td>
<td>0.4</td>
<td>2.5</td>
<td>52.6</td>
</tr>
<tr>
<td>North West</td>
<td>20.3*</td>
<td>18.9*</td>
<td>1.0</td>
<td>1.8</td>
<td>80.1*</td>
</tr>
<tr>
<td>Yorkshire &amp; Humber</td>
<td>20.7*</td>
<td>8.9</td>
<td>0.6</td>
<td>1.5</td>
<td>65.8*</td>
</tr>
<tr>
<td>East Midlands</td>
<td>8.9+</td>
<td>3.9</td>
<td>0.2+</td>
<td>1.6</td>
<td>42.4+</td>
</tr>
<tr>
<td>West Midlands</td>
<td>7.8+</td>
<td>5.2+</td>
<td>0.5</td>
<td>0.6+</td>
<td>42.1+</td>
</tr>
<tr>
<td>East</td>
<td>9.7+</td>
<td>9.1</td>
<td>0.8</td>
<td>1.2</td>
<td>51.5+</td>
</tr>
<tr>
<td>London</td>
<td>12.9</td>
<td>13.0*</td>
<td>3.2*</td>
<td>1.3</td>
<td>77.7*</td>
</tr>
<tr>
<td>South East</td>
<td>10.0+</td>
<td>6.2+</td>
<td>0.7</td>
<td>1.4</td>
<td>49.3+</td>
</tr>
<tr>
<td>South West</td>
<td>11.6</td>
<td>5.1+</td>
<td>0.3+</td>
<td>1.2</td>
<td>45.1+</td>
</tr>
<tr>
<td>Wales</td>
<td>7.9+</td>
<td>7.0</td>
<td>0.4+</td>
<td>1.7</td>
<td>48.6+</td>
</tr>
<tr>
<td>England &amp; Wales</td>
<td>12.3</td>
<td>8.8</td>
<td>0.9</td>
<td>1.4</td>
<td>57.1</td>
</tr>
<tr>
<td><strong>Females</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>2.0</td>
<td>1.8</td>
<td>0.2</td>
<td>0.4</td>
<td>28.7</td>
</tr>
<tr>
<td>North East</td>
<td>1.6</td>
<td>1.1</td>
<td>0.0+</td>
<td>0.3</td>
<td>28.6</td>
</tr>
<tr>
<td>North West</td>
<td>3.1*</td>
<td>3.9*</td>
<td>0.3</td>
<td>0.7</td>
<td>38.1*</td>
</tr>
<tr>
<td>Yorkshire &amp; Humber</td>
<td>206</td>
<td>1.7</td>
<td>0.1</td>
<td>0.7</td>
<td>30.4</td>
</tr>
<tr>
<td>East Midlands</td>
<td>1.2</td>
<td>0.7+</td>
<td>0.0+</td>
<td>0.5</td>
<td>23.5+</td>
</tr>
<tr>
<td>West Midlands</td>
<td>1.2+</td>
<td>0.8+</td>
<td>0.3</td>
<td>0.2</td>
<td>23.0+</td>
</tr>
<tr>
<td>East</td>
<td>1.4</td>
<td>1.5</td>
<td>0.2</td>
<td>0.5</td>
<td>23.1+</td>
</tr>
<tr>
<td>London</td>
<td>2.4</td>
<td>3.6*</td>
<td>0.9*</td>
<td>0.2</td>
<td>36.8*</td>
</tr>
<tr>
<td>South East</td>
<td>1.8</td>
<td>1.1+</td>
<td>0.1</td>
<td>0.1+</td>
<td>27.2</td>
</tr>
<tr>
<td>South West</td>
<td>1.6</td>
<td>0.7+</td>
<td>0.1</td>
<td>0.2</td>
<td>23.0+</td>
</tr>
<tr>
<td>Wales</td>
<td>2.3</td>
<td>1.0</td>
<td>0.0+</td>
<td>0.8</td>
<td>28.6</td>
</tr>
<tr>
<td>England &amp; Wales</td>
<td>1.8</td>
<td>0.9</td>
<td>0.4</td>
<td>28.7</td>
<td></td>
</tr>
</tbody>
</table>

* Significantly higher than England & Wales rate; + Significantly lower than England & Wales rate

Source: Table 7, Uren (2001)

Opiates generally account for a lower proportion of female deaths; other painkillers and antidepressants account for about half the drug deaths of women. Death rates from
heroin/morphine increased from 1.7 per million population in 1995 to 2.8 in 1999, having peaked in 1998 at 3.6. These rates are still far lower than those for males. Over the period 1995-9 there was little variation in female death rates for the other main drugs.

There are regional variations both in the overall mortality rates for DRDs and for specific drugs (Table 9). There is less regional variation amongst females. The North West and London had significantly higher rates than the average for England and Wales in 1993-9. Significantly low rates were found in the East and West Midlands, East and South West of England (Uren 2001). The North West has the highest mortality rates for both heroin/morphine and methadone, although London also has high rates for the latter. Cocaine rates for males and females in London were 3.5 and 4.5 times higher than the average. Whilst for most regions male heroin/morphine death rates were highest for those aged 25 years and over, this was the reverse in Yorkshire and the Humber. The North West had significantly high rates for methadone deaths amongst the under 25s.

Growth and Remoter Rural areas were found to have consistently low mortality rates. Areas with significantly high rates such as Inner London were generally in areas which had these common characteristics: a high proportion of unemployed, living in either social or terraced housing, and a high proportion of the population in partially-skilled and unskilled manual occupations. However, some County and Coastal Resorts such as Norwich, Bournemouth and Brighton also have high mortality rates, especially for heroin/morphine. This latter phenomenon may be due to unemployed drug addicts moving to coastal resorts and drawing their benefits there.

Scotland
In Scotland the General Register Office (GROS) is responsible for collecting data on all deaths. In 1994 a special database was set up for drug-related deaths which holds information taken from death certificates and from special forms completed by forensic pathologists for all deaths involving drugs or persons known or suspected to be drug dependent. Figures for the period 1994 and 1996-9 have been published and data for 2000 will be available in the near future (Arrundale and Cole 1995; Jackson and Cole 1998, 1999, 2000).

Data for the period examined here are coded to ICD 9, however the GROS employs a narrower definition than does ONS excluding, for example, suicides. This means that their published figures are considerably lower (by about one-third) than those supplied (using the ONS definition) via DrugScope to the EMCDDA for its Annual Report.

Figures published by GROS show that the number of DRDs in Scotland rose from 247 in 1994 to 340 in 1999 (Table 10). The number involving known or suspected drug addicts rose from 179 in 1998 to 227 in 1999, the number not so known rose from 97 to 113. Unpublished data for the EMCDDA Annual Report show a much reduced overall increase over the period 1994-9 from 422 to 492 deaths; most of the increase occurring in 1998-9.
Table 10: Drug-related deaths by dependence status, Scotland 1994-9

<table>
<thead>
<tr>
<th>Year</th>
<th>Persons known or suspected to be drug dependent</th>
<th>Persons not known or suspected to be drug dependent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Opiates¹</td>
<td>2 or more drugs²</td>
<td>1 drug³</td>
</tr>
<tr>
<td>1994</td>
<td>139</td>
<td>34</td>
<td>7</td>
</tr>
<tr>
<td>1995</td>
<td>155</td>
<td>14</td>
<td>9</td>
</tr>
<tr>
<td>1996</td>
<td>172</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>1997</td>
<td>142</td>
<td>32</td>
<td>18</td>
</tr>
<tr>
<td>1998</td>
<td>179</td>
<td>30</td>
<td>7</td>
</tr>
<tr>
<td>1999</td>
<td>227</td>
<td>30</td>
<td>7</td>
</tr>
</tbody>
</table>

1. Key opiates (e.g. morphine, heroin, methadone, pethidine) + illegal drugs (e.g. cocaine, ecstasy, LSD).
2. Two or more drugs in therapeutic use (excluding 'Opiates etc.')
3. Single drug in therapeutic use (excluding 'Opiates etc. ')

Source: Jackson and Cole (2000).

Using the ONS definition, the number of males who died in 1999 was 342 compared to 306 the previous year. The number of females who died increased from 143 to 150. The male:female ratio during this period has risen from 1.6:1 to 2.28:1 (the latter is almost identical to that for England and Wales).

Most deaths are accounted for by those aged 25-44: the proportions for 1999 were 58% and 65% respectively for unpublished and published figures. Of these, the higher figure is for those aged 25-29; this was also true of earlier years. In addition there is a significant proportion of deaths amongst those in their early 20s, especially in the case of females. As noted for England and Wales, there are a significant number of deaths which occur in the 65+ age group. Only 6 of the 27 cases aged 45+ in 1999 were known or suspected to be drug-dependent. The number in this age group has been falling in recent years (Table 11).
Table 11: Drug-related deaths by dependence status and age, Scotland 1996-9

<table>
<thead>
<tr>
<th>Age group and year</th>
<th>Persons known or suspected to be drug dependent</th>
<th></th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Persons not known or suspected to be drug dependent</td>
<td>Opiates$^1$</td>
<td>2 or more drugs$^2$</td>
<td>1 drug$^3$</td>
<td>Drug not stated</td>
</tr>
<tr>
<td>45+ years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1996</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>18</td>
<td>9</td>
</tr>
<tr>
<td>1997</td>
<td>4</td>
<td>4</td>
<td>9</td>
<td>26</td>
<td>5</td>
</tr>
<tr>
<td>1998</td>
<td>6</td>
<td>0</td>
<td>5</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>1999</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>12</td>
<td>7</td>
</tr>
</tbody>
</table>

Under 25 years

| 1996               | 54                                             | 14              | 1               | 8               | 8               | 85              |
| 1997               | 65                                             | 17              | 1               | 5               | 6               | 94              |
| 1998               | 74                                             | 9               | 2               | 3               | 5               | 93              |

25-44 years

| 1996               | 169                                            | 14              | 4               | 20              | 24              | 231             |
| 1997               | 84                                             | 14              | 8               | 11              | 13              | 130             |
| 1998               | 108                                            | 13              | 1               | 18              | 10              | 150             |
| 1999               | 147                                            | 20              | 4               | 30              | 19              | 220             |


Heroin/morphine was involved in 48% of deaths in 1999; diazepam in 40%, and methadone in 18%. It is important to note that diazepam was mentioned in 84/163 deaths involving heroin/morphine. The presence of alcohol was noted in 96/340 deaths, often with a relatively low blood-alcohol level. As in England and Wales, opiates and benzodiazepines were the types of drug most often mentioned on death certificates in recent years (Table 12). Whilst the involvement of heroin/morphine doubled between 1997 and 1999, the number of methadone-related deaths fell. The latter probably reflects a tightening up of the way in which methadone is dispensed by pharmacists in the Greater Glasgow area. There is a far higher rate of benzodiazepine use in Scotland especially diazepam, and despite much more restrictive prescribing of jelly-filled temazepam capsules introduced in January 1996. Cocaine deaths also appear to be increasing.

Table 12: Selected substances mentioned in drug-related deaths, Scotland 1996-9

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine (includes heroin in 1998 and 1999)</td>
<td>51</td>
<td>48</td>
<td>114</td>
<td>163</td>
</tr>
<tr>
<td>Heroin</td>
<td>31</td>
<td>25</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Methadone</td>
<td>91</td>
<td>79</td>
<td>64</td>
<td>62</td>
</tr>
<tr>
<td>Diazepam</td>
<td>72</td>
<td>69</td>
<td>105</td>
<td>135</td>
</tr>
<tr>
<td>Temazepam</td>
<td>37</td>
<td>32</td>
<td>46</td>
<td>52</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>7</td>
<td>2</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Cocaine</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
</tbody>
</table>

There are noticeable geographical differences in the involvement of some drugs involved in deaths. Half of the 38 deaths in Lothian were associated with methadone, compared to one-sixth of 112 deaths in Greater Glasgow. By contrast, heroin/morphine was mentioned in 69 of the deaths in Greater Glasgow but only in 7 of the Lothian cases. The presence of diazepam was noted in many deaths across Scotland, but temazepam featured chiefly in Greater Glasgow.

The proportion of deaths concerning persons known or suspected to be drug-dependent was lowest in Ayrshire and Arran, and in the Highland health board regions.

**Northern Ireland**

The General register Office in Northern Ireland also uses ICD 9 but their practice for coding deaths due to dependence is different to that used by GROS and ONS. As in Scotland, most deaths coded to 305 are due to alcohol. There are no ‘official’ published figures for DRDs in the Province. However, data using the ONS definition have been submitted for the EMCDDA Annual Report.

The overall number of DRDs varies a little from year to year, ranging between 28 and 46 during 1990-1998, since then it has risen and stood at 54 in 2000 (Table 13). The male:female ratio varied considerably during this time, from 1:1.79 to 2.33:1, but on average was 1.11:1. This ratio is much lower than in other parts of the UK. Most deaths over this 11-year period occurred amongst those aged 25-39, although there was a fairly even spread across the ages from 20 to 60. In 2000, 20% of deaths occurred in those aged 40-44 years.

The average age of those dying has gone up and down during the period 1990-2000. There has been an overall fall from 46.3 to 38.9 years between these dates. The average age for both genders has also varied; in some years the average age of males is higher than females, but in other years the reverse is true.


**Table 13: Drug-related deaths by gender, Northern Ireland 1990-2000 (using ONS definition)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>14</td>
<td>25</td>
<td>39</td>
</tr>
<tr>
<td>1991</td>
<td>18</td>
<td>28</td>
<td>46</td>
</tr>
<tr>
<td>1992</td>
<td>13</td>
<td>15</td>
<td>28</td>
</tr>
<tr>
<td>1993</td>
<td>12</td>
<td>16</td>
<td>28</td>
</tr>
<tr>
<td>1994</td>
<td>20</td>
<td>15</td>
<td>35</td>
</tr>
<tr>
<td>1995</td>
<td>26</td>
<td>20</td>
<td>46</td>
</tr>
<tr>
<td>1996</td>
<td>21</td>
<td>19</td>
<td>40</td>
</tr>
<tr>
<td>1997</td>
<td>19</td>
<td>20</td>
<td>39</td>
</tr>
<tr>
<td>1998</td>
<td>24</td>
<td>16</td>
<td>40</td>
</tr>
<tr>
<td>1999</td>
<td>35</td>
<td>15</td>
<td>50</td>
</tr>
<tr>
<td>2000</td>
<td>32</td>
<td>22</td>
<td>54</td>
</tr>
</tbody>
</table>

Source: Taken from Standard Table 6 of 2001 EMCDDA UK Annual Report
At present, there is only one SMR in the UK that publishes information on DRDs - the National Programme on Substance Abuse Deaths at St George's Hospital Medical School (NPSAD). Their coroners' database was started in July 1997. Information from this database is published in both six-monthly and annual reports on cases notified voluntarily by coroners in England and Wales. Coverage now extends to about four-fifths of all jurisdictions. Information is provided on data-collection sheets, although there are some electronic systems being developed to capture this data. In addition to the information contained on death certificates, the database receives further demographics, medical history, and other details of the deceased and the circumstances of their death.

The NPSAD case definition is one where any one of the following criteria are met at an inquest or Fatal Accident Inquiry:

- one or more psychoactive substances directly implicated in death
- history of dependence or abuse of psychoactive drugs, or
- presence of Controlled Drugs at post mortem.

These cases have been coded to ICD 10. A number of key findings have consistently emerged from the cases submitted.

- About three-quarters of cases are male and under 45 years of age.
- The majority of cases died from accidental poisonings. Males are more likely than females to die from accidental poisonings, whereas the reverse is true for intentional self-poisoning.
- About two-thirds of cases had a history of illicit drug use, and on average death was 16 or 17 years earlier than for those without such a history.
- Where specific drugs were identified, opioids were present at death in two-thirds of cases. On their own, opioids accounted for a third of deaths.
- Deaths involving methadone were more likely to be the result of illicit rather than prescribed drugs.
- Dextropropoxyphene accounted for three-fifths of deaths involving opioid/opiate analgesics.
- Antidepressants were implicated in about one-sixth of cases, mostly where the drug was prescribed for the deceased.

These findings are broadly consistent with those described above provided by the ONS database. This shows that the NPSAD data can be used as a cross-check for ONS data.

A number of things emerge from the second NPSAD annual report (Ghodse et al 2001).

- The difference in the average age between those with and those without a drug history had narrowed to 11 years.
- The proportion of deaths in which opioids were involved was 43%. Another 31% involved other opioid analogics.
- Cocaine was involved in 4.4% of cases compared to 3.0% of ONS death in 1999. This may suggest that the number of such deaths in the ONS figures for 2000 will continue to be at an elevated level.
- More than half of those who died were unemployed (54.7%) and only 28.3% were in employment. There were equal proportions of those living alone or with others (40%) whilst 5% were of no fixed abode.
- About 62% of cases died in a defined residential address, 28% in hospital, and 10% elsewhere (e.g. a public place). Being dependent on drugs made little difference to the place of death.

A number of coroners’ jurisdictions consistently report a significantly high rate of deaths per 100,000 population. These locations correspond closely to those identified by Uren (2001). Thus
in 2000, the 5 highest rates were found in Brighton and Hove (32.3), Furness (17.7), Inner North London (17.0), Reading (14.1), and Blackpool and Fylde (13.9). What is also of note is that there have been some significant shifts in rates between 1999 and 2000. These movements have been in both directions. Falls were noted for West Yorkshire Eastern (from 7.0 to 1.9), Blackpool and Fylde (18.7 to 13.9), Hitchin (10.0 to 1.3). By contrast, there were increases in Manchester Central (2.1 to 9.1), Peterborough (4.1 to 13.1), and the afore-mentioned Brighton and Hove (from 24.1 to 32.3). This lower level of information means that specific hot-spots can be identified and a closer examination made of the cases in those areas to see what interventions may be appropriate.

The coroners' database can act as part of an early warning system in quickly identifying new drugs including licit ones implicated in deaths, or new patterns of abuse of existing drugs. For example, the rising the number of deaths involving cocaine was identified before the official ONS figures were published. GHB (widely used by recreational drug users) was found in 5 cases. This information formed part of the evidence examined by the ACMD when they reviewed the status of this drug during 2001. At present, ONS do not include it in the official figures.

Other studies
Some of the features emerging from the GMRs and the SMR are exhibited in a study of methadone deaths which occurred in the Lothian Health Board area between 1997 and 1999 (Fiddler et al 2001). The majority (73%) of the 77 cases examined occurred in individuals who were not prescribed methadone at the time of their death. Medication other than methadone or dihydrocodeine was prescribed to 38 persons, of whom 30 (79%) were receiving benzodiazepines, and 10 were in receipt of antidepressants.

Nearly half of the study sample had a history of excessive alcohol consumption, and a half reported a history of psychiatric problems. Deliberate self-harm or accidental overdose had led to 60% previously attending Accident and Emergency departments. There were relatively high rates of infectious diseases: 11 persons were HCV positive, 6 HBV positive and 5 HIV positive. Low socio-economic status was associated with the highest rate of methadone-related deaths.

The annual mortality of all addicts is not known. However, a study of addicts notified from across the UK to the Home Office shows a decline between 1967-76 and 1984-93 in the annual age-standardised rates from 19.0/10,000 person years to 10.5/10,000 person years (Ghodse et al 1998). Generally excess mortality declined over the period from about 13 to 7 for males and from 16 to 10 for females.

A recent death rate of 1.2% during the period 1995-2000 was found by the NTORS project (Gossop et al 2001b). Overdoses accounted for 61% of the deaths in the NTORS sample (n = 1075 in methadone treatment). The profile of such overdoses was usually opiates in combination with alcohol and/or benzodiazepines. In only about one-fifth of cases was one substance found after death.

Some UK DRD trends
All UK data sources suggest that there is a trend for ‘acute’ DRDs to become more male-dominated, with male deaths in 1998 and 1999 outnumbering female ones by two or three to one. Generally speaking, the majority of DRDs in the UK occurred amongst 20-34 year-olds, for example 44.1% in England and Wales in 1998, 49.4% in Scotland in 1999, and 48.0% in Northern Ireland in 1999. However, for England and Wales in 1999, the proportion of 20-34 year olds fell to 40.6% compared to 44% of those aged 25-39. In Northern Ireland, one-fifth of deaths occurred amongst those aged 40-44.

Using the ONS ‘standard’ definition, the number of DRDs in the UK has risen since 1994, but the rate of increase has slowed down (Table 14). The rate of DRDs per 100,000 population was 5.52
for England and Wales in 1999; corresponding figures for Scotland and Northern Ireland are 9.6 in 1999 and 3.18 in 2000 respectively.

Table 14: Drug-related deaths using ONS 'standard' definition, United Kingdom, 1994-9

<table>
<thead>
<tr>
<th>Year</th>
<th>England &amp; Wales</th>
<th>Scotland</th>
<th>Northern Ireland</th>
<th>United Kingdom</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>2404</td>
<td>422</td>
<td>35</td>
<td>2861</td>
</tr>
<tr>
<td>1995</td>
<td>2563</td>
<td>426</td>
<td>46</td>
<td>3035</td>
</tr>
<tr>
<td>1996</td>
<td>2721</td>
<td>460</td>
<td>40</td>
<td>3221</td>
</tr>
<tr>
<td>1997</td>
<td>2858</td>
<td>447</td>
<td>39</td>
<td>3344</td>
</tr>
<tr>
<td>1998</td>
<td>2922</td>
<td>449</td>
<td>40</td>
<td>3411</td>
</tr>
<tr>
<td>1999</td>
<td>2943</td>
<td>492</td>
<td>50</td>
<td>3485</td>
</tr>
</tbody>
</table>

Source: John Corkery, Home Office 2001

A study by the EMCDDA (2001b) of the data collected by GMRs in a number of EU states shows that England and Wales has a higher rate of DRDs than Austria, Belgium, France, Germany, Holland and Sweden on both broad and restricted definitions, but that Sweden is a little higher using an all-inclusive definition. The age profile for England and Wales is broadly similar to those of France and Germany using a broad definition. The gender ratio in these countries is broadly similar using this definition. When one looks at the main drug types, England Wales have a markedly different profile. Opiates and other drugs account for a far higher proportion of deaths but opiates alone are at levels similar to those existing in Germany. (It should be borne in mind, however, that the data collection methods and interpretation of ICD coding varies from country to country.

Volatile Substance Abuse deaths
Data on deaths since 1971 associated with volatile substance abuse (VSA) have been collected by a special national register based at St George’s Hospital Medical School.

There were 73 deaths associated with VSA in 1999 compared to 80 in the previous year. This is the second lowest figure since 1983 and compares with the all-time peak of 152 in 1990 (Table 15). Concern about these high rates led to an advertising campaign by the Department of Health in 1992 throughout Great Britain. There was a sharp fall in deaths among children which has persisted, and a small fall amongst adults.

VSA deaths constitute an important proportion of all deaths in young people. Children aged 14-18 accounted for 55% of all VSA deaths in the period 1971-99. Compared to previous years, there was a shift in 1999 towards higher ages at death. Although VSA rates are similar for both genders, over the last 10 years males have accounted for 86% of VSA deaths.

Standard Mortality Ratios are highest in the North East, Northern Ireland, Scotland, and Yorkshire and the Humber. East Anglia and the South East have lower rates than would be expected.
Table 15: VSA deaths by country, United Kingdom, 1971-1999

<table>
<thead>
<tr>
<th>Year</th>
<th>England</th>
<th>Wales</th>
<th>Scotland</th>
<th>Northern Ireland</th>
<th>Channel Islands</th>
<th>Isle of Man</th>
<th>United Kingdom</th>
</tr>
</thead>
<tbody>
<tr>
<td>1971-89</td>
<td>748</td>
<td>39</td>
<td>147</td>
<td>30</td>
<td>2</td>
<td>-</td>
<td>966</td>
</tr>
<tr>
<td>1990</td>
<td>129</td>
<td>7</td>
<td>12</td>
<td>4</td>
<td>0</td>
<td>-</td>
<td>152</td>
</tr>
<tr>
<td>1991</td>
<td>89</td>
<td>1</td>
<td>21</td>
<td>10</td>
<td>1</td>
<td>-</td>
<td>122</td>
</tr>
<tr>
<td>1992</td>
<td>70</td>
<td>6</td>
<td>7</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>85</td>
</tr>
<tr>
<td>1993</td>
<td>57</td>
<td>7</td>
<td>9</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>79</td>
</tr>
<tr>
<td>1994</td>
<td>55</td>
<td>1</td>
<td>9</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>67</td>
</tr>
<tr>
<td>1995</td>
<td>62</td>
<td>3</td>
<td>9</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>77</td>
</tr>
<tr>
<td>1996</td>
<td>57</td>
<td>3</td>
<td>13</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>78</td>
</tr>
<tr>
<td>1997</td>
<td>68</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>78</td>
</tr>
<tr>
<td>1998</td>
<td>64</td>
<td>3</td>
<td>10</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>80</td>
</tr>
<tr>
<td>1999</td>
<td>52</td>
<td>7</td>
<td>8</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>73</td>
</tr>
<tr>
<td>Total</td>
<td>1451</td>
<td>78</td>
<td>250</td>
<td>70</td>
<td>6</td>
<td>2</td>
<td>1857</td>
</tr>
</tbody>
</table>

Source: Derived from Table 4, Field-Smith et al (2001)

In the decade ending 1999 the frequency of both aerosol- and glue-related deaths decreased significantly. Consequently, butane now accounts for a much greater proportion of deaths (53% in 1999), although the absolute number of such deaths shows no significant change.

Nearly half (49.3%) of deaths in 1999 occurred in the home, reflecting the fact that 63% of the abuse took place in this location-type. There are gender differences in the location where deaths occur. Males are more likely to die than females as a result of abuse in a public place or at work, whilst more females than males die at home or at the home of a friend. Children are more likely to die in a public place and adults at home.

It will be interesting to see what effect the introduction of new legislation to tighten up on the sale of butane lighter refills will have upon these figures. The Cigarette Lighter Refill (Safety) Regulations 1999 came into force on 1 October 1999, and made it an offence to sell such items to anyone aged under 18 years.

**‘Indirect’ drug deaths**

There are a number of categories in to which non-‘acute’ DRDs can be placed. Such deaths are ones that are not the immediate result of consuming drugs but rather those which occur as a consequence of having a drug habit which exposes individuals to the risk of dying in some other way. These risks can be defined as

- (a) an infectious disease acquired through a drug (mis)using habit/way of life e.g. HIV/AIDS;
- (b) complications arising from an infection acquired through long-term drug misuse e.g. hepatitis (especially HCV) causing liver failure, cirrhosis through the use of infected/contaminated drugs e.g. *clostridium novyi*;
- (c) violent deaths related to the supply and/or use of illegal drugs;
- (d) accidents (including road traffic ones) arising from impaired judgement as a result of consumption of drugs, whether prescribed or illicit.

The extent to which knowledge of each of these types exists in the UK varies, and is reflected in the comments below.
HIV/AIDS
In the UK the pattern of deaths (whether natural or otherwise) of those infected with HIV/AIDS reflects that of new cases notified. By the end of June 2001 there had been 12,186 deaths recorded by CDSC and SCIEH (2001), 67.7% of AIDS patients notified by them. Deaths peaked in England and Wales during 1994, but a year later in Scotland and Northern Ireland.

Deaths, from whatever cause, of persons who acquired HIV/AIDS through injecting drug use peaked in 1995 in England and Wales, and also in Scotland. There have only been a few such deaths in Northern Ireland. Deaths of IDU AIDS victims accounted for 6.2% of the total number of AIDS deaths in England and Wales up to the end of June 2001. In Northern Ireland the figure was 4.9%, but in Scotland it was 41.9%. Just over 31% of deaths of IDU AIDS victims in the UK have occurred in Scotland.

The decline in the number of deaths of IDU AIDS victims has continued. The UK figures for 1998 and 1999 are about one-third of their peak level in 1995, and show signs of falling further. This pattern seems likely to continue in England and Wales. However, the figure of 13 deaths notified so far for Scotland in 2000, the same as in the previous two years, may rise if further cases come to light.

Table 16: Deaths of AIDS cases (acquired through injecting drug use) notified by individual countries within the UK, to end of June 2001

<table>
<thead>
<tr>
<th>Year</th>
<th>England &amp; Wales</th>
<th>Northern Ireland</th>
<th>Scotland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not known</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>&lt; 1990</td>
<td>65</td>
<td>0</td>
<td>11</td>
<td>76</td>
</tr>
<tr>
<td>1990</td>
<td>41</td>
<td>0</td>
<td>13</td>
<td>54</td>
</tr>
<tr>
<td>1991</td>
<td>42</td>
<td>0</td>
<td>38</td>
<td>80</td>
</tr>
<tr>
<td>1992</td>
<td>61</td>
<td>0</td>
<td>24</td>
<td>85</td>
</tr>
<tr>
<td>1993</td>
<td>83</td>
<td>0</td>
<td>33</td>
<td>116</td>
</tr>
<tr>
<td>1994</td>
<td>83</td>
<td>0</td>
<td>48</td>
<td>131</td>
</tr>
<tr>
<td>1995</td>
<td>105</td>
<td>1</td>
<td>52</td>
<td>158</td>
</tr>
<tr>
<td>1996</td>
<td>96</td>
<td>1</td>
<td>43</td>
<td>140</td>
</tr>
<tr>
<td>1997</td>
<td>37</td>
<td>1</td>
<td>20</td>
<td>58</td>
</tr>
<tr>
<td>1998</td>
<td>32</td>
<td>0</td>
<td>13</td>
<td>45</td>
</tr>
<tr>
<td>1999</td>
<td>32</td>
<td>0</td>
<td>13</td>
<td>45</td>
</tr>
<tr>
<td>2000</td>
<td>11</td>
<td>0</td>
<td>13</td>
<td>24</td>
</tr>
<tr>
<td>2001</td>
<td>6</td>
<td>0</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>706</td>
<td>3</td>
<td>323</td>
<td>1,032</td>
</tr>
</tbody>
</table>

Sources: Unpublished data from CDSC and SCIEH (21 September 2001)

Hepatitis
An increasing area of concern is the potential increase in DRDs posed by hepatitis, especially HCV (see, for example ACMD 2000:89-90). A significant proportion of known cases of this infection have arisen through intravenous drug use. Unfortunately, there is no specific ICD 9
code for hepatitis C. Where the infection is the underlying cause of death, a code in the range 070.4 to 070.9, covering 'other and unspecified viral hepatitis', would probably be assigned. One of the more relevant codes would seem to be 070.5 'other specified viral hepatitis without mention of hepatic coma'. ICD 10 has specific codes (B17 and B18) that cover both acute and chronic viral hepatitis C which should facilitate the monitoring of changes in levels of deaths attributed to HCV from published general mortality statistics.

**Serious illness among IDUs**
Cases have also been reported of drug users dying as a result of necrotising fasciitis.

Reference was made in last year's DrugScope report of an outbreak of serious illness among IDUs in the UK and Ireland. Although first reported in April 2000, it now appears that cases may have occurred in late 1999. No further cases were reported in Ireland after 6 June 2000, in England and Wales after 7 July 2000, and in Scotland from 6 August 2000. The outbreak was officially considered over on 31 August 2000. The situation at the end of November 2000 was as given in Table 17.

**Table 17: Serious illness among IDUs, UK and Ireland 2000**

<table>
<thead>
<tr>
<th></th>
<th>Cases</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scotland</td>
<td>60</td>
<td>23</td>
</tr>
<tr>
<td>(Glasgow)</td>
<td>(50)</td>
<td>(19)</td>
</tr>
<tr>
<td>England</td>
<td>25</td>
<td>12</td>
</tr>
<tr>
<td>Ireland (Dublin)</td>
<td>23</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>108</strong></td>
<td><strong>43</strong></td>
</tr>
</tbody>
</table>

*Source: Dr L. Gruer, Greater Glasgow Health Board, 27 November 2000, personal communication*

**Table 18: Characteristics of cases of serious illness among IDUs reported between 1 April and 1 August 2000**

<table>
<thead>
<tr>
<th></th>
<th>England &amp; Wales</th>
<th>Scotland</th>
<th>Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>25</td>
<td>56</td>
<td>23</td>
</tr>
<tr>
<td>Male:female ratio</td>
<td>13:12</td>
<td>27:29</td>
<td>15:8</td>
</tr>
<tr>
<td>Median age and range (years)</td>
<td>33 (23-48)</td>
<td>30 (20-48)</td>
<td>30 (19-51)</td>
</tr>
<tr>
<td>Range of date of presentation to hospital</td>
<td>8 April - 4 July</td>
<td>19 April - 30 July</td>
<td>2 May - 26 June</td>
</tr>
</tbody>
</table>

*Source: John Corkery, Home Office 2001*

It can be seen from Table 17 that the heaviest concentrations were in the Greater Glasgow and Dublin areas. There were also many cases in the North West of England. Whilst the illness appears to affected equal numbers of males and females in the UK, this was not the case in Ireland (Table 18). Both the median age and the range of ages of the victims in the different countries were similar.

All cases were of heroin users who injected into muscle or otherwise extravaneously ("skin-popping"). *Clostridium novyi* was isolated from 13 Scottish cases, 2 in Ireland and 2 in England.
Other *clostridia*, especially *perfringens*, were isolated from a smaller number of cases, often the same cases as the *novyi*, as were some other bacteria. This suggests that contamination of the heroin had occurred with soil or faeces.

*Clostridia* survive indefinitely as spores, only germinating when the conditions are right, for example stimulation by heat and acid. Many of the Scottish cases were associated with the use of citric acid; this was initially thought to be the source of the infection. These bacteria need anaerobic conditions to grow, provided by muscle burnt by acid. The *novyi* strain produces a virulent toxin which attacks the vital organs, having gained access to the blood stream through necrotised body tissue.

The first cases in this outbreak presenting to hospital were in England, then Scotland and finally Ireland. It is believed that the heroin involved in these cases came from a large contaminated batch. Police intelligence suggests it originated in Afghanistan, possibly arriving in Liverpool and then distributed to Glasgow, Dublin and North West England. Some fatalities were recorded in London and South East England. *Clostridium novyi* was found to have infected an addict who was admitted to hospital in Oslo, Norway, on 22 August 2000. He had bought heroin in the centre of the city. The case was tentatively linked to the outbreak in the British Isles (*Eurosurveillance Weekly*, 14 September 2000 and 4 January 2001).

A Fatal Accident Inquiry into the deaths of 18 of the Scottish fatalities was due to open at Glasgow Sheriff Court on 4 June 2001. The Sheriff principal, Edward Bowen QC, adjourned the Inquiry until 29 October 2001 to enable the NHS trusts concerned time to prepare their cases. This is important because there are substantial medical issues and questions of clinical practice to be addressed.

An international scientific meeting has been arranged by the Royal College of Physicians and Surgeons on 15-16 October 2001 in Glasgow to discuss this outbreak.

During the first half of July 2001, a new outbreak of the illness occurred in western Scotland. Eight cases including one death were reported, 6 in the Greater Glasgow area and 2 in Argyll and Clyde. Three of the cases (including one death) involved necrotising fasciitis, 2 with blood infection and 3 with severe abscesses. *Clostridia* were identified in one of the cases of necrotising fasciitis. During this period the Department of Health in England issued advice to IDUs and doctors, alerting them to unconfirmed reports that more heroin from the batch which led to the cases in 2000, may be about to be released onto the UK market.

*Road Traffic Accidents (RTAs)*
Recent research by the Transport Research Laboratory (TRL) covering the period October 1996 to June 2000 shows that there has been a significant increase in the number of RTA fatalities who had consumed drugs (Tunbridge et al 2001). In 1985-7 7.4% of the sample population of a similar study were found to have used medicinal or illicit drugs, and 35% alcohol (Everest et al 1989). A decade later, the proportion taking drugs has risen to 24.1% but that for alcohol has fallen slightly to 31.5%.

In total 1184 fatalities were examined, of whom 17.7% tested positive for a single drug and 6.3% for multiple drugs i.e. a quarter of cases where drugs were detected had multiple drugs implicated. This contrasts with only 5.3% in the earlier study.

Two or more drugs were found in the majority (89%) of multiple drug users. Apart from cannabis, which was found in 11.9% of all cases examined, opiates (5.6%), benzodiazepines (4.8%) and amphetamines (4.5%) were the drugs most commonly detected. The majority of the combinations found would normally be regarded as illicit. Most of all illicit drug consumption (75.3%) was in those aged under 40, whilst the majority (78.3%) of medicinal use was in those aged 40 and over.
**Violent deaths associated with drugs**

There are three types of deaths that can be encompassed within this term. The first is where the administration of drugs by one party to another (whether at the request of the recipient or not) results in the latter's death. Secondly, fights and vendettas, etc. between individuals/organisations involved in drug supply and/or use that result in deaths. Thirdly, deaths which occur when the killer (or person responsible for causing death) was under the influence of drugs. This latter category can overlap with cases examined in the previous section i.e. RTAs.

Data on such deaths is not collected on a systematic basis. However, some limited information can be derived from the Homicide Indexes maintained by the Home Office (covering England and Wales) and by the Scottish Executive. The Scottish Drugs Enforcement Agency and the Metropolitan Police are also understood to record incidents falling within the second category above.

The Home Office database, which covers murder and manslaughter cases, records drug involvement when (i) either the suspect is reported to be under the influence of drugs at the time of the offence or (ii) the homicide is motivated by the need to obtain drugs, or money to obtain drugs or is drug-related in some other way, such as rivalry between dealers etc. Data have only been collected since 1995 for each police force area in England and Wales. The data do not include homicide where there is no suspect and relate only to those homicides where a suspect is convicted of murder or manslaughter. The types of death captured by this database have to meet fairly restricted definitions. It remains to be seen how a case such as that of Dr Shipman (see below) should be dealt with.

The Home Office data may contain some errors due to the largely subjective interpretation of 'drug-related' and the amount of information available to the police on the motive for a particular homicide, varying from case to case. The completion of returns by the police in such cases is also of concern; the standard of completion is very irregular. A current review of the Home Office Homicide Index is aiming to increase the accuracy of data on homicide. The review will probably be published in due course.

Some information has recently been published by Home Office in response to a Parliamentary Question (Table 19).

**Table 19: Drug-related murders, England and Wales, 1995-2000(a)**

<table>
<thead>
<tr>
<th>Period</th>
<th>Metropolitan Police(b)</th>
<th>England</th>
<th>England and Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>2</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>1996</td>
<td>3</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>1997</td>
<td>4</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>1997-8</td>
<td>3</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>1998-9</td>
<td>1</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>1999-2000</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

a: As at 11 September 2000 when recording was closed for publication purposes. Cases in the latest year may not have been dealt with by the courts and would not be included.

b: Excludes City of London where no such deaths were recorded.

Source: House of Commons Hansard Written Answers for 17 July 2001 (2711). 
www.publications.parliament.uk/pa/cm200102/cmhansrd/cm0110.../10717w15.htm
The Scottish Homicide Index records information on murder and the common law offence of culpable homicide (similar to the English offence of manslaughter). Like its Home Office equivalent, it does not cover statutory homicide e.g. causing death by dangerous or reckless driving. Since 2000 the Scottish Homicide Index has been collecting information to try and identify violent deaths associated with drugs. Information is due to be included in the Homicide Statistics for 2000 when they are published later in the year.

3.2(b) Mortality and causes of death in drug-users, trends

The number of DRDs continues to rise across the UK. The rate of increase in England and Wales appears to have slowed down. However, in Scotland and Northern Ireland the rate has increased in recent years, especially amongst known or suspected drug addicts.

Heroin/morphine
Of particular concern is the increased number of deaths involving heroin/morphine, particularly in Scotland. Apart from overdoses there have been problems with both contaminated heroin and of supplies infected with bacteria that have led to painful deaths of 'skin-popping' IDUs. In terms of illicit drugs, heroin appears to be the main target to warn users about. Not only is it dangerous in its own right but in combination with other drugs is often fatal. Combinations of opiates and other drugs, especially benzodiazepines and alcohol, appear to be on the increase, reflecting the additive effects of respiratory depression of these substances.

Cocaine
There has been a significant increase in the number of cases where cocaine is implicated, although numbers are still relatively small compared to those involving opiates. There are clearly issues of education and information to be addressed concerning such risks.

Methadone
Whilst there is an encouraging overall fall in the number of methadone-associated deaths, some areas still have pronounced problems. Many methadone overdoses involve supplies that have been diverted from legitimate channels. Where supervised dispensing schemes have become established, e.g. Greater Glasgow, and Wales, decreases have been seen in deaths involving the drug. This is an area in which more might be done in terms of preventing diversion.

Antidepressants and analgesics
Prescribed antidepressants and analgesics also account for significant proportions of DRDS, often being implicated in deliberate self-poisonings. Doctors may need to reconsider their approach to prescribing to patients at risk of overdosing. This is also true of the prescribing of distalgesic.

Some advances have been made in reducing the number of deaths involving paracetamol and salicylates following the introduction of tighter controls on the purchase of such analgesics. Since 16 September 1998, pharmacies have only been able to sell a maximum of 32 tablets of paracetamol or salicylate per sale (although in justifiable cases 100 tablets can be sold). Previously there was no limit. The maximum number for other retailers has been reduced from 24 to 16 tablets per sale.

A before and after study of 5 liver units and 7 general hospitals between September 1996 and September 1999 has demonstrated a fall in the annual number of deaths involving these substances (Hawton et al 2001). Cases of paracetamol poisoning fell by 21% and those of salicylates by 48%. The rate of non-fatal self-poisoning by paracetamol in any form fell by 11%. This was mainly because of a 15% reduction in overdoses of paracetamol in non-compound form.

The average number of tablets taken in paracetamol overdoses decreased by 7%, but the proportion of cases involving more than 32 tablets fell by 17%. Although the average number of
salicylate tablets taken in overdoses remained the same, there was a 34% fall in the number of cases involving more than 32 tablets.

There is a need for continued monitoring to see if these reductions persist in the study sample, and more importantly at a national level. Monitoring will also assist in detecting signs of substitution of other possibly more dangerous drugs in cases of self-poisonings. However, the fact remains that if an individual is sufficiently determined to self-poison they can make a number of purchases at different outlets or stockpile them. The new controls at least make impulsive attempts less likely.

**Populations at risk**

It is quite clear that there are different populations at risk of experiencing a DRD. Not only is this true of consumers of particular (combinations of) drugs, but also of individuals of different ages and/or genders, and those who differ in the purpose for which they take drugs.

In the last year or so, there has been an increase in the overall ratio of males to females who are dying as a result of ‘acute’ drug deaths. Most male accidental poisoning deaths occur amongst young age groups who consume illicit drugs, whereas typically it is older females who overdose deliberately on antidepressants and (opioid) analgesics. A notable feature is that proportionately more females than males appear to die in methadone-related cases.

Those who have a history of drug use/abuse die from a DRD at a much younger age than those without such a history. That said, however, the average age at death (of whatever cause) of drug addicts has risen over time. More than a half of those who die are unemployed. Two-fifths live alone, and 5% are of no fixed abode.

Socio-economic determinants appear to play a large part in the geographical distribution of DRDs both nationally and locally. It might be difficult to design national interventions, save in such areas as prescribing, dispensing and retail of prescribed and over the counter medicines. However, Drug Action Teams and other agencies working with them should be able to get an understanding of problems in their own locality and decide which interventions might be necessary and feasible for them.

**Overdose intervention**

Only 28% of those experiencing a DRD died in hospital. There thus appears to be great potential for reducing the number dying of overdose through interventions at an earlier point in time.

Teaching addicts how to recognise the signs of an overdose, as well as training them in Cardio-Pulmonary Resuscitation (CPR) and other first aid techniques may help to reduce deaths. The provision of naloxone to parties/families as well as to the emergency services may also be of assistance (although a proper evaluation needs to be undertaken of such a scheme).

Encouraging third parties/witnesses to overdoses to summon an ambulance as soon as possible rather than delaying or doing so away from the scene for fear of becoming involved with the police would mean medical treatment being provided more rapidly.

**VSA**

Although at a general level the number of VSA deaths in the UK has levelled off in recent years they still constitute a significant proportion of all deaths amongst young people. The introduction of tighter restrictions on the sale of butane gas lighter refills to young people will hopefully have an impact. It will be important to monitor what happens to the number of deaths of those aged under 18 years over the course of the next few years.

**HIV/AIDS and IDUs**

Deaths of individuals who acquired HIV/AIDS through injecting drug use account for a significant proportion of all those dying from the disease in Scotland each year. This rate had been falling
from 1996 (52.4%) to 1998 (46.1%) but has since risen. Whereas by the end of June 2000 the cumulative proportion of AIDS deaths in Scotland accounted for by IDUs was 40.8%, this rate had risen slightly to 41.3% a year later. The comparative rates for England and Wales and Northern Ireland are much lower. This regional pattern ties in very well with that for problematic drug use. This is particularly true of heroin. Overdoses involving this drug and more particularly cases of *clostridium novyi* infection are disproportionately high in Scotland.

The number of new HIV/AIDS cases acquired through injecting drug use showed signs of increase in the third and fourth quarters of 2000, and there was a very high number notified in the second quarter of 2001. Ten of these 11 cases were in Lothian (3 have died), and represent a significant proportion of all AIDS cases notified in that quarter (27 in total). The majority of the 386 AIDS cases amongst IDUs in Scotland have occurred in Lothian (222) which has a smaller population than Greater Glasgow (where there have been 47 cases); the remainder being mostly on Tayside (97 cases). These facts should alert these health authorities to the need to ascertain why the situation is Glasgow is so much better than in Lothian and Tayside, with a view to prevention and thus a reduction in future deaths.

**Hepatitis**

There has been no consistent trend over the last decade in the proportion of English and Welsh IDU cases being hepatitis B core antibody positive. However, there has been a rise from 3.4% in 1997 to 5.4% in 1999. Laboratory reports of acute hepatitis B infection also show an upward trend between 1994 and 1999, more than doubling in that period. The levels of hepatitis C antibodies have been screened for since 1998. These have been considerably higher than those for hepatitis B, and rose from 8.5% in 1998 to 9.0% in 1999 (Department of Health 2000). HCV prevalence amongst IDUs fell in London from 52% to 43% in these years, but only from 31% to 29% elsewhere.

Up to the end of June 2000, 58% of known cases in Scotland of hepatitis C antibody positivity had used drugs intravenously (SCIEH 2000). Three-quarters of those whose risk status was unknown were aged between 15 and 44 - the age group that covers most IDUs. The proportion of all cases acquiring the infection through injecting drug use has varied between 54.2% and 62.3% in the period up to 1999.

Even with this limited information, it is clear how widespread the infection is amongst drug users and how it might impact on mortality rates of IDUs.

**Clostridium**

The *clostridium novyi* outbreak in 2000 has led to public health advisors advocating that IDUs change their method of use. Instead of injecting heroin intramuscularly or subcutaneously, addicts are advised to inject intravenously if they cannot abstain. Alternatively, those who already smoke tobacco would be advised to ‘chase the dragon’.

**Drugs and driving (RTAs)**

Increasing drug use, especially polydrug use, is reflected in the number of road traffic fatalities where drugs are detected. These include both illicit as well as prescribed drugs, often associated with alcohol. The exact contribution of these substances to RTAs is little researched, and in some cases there are opposing views. At the very least, caution needs to be observed by those taking drugs in case these substances do impair their driving abilities or judgement in some way.
3.3 Drug-related infectious diseases

3.3 (a) HIV and AIDS

New data on HIV prevalence among injecting drug users (IDUs) were received from the Unlinked Anonymous Prevalence Monitoring Programme (UAPMP) survey of injecting drug users attending treatment services in England and Wales. Data are presented for England and Wales as a whole, and also for London versus outside London.

For England and Wales as a whole, prevalence in 1999 was 0.8%, and prevalence over the period 1992-1999 has remained less than 2%. Prevalence was lower among younger IDUs compared to their older counterparts, and also among recent initiates to injecting compared to those with longer injecting careers. However there was no discernible trend in prevalence by gender.

Every year prevalence of HIV in London was higher than in the rest of England and Wales, for example 2.9% in London and 0.3% in the rest of England and Wales in 1999. For both areas prevalence was generally lower among younger IDUs, mirroring overall trends for England and Wales as a whole.

3.3(b) Hepatitis B and C

New data on prevalence of antibodies to hepatitis B core (anti-HBc) and hepatitis C (anti-HCV) were received from the UAPMP survey of injecting drug users attending treatment services in England and Wales, and the Scottish Centre for Infection and Environmental Health’s (SCIEH) survey of injecting drug users recruited from community settings in Glasgow. Again, UAPMP data are presented for England and Wales as a whole, and also for London versus elsewhere. Figures presented are not adjusted for the estimated 80% sensitivity of the laboratory test.

For hepatitis C in England and Wales as a whole, prevalence declined from 35% in 1998 to 32% in 1999. There was a marked increase in prevalence with age. For example in 1999, prevalence was 12% among IDUs aged under 25 years, rising to 31% among IDUs aged 25 to 34 years, and 55% among those aged 35 and above. Prevalence was also higher in London than elsewhere (45% versus 29% respectively in 1999), though this trend may in part be due to IDUs recruited in London having longer injecting careers.

Prevalence of anti-HBc declined from 35% in 1992 to around 20% between 1995 and 1999. As with anti-HCV, prevalence increased with increasing age, so for example in 1999, prevalence was 5% among IDUs aged under 25 years, increasing to 17% among those aged 25 to 34, and 41% for those aged 35 and above. Anti-HBc prevalence was generally higher in London than elsewhere.

The SCIEH survey of IDUs recruited from community settings in Glasgow found a prevalence of anti-HCV of 56% in 1996. Prevalence was much lower among recent onset IDUs compared to longer term IDUs (36% versus 63% respectively). There was little difference in prevalence by gender (62% for males and 58% for females).

SCIEH also provided notification data for persons in Scotland reported to be hepatitis C antibody positive. The total number of cases reported has risen from 378 in 1992 to 1,954 in 1999. Similarly the number of cases of IDUs has risen from 145 in 1992 to 1,272 in 1999. The percentage of all cases with a known transmission route attributed to IDU has risen from 57% in 1992 to 95% in 1999. Around 70% of all IDU notifications were for males, and approximately 20% to 25% were for IDUs aged under 25 years.

3.3(c) Other

In 1999 the UK Department of Health invited proposals for research into hepatitis C and drug use, and by June 2000 five projects had been commissioned:
1. Comparison of the sensitivity and specificity of oral fluid and dried blood spot laboratory tests to detect antibodies to hepatitis C virus among injecting drug users (Ali Judd, Imperial College)

2. Addition of anti-HCV testing to the Unlinked Anonymous survey of injecting drug users in 2001 (Vivian Hope, Communicable Disease Surveillance Centre)

3. The efficacy of enhanced counselling in the primary prevention of hepatitis C among injecting drug users: a randomised controlled trial (Mohammed Abou-Saleh, St George's Hospital Medical School)

4. A study of the impact of HCV screening on injecting risk behaviour reported by injecting drug users (Mark Walker, Public Health Laboratory Service, Bangor)

5. A cohort study to assess the prevalence and incidence of, and risk factors for, hepatitis C virus infection among new injecting drug users (Ali Judd, Imperial College)

In addition, Avril Taylor and colleagues at SCIEH gained funding from the Chief Scientist Office of the Scottish Executive for a new cross sectional survey of hepatitis C prevalence among Glasgow injecting drug users who commenced injecting after the full implementation of harm reduction interventions.

There have been no routine surveys or one-off large scale research projects measuring other drug-related infectious diseases such as TB among IDUs in recent years.

3.4 Other drug-related morbidity

3.4(a) Non-fatal drug emergencies

Specific harms experienced by the user range from minor adverse physical or psychological morbidities, which are induced by an illicit substance, to acute problems such as overdose to chronic health disorders. It is useful to differentiate between the use of substances and the harms that are directly or indirectly related to use. Harms may be caused by drug use itself and also by how the drug is taken (i.e. the route of administration).

A focus of concern and research in recent years has been fatal and non-fatal drug emergencies relating to the consumption of opioids and other central nervous system depressants. For an individual, consumption of opioids substantially above tolerant levels can cause respiratory depression leading to oxygen depletion in the brain, leading to coma and potentially death. A sizeable proportion of UK opioid injectors have experienced an overdose and overdose is the most common cause of premature death in this population, particularly amongst people in their 20s and 30s. For example, a study of London heroin injectors reported some 38% had overdosed at least once (Powis et al., 1999). In 1998, there were 632 deaths recorded attributed to opioid poisoning in England and Wales (Office for National Statistics, 2000c), while in Scotland some 163 deaths were directly linked to opioid poisoning in 1999 (Jackson et al., 2000).

Research has shown that the risk of overdose is increased for heroin users who have also consumed other central nervous system depressants – commonly other opioids, alcohol and benzodiazepines. There have been several studies in the UK that have examined this risk behaviour both fatal overdose events and non-fatal overdose phenomena (see comprehensive summary reviews by Best et al., 2000 a,b). Some 40% of surveyed heroin injectors who had overdosed reported that they had used at least one other drug prior to last overdose (Strang, 1999).

Retention in treatment – particularly in opioid pharmacotherapy (maintenance) - confers a marked protective effect in terms of reduced overdose morbidity and mortality. This has been confirmed in several studies, for example by a GP-setting treatment outcome study in Scotland (Hutchinson et al., 2000). Preventing drug overdose and overdose mortality is now a specific priority area. A review of drug-related deaths and prevention options has been published.
(Advisory Council on the Misuse of Drugs, 2000) and there is a recognition of the importance of ensuring that all services that which have contact with opiate users, should have prompt access to the injectable opiate antagonist naloxone. This medication may be administered intravenously, intramuscularly or subcutaneously and can be life-saving in the event of an opioid overdose (Strang et al., 1999).

3.4(b) Psychiatric co-morbidity

National surveys have identified a significant prevalence of co-morbid substance use and other psychiatric disorders in the general population in the UK, and a markedly high prevalence amongst the prison population. For people with primary substance use problems - and particularly those who are dependent on one or more drug types - a history of concurrent problems with mood disorders (anxiety and affective conditions) is common (Farrell et al., 1998). Clinical studies suggest that half of opioid or cocaine dependent individuals have a lifetime depressive episode, while a third have depressed mood at intake to addiction treatment. Amongst the 1075 clients recruited to the NTORS some 29% reported having had suicidal thoughts during the three months before intake to treatment and female clients had higher symptom severity levels than males in all psychological symptoms measured.

In the UK, psychotic disorders and drug-induced psychosis are currently rarely encountered by specialist drug treatment services attending to individuals with primary substance use disorders. In contrast, community mental health services and other psychiatric service providers typically encounter clients with severe mental illness (with bipolar and psychotic disorders being relatively prevalent). Amongst this severely mentally ill population, use of certain types of drugs – particularly alcohol and cannabis – appears to be quite common. A survey of 10,040 suicide cases in England and Wales (April 1996-March 1998) indicated that the sample had substantial social problems and health care needs before their death (Appleby, et al., 1999). The most frequently reported psychiatric disorders recorded were depression, schizophrenia, personality disorder and alcohol-related problems. Combined alcohol and drug misuse was reported in 17% of cases.

3.4(c) Other important health consequences

Acute medical emergencies attributed to other illicit substances are rare in the UK. There have, however, been some reports of problematic toxic reactions to ecstasy and these have posed etiological and medical management challenges for hospital accident and emergency services. On rare occasions, use of amphetamines, cocaine and ecstasy can lead to intracerebral and subarachnoid haemorrhage. For example, a clinical report of 13 ecstasy users described how these individuals had sustained intracerebral haemorrhage, although in nine of these cases the haemorrhage appeared to be related to an underlying vascular malformation (McEvoy, et al., 2000).

There are several chronic health conditions that are associated with sustained illicit drug use and it is important to note that drug misuse populations may be multiply co-morbid. Individuals may experience physical health symptoms and medical complications that relate to the action of the drug(s) taken, to the route(s) of their administration and to general issues of poor nutrition and health care.
4. SOCIAL AND LEGAL CORRELATES AND CONSEQUENCES

4.1 Social problems

4.1(a) Social exclusion (housing, unemployment, minorities, education)

There is considerable evidence to suggest that drug misuse is related to social exclusion in the UK. Drugs have emerged as a key issue in community decline in a wealth of research in then UK and the experience of drug services, backed by research, has identified that the poorest communities are often the main places where drug use occurs (Burgess, 2001). In 1998 a report produced by The Advisory Council on the Misuse of Drugs which looked at environmental factors and drug misuse found that any statistical relationship between drug use and deprivation seemed to apply more to problematic drug use. The results from the 2000 British Crime survey are consistent with this, which suggest that cocaine use is relatively widespread across the general population while heroin tends to be associated with less affluent groups. The proportion that used heroin in the last year was found to be highest in the poorest households for the age groups 16 to 19, 20 to 24 and 25 to 29. The use of any drug, heroin and Class A drugs by 16 to 29 year olds was higher among the unemployed. Owner-occupiers tended to have lower levels of any drug use within the last year compared to those living in rented accommodation for 16-59 year olds (Ramsey et al 2001). In terms of education it was found in a survey of school children aged 11-15 (Goddard and Higgins 2000) that those who did not think that they were going to live up to other people’s expectations of them in terms of examination results had the highest levels of drug use. The use of heroin was more prevalent in those proportion of 16-19 year olds with fewer qualifications, this given the link between qualifications and income, confirms the pattern of heroin use across income groups (Ramsey et al 2001). Whether all these data indicate that drug use has a major impact on exclusion, or whether exclusion may encourage drug use, may not be absolutely understood.

The government’s Social Exclusion Unit is attempting to address both sides of the equation. In particular part of the Social Exclusion Unit, the Rough Sleepers Unit has made considerable efforts to aid drug misusing homeless people. Rough Sleeping - Report by the Social Exclusion Unit (1998) (http://www.cabinet-office.gov.uk/seu/1998/rough/srhome.htm) found that about 2,000 people slept rough each night and 10,000 slept rough over the course of a year. It set a target of reducing numbers sleeping rough by two thirds by 2002. A one third reduction in rough sleeping was achieved between June 1998 and June 2000. The Rough Sleepers Unit (RSU), within the Department for Transport, Local Government and the Regions now co-ordinates action to tackle rough sleeping nationally. They have funded Contact and Assessment Teams across England to engage homeless people into housing and drug treatment. They funded DrugScope to produce a series of guidance documents to assist homeless agencies working with drug users. They funded pilot tailor made drug treatment programmes for homeless drug users across England, which will be evaluated.

Some housing associations have housing support workers to help vulnerable people, including drug users to maintain their tenancies.

A preliminary report ["Bringing Britain Together" 1998] (http://www.cabinet-office.gov.uk/seu/index/whats_it_all_about.htm) gave a detailed picture of the concentration of interlocking problems in deprived neighbourhoods: poor health and housing, high unemployment and crime. It announced that 18 Policy Action Teams, bringing together Government officials with front-line practitioners, residents of neighbourhoods and a host of others, would be set up to work on solutions. Their recommendations were distilled into a second report. A major programme of consultation was carried out on its proposals, and the results of this process were drawn together into A New Commitment to Neighbourhood Renewal: National Strategy Action Plan, published in 2001.

The Action Plan sets out 105 firm commitments which will contribute to meeting the Government’s aim that within ten to twenty years, no-one should be seriously disadvantaged by
where they live. It includes targets to improve employment levels, educational attainment, health and housing and to reduce crime in the most deprived neighbourhoods, backed up by mainstream funding. The goals of the Action Plan will be delivered through new ways of working at local level. Local Strategic Partnerships will use the £900m Neighbourhood Renewal Fund to tackle deprivation and improve local services. At grass roots level, Neighbourhood Management will be piloted, giving residents a single person or team responsible for beginning to tackle persistent problems.

The strategy includes a range of additional funds to empower communities: a £50 million Community Chest to provide direct funding for small scale community projects; a £35 million Community Empowerment Fund to help communities play their part in Local Strategic Partnerships and £45 million for at least two rounds of Neighbourhood Management pilots.

A cross-cutting Neighbourhood Renewal Unit (NRU), based in the DETR, is responsible for driving forward the implementation of the National Strategy for Neighbourhood Renewal.

New Deal is an employment agency project aimed to get long-termed unemployed people into work. They should consider the effect of drug misuse on the long-term unemployed and assist them in accessing treatment to facilitate employment opportunities.

The government asked a group of experts to develop a draft Black and Minority Ethnic Communities and Drugs Strategy and to go alongside the UKADCU National Drug Strategy. They are currently considering the proposals made by the group.

The University of Lancashire is enabling black and minority ethnic communities across England to conduct their own local drug needs assessments in their communities.

At least one million children truanted and almost 13,000 were permanently excluded from school a year when the Truancy and School Exclusion Report by the Social Exclusion Unit (1998) (http://www.cabinet-office.gov.uk/seu/1998/trhome.htm) report was written. The report set out an action plan to deliver a one-third reduction in truancy and exclusion levels by 2002. The number of pupils permanently excluded from school fell from 10,400 in 1998/99 to an estimated 8,600 in 1999/2000. This represents an 18 per cent decrease and is nearly a third less than the peak of 12,700 in 1996/97. The Government’s target for 2002 is 8,400. The Children and Young People’s Unit (CYPU), which is based within the Department for Education and Skills now co-ordinates follow-up action to this report.

DrugScope are conducting research into the needs and resources available to children excluded from school in 45 local authorities, the results of the research will be used to develop services and interventions appropriate to this group of vulnerable young people. Mentoring schemes for young people have been set up by voluntary organisations across the country to aid social inclusion.

4.1(b) Public nuisance, community problems
Each local authority in England have developed Crime and Disorder Partnerships, consisting of local police and other statutory services such as social services, health and education. The aim of the partnerships is to develop local plans to reduce both drug availability and demand locally, they have monies at their disposal to facilitate new interventions.

4.2 Drug offences and drug-related crime
4.2(a) ‘Arrests’ for use/possession/traffic and trends.

Data on the number of arrests for drug offences are collected at a force level for England and Wales and submitted to the Home Office. Until recently, this information was not made publicly available. However, in October 2001, the Home Office published for the first time a statistical summary of arrests for notifiable offences (Ayres et al., 2001). The summary contains information
on the number of persons arrested for all drug offences. Unfortunately, the data are not broken down by offence type. However, some information is provided on the sex and age of the arrestee and police force area.

The figures show that the total number of persons arrested for drug offences in England and Wales during the financial years 1999/2000 to 2000/2001 decreased by 8 per cent. In the financial year 2000/2001, approximately 111,000 persons were arrested for drug offences, compared with about 121,000 persons in 1999/2000. In 2000/2001, the majority of persons arrested for drug offences were male (88%) and aged 21 or over (63%). The highest proportion of arrests for drug offences was reported by Dyfed Powys police force area (17% of all arrests were for drug offences) and the lowest proportion was reported by Humberside police force area (4% of all arrests were for drug offences).

4.2(b) Convictions and court sentences for drug offences, imprisonment for drug law offences

Drug Offences 1996-1999

Table 20 presents data on the number of persons who were found guilty, cautioned, given a fiscal fine4 or dealt with by compounding5 for drug offences between 1996 and 1999 (inclusive) and the number of drug trafficking and possession offences recorded over the same period (Corkery 2001).

Absolute levels

In each of the four years shown, and for each drug type, substantially more drug possession offences were officially recorded than drug trafficking offences. In 1999, there were six times as many possession offences recorded as trafficking offences. In relation to cannabis, there were seven times as many possession offences as trafficking offences and for amphetamines, there were four times as many possession offences as trafficking offences. In relation to the remaining drug types, possession offences were more than twice as common as trafficking offences.

In 1999, more than 120,000 persons were found guilty, cautioned, given a fiscal fine or dealt with by compounding for all drug offences. Of these, the majority (74%) had been processed for cannabis-related offences. Eleven per cent (nearly 13,000) had been processed for offences relating to heroin and 10 per cent (more than 12,000) had been processed for amphetamine-related offences. Less than five per cent were processed for cocaine, crack, ecstasy, or methadone-related offences and less than one per cent was processed for offences involving LSD.

In the three years preceding 1999, the majority of drug offenders were found guilty, cautioned, given a fiscal fine or dealt with by compounding for cannabis-related offences. The second most frequently processed drug offences were in relation to amphetamines and the third were in relation to heroin. In 1999, the rank position of amphetamines and heroin reversed, with 12,760 offenders processed for offences involving heroin, compared with 12,102 for offences involving amphetamines.

Changes in absolute levels

The number of persons found guilty, cautioned, given a fiscal fine or dealt with by compounding for all drug offences increased steadily between 1996 and 1998 (from 95,199 to 130,253). During this period, there were notable increases in the number of persons processed for offences relating to all drug types, with the exception of LSD and ecstasy. However, between 1998 and 1999 there was an overall decrease in the total number of drug offences. This was a result of a reduction in the number of people processed for offences relating to cannabis, amphetamines,

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4 A 'fiscal fine', available only in Scotland, is a financial penalty imposed by procurators fiscal in relatively minor cases where there is no formal admission of guilt.
5 'Compounding' is a payment of a compound settlement in lieu of prosecution for minor personal use drugs offences (Customs and Excise Management Act 1979, Section 152).
LSD, and (to a lesser extent) methadone. The largest absolute decrease (in terms of total number of offences) was in relation to cannabis, whereas the largest proportionate decreases (in terms of percentage change) were in relation to LSD (a reduction of 22%) and amphetamines (a reduction of 20%). Over the same period, there were increases in the number of persons found guilty, cautioned, given a fiscal fine or dealt with by compounding for offences relating to heroin, cocaine, crack and ecstasy.

Discussion
Three observations can be made from Table 20 (see next page). The first is the preponderance of offences relating to cannabis, secondly, the high proportion of possession offences among all drug offences and lastly, the gradual increase in the number of persons found guilty, cautioned, given a fiscal fine or dealt with by compounding for most drug offences up to 1998 and the sudden switch in 1999 to a more bifurcated pattern of decreased numbers of people processed for cannabis, amphetamines, and LSD and increased numbers processed for heroin, crack and cocaine.

The finding that 74 per cent of all persons found guilty, cautioned, given a fiscal fine or dealt with by compounding for drug offences in 1999 were processed for cannabis-related offences may be explained either as a result of enforcement and processing decisions or as a result of the proportionately higher levels of use of this drug. There is some evidence from other sources that provides support for each of these views. Home Office statistics show that cannabis is the most frequently seized drug, which may result in a higher proportion of cannabis-related offenders entering the system. Conversely, there is also evidence from surveys of the general population and from surveys of arrestees that cannabis is the most frequently misused drug. The most reasonable explanation is that the preponderance of cannabis offences is a product of both influences.

The second point relates to the finding that more drug offenders were found guilty, cautioned, given a fiscal fine or dealt with by compounding for drug possession offences than for drug trafficking offences. The most recent figures (for 1999) show that nine-tenths of all drug offenders were processed for unlawful possession. The majority of these (more than three-quarters in each year) were processed for cannabis-related offences. This finding may also be explained as a result of processing decisions or consumption patterns. It would be expected that routine policing (which includes stop and search) would reveal more cases of possession than of trafficking (the former being easier to detect and to prove). However, it is not known whether the recorded difference in the proportions of possession and trafficking is wholly a product of processing decisions. It would also be expected that in any drug market there would be more consumers than sellers. Hence, the observed distribution between possession and trafficking offences is likely to reflect both processing decisions and drug market characteristics.
Table 20: Persons found guilty, cautioned, given a fiscal fine or dealt with by compounding for offences involving selected drug types by type of offence and year

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Source: Drug Seizure and Offender Statistics: United Kingdom 1999 (Corkery 2001)

Methodological comments on Table 20

Definition: Figures extracted from Home Office Statistical Bulletin 5/01 "Drug Seizure and Offender Statistics, United Kingdom 1999" by J.M. Corkery (Home Office 2001). 'Compounding' is a payment of a compound settlement in lieu of prosecution for minor personal use drugs offences (Customs and Excise Management Act 1979, Section 152). A 'fiscal fine', available only in Scotland, is a financial penalty imposed by procurators fiscal in relatively minor cases where there is no formal admission of guilt.
Statistical unit: Totals refer to the number of persons found guilty, cautioned, given a fiscal fine or dealt with by compounding per year for: unlawful production, unlawful supply, possession with intent to supply, unlawful possession, permitting premises to be used for unlawful purposes, other Drugs Act offences, unlawful import or export, or other drug offences. Although a person may be officially processed more than once per year, each processing event is recorded separately (as if in respect of a separate person). Persons with more than one offence (dealt with at the same processing event) are counted as a single offender in the totals but are counted once for each separate type of offence. A person who has committed cannabis possession and trafficking offences will therefore be included once for each offence type but only once in the total.

Offence type: Drug-related use = unlawful possession. Drug-related trafficking = unlawful production, unlawful supply, possession with intent to supply, and unlawful import or export (Home Office Statistical Bulletin 5/01, pg 31).

Substance type: All drugs = cannabis, heroin, diconal, cocaine, crack, methadone, amphetamines, ecstasy, LSD, anabolic steroids, and other drugs.

The third major finding concerns the decrease in number of persons found guilty, cautioned, given a fiscal fine or dealt with by compounding for cannabis, amphetamines, and LSD-related offences between 1998 and 1999, following several years of increase (although the decline in LSD-related offences preceded this); and the increase in the number of persons processed for heroin, crack, and cocaine-related offences during the same period. The major contributing factor to the recent overall decline in the number of persons processed for drug offences was the decline in numbers processed for cannabis offences. There is little evidence to suggest that this decline was the result of changes in consumption patterns. In fact, there are a number of surveys of the general population and other selected groups that show that cannabis use increased over this period. It is most likely that the reduction in cannabis-related offences is a result of changes in enforcement and processing patterns. Home Office statistics show that the number of drug stop and searches decreased from the previous year by nearly one-quarter and the number of drug seizures also decreased substantially during the period 1998 to 1999. These changes would have had the effect of reducing the number of persons entering the system and would have reduced the number of cases processed. Conversely, there is some evidence (from surveys of the general population and from surveys of arrestees) that there have been real increases in the use of heroin, crack, and cocaine. Hence, at least some of the increase in official processing might be a result of changes in consumption patterns.

In 1999 (the latest year for which data are available), 11,275 persons were sentenced to immediate custody for drugs offences. This was a 2.5% increase on 1998. Of those, just over 2,000 received sentences of one month or less. The average length of sentence was 20.1 months. At 30 June 1999, there were 8,150 persons under sentence in prison for drug offences.

4.2(c) Drug-related Crime

Table 21 (see next page) shows the correlation between drug use and crime based on data from the second developmental stage of the NEW-ADAM programme (Bennett 2000). The NEW-ADAM programme is a national programme of research that investigates drug use and criminal behaviour among arrestees. The programme is based on surveys of current arrestees held in police custody suites in 16 locations across England and Wales. As part of the survey, arrestees are asked whether they have ever or recently committed any of eleven types of acquisitive crime. They are also asked whether they have used any of 21 drug types over various periods of time. As a further measure of drug use, arrestees are asked to provide a urine specimen for scientific analysis. The urinalysis is able to detect whether any of seven drug types (opiates, cannabis, benzodiazepines, amphetamines, methadone, alcohol, cocaine) have been consumed within the past few days (in some circumstances, cannabis use can be detected for up to a month).
Table 21 compares a number of measures of drug use and criminal behaviour. The first comparison is the number of positive tests for drugs (excluding alcohol) and four measures of criminal behaviour. The table shows a statistically significant correlation across all four measures. Arrestees who tested positive for three or more drug types reported on average three times as many acquisitive crimes (mainly property offences) as those who had zero positive tests. They reported committing more than twice as many offence types and reported having eight times the illegal income. They also reported twice as many experiences of arrest in the last 12 months.

With regard to specific drug types, half of the arrestees held for burglary in a non-dwelling (e.g. commercial premises) tested positive for cocaine (including crack) and more than two-thirds tested positive for opiates (including heroin). A large proportion of arrestees held for shoplifting offences also tested positive for these drug types (41% for cocaine and 64% for opiates). Of the arrestees held for assault, less than one-quarter tested positive for opiates and less than one-eighth tested positive for cocaine. Nearly one-third, however, tested positive for alcohol.

The second measure of drug use shown in Table 21 is expenditure on drugs in the last seven days. The table shows that there is also a statistically significant association between this measure of drug misuse and each of the measures of criminal behaviour. In relation to three of the four measures, there is a clear linear progression; with the various measures of involvement in crime increasing as the measure of drug misuse increases. Arrestees who reported spending £100 or more on drugs reported ten times the number of offences as those who reported no expenditure on drugs. They also reported four times the mean number of offence types committed in the last 12 months, eight times the mean illegal income and almost twice as many arrests.

The third measure of drug use shown is the number of self-reported drug types used in the last 12 months. There is also a clear relationship between this measure of drug use and all of the measures of criminal behaviour (all correlations were statistically significant). Arrestees who reported using three or more drug types in the last 12 months, reported more offences, more offence types, greater illegal income and more arrests than those who reported using no drug types.

The Bennett report also investigated links between certain kinds of crime and certain kinds of drug use. Arrestees who reported using heroin and cocaine or crack in the last 12 months committed substantially more acquisitive crimes than non-users. Users of heroin (either alone or in combination with cocaine or crack) were more likely than other arrestees interviewed to report theft from a shop or handling stolen goods in the last 12 months.
Table 21: Various measures of involvement in drug use by various measures of involvement in crime

<table>
<thead>
<tr>
<th>Number of positive tests (excluding alcohol) n=506</th>
<th>Mean number of offences committed in the last 12 months (n=740)</th>
<th>Mean number of offence types committed out of 10 property crime types in the last 12 months (n=740)</th>
<th>Mean illegal income in the last 12 months (n=740)</th>
<th>Mean number of arrests excluding current arrest in the last 12 months (n=740)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>48</td>
<td>0.7</td>
<td>1,645</td>
<td>1.7</td>
</tr>
<tr>
<td>1</td>
<td>114</td>
<td>1.3</td>
<td>3,575</td>
<td>3.9</td>
</tr>
<tr>
<td>2</td>
<td>125</td>
<td>1.5</td>
<td>9,231</td>
<td>2.8</td>
</tr>
<tr>
<td>3 or more</td>
<td>171</td>
<td>2.2</td>
<td>13,267</td>
<td>4.2</td>
</tr>
<tr>
<td>***</td>
<td>***                                                      **</td>
<td>**</td>
<td>*</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenditure on drugs in the last 7 days n=740</th>
<th>Mean number of offences committed in the last 12 months (n=740)</th>
<th>Mean number of offence types committed out of 10 property crime types in the last 12 months (n=740)</th>
<th>Mean illegal income in the last 12 months (n=740)</th>
<th>Mean number of arrests excluding current arrest in the last 12 months (n=740)</th>
</tr>
</thead>
<tbody>
<tr>
<td>£0</td>
<td>28</td>
<td>0.5</td>
<td>2,140</td>
<td>2.0</td>
</tr>
<tr>
<td>£1-99</td>
<td>80</td>
<td>1.3</td>
<td>1,633</td>
<td>2.7</td>
</tr>
<tr>
<td>£100 or more</td>
<td>246</td>
<td>2.3</td>
<td>16,881</td>
<td>3.8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of drug types used out of 19 self-report categories (excluding tobacco and alcohol) in the last 12 months n=740</th>
<th>Mean number of offences committed in the last 12 months (n=740)</th>
<th>Mean number of offence types committed out of 10 property crime types in the last 12 months (n=740)</th>
<th>Mean illegal income in the last 12 months (n=740)</th>
<th>Mean number of arrests excluding current arrest in the last 12 months (n=740)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>10</td>
<td>0.2</td>
<td>2,211</td>
<td>1.0</td>
</tr>
<tr>
<td>1</td>
<td>26</td>
<td>0.5</td>
<td>1,100</td>
<td>1.6</td>
</tr>
<tr>
<td>2</td>
<td>95</td>
<td>1.5</td>
<td>3,481</td>
<td>4.0</td>
</tr>
<tr>
<td>3 or more</td>
<td>176</td>
<td>1.9</td>
<td>9,671</td>
<td>3.7</td>
</tr>
</tbody>
</table>

|                                                                                                               ***                                                   | ***                                                      ***                               | ***                                     | ***                                          |

Notes: * p<0.05, ** p<0.01, *** p<0.001.

[1] The ten property crime types include: burglary in a dwelling and non-dwelling, theft of and from a motor vehicle, shoplifting, handling, fraud/deception, drug supply, theft from a person and robbery.

4.3 Social and economic costs of drug consumption

There have been a number of attempts at quantifying the economic burden of illicit drug consumption – the most notable examples having been conducted in North America. These studies - sometimes referred to as ‘cost-of illness’ exercises - have set out to assess the total burden imposed by illegal drugs on economic performance and societal well-being more broadly defined. They have typically set out to value the health care resources devoted to dealing with drug-related health problems, law enforcement costs in responding to drug related crime and economic losses expressed in terms of reductions in economic productivity arising from morbidity and premature death. The latter have been found to be by far the most important element in these economic burden assessments. For example, in an often-cited US study around 80% of the costs to the US imposed by illicit drug use – estimated at $58 billion (in 1988 prices) - were attributed to lost economic output (Rice et al 1990).

4.3(a) Studies and estimates of health care costs, other social costs

The Government estimates it spends £1.4 billion annually on drug related activity, and that the social and economic costs of drug use amount to £4 billion per year (Quirk, 1998). Tackling Drugs to Build a Better Britain (1998) states that annual costs arising for the most serious drug misusers alone are well over £4 billion. Hansard UK (1998) estimates annual cost of drug smuggling as follows: costs put between £3.2 billion & £3.7 billion, made up of: £100 million health care costs; £600 million unemployment and sickness benefit payments; £500 million criminal justice system costs and £2.5 billion to victims of drug related crime. Edmunds et al (1998) estimate: £100m costs to specialist substance misuse health and social services; £600 million unemployment and sickness benefit payments; a minimum of £2.5 billion to victims of drug related crime, with the figure more likely to be in the region of £3-£4 billion. Between £0.5 and £1 billion to the criminal justice system and their estimate is that generic health care costs far exceed those reported by the Hansard above, especially when taking into account the costs of treatment for infection with blood borne viruses. The National Treatment Outcome Research Study (NTORS) has also estimated that health care and crime-related costs associated with over 1000 problem drug users referred to addiction treatment services throughout England to be in excess of £12 million annually (Healey et al. 1998).

It should be stressed that assessing the economic burden of any social problem is not an exact science. Most of the high profile estimates on drug use from North America contain some questionable assumptions and, for many academic economists, are fundamentally flawed in the general methodological framework they adopt. Nevertheless, it is easy to get drawn into the numbers game, and social problems that are expressed in terms of billions of pounds or dollars provide eye-catching newspaper headlines. Perhaps more worryingly they also provide a louder voice for those who are keen to attract more resources towards social policy initiatives that tackle the problems created by illicit drugs markets, without careful consideration of what these interventions can actually achieve.

4.3(b) Estimates of total consumption and of users’ expenditure on drugs

Consumption

Estimates of the total consumption of illicit drugs in the UK can be taken from a recent study commissioned by the Home Office entitled ‘Sizing the UK market for illicit drugs’ (Bramley-Harker 2001). This study estimated the ‘street/retail quantities’ of the drugs rather than the ‘pure quantities’ due to the lack of reliable information about street purities. Estimates of consumption (and expenditure) where taken from ‘regular users’ where taken from ‘regular users’, defined as having used a particular drug at least once a week, or four times during the last month and also included prevalence of ‘occasional users’ derived from 1998 British Crime Survey and 1998/1999 Youth Lifestyles Survey plus data from prisons derived from Mandatory Drug Testing (MDT) in 1999/2000.
Although the majority of data relates to England and Wales, final estimates of a UK perspective have been obtained by inflating, on a pro-rata basis, the original data. The data was derived from the NEW-ADAM programme (New English and Welsh Arrestee Drug Abuse Monitoring Programme) and therefore likely to be unrepresentative of the UK as a whole, but still provides some useful estimates and a basis for future work.

To achieve estimates of consumption, data from the study’s estimates of the number of ‘regular’ drug users was combined with expenditures to obtain estimates of the value of the market. To convert this into physical quantities, expenditure estimates were divided by the estimated per unit street prices (obtained in the study from National Criminal Intelligence Service).

**Table 22: Estimates of the size of the UK [retail] market for illicit drugs for 1998**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Value of market</th>
<th>Street price</th>
<th>“Street quantity” (= value of market/street price) (converted to kg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamines</td>
<td>£257.7million</td>
<td>£10 per gram</td>
<td>25,772</td>
</tr>
<tr>
<td>Cannabis</td>
<td>£1577.9 million</td>
<td>£92 per oz (28 grams)</td>
<td>486,224</td>
</tr>
<tr>
<td>Cocaine</td>
<td>£352.8 million</td>
<td>£77 per gram</td>
<td>4,582</td>
</tr>
<tr>
<td>Crack</td>
<td>£1817.4 million</td>
<td>£20 per dose (0.2 grams)</td>
<td>18,174</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>£294.6 million</td>
<td>£11 per dose</td>
<td>26,786 (000 tablets not kg)</td>
</tr>
<tr>
<td>Heroin</td>
<td>£2313.0 million</td>
<td>£74 per gram</td>
<td>31,257</td>
</tr>
</tbody>
</table>

Source: Sizing the UK market for illicit drugs (2001)

From Table 22, in terms of gross weight cannabis is estimated to be the most widely consumed illicit drug in the UK, at 486,224 kg. This corresponds with 1998 and 2000 BCS data which state that cannabis is the most commonly used drug. It has the lowest retail price and developments in attitudes towards the drug in the general public in recent years (see section 1.3) could have contributed to its wide consumption.

Heroin is estimated to be the second most widely consumed drug, although the estimate of the value of the market for this drug is highest, this is due to the expense per gram (retail). Cocaine is estimated to be the least consumed illicit drug, this may be due to the higher price of the drug compared to the other drugs in the study (although it is not much more expensive than heroin), or it may be due to availability.

Amphetamines, crack and heroin are estimated as having a relatively similar level of consumption compared to cannabis and cocaine. Amphetamines and crack, also, have on average fairly low retail prices in comparison to heroin and cocaine, and are more widely consumed than cocaine again this may be due to availability. It is difficult to compare ecstasy consumption with the other drugs due to the difference in measures. Also the cocaine figures derived from NEW-ADAM (regular users) are likely to be an underestimate as the author suggests cocaine users may not have the same probability of arrest as heroin or crack users.

**Expenditure**

From the study ‘Sizing the UK market for illicit drugs’ (Bramley-Harker 2001), the estimated total value of the UK of the drug market in 1998 was around £6.6 billion. There are uncertainties based around this estimate though which need to be highlighted. The data is taken from the NEW-ADAM survey and this data only covers metropolitan areas or large conurbations, not rural areas. In order to obtain an estimate for the whole of the UK, the data from England has been extrapolated. The information from the ONS population trends (ONS 2000d) suggests that only
30% of the population of England and Wales live in rural areas, this gives a broad indication of the level of over-estimation in the Bramley-Harker 2001 study. The actual market may be significantly lower than estimated.

Estimates regarding the annual and monthly expenditure on varying illicit drugs for ‘regular’ users (defined as above) have also been made in the ‘Sizing the UK market for drugs’ study. Again care is needed when considering the estimates. The data covers England only.

Table 23: Estimating annual expenditures of regular users (England)

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Average no. of days used in last 30 days</th>
<th>Average expenditure per day used (£)</th>
<th>Average monthly expenditure (£)</th>
<th>Average annual expenditure (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamines</td>
<td>15.2</td>
<td>9.31</td>
<td>141.2</td>
<td>1,695</td>
</tr>
<tr>
<td>Heroin</td>
<td>24.6</td>
<td>28.8</td>
<td>709.6</td>
<td>8,516</td>
</tr>
<tr>
<td>Cocaine</td>
<td>17.0</td>
<td>13.68</td>
<td>231.9</td>
<td>2,783</td>
</tr>
<tr>
<td>Crack</td>
<td>20.2</td>
<td>-</td>
<td>848.6</td>
<td>10,183</td>
</tr>
<tr>
<td>Cannabis</td>
<td>20.6</td>
<td>6.4</td>
<td>132.0</td>
<td>1,583</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>9.0</td>
<td>29.94</td>
<td>257.2</td>
<td>3,086</td>
</tr>
</tbody>
</table>

Source: Sizing the UK market for illicit drugs (2001)

Notes: (i) Figures for cannabis and ecstasy are included for illustration only.
(ii) Numbers may not add due to rounding.

Table 24: Estimated total expenditures of regular users, England (£m)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Estimated no of regular users in the community</th>
<th>Annual average expenditure (£)</th>
<th>Total expenditure (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamine</td>
<td>105,925</td>
<td>1,695</td>
<td>179.5</td>
</tr>
<tr>
<td>Heroin</td>
<td>225,954</td>
<td>8,516</td>
<td>1,924.1</td>
</tr>
<tr>
<td>Cocaine</td>
<td>98,344</td>
<td>2,783</td>
<td>273.6</td>
</tr>
<tr>
<td>Crack</td>
<td>148,832</td>
<td>10,183</td>
<td>1,515.6</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>-</td>
<td>3,892.8</td>
</tr>
<tr>
<td>Cannabis</td>
<td>563,209</td>
<td>1,583</td>
<td>891.6</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>70,486</td>
<td>3,086</td>
<td>217.5</td>
</tr>
</tbody>
</table>

Source: Sizing the UK market for illicit drugs (2001)

Notes: (i) Figures for cannabis and ecstasy are for illustration only.
(ii) The total number of regular users in the community is not the summation of users of individual drugs. Poly-drug use is common and many regular users will use more than one drug.
(iii) Numbers may not add due to rounding.

Table 24 shows that the estimated total expenditure for regular users in England for amphetamines, heroin, cocaine and crack is £3892.8 million. This figure would obviously increase if cannabis and ecstasy were included.

Individually, crack is estimated to have the highest average annual expenditure for regular users at £10, 183. Heroin is estimated to be second at £8,516, followed by cocaine at £2,783 and finally...
amphetamines at £1,695. This may alter if cannabis and ecstasy are included, particularly as cannabis is the most widely consumed drug in the UK (but it is the least expensive).

The estimated total of monthly expenditure on all drugs (see Table 23) is consistent with estimates from other sources (Parker and Bottomley 1996; Edmunds et al. 1998). Crack is estimated to have the highest monthly expenditure for regular users, followed by heroin, amphetamines then cocaine.

It is important to consider, however, that the estimates for cocaine and amphetamines may be inaccurate due to users being less likely to be involved in acquisitive crime and therefore less likely to be arrested. Also, there may be some degree of overlap between all drugs as many users are polydrug users.

5. DRUG MARKETS

5.1 Availability and supply

5.1(a) Availability of different drugs, trends and possible reasons

There is still, as with last year’s report, a lack of useful data concerning availability of drugs in the UK, although National Criminal Intelligence estimates suggest that between 20 and 30 tonnes of heroin and between 25 and 40 tonnes of cocaine are smuggled into the UK each year. Class A synthetic drugs are more difficult to estimate but it is likely to be a matter of tonnes or many millions of tablets. In addition, reports from police forces and published sources indicate that most drugs, including heroin, cocaine, crack and Ecstasy are widely available in most parts of the UK (NCIS 2001).

As noted in section 4.3 b), the most developed quantitative research so far has been the ‘Sizing the UK Market for Illicit Drugs’ (Bramley-Harker 2001). The study attempted to provide a methodology for estimating the size of the UK market for illicit drugs using estimates of prevalence and consumption by regular users. It is anticipated that the basis of this research will enable a measurement of the size of the UK market to be made in the future.

5.1(b) Sources of supply and trafficking patterns within country

In relation to middle and upper level trafficking, there is an increasing trend of traffickers smuggling more than one drug, particularly noticed by law enforcement with white British criminals, for example heroin traffickers also dealing in crack. This seems to reflect the increase in multi-drug use (NCIS 2001).

The vast majority of the heroin smuggled into the UK originates from Afghanistan, much of it supplied by trafficking organisations in Turkey after being processed. Although the most direct route from Afghanistan is through Iran, the Iranian authorities have recently been clamping down on the traffickers. Heroin is taken out of Turkey and travels by air or sea to the UK, although the number of lorries bringing heroin directly from Turkey into the UK has decreased. Heroin also comes from the Netherlands, at a significantly lower wholesale price than in the UK, and Pakistan (ibid). The Netherlands has become a major distribution point for heroin, cocaine and cannabis, and the main manufacturer of Ecstasy and amphetamines, due to its geography, transport links and the presence of established Dutch and foreign traffickers. It is also where the majority of traffickers based in the UK seem to obtain their supplies (NCIS 2001). Most of the heroin arrives in the UK through the south-eastern ports, with some coming in through the major UK airports with links to Turkey, northern Cyprus and Pakistan. Two-thirds of the criminal groups known to be dealing in heroin alone are based in the southeast of England, mainly in London. The main distribution point for heroin in the UK is London, although there are large heroin markets in all the UK’s major cities, with lines of supply to smaller towns in the surrounding areas. Significant
amounts of heroin are supplied by groups in the northwest to traffickers in Scotland, North Wales, Northern Ireland and the Irish Republic (NCIS 2001).

The coca plant is produced predominantly in Bolivia, Peru and Colombia, although as coca cultivation has decreased steadily in Bolivia and Peru from the mid-1990’s due to crop eradication programmes, in Colombia it has continued to increase significantly (after accounting for two thirds of the world’s coca crop in 1999). Cocaine is transported from laboratories in Colombia and neighbouring countries by air across the region and also to the Caribbean and by road to the Colombian coasts and to other South American countries. Cocaine is exported from South America primarily by sea in mother ships. Colombians based in Spain are thought to play a major part in importing cocaine into Spain for distributing throughout Europe. Some cocaine is also shipped directly into the main ports of northern Europe (NCIS 2001).

It is known that cocaine has been imported directly into the UK in bulk in container traffic and also in feeder vessels from Rotterdam, Antwerp and Hamburg to container ports in southern and eastern England. Cocaine also arrives in the UK in small private boats. However it is estimated that up to three-quarters of cocaine coming into the UK from Europe is carried across the channel in lorries, private vehicles and by foot passengers. Increasingly, British criminal groups are buying cocaine directly from suppliers in the Netherlands, Belgium and Spain, and importing it themselves (NCIS 2001). A great deal of cocaine is also brought into the UK by air, either with passengers or in baggage and freight. Couriers arrive at all the major international airports in the UK either direct from South America or the Caribbean, or via the USA, Spain, the Netherlands or other European countries, particularly Germany, to reduce the risk of suspicion. London is the main distribution point for cocaine coming into the UK, although there are signs that this is becoming less so as importers and distributors outside the capital are becoming more significant. Consignments are then broken down for distribution (NCIS 2001).

Crack cocaine is manufactured in the UK from cocaine and its importation is rare. Ecstasy is produced primarily in Europe, mainly in the Netherlands. An assessment carried out in late 2000 identified the Netherlands as the UK’s biggest source of Ecstasy, although it is also supplied from other areas of Europe, including Belgium, France and Spain, as well as being manufactured in the UK itself (NCIS 2001).

5.2 Seizures

5.2 Trends in quantities and number of seizures

The number of drug seizures fell in 1999 from 1998 by 13% to 132,194, following an increase of 9% from 1997 in 1998. The number of seizures involving heroin and crack decreased slightly from 1998 (by 0.5% and 2% respectively) although seizures of cocaine increased by 8%. Cannabis seizures fell by 15%, but continued to represent the majority of all seizures (74%). (See graph below). There was an increase in seizures within the UK involving Class A drugs between 1998 and 1999 from 28,795 to 30,032, an increase of 4.3%. The police make the majority of seizures, although customs seizures constituted a higher quantity of drugs for all drugs except cannabis plants, crack and heroin (Corkery 2001).

Cannabis

In 1999, both the number and quantity of seizures of cannabis overall (by all enforcement agencies) were down from 1998. The number of seizures fell from 114,667 to 97,356 and the quantity of seizures fell from 109,659kg to 70,684kg. Police seized 13,963kg and customs seized 56,721kg. In addition, although both the number and quantity of customs seizures were down on 1998, the quantity of police seizures fell by 42% from 24,262.8 to 13,963kg (Corkery 2001).

Heroin
In 1999 15,108 seizures of heroin were made overall, which is similar to the 1998 figure (15,188). However, the quantity of heroin seized in 1999 was 2,341.7kg (a 74% increase from 1998). The police again made the majority of the heroin seizures in terms of both number and quantity. The police made 14,950 seizures totalling 1,493.8kg while customs made 158 seizures of 848kg. The number of heroin seizures carried out by both police and customs had increased from 1998 (a 2% increase by police and a 7% increase by customs). The quantity of customs seizures decreased by 14% from 1998 while the quantity of police seizures increased by 320% (355.6kg to 1,493.8kg) (Corkery 2001).

Amphetamines
13,194 seizures of amphetamines were made overall in 1999, a decrease of 29% from 1998, although the quantity of seizures increased by 11% from the previous year (2,016.5kg). The police made the majority of seizures in terms of numbers (13,092 in comparison to custom’s 102) while the quantity of seizures was similar for both customs and police (1,117.6kg and 898.9kg respectively). The number of seizures by both police and customs fell from 1998 (28% and 25% respectively) and the quantity of customs seizures also fell by 7%. However, the quantity of police seizures increased between 1998 and 1999 by 50% (Corkery 2001).

Ecstasy
Overall 6,438 seizures of Ecstasy of 6,323,469 doses were made in 1999, which was an increase of 36% and 202% respectively from 1998. The police (6,313) made the vast majority of seizures in terms of numbers with customs making only 125, while the majority of seizures in terms of quantity were made by customs (4,825,421 doses) compared to 1,498,048 doses made by police. Both the number and quantity of seizures by both police and customs increased between 1998 and 1999. The number of police seizures rose by 36% while the quantity increased by 35%. The number of customs seizures rose by 40% and the quantity increased by 388% (Corkery 2001).

Cocaine
Overall 5,619 seizures of cocaine were made in 1999, which was an 8% increase on 1998. 2,956.5kg of cocaine were seized, which was within 2kg of the 1998 figure. The police made 4750 seizures while customs made 869. However, customs (2,485.3kg) made more seizures in terms of quantity than the police (472.1kg). The number of seizures by police increased by 15% from 1998 while the quantity by police increased by 209% (Corkery 2001).
5.3 Price and purity

5.3 Distinguish trends at retail level

Price
Information on the average price of drugs is provided by the National Criminal Intelligence Service (NCIS) who collect data from police test purchase operations. The average price of a gram of heroin in 2000 was £70, which is £5 more expensive than in 1999, although less than the average price in 1997 and 1998 (both £74). A gram of cocaine was £65 on average in 2000, which is similar to the 1999 figure (£63) but less than the average price in 1996 (£69), 1997 (£71) and 1998 (£77). A rock of crack cost £23 on average in 2000, which is slightly more than the unchanged price between 1996 and 1999 (£20). Cannabis (leaves and resin) cost £3 per gram on average in 2000, which is the same as for the last three years. The average price of an Ecstasy tablet was £9 on average in 2000, which is slightly cheaper than the unchanged price between 1996 and 1999 (£10). On an inflation-corrected basis, all drug prices in the UK have continued to fall.

Purity
Information on the average purity at street level of certain drugs is provided by the Forensic Science Service, which analyzes seizures made by the police. Heroin, on average, was 47% pure in 2000, which continues the increasing trend in purity over the last few years (in 1997 the average percentage was 35%, in 1998 it was 37% and in 1999 it was 43%).

In 2000 cocaine was 52% pure on average, which was 10% lower than in 1999, although it is a similar percentage to 1997 (52%) and 1998 (54%). The purity of crack in 2000 (66%) is the lowest for the last five years, with the average purity between 1996 and 1999 ranging from 80-84%.

Continuing the trend, amphetamine (5%) also had the lowest percentage for average purity over the last five years in 2000; while between 1997 and 1999 the percentage was between 14% and 16%.
Other Forensic Science Service data suggests that the average MDMA drug content of tablets was 74mg in 2000, which is less than the 1999 figure (80mg) but is in line with the figures for 1997 and 1998 (both 75mg). However, as with previous years, the sample size is relatively small and it is not clear how they were selected for testing.

6. TRENDS PER DRUG

6(a) Information from different indicators and other sources

See sections 2 and 3 above.

6(b) Analysis by drug

Cannabis
For respondents aged 16-59 in England and Wales (Ramsey et al. 2001), cannabis ‘ever’ use was 21% in 1994, 22% in 1996, 25% in 1998 and 27% in 2000. Last year use was 8% in 1994, 9% in 1996, 9% in 1998 and 9% in 2000.

For respondents aged 16-29, cannabis ‘ever’ use was 34% in 1994, 36% in 1996, 42% in 1998 and 44% in 2000. Last year use was 20% in 1994, 21% in 1996, 23% in 1998 and 22% in 2000.

Synthetic drugs (amphetamine, ecstasy, LSD, other/new)
For respondents aged 16-59 in England and Wales (Ramsey et al. 2001), ecstasy ‘ever’ use was 2% in 1994, 3% in 1996, 4% in 1998 and 5% in 2000. Last year use was 1% in 1994, 1% in 1996, 1% in 1998 and 2% in 2000. For respondents aged 16-29, ecstasy ‘ever’ use was 6% in 1994, 9% in 1996, 10% in 1998 and 12% in 2000. Last year use was 3% in 1994, 4% in 1996, 4% in 1998 and 5% in 2000. For respondents aged 16-59, amphetamines ‘ever’ use was 8% in 1994, 9% in 1996, 10% in 1998 and 11% in 2000. Last year use was 2% in 1994, 3% in 1996, 3% in 1998 and 2% in 2000. For respondents aged 16-29, amphetamines ‘ever’ use was 14% in 1994, 16% in 1996, 20% in 1998 and 22% in 2000. Last year use was 7% in 1994, 8% in 1996, 8% in 1998 and 5% in 2000.

Although new drugs are becoming more prevalent throughout the dance scene, large amounts of Ecstasy and Amphetamines are still being used (Calafat et al. 1999). Amphetamine use was mostly restricted to younger people, being most popular with young males between the ages of 15 and 18 years of age. Some ‘Nightlife’ panel members (see section 2 above) believed young women could be using amphetamines as an aid to weight loss. Despite frequent reports of bad tablets, Ecstasy use was still very prevalent, especially within the dance scene, though panel members suggested that use had decreased from its peak a few years ago. It was also believed that the poor quality of Ecstacy tablets might have been a contributory factor to the increase in cocaine powder use within the dance scene (Calafat et al. 1999). Stimulants such as amphetamine and ecstasy were unpopular in ethnic minority groups, with only very low levels of use in comparison to drugs such as cannabis and cocaine. It was felt that this trend had a lot to do with the image of these drugs as being ‘a white man’s drug’ (Calafat et al. 1999).

Heroin/opiates
In the British Crime Survey, heroin ‘ever’ use was around 1% from 1994 to 1998 and 2% in 2000. ‘Last year’ use was 1% in 1994, under 1% in 1996 and 1998, and 1% in 2000 (Ramsey et al. 2001). In the period ending September 2000, heroin was the most frequently reported main drug in the Regional Drug Misuse Databases (RDMDS), accounting for 64% of users. The percentage share has increased from 46% in the period ending September 1993. Conversely, the proportion reporting methadone as a main drug has decreased and was 10% in the period ending September 2000 (Department of Health 2001b).
In the Nightlife study, addiction was another major concern of panel members, as this leads to a whole host of associated problems. One panel member commented “...a drug like heroin is so addictive, it will always come first and can lead to prostitution, theft, anything to feed the habit...(it’s) really damaging socially and mentally (in the) long term”. This was of particular concern to those professionals in the law enforcement sector (Calafat et al. 1999). There is also growing evidence that the use of these drugs was on the increase amongst young people from ethnic minority backgrounds, predominantly from South East Asia. This was of particular concern to some ‘Nightlife’ panel members, who felt that the exploding Asian youth population could fall into very real difficulties if this trend continues (Calafat et al. 1999). Heavy cannabis use was also described in African-Caribbean, Asian and black British communities and this was generally thought to be more widespread than in white British or white Europeans on a national level. Cannabis was also believed to be the primary drug of choice for this population and its use far outweighed that of all the other drugs. One panel member whose main interest was prevalence and patterns of drug use in Asian young people felt that this may be attributed to the Afro-Caribbean/black American culture many young Asians identified with. Cannabis use is also harder for parents and family to detect than alcohol, a drug which is heavily frowned upon in Asian culture (Calafat et al. 1999).

Cocaine/crack
For BCS respondents in England and Wales aged 16-29, cocaine ‘ever’ use was 3% in 1994, 6% in 1996, 6% in 1998 and 10% in 2000. Last year use was 1% in 1994, 3% in 1996 and 5% in 2000 (Ramsey et al 2001).

In the Nightlife study, informants felt that cocaine presented a major concern for young people. England has seen a huge increase in the availability of cocaine powder over the last few years and the current price has dropped to between £30 and £45 per gram (These figures have been obtained from drug users themselves who may get drugs at a cheaper price from their regular dealer and contrast with those in Table 22 which were obtained from police test purchase operations. The dealer would charge a higher price for the drug to first time buyers). The combination of these factors has resulted in the increase in the use and abuse of cocaine powder. Cocaine was also described as a very mechanical drug, where the user would receive the desired stimulatory effect every time. In this sense, cocaine was described as an easy drug to ‘learn’ (Calafat et al. 1999). It was also considered to be preferable to amphetamine, as the duration of its effects is only up to an hour, giving the user more control over their night (Calafat et al. 1999). Several informants thought cocaine’s popularity may also have been increased by the diminishing quality of Ecstasy tablets over the past few years. All the panel members stressed that the current use of cocaine was of major concern to them, and many expressed the view that increased cocaine use in clubs had the potential to ruin the dance scene. One night club owner commented “if it continues at the current rate the Charlie (cocaine) will fuck it up for everyone” (Calafat et al. 1999).

Some panel members felt the increase in availability of cocaine powder had arisen in conjunction with the rise in crack cocaine use, as more cocaine was being brought into the country to be turned into more profitable crack cocaine. This drug has also seen a rise in popularity in the last few years, particularly amongst heroin users, although this has not proved as yet to be as big a trend as was initially expected (Calafat et al. 1999).

Other (including pharmaceutical products, solvents)

Prescription drugs
Between 1990 and 2000 the total number of prescriptions in England rose from 395m to 552m and the average number of prescriptions from 8.2 to 11.0 per head of population (Department of Health 2001c)

A comprehensive review of studies undertaken between 1980-1995 found that prescribing of drug dosages outside their therapeutic range was the most frequent cause of reported forms of inappropriate drug use (e.g. excessive duration of benzodiazepine prescribing, sub-therapeutic carbidopa dosages in Parkinson’s disease) (Bueto et al. 1996). Other factors were invalid
indications for drug treatment, questionable choice of drug(s), failure in communication (e.g. between prescriber and patient or prescriber and pharmacist).

While there are studies which have documented particular instances of inappropriate prescribing, there are no surveillance systems in place which can be used to determine the scale of such prescribing in the UK (Buetow et al. 1996). In Glasgow a survey of about half the city's general practices indicated that about 12,000 patients were abusing prescribed drugs and other evidence indicated that a similar number might have been abusing drugs unknown to their GP (Greater Glasgow Health Board 1993).

7. CONCLUSIONS

7.1 Consistencies between indicators

The main trend, which is consistent with the majority of indicators, is that drug use has remained relatively constant across the UK over recent years. Young people still reported the highest rates of any drug use and from prevalence measures cannabis was still seen to have the highest number of users who have 'ever' tried the drug. This reflects survey data showing that it is the most widely consumed illicit drug in the UK.

Evidence shows that there has been a significant increase, in Britain, in the proportion of people using cocaine between 1994 and 2000 (although from 1998 to 2000 the increase in cocaine was not statistically significant) and also that there have been new outbreaks of heroin use among young people. This is consistent with the Nightlife survey in which the young people sampled believed that drugs were generally more widely available and that the range of drugs available was increasing from previous years.

This increasing availability could have also contributed to the increase in problem drug users, particularly as heroin was the main drug of use for over half of the sample. The new outbreak seems to be supply led with heroin being cheaper but still remaining of high purity. There has also been an increase in new clients receiving treatment.

An increase in needle sharing has arisen in recent years and this could contribute to the transmission of Hepatitis C and Hepatitis B in intravenous drug users, which has become a major problem in the UK. However, contrary to this, HIV infection still remains low.

The number of drug-related deaths continues to rise across the UK. The rate of increase in England and Wales appears to have slowed down. However, in Scotland and Northern Ireland the rate has increased in recent years, especially amongst known or suspected drug addicts. The UK had the highest rate of drug-related deaths in any country in the European Union in 1997.

During 1995-1999 the most commonly associated illicit drug with drug-related deaths were opiates (heroin, methadone and morphine) and this increase is of particular concern especially in Scotland where the increase was considerably greater than any other country in the UK. There have been problems with both contaminated heroin and of supplies infected with bacteria that have led to painful deaths of 'skin-popping' IDUs as well as overdosing.

Increasing drug use, especially polydrug use, is reflected in the number of road traffic fatalities where drugs are detected. These include both illicit as well as prescribed drugs, often associated with alcohol. The exact contribution of these substances to RTAs is little researched, and in some cases there are opposing views. At the very least, caution needs to be observed by those taking drugs in case these substances do impair their driving abilities or judgement in some way.
Although cannabis is still the most consumed illicit drug and use of this drug has increased across the UK, contradictory evidence from police and customs information shows that drug offences related to this drug decreased from 1998-1999 and seizures of this drug also decreased during the same period. This may reflect changes in enforcement decisions.

There is a strong association between drug use and criminality, with most offenders more likely to be consumers of prohibited drugs than true of the rest of the general population.

7.2 Implications for policy and interventions

7.2(a)(b) Possible hypotheses and reasons for main trends and new developments in drug use. Relevance to policy issues or interventions for policy makers and professionals.

As a result of growing recognition of the need for relevant, up to date, strategic information about drug use and treatment responses, a range of information and research initiatives has been put in place across government departments. These include the Department of Health’s Drug Misuse Research Initiative and Strategic Review of the Drug Treatment Information (Donmall & Hickman, 2000). This latter has resulted in the development of the new National Drug Treatment Monitoring System (NDTMS) that will provide better and more timely information for public health, policy formation and treatment responses. The NDTMS directly addresses relevant information needs of ‘Tackling Drugs to Build a Better Britain’; the government’s 10 year Drug Strategy published in 1998, and provides policy information at a national and local level. Within this development, efforts at enhancing and harmonizing TDI data collection across the UK are also ongoing.

7.3 Methodological limitations and data quality

The Drug Misuse Database relies on anonymized reports provided by over 600 specialist drug treatment agencies and General Practitioners. Reports are expected for all new presentations for treatment by drug users and for all re-presentations following a service absence of six months or more. Basic epidemiological data are provided on a case basis by each agency that include socio-demographic information, detailed current drug profile and service related data. Double counting is minimized at a regional level by use of an attributor (initials, date of birth and gender). Feedback reports are provided by regional centres to drug services and key stakeholders such as local health authorities and drug action teams, and subsets of data that exclude the attributor are sent to the Department of Health on a six monthly basis for national aggregation.

Data quality is generally considered to be good for the majority of fields (including all those reported in Tables 3 and 4). This is a well-established system that collects information consistently across most of the country. Methodological limitations of the existing system centre on the need for clearer case control definitions, inclusion criteria (agencies and treatment modalities), and the exclusion of information about the in-treatment population and outcomes. However all these limitations have been addressed in the new National Drug Treatment Monitoring System introduced in April 2001 (see below). All national systems rely on the co-operation and understanding of treatment agencies and it is important to ensure that the data collected are relevant to their needs in addition to those of national bodies, and feedback of information to participant agencies is therefore of paramount importance. Coverage across the country has improved greatly in recent years and is now estimated at around 85% of specialist drug agencies. In terms of the European Treatment Demand Indicator requirements, methodological limitations are few.

In interpreting all figures based on main drug of use, it is important to note that the reported main drug reflects only partially an individual’s drug use. It is most likely that the main drug better reflects the available treatment modalities and service profile than the full drug use profile of individual users. Hence the predominance of heroin as a main drug of use in the UK reflects the focus of the majority of drug services. Please note that this is a limitation of the European TDI
The new National Drug Treatment Monitoring System was implemented in April 2001. This system operates in the same basic way as the Drug Misuse Database but with refined definitional parameters and a more focused data set that allows for better monitoring of treatment processes and interventions. The most significant development in the new system is the inclusion of Client Review, a one year follow-up of each reported client, that provides information on the in-treatment population (interventions and basic outcomes) in addition to the familiar profiles of the treatment demand or 'presenting' population. The first Client Review will take place in April 2002. The data on which this report is based are derived from the former system of Drug Misuse Databases; future reports will utilise information from the new National Drug Treatment Monitoring System.
PART 3: DEMAND REDUCTION INTERVENTIONS

8. STRATEGIES IN DEMAND REDUCTION AT NATIONAL LEVEL

8.1 Major Strategies and activities

Northern Ireland’s anti-drugs strategy was launched in August 1999. It embraces the aims of ‘Tackling Drugs to Build a Better Britain’ (1998) and has adapted these to suit the Northern Ireland’s particular circumstances.

The Scottish Executive’s Drugs Action plan, published in May 2000, sets out the Executive’s actions in support of the implementation of Scotland’s 1999 anti-drugs strategy ‘Tackling Drugs in Scotland: Action in Partnership’.

The strategy ‘Tackling Substance Misuse in Wales: a Partnership Approach’ was launched in May 2000. The Welsh strategy is implemented by the 5 Drug and Alcohol Action Teams (DAATs) in Wales. Each DAAT has reviewed the particular problems and needs of it’s area and is developing a local strategy to dovetail with that for Wales as a whole.

In the UK, Drug Action Teams (DATs) are the key to delivery of the anti-drugs strategy at local level, taking a strategic view of their areas drugs problems, and thus ensuring a co-ordinated response.

See also sections 2 and 3 above.

Synthetic description of major national strategies in demand reduction and new developments

This section takes up from where section 1.1 leaves off. The United Kingdom Anti Drugs Co-ordination Unit launched its third annual plan.

The strategy centres on 4 main key areas being young people, communities, treatment and availability.

Progress is being made in relation to all targets for 2002:
- There has been an expansion and improvement of drug education in schools.
- 16% more people presented for treatment in the six-month period of April – September 2000 compared to the six-month period of April-September 1998.
- All prisons now provide Counselling, Assessment, Referral, Advice and Throughcare (CARAT) services.
- The number of rehabilitation programmes in prisons has doubled since 1997.
- Drug Testing and Treatment Orders (DTTO’s), an alternative to custody, have been available to the courts in England and Wales.
- We are seizing more Class A drugs, increasing the amount of assets we confiscate from drug traffickers and increasing the number of drug trafficking; and
- Assets seized from drug traffickers in the UK are channelled back into anti-drug activity in support of the strategy.

Source: (United Kingdom Anti-Drugs Co-ordinator’s Annual report 2000/01)

8.2 Approaches and new developments

8.2(a) New and Innovative approaches

The integrated young people’s substance misuse plan – an integrated approach to substance misuse services - is intended to promote effective strategic planning at local level in line with the Government’s national priorities. It is designed to ensure that services respond to people’s needs in an effective and immediate way.
8.2(b) Socio-cultural developments relevant to demand reduction

New Deal for Communities is a key programme in the Government's strategy to tackle multiple deprivations in the most deprived neighbourhoods in the country, giving some of our poorest communities the resources to tackle their problems in an intensive and co-ordinated way.

8.2(c) Developments in public opinion

See section 1.3 above.

8.2(d) New research findings

See section 1 above.

8.2(e) Specific events during the reporting year

The Advisory Council on the Misuse of Drugs (2000) published ‘Reducing Drug Related Deaths’. The report highlights the highest levels of deaths recorded due to drug misuse in this country. The report outlines a range of actions to reduce these deaths.

As noted above in section 1.2, in June 2001 the Government passed an amendment to Section 8(d) of the Misuse of Drugs Act 1971 whereby premises owners can now be prosecuted for allowing the use of any controlled drug on their premises. Previously liability with regard to use was limited to permitting the smoking of cannabis or prepared opium. The change in the law has not yet come into force. Before it is enacted the Home Office will provide guidance for law enforcement agencies.

8.2(f) Dissemination of information on demand reduction among professionals (network, Intranet, etc)


9 INTERVENTION AREAS

9.1 Prevention

9.1 Description of news developments in prevention strategies.

As noted in section 2 above, the Drug Prevention Advisory Service (DPAS) within the Home Office was set up to strengthen society’s resistance to drugs by supporting the delivery of all 4 aims of the government’s anti-drug strategy, ‘Tackling Drugs to Build a Better Britain’, through work at national, regional and local levels. At a local level they provide support for the Drug Action Teams (DATs). These are local, multi-agency coordinating groups/bodies charged with implementation of the national strategy. They are headed up by a Chair and most have a co-ordinator. DRGs (Drug Reference Groups) are made up of various local professionals who advise DATs on policy and practice. Scotland, Wales and Northern Ireland have similar but separate strategies and local coordinating groups. The Welsh Drug and Alcohol Unit functioned until May 2001 to provide advice and practical support for implementation of the Substance Misuse in Wales strategy (see earlier entry) and produced a Strategic Prevention Action Plan for Drugs and Alcohol in Wales.
The Health Advisory Service has established a framework of 4 tiers of intervention/care. In terms of education and prevention Tiers 1 and 2 are most relevant.

Tier 1 – Frontline of service delivery. Primary and direct access services. Concerning continuity of care, identification and screening of risks, improvement and maintenance of health and educational achievement. These include general practitioners, teachers, voluntary agencies, social services, school medical services, Police and nurses in primary care.

Tier 2 – Frontline of specialist services. Youth-oriented services provided by individual practitioners who have some specialist knowledge of drugs and alcohol and of young people.

Tier 3 – Interventions offered by specialist Agencies in which staff work together in teams. The agencies involved will be generally youth oriented specialist addiction services that have the capacity to work with child and adolescent mental health and other specialist youth services.

Tier 4 – Very specialised care and interventions. This tier provides for intervention with individuals who have highly specific and complex problems that require considerable resources (HAS, 2001).

The Health Development Agency (HDA), through it’s ‘Evidence Base’ database, aims to provide access to the best available information on what works to improve health and reduce health inequalities through the internet http://www.hda-online.org.uk/. The resource is aimed at a wide range of practitioners and researchers engaged in public health work. Evidence Base is still in development, however the catalogue has been divided into sections including, Level of intervention, Target population, Health behaviours, Burden of disease and disability and Approaches to the intervention. Within Target groups, two main headings are Infants and Children and Young People, while within Health Behaviours Drugs and Alcohol is a category (Health Development Agency, 2001).

9.1.1 Infancy and Family

9.1.1(a) Intervention in different fields

Sure Start is a £452 million government initiative, which aims to work with parents and children to promote the physical, intellectual and social development of pre-school children, particularly those who are disadvantaged. The programme links with other government initiatives and works in partnership with parents and professionals from the voluntary and statutory sectors to improve the life chances of children under 4 in areas of need by improving access to health, family and educational services. The aim is to have at least 250 projects established in England by 2002.

Sure Start Plus is designed to support young parents back into education and employment. This is a three-year pilot programme, which commenced in April 2001 and covers 20 Local Authorities.

The Teenage Pregnancy Unit (TPU) is a cross-departmental unit set up to connect government action on unplanned pregnancy in young girls/women and to oversee the implementation of the strategy. The strategy aims to reduce risk of long-term social exclusion and poverty resulting from teenage pregnancy. All Local Authorities have a teenage pregnancy co-ordinator with local responsibility for joining services and developing local strategies. Funding of £11.5 million is available for 2001-2002.

The Scottish Executive has set up the Changing Children’s Services Fund to tackle child poverty and deprivation. It is designed to support integrated services and other new approaches for the most vulnerable children and young people. Of the total of £100 million, available from 2002, £18 million has been earmarked for support of children and families affected by drug abuse and is available in 2001 (Scottish Executive 2001).

The groups/individuals who these initiatives are aimed at are considered to be vulnerable to substance misuse and although these initiatives are part of a wider context they should have significance in relation to young people taking up drug use.
9.1.1(b) Interventions in crèche/kindergarten and other specific interventions

See section 9.1.1(a) above

9.1.1(c) Statistics and evaluation results

See section 9.1.1(a) above, because these are new projects as yet there are no statistics or evaluation results available.

9.1.1(d) Specific training

9.1.2 School Programmes

9.1.2(a) Mandatory, recommended or voluntary at different school levels

The role of schools is integral in delivering the government’s 10-Year strategy, ‘Tackling Drugs to Build a Better Britain’ (HMSO 1998). They teach a comprehensive drug education program to children and young people, making drug education an element within the personal, social and health education (PSHE) curriculum and reducing exclusions arising from drug-related incidents (Alcohol and Drug Education and Prevention Team, 2001). Drug education also has an important role in the implementation of the government’s public health strategy, to improve health and reduce health inequalities, ‘with particular focus on ...issues such as drugs....’ (Department of Health, 1999).

The National Curriculum document, states that the school curriculum should aim to provide opportunities for all pupils to learn and achieve. In terms of drug and alcohol education it should ‘develop (pupils’) physical skills and encourage them to recognize the importance of pursuing a healthy lifestyle and keeping themselves and others safe...’ (Drug and Alcohol Education and Prevention Team, 2001).

The Connexions Service, established in April 2001, is a new approach to guiding and supporting young people through their teenage years and in their transition to adulthood and working life. It is designed to support and encourage young people to remain in or return to education and training during their teenage years. One of the key barriers to learning it seeks to address is drug misuse. This service is primarily delivered through a network of personal advisers who coordinate with specialist support services (Drugs Prevention Advisory Service, 2000). Personal Advisers undergo an intensive 6 month training period. The first 16 services have been established with the remaining 31 to be established from April 2002. The Connexions Service will also be inspected by OFSTED for policies and practice in drug education and management of drug related incidents.

In Wales, it is planned to publish new guidance on substance misuse education for schools, youth workers and other organisations who offer educational opportunities to young people in 2002.

In Northern Ireland, the recruitment of two full-time officers to each of the five Education and Library Boards has strengthened the focus on drug issues in education. They will work on developing drug education programmes within schools and will also provide training for teachers, parents and governors (United Kingdom Anti Drugs Co-ordination Unit (UKADCU), 2001).

All schools in Scotland are expected to provide a programme of drug education for all pupils by 2002. Good progress is being made towards this with reported statistics for 2000/2001 being that 97% of Scottish schools now provide drug education.
As part of the Scottish Executive’s Changing Children’s Services Fund drugs programme (£18 million) mentioned above, £3 million is separated for drug education initiatives, mainly within schools (Scottish Executive, 2001).

9.1.2(b) General (health promotion, life skills) or specific (directed to high risk groups) and types of approaches

The National Healthy Schools Standard (NHSS) forms a key part of a programme led by the Department for Education and Skills (DfES) and the Department of Health (DH), the National Healthy Schools Programme. With the support of other agencies a healthy school is in a key position to improve children’s health and educational achievements. Drug, alcohol and tobacco education is a key theme in the standard. The NHSS also provides an accreditation process for education and health partnerships. The target is for all Local Education Authorities (LEAs) to be involved in an accredited Local Education and Local Health Authority partnership by March 2002. Currently there are 101 accredited partnerships (more than half).

The Department of Health Drug Prevention Projects Programme managed by the Bradford Health Authority has over 180 drug (misuse) prevention projects associated with it. The programme is charged with providing or brokering support for the projects as well as putting in place central monitoring and national evaluation processes. There are two categories of projects: Health Action Zone (HAZ) Pump Priming Drug (Misuse) Prevention Projects for Vulnerable Young People (described in 9.1.3 Youth Programmes Outside Schools); and Primary School/Primary Care Health Links Projects operating within the Healthy Schools Standard.

9.1.2(c) Involvement of: Teacher, parent, community

The Primary School/Primary Care Health Links Projects operating within the Healthy Schools Standard aim to establish links between primary and community health care professionals and primary schools. This project is designed to support teachers in delivering health education with the National Healthy Schools Programme including substance misuse issues.

The Department for Education and Skills (DfES) announced £1m in November 2000 to develop a Drug, Alcohol and Tobacco Education training package with further funding available in 2002-2003 and 2003-2004. The package also aims to support teachers, PSHE educators and LEA School Drug Advisers and other members of the school community including parents, governors and non-teaching staff.

Further £5 million in funding from the DfES for School Drug Advisers who give teachers and schools guidance on drug education, while £7.5 million has been provided for LEAs and individual schools to use in drug, alcohol and tobacco education initiatives.

9.1.2(d) Guidelines for school policy

National Curriculum guidelines on drug education indicate where content should be taught and what young people should be taught in each age group. The set of three documents produced by SCODA (now DrugScope) give schools guidance in establishing drug related policy in dealing with incidents (SCODA, 1999a), establishing quality standards in drug education (SCODA, 1999b) and in selecting drug education materials, (SCODA / The Drug Education Forum, 1998).

In June 2000, as part of the remit of the School drug Safety Team (SDST), all schools were provided with Guidelines for the Management of Incidents of Drug Misuse in Schools. Schools are now expected to have written procedures for dealing with any incidents by 2002. The SDST also produced a final report which provides a useful overview of drug education in schools and
contains 35 recommendations which impact on the curriculum, management and co-ordination within the school, quality assurance, teacher education and multi-agency training. Scottish Ministers accepted the recommendations in full and have made £1m available annually over the next three years to assist implementation.

9.1.2(e) Specific research results, statistics and evaluation results

The Office for Standards in Education (OFSTED) monitor schools’ policies and practice in drug education and management of drug related incidents as part of regular programme of inspections (OFSTED, 2000).

A recent Ofsted report on a survey of drug, alcohol and tobacco education in 1,500 schools showed a marked improvement since 1997. Almost all secondary (93%) and three quarters of primary schools now have drug, alcohol and tobacco education policies.

9.1.3 Youth Programmes outside schools

9.1.3(a) Types, settings of activities

In line with the government’s policy of reducing health inequalities and reducing social exclusion, youth programmes and interventions outside schools target children and young people who may be vulnerable to drug use. These include, young offenders, the homeless, those children looked after by social services and school excludes and truants. There are a large number of local drug education programmes and interventions that focus on these young people and their parents and carers. The programmes range from peer education to diversionary activities, with funding from a variety of sources within the voluntary and statutory sectors.

HAZ Pump Priming Drug Misuse Prevention Projects for Vulnerable Young People consists of 130 projects and initiative in the 26 HAZs. They are multi agency in nature and cover a wide spectrum of vulnerable young people thought to be a risk of misusing drugs. HAZs are multi agency partnerships located in some of the most deprived areas in England and their aim is to tackle health inequalities through health and social care modernisation programmes (Department of Health, 2001a).

The Confiscated Assets Fund channels money from assets seized from drug traffickers back into anti-drugs activities supporting the government’s drug strategy. An example includes Positive Futures, an initiative with Sport England, the Youth Justice Board and Home Office that aims to use sport to reduce antisocial behaviour, crime and drug use among 10-16 year olds. While the Children and Young Peoples Fund (£450 million) aims to help children aged 5-13 years, before they reach a crisis point (UKADCU, 2001).

In Northern Ireland the full-time officers employed by the Education and Library Board will also work with youth clubs to develop drug education programmes and provide training for youth leaders as well as teachers (UKADCU, 2001).

The Northern Ireland (NI) Health Promotion Agency and NI Drugs Campaign jointly host a Drugs Website [http://www.healthpromotionagency.org.uk/](http://www.healthpromotionagency.org.uk/). The NI Drugs Campaign produces a series of posters designed for display in pubs and clubs throughout Northern Ireland. There is also a drug leaflet available.

The Scottish Executive’s Drugs Action Plan, initially published in May 2000, has announced extra funding to commence from 2001/02 for three financial years. As part of this funding an extra £21 million for children, young people and families will target key areas of work with young people (UKADCU, 2001).
Lloyds TSB Foundation for Scotland has allocated £1.5 million over three years (1999-2001) to the Partnership Drugs Initiative. This is a strategic funding programme for voluntary sector organizations to support development of services for children and young people, which promote effective prevention of drug misuse. The funding is in partnership with the Scottish Executive, DATs and other interested parties. Applications for funding are made through local DATs (Lloyds TSB Partnership Drugs Initiative, 2001).

9.1.3(b) Peer-to-peer approaches

The CASCADE programme was established in 1992 and is an example of peer education. The organisation trains and supports young people (up to 25) to work directly with other young people, on the issue of drug and substance use and misuse. It has recently developed into a national programme, running the DfES Millennium Volunteers Programme from October 2000 until November 2003. Throughout the life of the programme 240 young people (aged 16-24 years) will be ‘recruited’, trained and supported as Millennium Volunteers. They will be working in four Regional projects as credible and positive role models to challenge drug misuse and promote healthy lifestyles and safer communities.

9.1.3(c) Target groups

The Youth Justice Board’s Youth Offending Teams (YOTs) work to prevent re-offending by children and young people. Drug and alcohol abuse is one of the major factors that puts young people at risk of offending. Every YOT has a named drug worker; they assess young offenders for drug abuse and where appropriate, offer interventions to prevent it.

9.1.3(d) Specific research results, statistics and evaluation results

Youth services are inspected by OFSTED for provision of drug education. Those organisations inspected are required to produce an action plan in response to key issues for attention identified in the inspector’s report.

9.1.3(e) Specific training

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9.1.4 Community Programmes

9.1.4(a) Drug Specific/drug non-specific

There are a large number of community groups working locally to address drug issues and they can be divided into (i) those generic community groups which provide advice and support to the community on a range of issues including drugs and (ii) those drug specific groups which focus on providing support for those affected by drug misuse and deliver drug education and prevention amongst other activities. There is currently no central source of information about the range of community initiatives that are taking place. However, DrugScope is currently developing its contacts with community groups and organisations that are working in this field.

DrugScope is currently administering two grant schemes, which are aimed at enabling individuals and community and voluntary organisations to address drugs issues. The grants schemes are the Community Action on Drugs Grants scheme: 45 local community groups have been supported with grants of between £2,000 and £15,000 and DrugScope Millennium Awards: Launched in May 2001, this scheme will award grants of between £1000 and £3500 to individuals and small groups who wish to address drug issues within their community.

9.1.4(b) Cities/Rural area
For the community Action on Drugs grants scheme 256 applications were received requesting a total of £2.4m from across England, which indicates the amount of activity taking place. A broad spread of projects operating in both cities and rural areas applied for funding. Successful applications can be split into 13 from rural areas and 32 from cities.

9.1.4(c) Cooperation Structures

The Drugs Prevention Advisory Service which is based in all 9 English regions as well as the 150 Drug Action Team coordinators are the main points for local knowledge and expertise about activity within each community which is addressing drugs. Funding is being allocated to each of the Drug Action Teams to enable them to connect more with local community groups.

9.1.4(d) Statistics and evaluation results

There is little evidence currently about what works in the community setting in relation to addressing drug issues. As a result of the evaluation reports being requested from grant recipients for both schemes, DrugScope hopes to build up evidence of what works and develop some models of best practice.

9.1.4(e) Specific training

Community groups have a variety of training needs and access training in areas including: basic drugs awareness, setting up and managing support groups, fundraising, overdose prevention, therapeutic interventions etc.

9.1.5 Telephone Help-lines

9.1.5(a) Interventions at national, regional and local levels

On a national level, ‘The National Drugs Help-line’ operates a 24-hour help line service, free of charge. Out of office hours, trained volunteers staff the phones. You can also submit a question through e-mail and receive a reply in 1 working day.

*Release* also provide a 24 hour drug help line. They specialise in free legal advice to callers relating to drug offences, drugs in the work place etc.

There are numerous regional help lines, which are run by local drug agencies and are often more specialised. For example CITA (Council for Involuntary Tranquilliser Addiction) run a help line based in Liverpool. Similarly The Pontefract Drug & Solvent Help line operates in Yorkshire. Community based drug help lines are less likely to be 24 hour and are not free phone numbers in most cases.

9.1.5(b) Statistics and evaluation results

Between April 2000 - March 2001, National Drugs Help-line received 275,000 calls from all over the UK [there were fewer calls to the help-line in 2000/2001 than in the previous year, but this is a function of promotion rather than other factors] providing information and advice to users, and their family & friends. They have evaluated the service they provide and claim that 99% of enquiries can be answered straight away over the phone, indicating a high standard of service being provided.
Around 50% of the calls taken by the help-line are from people concerned about the drug use of others. 52% came from men and 48% from women. Overall, the most common drug of concern was cannabis followed by heroin.

The Release help line took 350,000 calls last year.

9.1.5(c) Specific training

9.1.6 Mass media campaigns

9.1.6(a) Types and characteristics of mass media campaigns (TV, radio, posters...)

Mass media campaigns, for the purposes of demand reduction, have had no place in the UK’s communications strategies on drugs in 2000, either from the Government or the independent sector.

Communications on drugs have instead been centered on political debates around, amongst other things, community action and law reform (see section 1.3 above).

Any campaign work has focused on a) harm reduction (for example, a campaign to reduce the risks of blood-borne disease infection targeted at particular groups and not visible to a mass audience) and b) enforcement (for example, a poster campaign to encourage people to phone police with information on drug dealers).

The UK seems unwilling to embark on mass media demand reduction campaigns, as the use of such techniques remains widely discredited amongst drugs professionals. This is after several large-scale mass media drug prevention campaigns run in the 1980s, including the UK’s Anti Heroin Campaign ‘Heroin Screws You Up’, were widely criticised. A number of UK Government departments (including the Department of Health and the Home Office) are currently considering the development of communications initiatives covering different aspects of the drugs problem. It seems likely that future drugs campaigns will be aimed at closely and well-researched target groups and will transmit sensitive and relevant messages in appropriate language.

9.1.6(b) Cooperation with mass media (costs and cost-sharing with media)

See section 9.1.6(a) above.

9.1.6(c) Statistics and evaluation results

See section 9.1.6(a) above.

9.1.6(d) Specific training

See section 9.1.6(a) above.

9.1.7 Internet

9.1.7(a) Use of internet for:

*Prevention*

One of the intervention methods used in drug websites are ‘facts files’ about drugs, their effects and the potential risks involved in using them. This type of basic standard education is a feature
of most drug websites. The use of Frequently Asked Questions (FAQ) and Question and Answer (Q&A) sections is also very widespread. It is also common for sites have links to other relevant sites in order to gain additional perhaps more specialised or in depth information.

There are a host of sites specifically targeted at young people. For example the National Drug Help-line have recently launched a new site aimed at 14-16 year olds www.D-2K.co.uk. It is an interactive website which incorporates ‘fact files’, free CD-ROMs & publications, ‘chat rooms’ facilitating debate on drug issues and contact details of local drug agencies who work specifically with young people. These are generally done in a magazine style and often feature games & quizzes also.

Dissemination of prevention know-how.
The government will launch www.drugs.gov.uk on 19th October 2001 as a resource for a wide range of professionals. It will also have links to individual DAT websites where available.

Currently a Department of Health site features ‘Drug Misuse Information’, a broad range of information including policy & health guidance, drug misuse statistics and evaluation of interventions and research. Also documents such as the UKADCU annual report are downloadable in PDF format, an effective method of disseminating large documents.

The Drug Misuse in Scotland site, www.drugmisuse.isdscotland.org, which is maintained by ISD Scotland on behalf of the Scottish Executive acts as a focal point for the dissemination of information in line with the Scottish Drug Misuse Information Strategy. Statistics and research findings from a variety of sources are presented on the site, as are key policy guidance at local, UK and European level and links to the latest questions and debates in the Scottish Parliament.

The Substance Misuse Intervention Branch at the National Assembly for Wales is developing a website which will go live in 2002.

The internet has proved a good means of disseminating educational resources to a range of professionals in different settings.

On the DrugScope site there is an online search called Resource Net providing reviews of teaching materials for drug education purposes and where to obtain them. There is also a service called LocateNet in which you can search for community based projects and national organisations online.

There are numerous websites for those working in schools and with young people. Generally these tend to cover not only drug education but other social issues as well such as sexual health and mental health. www.wiredforhealth.gov.uk is a collaboration between Department of Health and DfES, it is specifically for professionals in schools and provides teaching material for the key stages 1-4. Another site developed specifically for teachers is www.educari.com/SNADE. This offers specific drug education teaching materials & resources for special needs pupils.

9.1.7(b) Statistics and evaluation results

Online databases such as these are a valuable and popular online facility. The LocateNet service received an average of 4889 hits per month so far in 2001 (January – August 2001).

9.2 Reduction of drug related harm

9.2 Description of new developments in strategies aiming at prevention of drug related harm

‘Making Harm Reduction Work’ was a joint project of DrugScope, University of Kent and Exchange Campaigns to encourage the development and continuation of harm reduction
practices with injecting drug users, funded by the Department of Health. Eight English regional seminars were run free for drug services, commissioners, managers and practitioners to: enhance understanding of harm reduction; the achievements of harm reduction; consider how harm reduction can be improved; and to highlight specific examples of good practice. Specific topics included quality in needle exchange services, overdose prevention, blood borne viruses, and reducing initiation into injecting. The seminars were supported by a pack of briefings highlighting: harm reduction; QuADS standards on needle exchange; issues for commissioners of needle exchange; latest facts and figures, including blood borne viruses and needle exchange for under 18 year olds.

9.2.1 Outreach work

9.2.1(a) Outreach work
The series of free harm reduction regional seminars mentioned above was designed to improve the effectiveness of outreach and low threshold interventions with intravenous drug users.

9.2.1(b) Target Groups

‘Making Harm Reduction Work’ initiative funded by the Department of Health was aimed at specifically at increasing the uptake of hepatitis vaccination and reducing the number of new injectors by increasing resistance of current injectors to initiate others to injecting.

9.2.1(c) Synthetic description of actors and instruments

All those involved with drug treatment service delivery were targeted - including drug service commissioners and providers - to help develop the role of harm reduction in their services as well as increased peer involvement.

9.2.1(d) Statistics and evaluation results

Evaluation of the ‘Making Harm Reduction Work’ seminars elicited excellent overall feedback and there was a demand to re-run seminars. 64% of attendees found the information on the day to be very useful, 33% fairly useful. 76% of attendees said they would send colleagues to future events. The overall consensus was that the organisation at the seminars was friendly and professional.

9.2.1(e) Specific training

No specific training was available at the above seminars, but clear descriptions of how to use campaign materials in seminars was provided.

9.2.2 Low Threshold services

9.2.2(a) Organisational framework: structures (public service, NGO, cooperation schemes), task and special services

Needle exchange facilities include all outlets which provide sterile equipment to drug users free of charge including agency - and pharmacy - based schemes, Accident and Emergency, mobile and outreach schemes.

Other non-drug specific services such as homelessness projects, may provide low threshold interventions, a number of initiatives have been developed to encourage this role.

9.2.2(b) Target Groups
Include young people seeking advice, intravenous drug users and drug users among existing client groups.

9.2.2(c) Statistics and evaluation results

1,700,000 syringes were reported as being as distributed from 1700 sites in April 1997. (UK Syringe Exchange Survey, 1997).

9.2.2(d) Specific training

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9.2.3 Prevention of infectious diseases

9.2.3(a) Synthetic outline on organisation, strategies and actors

All Health Authority and Health Boards in England, Wales and Scotland provide Needle Exchange Service, but only one exists in Northern Ireland, recently opened.

Launch of the National Hepatitis C Resource Centre. The Centre represents a milestone for work on Hepatitis C in the UK. It will increase the information to patients, the voluntary and public sectors, carers and other members of the public.

The Substance Misuse Advisory Service (SMAS) have published standards to provide guidance as well as to act as an assessment or review tool for the development of commissioning practice.

The Department of Health published Hepatitis C guidance: working with drug users. It describes the hepatitis C virus, its consequences, the size of the problem and gives information about injecting and sharing and current public health measures. See section 1.2(c) above. It also sets out principles of prevention, current evidence base that should guide local prevention strategies, and also gives advice regarding specific approaches to the prevention of transmission. It defines the range of potential roles of those working in drug and other service structured on the basis of the worker’s level of interaction with the drug user and describes the resources that are available in this area.

9.2.3(b) Principal Interventions

i. Needle and syringe exchanges

1,700,000 syringes were reported as being as distributed from 1700 sites in April 1997. After adjustment – 2,300,000 from over 2000 sites in April and over 27 million annually. (UK Syringe Exchange Survey 1997)

ii. Safer sex/safer education

The first national strategy on sexual health and HIV services was published in July 2001, backed by an investment of £47.5 million to support a range of initiatives set out in the strategy.

The strategy will modernise and restructure services to meet patients’ needs, aiming to prevent the spread of sexually transmitted infections (STIs) and HIV and improve care and treatment for those who need it. The strategy also signals a new national information campaign to promote safe sex and prevent STIs and HIV. The National Assembly for Wales has published a strategic framework and action plan for promoting sexual health in Wales.
iii. Testing/vaccination
Testing for HIV and Hepatitis C should be available to all intravenous drug users in every Health Authority in England and Wales; this may involve a visit to the Genito Urinary Medicine clinic. This service is only available from 20% of drug services.

The Department of Health has made funding available for vaccination for hepatitis B. For more details see National Health Service Modernisation Fund circular (HSC 036/99).

iv. Treatment
Hepatitis C is most effectively treated with a combination of two drugs, interferon alpha and ribavirin (Shepherd, Waugh, and Hewitson 2000). This should be available to all drug users who meet treatment criteria. Treatment will not usually be available for: continuing injecting drug users and heavy drinkers; non-responders to monotherapy; decompensated cirrhosis (which is end stage liver disease where the patient will have Ascites (fluid in the abdomen) possibly swelling of the legs, jaundice and general failing of health with weakness, muscle wasting and weight loss; those with conditions for which the drugs are contra-indicated (see Department of Health full guidance for details), or who have to discontinue because they do not tolerate the drugs.

9.2.3(c) Providing equipment

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9.2.3(d) Statistics and evaluation results
The transmission of hepatitis B virus continues at comparatively high rates. Reports of acute hepatitis B infection have tripled. Exposure to hepatitis B core has declined in the early 1990’s but has levelled off since. Studies suggest that HCV prevalence is less than 40% among injecting drug users (Hope et al, 2001). Estimated incidence of HCV among recent initiatives (0-1 yrs) is low at 6%. Prevalence of HIV among injecting drug users in the UK is stable and low, needle exchanges and methadone prescribing have been effective in averting an HIV epidemic. Low HIV prevalence has been attributed to swift introduction of harm reduction interventions. (Hunt et al, 2001)

9.2.3(e) Specific training

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9.3 Treatments

9.3.1 Treatments and Health care at National Level

9.3.1(a) Services offered and their characteristics (typology, staffing, monitoring and other relevant aspects)

Drug Action Teams in England and Scotland and the Drug and Alcohol Action Teams in Wales are asked to report on their specialist treatment services that are designed to meet the needs of the adult population seeking treatment fro their drug problems. These services are divided into two broad categories; open access treatment; structured care, a separate category for assessment and care planning is now included.

Open access services include, advice and information, needle exchange facilities and assessment and care planning services. Structured care services include, prescribing interventions which include inpatient prescribing, community prescribing specialist services and GP-led prescribing services. Non-prescribing structured care include, care-planned counselling, structured day programmes and residential rehabilitation.
Young people’s services are requested to be comprehensive – multi-disciplinary, addressing a range of needs; competent – in working with both young people and drug misuse problems; child specific - provided separately from adult services.

Drug treatment is provided by both statutory and voluntary services.

9.3.1(b) Objectives: drug-free treatment, not drug-free treatments

See section 9.3.1(a) and section 12.2(a).

9.3.1(c) Criteria for Admission

Not usually stringent but there can be a long wait for some services. In Wales, referral pathways including criteria for 'admission' to tier 3 services are being implemented in some areas in an effort to resolve capacity problems.

9.3.1(d) Involvement of public health services and GPs

Drug treatment has to be provided by all Health Authorities in England and Wales and all National Health Service Boards in Scotland. General Practitioners are encouraged to provide prescriptions for drug users with specialist service involvement (shared care). Extra money was made available by the Department of Health in 2000 for developing shared care.

9.3.1(e) Co-ordination between public health services and other community drug services

Locally Drug Action Team Co-ordinators are responsible for drug services in their area. They hold pooled treatment budgets, overseen by the National Treatment Agency with funding from health (including social services) and the Home Office. The pooled budgets and NTA do not apply in Wales, Scotland or Northern Ireland.

9.3.1(f) Special services

New funding has been made available to support the implementation of an integrated local plan for young people’s substance misuse services (The Young People’s Substance Misuse Plan). All Drug Action Teams have to develop a demand reduction plan for young people.

The Good Practice Unit for Young People and Drug Misuse at DrugScope host a National Young People’s Drug Treatment Forum, which is a free event held quarterly. The current membership stands at 206. Along with that, DrugScope produce a free newsletter, which is circulated to professionals who work towards the provision of effective treatment services for young people who take drugs, from practitioners to strategists.

9.3.1(g) Financing

Drug treatment is financed locally with central Government money, which is used to develop drug treatment for both statutory and non-statutory organisations. This year the Government’s Comprehensive Spending Review (SR2000) allocated extra money for drug treatment.

9.3.1(h) Statistics and evaluation results

The Department of Health Statistical Bulletin (Department of Health 2001b), summarising information from the Regional Drug Misuse Databases (RDMD) for the six months ending March 2000, shows that heroin was reported as the main drug of use by 64% of users, methadone by 10% of users, cocaine by 6% of users, and amphetamines by 4% of users. Of patients reporting heroin as their main drug of use, 58% were injecting the drug. Of those reporting cocaine as their
main drug, 4% were injecting the drug and of those patients with amphetamines as their main problem drug, 44% were injecting the drug.

There are marked regional variations in the proportions of amphetamine users presenting to services (Department of Health 2000). The proportion of stimulant users who would need treatment is unknown. However, the scale of use and numbers of amphetamine injectors presenting to needle exchanges would suggest that there are many in need of treatment (Stimson et al. 1988).

In addition to those drug users who primarily misuse stimulants, a significant number of drug misusers entering treatment use stimulants in the context of multiple drug use. For example, in the NTORS study, although heroin was the most-used drug prior to entering treatment, more than half the subjects had used stimulants in the three months prior to treatment, and stimulants were the second most frequently used category of drugs (Gossop et al. 1998).

9.3.1(i) Specific training

The Department of Health have been developing and implementing a range of courses including a competency based training course operational from April 2001 for General Practitioners - RCGP Certificate in the Management of Drug Misuse in Primary Care.

9.3.2(j) Other national specifications

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9.3.2 Substitution and maintenance programmes

9.3.2(a) Organisation and delivery of substitution drugs

Drug Dependency Units, Community Drug Teams and general practitioners are paid by the National Health Service to administer substitution drugs.

9.3.2(b) Criteria for Admission

Opiate dependant persons may qualify. There are some dexamphetamine prescribing initiatives.

9.3.2(c) Mode of prescription

‘Drug Misuse and Dependence - Guidelines on Clinical Management’ (Department of Health, the Scottish Office Department of Health, Welsh Office and the department of Health and Social Services, Northern Ireland) recommend supervised consumption for the first three months, however this is not as widely implemented in England as in Scotland. Supervised consumption varies across Wales, but all areas are working towards total coverage. The usual practice in England is to collect the medication daily from pharmacies.

9.3.2(d) Objective (gradual detoxification, maintenance)

A full range of prescribing options are available from rapid detoxification to methadone maintenance.

9.3.2(e) Substitution drug/s, mode of application
Main substitution is methadone mixture of 1mg/ml but new initiatives have seen an increase in buphrenorphine (as Temgesic) prescribing. Some diamorphine prescribing and dexedrine available in some areas.

9.3.2(f) Psycho-social counselling (requirements and practice)

Counselling is an intervention that can be employed in all of the main treatment modalities described in this document. It is usually offered as part of a package of care that may also consist of prescribing, education and training, the management of physical and psychological health problems and of social and forensic issues. A number of theoretical approaches may be employed including brief interventions, cognitive-behavioural and motivational interviewing.

The Effectiveness Review (Task Force to Review Services for Drug Misusers 1996) identified three structured approaches to counselling: cognitive behavioural approaches; 12 step addiction counselling; other approaches including gestalt, family therapy.

9.3.2(g) Drug testing

A urine test shows the range of drugs that are being used and, unless specially requested, results from the laboratories are qualitative rather than quantitative. Urine tests are used prior to prescribing to ensure opiate use.

9.3.2(h) Diversion of substitution drugs

Supervised consumption with an appropriate professional provides the best guarantee that the drug is being taken as directed. Other methods for improving compliance include urine testing, daily pick up and installment prescribing.

9.3.2(i) Statistics

All Health Authorities and Health Boards in England, Wales and Scotland provide needle exchanges, the first needle exchange in Northern Ireland being opened in 2001. There are over 2000 needle exchange outlets in the UK, this includes needle and syringe exchanges, mobile exchanges and pharmacy-based activity. 1,700,000 syringes were reported as being distributed from 1,700 sites in April 1997. After adjustment –2,300,000 from over 2000 sites in April and over 27 million annually

9.3.2(k) Specific research results

Studies have shown a positive correlation between access to counselling and improved outcomes for methadone prescribing. Where this positive correlation exists, it is primarily due to the quality of the counselling offered and access to other services such as housing, employment and training opportunities (Kraft et al. 1997).

9.3.2(l) Evaluation results

There is a growing body of evidence that treatment works. Methadone well evaluated internationally.

9.4 After-care and re-integration

9.4(a) Organisation
Residential rehabilitation services have been pioneered and sustained mainly in the voluntary sector and by independent services on a non-for-profit basis. There are approximately 70 programmes operating in England with some 1200 beds available. There are three types of programmes, short-term residential rehabilitation for three months, long-term residential for up to six months plus or primary/secondary treatment split.

9.4(b) Accessibility for different target groups (after treatment, after prison, for long-term substitution clients)

Clients of residential rehabilitation programmes are either dependant drug users who have drug related problems and meet dependence criteria or drug users in recovery; this group is made up of individuals who have achieved a state of abstinence from their main problem drug. For prisons, see section 9.5 below.

9.4(c) Education and training

Most residential rehabilitation provide a structures programme with the basic following features: maintenance of abstinence form of illicit drugs in a controlled or semi controlled therapeutic environment; communal living with other users in recovery; emphasis on shared responsibility by peers and group counselling; relapse prevention-orientated counselling and support; individual support and promotion of education, training and vocational experiences; improved skills for activities of dealing living; housing advocacy and resettlement work and aftercare and support.

9.4(d) Employment

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9.4(e) Housing

It is difficult for drug users to access tenancy agreements with many local authorities, however there are a growing number of initiatives around the country that seek to address this problem.

9.4(f) Other national specifications

There has been a recent threat to residential services from Care Standards Act and the adoption of minimum standards – while improved quality is welcomed some are concerned that the changes are too great and may cause up to half to close down.

9.4(g) Statistics and evaluation results

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9.4(h) Specific training

A competency development framework is being developed for drug and alcohol workers, the National Occupational Standards.

9.5 Interventions in the criminal Justice system

9.5(a) Interventions

Drug interventions in the Criminal Justice system offer an effective means of putting offenders who are using illegal drugs in touch with appropriate services, to help them reduce their drug use, and to achieve consequential reductions in related criminal activity. A range of Government policies have been introduced in the Criminal Justice System that aim to identify drug misusing
offenders, particularly those using Class A drugs, earlier on in their drug using career and, help them access appropriate treatment and/or programmes of help.

At the point of arrest there are arrest referral schemes that use the point of arrest as a key opportunity to encourage problem drug users who are arrested to take up appropriate treatment or other effective programmes of help. See Section 4.2 above.

Drug Treatment and Testing Orders (DTTO) provide for a community sentence targeted at persistent offenders who have committed a large amount of crime to fund their drug misuse and who might otherwise be sent to prison. While subject to the Order, offenders are closely supervised for the duration and required to undertake an intensive treatment programme with mandatory testing. The court responsible for the Order will receive regular reports of the offender's progress and can decided to amend the Order or re-sentence the offender for the original offence.

The need of a majority of prisoners who have misused drugs will be met through the counselling, assessment, referral, advice and throughcare service (CARATs). CARATs is available in all prisons in England and Wales and is readily accessible to all prisoners. Prisoners who have been identified as having drug-related problems can be referred to CARATs by a member of staff or they can self refer. Referral may also be by outside bodies such as external drug agencies, the courts or probation.

CARATs provides a low threshold, low intensity, multi-disciplinary drug misuse intervention service which meets the needs of most prisoners with drug problems. CARAT workers create care plans based on prisoners' specific needs and ensure that links are made between the various departments within prisons including education, healthcare and sentence planning. CARATs workers can refer prisoners to detoxification, intensive treatment programmes and to external drug agencies on release.

Medical (detoxification, drug substitution)
In December 2000, the Prison Service introduced a new standard for clinical services for substance misusers. This ensures that good quality detoxification services are available in all local and remand prisons to a level at least comparable with that in the community and to a standard set by the Department of Health.

Drug-free programme
The Prison Service has introduced voluntary testing across the Service for all suitable prisoners and has a target of 28,000 prisoners on voluntary testing compacts by April 2002.

Self-help groups
Self-help groups exist in many prisons.

Relapse prevention
The clinician has a responsibility to ensure that the prisoner receives the correct dose and that appropriate efforts are taken to ensure that the drug is used appropriately. Clinicians also need to understand the crucial role of broader psychosocial interventions in achieving and maintaining abstinence. This approach involves multi-disciplinary team care.

HIV/Hepatitis prevention (needle and syringe exchange)
There are no needle exchange services within prisons. However testing for HIV is available. But a new initiative which will be rolled out nationally will introduce tablets for self-cleaning of needles and syringes

9.5(b) Drug testing
Drug Testing and Treatment Orders (DTTO) provide a means for sentencers to direct drug using offenders to drug treatment. It is a key Government initiative to combat drug-driven crime. The DTTO is recommended for high tariff offenders who have a propensity to misuse drugs. Requiring these offenders to undergo frequent mandatory drug tests, it is considered an alternative to custody. See section 1.2 above.

**Piloting of drug testing across the Criminal Justice System**

New drug testing powers were introduced by the Criminal Justice and Court Services Act 2000 to drug test persons (as outlined above in Section 9.5(a)). The tests are limited to specified Class A drugs (heroin and crack/cocaine) as research has shown that these are the drugs most commonly associated with drug-related crime. Drug testing in the pilot will be undertaken using oral fluids.

**Mandatory drug testing**

In each prison mandatory drug tests are carried out on a random proportion of either 5% or 10% of prisoners per month, depending upon the size of the prison population. The percentage of positive results from the random MDT programme has fallen from 24.4% in 1996/97 to 12.4% in 2000/01.

**Voluntary Drug Testing**

Voluntary drug testing allows prisoners to make a commitment to remain drug free and undergo drug testing more frequently than under MDT; typically at least 18 times per year. Voluntary testing has been introduced across the Service for all suitable prisoners and a target of 28,000 prisoners on voluntary testing compacts by 1 April 2002 is in place.

9.5(c) **Release: referral to treatment, aftercare and probation**

The needs of the majority of prisoners who have misused drugs will be met through the integrated counselling, assessment, referral, advice and throughcare service (CARATS) within and across the prison service.

9.5(d) **Statistics and evaluation results**

A Home Office research study involving the urine testing of arrestees found that 61% had taken at least one illegal drug, with one in five testing positive for heroin, and one in ten for crack/cocaine. See sections 1.2 and 4.2.

9.5(e) **Specific training**

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9.6 **Specific targets and settings**

9.6(a) **Description of new trends and development**

The National Treatment Agency was set up in April 2001. It will play a leading role in the setting and monitoring of standards in the substance misuse treatment field in England. See section 1.2.

The number of drug misusers presenting for drug treatment in England has increased steadily from September 1998 to September 2000, an increase of 16%. The government aim to increase numbers by 100% between 1998 and 2008.

9.6(b) **Specific services and intervention**


The Association of Chief Police Officers trained police officers in drug recognition techniques and field impairment testing to help them confirm that driving has been impaired through drugs. A report on the research that informed the training has been published by the Department for Transport, Local Government and the Regions.

As part of strengthening the Prison’s Services response to attempts to smuggle drugs into prisons, 2,577 visitors were banned and 651 prisoners were placed on closed visits.

9.6(c) Statistics and evaluation results

9.6(d) Specific training for special target groups

Parenting skills for drug using parents: pilot parenting classes are about to be offered to drug using parents in six sites across England.

Policy guidance has been written by Alcohol Concern and DrugScope to develop workplace drug and alcohol policies and the National Assembly for Wales plan to publish workplace policy guidance in the near future.

A drugs and black and ethnic minority draft strategy has been developed for a government department which will undergo consultation and implementation.

10. QUALITY ASSURANCE

10.1 Quality Assurance procedures

10.1(a) Formal requirements for quality assurance

By March 2002, all drug and alcohol services in England will be expected to meet the Quality Standards in Alcohol and Drug Treatment (QuADS), published by Alcohol Concern and DrugScope (1999). To help services achieve this target DrugScope have developed a consultancy service, which local co-ordinators of Drug Action Teams can commission.

Drug education in schools should be delivered according to SCODA (1999b) standards.

Until 2002 there are no formal requirements for drug treatment but this is currently being developed. All schools should develop drug policies according to SCODA (1999a) guidance.

10.1(b) Criteria and instruments applied in quality assurance

Drug treatment services should be commissioned in line with SMAS (1999) ‘Commissioning Standards for Drug and Alcohol Treatment and Care’.

Drug treatment services should be provided in line with Alcohol Concern and DrugScope (1999) ‘Quality Standards in Alcohol and Drug Treatment (QuADS)’.

National Occupation Standards for drug treatment practitioners, specialist and mainstream are currently being developed.

Schools should develop drug education to SCODA (1999b) standards and policies to SCODA (1999a) guidance.
10.2 Treatment and prevention evaluation

10.2(a) Evaluation policy

Most treatment evaluation is conducted internally by the services involved. The National Treatment Outcome Research Study is a longitudinal study that is still ongoing. Further treatment research is funded by charitable trusts, universities, pharmaceutical companies, and government bodies as appropriate. All new government initiatives in treatment and prevention are evaluated.

Projects established through the Drug & Alcohol Treatment Fund, a Welsh initiative to develop substance misuse treatment services, particularly for young people, are subject to ongoing independent evaluation.

10.2(b) Requirements for evaluation

10.2(c) Use of evaluation results

10.2(d) Evaluation training

10.3 Research

10.3(a) Demand reduction research projects: objectives, structures and organisation

The Rough Sleepers Unit (RSU) have funded nine projects across the country to provide tailored drug treatment packages to entrenched rough sleepers with substance misuse problems. These projects have been funded under the Drug and Alcohol Specific Grants (DASG) scheme. Since March 2001, DrugScope have been carrying out an evaluation of the Rough Sleepers DASG projects for the RSU. The evaluation focuses on project implementation and the quality of interventions being provided to the rough sleepers.

Evaluation of Tier 4 pilot services for young people has been set up in 4 areas in England: Essex, Derbyshire, Staffordshire and Manchester. Tier 4 services provide very specialised and intensive forms of interventions for young drug users with complex care needs. Services may include specialist residential services and mental health teams.

DrugScope's role in the evaluation is to carry out process evaluation; evaluating the implementation of each project against its service specification and own aims and objectives, impact evaluation; client throughput and client initial outcome and advice and support on policy and procedure development. The project outputs are comparative and process analysis of each site, advice and consultation service to the sites, professional publication of models of good practice and evaluation report to be published in a professional journal.

The Drug and Alcohol Education and Prevention Team is a joint project between Alcohol concern and DrugScope. The team support the implementation of drug policy and practice in schools and the youth service.

10.3(b) Relations between research and drug services
‘Drug and Alcohol Findings’ is produced to improve Britain’s response to drug and alcohol problems by disseminating practice-relevant evaluation findings on the effectiveness of interventions including prevention, community safety and treatment.

10.3(c) Funding of demand reduction research
Funding grants for demand reduction research are mainly available from Government departments such as the Department of Health, the Home Office and the Department of Education and Skills.

10.3(d) Training in demand reduction research

10.4 Training for professionals

10.4(a) Training in quality assurance and evaluation: type and structures
Competency based training has been made available to new practitioners in drug treatment provision. DrugScope have developed a service to help service managers improve the quality of their work aiming to become compliant with QuADS (1999).

10.4(b) University training, non-university vocational training, in-service training
STRADA is a partnership between The University of Glasgow’s Centre for Drug Misuse Research and DrugScope. STRADA was launched in August 2001. The aims are to ensure that the competence of the professional staff addressing alcohol and drug misuse is raised throughout Scotland and that interventions to address alcohol and drug misuse are based on the evidence of what works.

10.4(c) Statistics and evaluation results
Initial evaluation of the competence based training available in England is very positive, the STRADA programme is due to be rolled out in 2001 and as such evaluation results are not yet available.
PART 4: KEY ISSUES

11. POLYDRUG USE: DRUG, SET AND SETTING

Definition in terms of substances and combinations considered

DrugScope (2001a) defines polydrug use as 'the use of more than one drug, often with the intention of enhancing or countering the effects of another drug', adding that polydrug use may 'simply occur because the user's preferred drug is unavailable (or too expensive) at the time.'

The frequency with which different substances are used varies. Some combinations of drugs are used on a daily basis, concurrently (for example heroin and crack cocaine mixed together and injected), whilst others are used less frequently or consecutively (such as alcohol before a club at the weekend, stimulants at the club, and cannabis after it). Those who use ecstasy may be unaware that they can be defined as polydrug users because of the other substances (such as amphetamines) commonly substituted and sold as ecstasy.

Polydrug use includes the use of licit drugs, especially alcohol, but also 'high energy' drinks (such as Red Bull, which contains taurine and the stimulant caffeine), prescribed drugs such as benzodiazepines and methadone (obtained legitimately or on the illicit market), and over-the-counter medicines such as cyclizine (eg Valoid, an anti-nausea / travel sickness preparation, used to give a 'buzz' to methadone), ProPlus (an analgesic 'pep pill', high in caffeine) and medicines containing codeine (an opiate).

Some drug users in treatment are prescribed more than one drug: methadone and benzodiazepines are commonly prescribed together for dependent heroin users, for example, and some private doctors prescribe additional substances for their drug-dependent patients, such as dexamphetamine sulphate (Dexedrine) and flunitrazepam (Rohypnol) (Fountain et al, 1996).

11.1 Patterns and user groups

11.1(a) Combinations and effects sought

Combinations

The most common combinations of substances currently used by polydrug users in the UK fall into two very broad groups:

1. Two or more of: heroin, methadone, alcohol, benzodiazepines, cocaine. Heroin and cocaine used concurrently are known as 'speedballs', 'snowballs', or 'goofballs'.

2. Two or more of: ecstasy (or substances sold as ecstasy), cocaine powder, cannabis, alcohol, amphetamine, amyl nitrite ('poppers'), GHB and, to a lesser extent, hallucinogens (LSD, 'magic mushrooms,' ketamine).

The availability of substances obviously plays a role in the combinations of drugs used. For example, a study of young people by Boys et al (2000) reveals that if those whose preferred stimulant was ecstasy could not obtain it, amphetamines were substituted, and vice versa. Similarly, if heroin is unavailable, those dependent on it have been reported to mimic its effects with a combination of methadone, benzodiazepines and alcohol, or methadone benzodiazepines and a stimulant (Fountain et al, 1999). It should be stressed here that opiate addicts do not generally use methadone (particularly the oral formulations) for its pleasurable effects. Rather, its main roles in polydrug-using repertoires are a cheap and safe medication to reduce withdrawal symptoms and a base for drug cocktails (Dale and Jones 1992; Haw 1993; Fountain et al, 2000).

Effects sought

The effects are sought by polydrug users can be categorised as:
To enhance the effect of another substance - for example, methadone and dexamphetamine sulphate; benzodiazepines and alcohol; benzodiazepines and methadone; ecstasy and a stimulant or hallucinogenic.

To balance the effect of another substance - for example, cocaine and heroin; any stimulant and alcohol.

To terminate an effect of another substance - for example, benzodiazepines, cannabis or alcohol to counteract stimulant-induced insomnia or hyperactivity.

To create a distinct effect - for example, cyclizine and methadone for a 'buzz'; sildenafil citrate (Viagra) and ecstasy to stimulate and enhance sexual activity.

Some polydrug users have a clear and accurate idea of how different drugs combine to give the desired effect. For example, cocaine and heroin are injected together because the cocaine gives the desired 'rush' or 'flash,' and the heroin helps deal with the depressive mood which follows the relatively short effect of the cocaine. Other combinations appear less rational: for example, the effect of the popular combination of methadone and benzodiazepines is explained by users as the benzodiazepine boosting the effect of methadone, although there is little clinical evidence to support this belief (Strang et al, 1993). A final example is the brief popularity enjoyed by ecstasy and fluoxetine (Prozac) in the late 1990s. Users of this combination variously believed that fluoxetine helped to counteract the damaging effects of ecstasy, ease the 'comedown,' or boosted serotonin levels to produce a greater 'high' from the ecstasy.

11.1(b) Historical perspective and new patterns

It is useful to divide current polydrug users in the UK into two very broad groups: those who are dependent on opiates or opioids (referred to as opiates throughout this document) and young 'clubbers' (aficionados of the dance music scene). These groups are examined separately in this section. In addition, of course, there are chaotic polydrug users (who use any drug available because of shortages in supply of some drugs, poverty, or because they are simply experimenting), and irregular polydrug users, who use additional drugs as a 'treat' outside their usual drug usage.

Combinations of drugs used are dependent on availability, fashion, and, where they include drugs prescribed to drug users in treatment, local prescribing practices (Whynes et al, 1989; Haw 1993; Fountain et al, 2000). Gossop, Marsden, Stewart and Treacy (2000), for example, note regional variations of patterns of drug use amongst 1075 drug users in treatment which can be explained by one or more of these factors, and this report cites several regional differences in the drugs used by clubbers. The intricacies of local and regional differences in drug use during the British heroin epidemic of the 1980s are examined by Pearson and Gilman (1994).

Opiate dependent polydrug users

In the UK, any study of heroin users reveals the high prevalence of polydrug use, whether or not the sample are receiving drug treatment. For example:

NTORS found that, of 1075 drug users at intake into drug treatment, the most common drug problem was long-term, high-dose heroin dependence often in conjunction with polydrug and/or alcohol problems (Gossop et al, 1998).

Of 561 drug service users in Liverpool and Manchester, only one-fifth were currently using one drug only (Big Issue in the North Trust, 1999).
Of 324 homeless drug users in London, 45% had used both heroin and crack cocaine in the last month and half of these had also used benzodiazepines (Fountain and Howes, 2001). The average number of drugs used in the last month was three to four.

Opiate dependent polydrug users: historical perspective

Opiate users have been shown to adjust the ingredients of their drug menus according to the availability of drugs on the market. The adjustment has been made by substituting the unavailable substance with another of the same type, such as one benzodiazepine with another (Fountain et al, 1999). The adjustment can also be a different type of drug, however: for example, in the 1970s, methylamphetamine (Methedrine) was voluntarily withdrawn by the manufacturer, and barbiturates became the favoured substitute, despite that Methedrine is a stimulant and barbiturates are a depressant.

At the end of the 1970s, the majority of clients seen by drug clinics and street agencies were polydrug users, primarily dependent on heroin (Mitcheson 1994). Power (1994) charts the drugs used by opiate dependent polydrug users in the 1970s and 1980s. In this period, a new range of pharmaceutical products began to be sold on the illicit market, following changes in the drug treatment of opiate users, which included the lower doses of heroin legitimately available.

The opiate dipipanone hydrochloride (Diconal, which at the time also contained cyclizine) was a favourite with polydrug injectors during the 1970s. Diconal virtually disappeared from the illicit market after restrictions were placed on prescribing and some drug users substituted dextromoramide (Palfium). Power also notes that in 1981, heroin and cocaine were being used together and named, as today, 'speedballs.'

Also in the 1970s and 1980s, the barbiturate Tuinal was used by 'speed freaks' to alleviate the stimulatory effects of amphetamine sulphate. Concern over barbiturate-related deaths led to a decrease in those receiving it on prescription and an increase in the prescribing of benzodiazepines, which became an integral part of the illicit drug user's repertoire. By the mid 1980s, Power reports that temazepam had become the drug of choice amongst some drug-using populations, especially in Scotland, where injecting temazepam was preferred to injecting heroin.

Power lists research in other areas of the UK, which show that, in the late 1980s, polydrug combinations (often as response to the unavailability of heroin) have variously centred around the pharmaceutical drugs cyclizine (Valoid), buprenorphine (Temgesic, an opiate), temazepam, methadone and dihydrocodeine tartrate (such as DF118).

Historically, then, opiate dependent polydrug users display an enthusiasm to experiment with different combinations of drugs, despite the lack of obvious benefit of combining some of them (such as methadone and benzodiazepines) and the 'apparently paradoxical interaction' of other combinations, such as barbiturates and amphetamines (Strang et al, 1993).

Opiate dependent polydrug users: new patterns

No recent data on new patterns of polydrug use amongst this group have been found since the introduction of crack cocaine into their drug-using repertoires in the early-mid 1990s: the most commonly used combinations remain methadone and benzodiazepines; methadone, benzodiazepines and alcohol; heroin and crack cocaine concurrently; and heroin and methadone.

Recent research (Sangster et al, forthcoming) suggests that the drug use of different Black and minority ethnic groups may vary, but little research has been conducted on this, particularly in terms of polydrug use.
Young, polydrug-using clubbers

Studies of drug-using clubbers in the UK have produced differing proportions of polydrug users. For example, Winstock\(^6\) found that the majority of ecstasy users in a sample of clubbers had used alcohol, amphetamines, cannabis and cocaine on the same night. However, these respondents were those who had responded to a questionnaire about their drug use in a club/dance magazine and may not be typical of all clubbers. Although Hammersely et al (1999) found that the entire sample of 209 clubbers in Glasgow who had used ecstasy at least once had done so in the context of polydrug use, Henderson (2000) found a far lower prevalence of polydrug users amongst her sample of clubbers in Liverpool.

Specific drugs or drug types are used at different stages of a clubbing episode. Popular pre-club drugs are alcohol, cannabis, ecstasy and cocaine, to 'get in the mood'; the main drugs used at a club whilst dancing are stimulants or hallucinogens, to increase and prolong energy levels and/or accentuate the effects from the music and lights; and post-club drugs include alcohol and cannabis, to aid relaxation, alleviate the 'comedown' (when the effects of stimulants wear off) and induce sleep. Henderson (2000) presents a menu of drugs used by her sample of 100 clubbers in Liverpool, with which Winstock et al (in press) concur in a presentation of results from a study of 1151 subjects accessed through the club/dance magazine Mixmag. Alcohol features largely in all the most common combinations:

The most popular pre-club drug cocktail is alcohol and cannabis. Also used are alcohol, cannabis and ecstasy; alcohol and ecstasy; and alcohol and cocaine.

Once in the club, the combinations are most commonly alcohol, cannabis and ecstasy. Alcohol with ecstasy and amphetamine with ecstasy are also used.

After-club combinations of drugs most often reported are alcohol and cannabis. Other combinations are cannabis and ecstasy; cannabis and cocaine; and alcohol, cannabis, cocaine and ecstasy.

Young polydrug-using clubbers: historical perspective

In the 1960s and 1970s, a distinctive youth culture became established in the UK, and there was extensive publicity on the drug use within it, especially amongst the student population (Plant, 1994).

It was noted above that opiate users have enthusiastically experimented with a range of drug combinations, and young clubbers also display this willingness to experiment, particularly with combinations including ecstasy. In the recent past (mid-1990s), they have included cough syrups, cold remedies and nasal decongestants (such as Vicks Sinex and Sudafed, which encourage the body to release a certain type of adrenaline) in their drug-using repertoires. These preparations were used in combination with ecstasy and amphetamine to increase the stimulant effect.

As described earlier, ecstasy and Sidenafil citrate (Viagra) were fashionable in the late 1990s, as was ecstasy and fluoxetine (Prozac).

Young polydrug-using clubbers: new patterns

The most recent British Crime Survey (Ramsey et al., 2001) indicates significant increase since 1994 in the numbers of 16-29 year olds in England and Wales who have ever used cocaine. Boys et al (2001b) discovered that cocaine powder was preferred over amphetamines and ecstasy because its effects were seen as less intense, easier to control, more short-lived and that the quality of cocaine was more consistent and predictable than that of ecstasy. Henderson

\(^6\) Personal correspondence, based on research and conference papers by Winstock et al, with papers in preparation or currently being considered for publication (see also Winstock et al, in press).
(2000) reports that an increase in cocaine use by clubbers she studied was also explained in terms of it being a healthy alternative to other drugs.

The inclusion of cocaine powder into the polydrug-using repertoires of young people is a cause for concern. Boys et al (2001b) suggest that young people's positive attitude to cocaine powder use (unlike their negative attitude towards crack cocaine) is a serious challenge to prevention and harm reduction initiatives, and that 'patterns of use may be developing that could give increased problems requiring health and social care interventions.' However, the young people interviewed by Boys et al did not think they would ever have sufficient money to use cocaine powder frequently enough to risk physical harm or psychological addiction.

Winstock et al (in press) report a high level of alcohol use amongst cocaine users and ecstasy users. In their study of young cocaine users, Boys et al (2001b) report a 'tight bond' between cocaine and alcohol. Some use cocaine to help manage the undesirable effects of alcohol, enabling them to drink more, whilst others use alcohol to moderate the effects of cocaine, helping them to relax and sleep.

Current regional trends are reported7 as the combination of ecstasy and so-called amphetamine ‘base’ (usually in the form of a paste) amongst clubbers in Scotland, who are also thought to be using more GHB with ecstasy. In the south of England, the combined use of ketamine and ecstasy by clubbers is thought to be increasing.

As noted above regarding the polydrug use of those dependent on opiates, recent research (Sangster et al, forthcoming) suggests that the drug use of different Black and minority ethnic groups may vary, but little research has been conducted on this, particularly in terms of polydrug use.

### 11.2 Health and social consequences

#### 11.2(a) Health consequences and negative effects

The health consequences of polydrug use may be due to single or multiple interactions between substances, and alcohol increases the effect. DrugScope (2001a) summarises these interactions, which are currently poorly understood: it is likely that drugs of a similar nature and action upon the body (that is, two or more depressants or two or more stimulants) will have an additive effect. However, mixing drugs which bring on opposite effects has more unpredictable consequences. The effects of mixing drugs - especially those of different types (that is, stimulants and depressants) - can also depend on factors such as the user's mood, individual reaction to each drug, the order in which the drugs are used, the quantity used, and the user's weight, gender and general health. If hallucinogens are involved, the user's mood, situational circumstances and personality play a greater role in the effect.

#### 11.2(b) Negative effects of common combinations of drugs

The following briefly describes the health risks of common combinations of substances (largely extracted from DrugScope 2001a). Obviously, the strength and specific effects of any combination is somewhat uncertain because of the unknown composition, purity of illicit substances.

**Depressants and alcohol**

Both alcohol and benzodiazepines are central nervous system (CNS) depressants, and work by enhancing inhibitory effects. A consequence of use is the depression of the CNS and respiratory system. Behavioural consequences include disinhibition, ataxia and accidents. Whilst it is

7 Response to questions from the author by researchers, commentators, and representatives of various drug treatment, prevention, education, and harm reduction agencies, throughout the UK, via personal communication.
difficult to overdose on benzodiazepines alone, the combination of a large dose of benzodiazepines and a large dose of alcohol could be fatal.

The effect of GHB (gamma-hydroxybutyrate or sodium oxybate, often sold as liquid ecstasy), an anaesthetic with sedative rather than painkilling effects, is enhanced by alcohol. The combination of the two substances leads to vomiting, increased aspiration, sedation, coma, and, in the extreme, respiratory arrest. In a recent study of 129 users of GHB, almost two-thirds had used the drug with alcohol and three quarters of them reported such problems, and the combination has been responsible for several recent deaths in the UK.

Stimulants and alcohol
Alcohol impairs thermal regulation and increases dehydration. When used with ecstasy, the risk of central neurotoxicity and impaired cardiac function increases. Additional increased risks are accidents and risky sexual behaviour.

Cocaine reduces alcohol-related sedation, and alcohol helps with insomnia and anxiety from cocaine use. Both substances lead to coronary vasoconstriction and impair myocardial function, and in the body it is thought they combine to form cocaethylene. Research on this substance is in its early stages, but suggests it is more directly toxic to the heart than either cocaine or alcohol, and prolongs the elevation of blood pressure, thus compounding the risk: alcohol is found to be present in most cocaine cardiac deaths. Other health risks are strokes, liver damage, seizures, withdrawal anxiety, aggression and trauma.

Alcohol and amphetamines are associated with aggressive behaviour.

Stimulants and depressants
Heroin and cocaine used together can enhance the effects of one drug over another to the extent that the quantities of heroin to which a user is normally tolerant may be sufficient to cause overdose. This combination also endangers the heart and kidneys.

More than one depressant
The combined use of different depressant drugs can lead to over-sedation of the CNS and respiratory system.

More than one stimulant
The combined use of different stimulants can lead to sympathetic hyperactivity. Physically, this can result in impaired thermal regulation, impaired cardiac functioning, increased activity levels, and possibly neurotoxicity. Psychologically, a polystimulant (and stimulant) user can experience panic, anxiety, paranoia, aggression and the depression of a ‘comedown.’

Cannabis and alcohol
This is a common combination and the degree of impairment is linked to the tolerance of one or both substances. The combination can lead to increased sedation, ataxia, confusion, disorientation, disinhibition, disorientation, amnesia, nausea and vomiting. The combination has a marked impact on driving.

Cannabis and other drugs
Strong varieties of cannabis, such as ‘skunk’ may intensify the effects of other drugs, particularly hallucinogens and stimulants, increasing the likelihood of paranoia or anxiety.

Overdose

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8 Personal correspondence, based on research and conference papers by Winstock et al, with papers in preparation or currently being considered for publication (see also Winstock et al, in press).
Neale (2001) reports on a study of 153 drug users who had experienced overdose. She asked about the drugs taken prior to last losing consciousness, and overall, 30 different substances were cited. More than one drug had been used in 111 (73%) of cases. The most popular combinations were heroin and temazepam or heroin and alcohol, and a common explanation for the overdose in question was that these combinations had caused it. Other commentators, including Bennett and Higgins (1999) and Strang et al (1999), have also found that that mixing drugs was a common explanation for overdoses. A study in Glasgow (Taylor et al, 1996) reveals that non-fatal overdosing is more likely not only amongst polydrug users, but also if heroin is included in the substances used and if drugs in addition to heroin are injected.

Death
The latest statistical information available from the Office for National Statistics (ONS) on drug-related deaths (reproduced in DrugScope, 2001a) are from 1997. Due to the methods of compiling these statistics, only estimates of the number of deaths associated with particular substances can be obtained, rather than the exact number directly due to these substances. Nevertheless, these statistics reveal something of the extent of polydrug use. For example, of the 445 deaths associated with heroin or morphine (into which heroin breaks down in the body), at least one other drug was involved in 112 (25%) cases, and alcohol in 109 (24%) cases; of 11 deaths associated with MDMA (ecstasy), at least one other drug was mentioned in 8 (73%) cases and alcohol in one (9%) case; and of the 38 deaths associated with cocaine, at least one other drug was mentioned in 21 (55%) cases and alcohol in 5 (13%) cases.

11.2(b) Specific social consequences for polydrug use
The social consequences of drug use include drug-related and drug-driven crime (including violent behaviour and activities to raise the funds for drugs), and the effect of drug use on relationships, employment, and education. However, this is an under-researched area in the UK, particularly in relation to polydrug use, and it is not known whether the social consequences of drug use are exacerbated or diminished by the use of more than one drug.

11.3 Risk assessment and local market
11.3(a) Products and physical description
The products and formulations of the drugs most commonly used by polydrug users available on the UK market are:

**Heroin**
Usually in the form of brown powder. Polydrug users in the UK can include diamorphine (heroin) in the form of tablets or injectable ampoules in their drug-using repertoires.

**Methadone**
In the UK, the formulation of methadone most commonly used by polydrug users is methadone linctus, which is various shades of green in colour. Injectable methadone ampoules (Physeptone) are also used, and, far less commonly, methadone tablets (Physeptone) and concentrated methadone mixture, which is blue in colour.

**Other opioids**
Also used, but less commonly available are tablets of dihydrocodeine (for example, DF118), buprenorphine (Temgesic), dipipanone hydrochloride (Diconal), morphine (for example MST Continus) and dextromoramide (Palfium).

**Benzodiazepines**
A range of benzodiazepines are used by polydrug users. Most popular are diazepam tablets (for example, Valium) and occasionally, injectable diazepam ampoules, and temazepam tablets. In the UK, Gel-filled temazepam capsules (for example, Gelthix) can be prescribed only by private
doctors, as can flunitrazepam tablets (Rohypnol). Less popular are other forms of benzodiazepines in tablet form such as nitrazepam (for example, Mogadon), lorazepam (Ativan) and chlordiazepoxide (for example, Librium).

**Ecstasy (or products sold as ecstasy)**
Ecstasy is most often found in tablet form (and commonly called ‘pills’), although GHB (gamma-hydroxybutyrate or sodium oxybate) is sold as ‘liquid ecstasy.’ Ecstasy capsules are also available. Ecstasy tablets are available in a wide variety of shapes and colours, often with a logo imprinted on them.

**Cannabis**
The main form of cannabis used in the UK is cannabis resin (‘hash’ / ‘hashish’). Herbal cannabis - some home-grown - is also widely used, including that with a high tetrahydrocannabinol (THC) content, such as ‘skunk’ and ‘northern lights.’ Cannabis oil is used far less often.

**Cocaine powder**
A white powder.

**Crack cocaine**
White ‘rocks’ of crack cocaine are about the size of a raisin.

**Amphetamines**
Illicitly-produced amphetamine sulphate (‘speed’) is available as a white, pink or off-white powder. The licit amphetamines most often used by polydrug users are dexamphetamine sulphate (Dexedrine) tablets. Amphetamine paste and methamphetamine are also available.

**Amyl and butyl nitrite**
‘Poppers’ are sold in shops catering for the sex and dance industry, in small glass bottles or capsules.

**LSD**
Usually in the form of small square pieces of paper, with a logo printed on them.

**Ketamine**
Ketamine is found in a variety of forms - liquid, tablet and powder - and has also been reported to have been a substitute for ecstasy.

11.3(b) **Combination of different substances on the local market**

Little research has been conducted on drug markets in the UK and it is therefore not possible to provide accurate details on the combinations of drugs available on local markets.

In terms of ‘marketplaces,’ there are regular media reports of ecstasy, amphetamine, cocaine powder and cannabis dealing in clubs and bars for the clubbing population. It is likely, however, that many young clubbers obtain their drugs via friends rather than dealers. Some of the marketplaces patronised by those who buy and sell heroin, crack cocaine and prescription drugs (such as benzodiazepines) are well-known, but are separate from those for clubbers, and different substances are sold in different marketplaces: some concentrate on diverted prescription drugs whilst others trade primarily in heroin and/or crack cocaine (for example, Edmunds et al, 1996; Fountain et al, 2000). In case of diverted prescribed drugs, distribution is conducted by a large number of people each selling some or all of their own prescribed drugs (Fountain et al, 2000).

The UK National Focal Point (DrugScope 2001b) for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) suggests that the growing trend of polydrug use means that it is likely that multi-drug supply will develop throughout the supply network. Research which
indicates that clubbers use prescribed drugs such as benzodiazepines (for example,\textsuperscript{9} Akram and Galt, 1999) supports this supposition.

11.4 Specific approaches to interventions

Data for inclusion in this section are limited. Literature and other database searches yield plenty of results when variations of ‘polydrug’ (such as poly-drug, poly drug, multiple drug, etc) are entered as a keyword, but closer examination of these results reveal that polydrug use is rarely the focus of publications and projects which use it as a keyword\textsuperscript{10}.

11.4(a) Prevention, treatment and harm reduction

\textit{Prevention}

Whilst there is plenty of literature available for drug awareness, education and prevention purposes, none has been found which deals exclusively with polydrug use. Rather, the issue is dealt with by messages about not mixing drugs, not always naming specific substances, nor the consequences clearly spelt out.

\textit{Treatment}

The Regional Drug Misuse Database reports the main and subsidiary drug used by drug users presenting for treatment. In the six months to September 2000, this was heroin in 64\% of 33,093 cases in England (Department of Health, 2001b). However, the extent of polydrug use is illustrated by a total of 62,790 drugs being used by the 33,093 individuals. Just under half (46\%) were recorded as using only one drug; 28\% two drugs; just under one-sixth (15\%) three drugs; 7\% four drugs; and one in twenty-five (4\%) five drugs. Some drugs were more likely to be reported as a subsidiary drug than a main drug, including benzodiazepines (626 reported this group of drugs as a main drug, whereas 4,581 reported it as a subsidiary drug), and cocaine (2,032:4,798).

Despite the prevalence of polydrug use, the UK’s Guidelines on Clinical Management (Department of Health et al, 1999) address this behaviour only briefly, yet drug users presenting for treatment with heroin, benzodiazepines, alcohol and stimulant problems are commonplace. Treatment for the stimulant element of this menu is problematic: drug treatment in the UK relies on the medical model (that is, substitute prescribing), and the issue of prescribing the drug of choice for those dependent on amphetamines or cocaine is a contentious one. Whilst a maintenance programme of a prescribed stimulant (dexamphetamine) offers stabilisation, as a methadone maintenance programme does for a heroin user, many GPs and drug agencies will not prescribe stimulants because of the risks associated with continued stimulant use and its inherent psychological and physical consequences, and the UK’s prescribing guidelines (Department of Health et al, 1999) stresses that stimulants should not be prescribed to polydrug users.

The only drug treatment therefore likely to be offered for the stimulant component of a polydrug user’s repertoire is antidepressants (\textsuperscript{11}; DrugScope, 2001a), although a two-centre randomised

\textsuperscript{9} Personal correspondence, based on research and conference papers by Winstock et al, with papers in preparation or currently being considered for publication (see also Winstock et al, in press).

\textsuperscript{10} Databases searched include the internet-based DrugScope Library, Locate (details and evaluations of education and prevention services for young people to promote the sharing of good practice), the UK entries in EDDRA (Exchange on Demand Reduction Action), and the UK entries on the qualitative drug research website, www.QED.org.uk.

\textsuperscript{11} Response to questions from the author by researchers, commentators, and representatives of various drug treatment, prevention, education, and harm reduction agencies, throughout the UK, via personal communication.
controlled pilot study of dexamphetamine substitution as a treatment of amphetamine dependency is currently being conducted from Salford. Otherwise, treatment for the stimulants used by polydrug users is non-drug therapy, such as day programmes, counselling, cognitive behavioural therapy, and acupuncture and other complimentary therapies. However, such interventions are not systematically implemented\textsuperscript{11}. In short, if a drug treatment agency specialises in one type of drug, their polydrug-using clients may only get treatment for part of their drug use. Nevertheless, NTORS showed that after one year, the opiate users who were frequent users of stimulants at intake showed marked improvements in terms of reduced levels of opiate \textit{and} stimulant use (Gossop et al, 2001a).

Prescribing benzodiazepines for polydrug users has been questioned recently. Seivewright (2001), whilst arguing that controlled prescribing of benzodiazepines may be necessary because of the dangers of withdrawal by those dependent on them, also points out that ‘giving these drugs to polydrug users must, however, be approached as something of a security exercise, as with only a minority of individuals truly dependent and many others simply aiming at intoxication or enhancing drug effects, there is every chance of rendering users much less stable.’

Current treatment for polydrug users is based on with priorities\textsuperscript{11}. For instance, a client who is dependent on each substance in the common polydrug combination of alcohol, benzodiazepines and an opiate is likely to be referred for in-patient treatment: NTORS discovered that polydrug use was more common in those admitted to residential treatments (Gossop et al, 1998). The substance (or route of administration if this is injecting), which is immediately causing the most risk of harm, is addressed first. Thus, to continue with this example, a client-injecting heroin may be given oral methadone, a reduced amount of benzodiazepines, and disulfiram (Antabuse), which induces vomiting if alcohol is consumed. However, if crack cocaine is part of the polydrug-using repertoire, the client may be very depressed or even suicidal, and psychological help is prioritised.

Treatment for young polydrug-using clubbers - indeed, all young people - is problematic. Most drug services in the UK are only equipped to deal with adults, and, although new guidelines have been set out, there are a number of legal complications involving confidentiality and parental involvement which can result in agencies refusing to offer care when faced with these complications (DrugScope 2001b).

\textit{Harm reduction}

As for prevention initiatives, whilst there is plenty of harm reduction information for drug users, but none has been found which deals exclusively with polydrug use. As noted earlier, the issue is dealt with by messages about not mixing drugs, not always naming specific substances, nor the consequences clearly spelt out.

For drug users in treatment, harm reduction measures includes addressing behaviour patterns, including the influence of peer group, and encouraging stability such as keeping appointments\textsuperscript{12}. Some polydrug users devise their own harm reduction measures. For example, Akram and Galt (1999) found that just under half of a sample of 125 respondents (particularly females) had taken 'dance drugs' with prescribed or 'over the counter' medication as a harm reduction measure.

Some harm reduction measures can impact on polydrug-using repertoires in unexpected ways. For example, Fountain et al (1999) describe how, when National Health Service doctors were no longer allowed to prescribe temazepam gel-filled capsules because of the harm caused by from injecting them, a sample of polydrug users began to experiment with other benzodiazepines and combinations of other drugs in order to achieve the desired effect. Another example is the

\textsuperscript{12} Response to questions from the author by researchers, commentators, and representatives of various drug treatment, prevention, education, and harm reduction agencies, throughout the UK, via personal communication.
suggestion (by, for example, Boys et al, 2001a) that concentration on the dangers of ecstasy has led to an increased use of cocaine powder.

11.4(b) Evaluation results

Searches of databases which report on and evaluate prevention, education and treatment initiatives for polydrug users in the UK revealed little on the evaluation of interventions for polydrug users.

11.5 Methodological issues

11.5(a) Limitations in data availability

There is a general impression amongst commentators that polydrug use has increased in recent years. Explanations for this include that more drugs are available and that distribution systems are increasingly effective; the creation of ‘designer drugs’ such as ecstasy; and that, amongst young people, the use of some drugs has become normalised, especially since the growth of the club industry. However, given the lack of information on aspects of polydrug use other than prevalence, it appears that although research shows that it is likely that a large proportion of those who use illicit drugs in the UK are polydrug users (especially if alcohol is included), the issue remains poorly understood.

Whilst it can be assumed that drug service providers are aware of the extent of polydrug use amongst their clients, the question of whether drug policy-makers are also aware of this phenomenon is questionable, and policies, which concentrate on one drug, only are unlikely to be fully effective. Sensationalist media reports which concentrate on the ‘menace’ of one particular substance, such as crack cocaine or ecstasy, serve only to hinder a greater understanding of patterns of drug use in the UK. The lack of evaluations of drug services aimed at polydrug use further hinders development in this area and the dissemination of good practice.

Researchers and drug treatment agencies collect and present data on the primary and secondary drug used by their samples/clients, but accuracy of the picture of drug use that published results give must be questioned. Such data are questionable as indicators of treatment demand, for example. The UK National Focal Point’s ‘UK drug situation 2000’ maintains ‘one of the challenges facing treatment agencies today is the increasing number of cocaine/crack and polydrug users.’ However, in terms of drug users requiring treatment, these are not necessarily two separate groups of drug users.

11.5(b) Future needs

More research on aspects of polydrug use other than prevalence is necessary, in order that a greater understanding of this behaviour is achieved. For example, Boys et al (2001a) have investigated the functions of polydrug use by young people and how they make decisions about patterns of consumption. This perspective, applied to all drug users, is likely to yield fruitful information for effective prevention, treatment and harm reduction initiatives. The study of problematic patterns of drug use amongst young polydrug-using clubbers rather than

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13 Personal correspondence, based on research and conference papers by Winstock et al, with papers in preparation or currently being considered for publication (see also Winstock et al, in press).

14 Databases searched include the internet-based DrugScope Library, Locate (details and evaluations of education and prevention services for young people to promote the sharing of good practice), the UK entries in EDDRA (Exchange on Demand Reduction Action), and the UK entries on the qualitative drug research website, www.QED.org.uk

15 Response to questions from the author by researchers, commentators, and representatives of various drug treatment, prevention, education, and harm reduction agencies, throughout the UK, via personal communication.
concentration on specific substances is also suggested as a more adequate information base to inform effective drug prevention and harm reduction measures (Winstock et al, in press). Such work would enable the development of interventions before harmful habits develop, and should include both quantitative and qualitative research methods.

Drugs and alcohol are possibly the most underrated combination in terms of health risks, and the inclusion of alcohol into the ‘recreational’ drug-using repertoires of young people requires an urgent health education response. In addition, drinking problems amongst illicit drug users entering treatment have been given insufficient attention and Gossop, Marsden, Stewart and Rolfe (2000a) call for efforts to be made to ‘develop and strengthen the assessment and treatment of drinking problems among drug misusers.’

As Henderson (2000) points out, research findings on the drug use of a particular group represent a particular moment in time, and target groups should be mapped as an evidence base for developing policy and intervention. Treatment, prevention, education and harm reduction demands change as drug users discover new combinations of drugs: it is vital that trends are monitored so that the appropriate responses can be developed.

The group categorised above as ‘opiate dependent polydrug users’ are clearly aware of the dangers of mixing different substances, as shown by those studies which ask for perceptions of why they had overdosed (for example, Bennett and Higgins 1999; Strang et al, 1999; Neale 2001). However, the ‘polydrug-using clubbers’ group appear to be less aware of the dangers of this behaviour. More relevant education for these young people is therefore necessary.

Given that polydrug use is implicated in overdoses, those polydrug users who arrive in Accident and Emergency Departments should be referred onto the appropriate drug services: Neale (2001) reports that this is currently not always the case.

Examples of good practice of services for polydrug users who include stimulants in their drug-using repertoires should be widely disseminated.

11.5(c) Methodological proposal

As noted above (11.5B), treatment, prevention, education and harm reduction demands change as drug users discover new combinations of drugs: it is vital that trends are monitored in all groups of drug users to provide an evidence base for developing policy and intervention. The potential for the merging of the currently separate markets for users of heroin, crack cocaine, and pharmaceutical drugs with those used by young clubbers (ecstasy, cocaine powder, amphetamines, cannabis) should be an element of this monitoring exercise.

Such a research study should involve both quantitative and qualitative methods, and examine existing methods of trend monitoring, such as Antenna in the Netherlands which has been ongoing since 1993 (Korf and Nabben, 2000), to ensure efficient and rapid reporting of, and action on, results.
12. SUCCESSFUL TREATMENT: THE EFFECTIVENESS OF THE INTERVENTIONS

12.1 The approaches to treatments and the related concepts of success

12.1 Concepts of success

Attenuation or cessation of drug and alcohol consumption are the obvious primary indicators of success for this treatment population. However, individuals entering treatment often present with chronic and acute medical, psychological and social problems. Reflecting this an established body of research has focused a three core domains of personal and social functioning: (a) drug and alcohol consumption; (b) health problems; and (c) personal and social functioning (to including relationship problems, employment and crime involvement). The risk of exposure of substance users to the human immunodeficiency virus (HIV) and other blood-borne viruses has led to the important addition of a fourth assessment domain concerning risk behaviour for transmission of blood-borne infections.

12.1(a) The concept and criteria for success considering:

Intervention approaches
For activity reporting purposes structured intervention approaches in the UK are categorised as follows:

Prescribing interventions:
Inpatient Prescribing - includes specialist NHS facilities that offer stabilisation, detoxification services.

Community Prescribing - a) Specialist services: provided mainly by NHS Trusts’ secondary care services, notably Community Drug Teams and out-patient prescribing by Drug Dependency Units. Some of these services are also provided by the voluntary sector; b) GP-led prescribing services: include prescribing services provided by Primary Care Physicians and Teams and include those GPs who are involved in a formal shared care scheme.

Non-prescribing interventions
Care planned counselling: services offering formal structured counselling approaches with assessment, clearly defined treatment plans and treatment goals and regular reviews. This is contrasted with advice and information, drop-in support and informal key-working.

Structured day programmes: services where clients are expected to attend four or five days a week, for several hours each day and offer a structured approach to rehabilitation, working with a defined length of the treatment programme.

Residential rehabilitation: mainly provided by the independent sector and span treatment programmes including therapeutic communities, concept houses, 12 step Minnesota model programmes and general houses including those with a Christian-based philosophy.

Target groups
Young people
The national drugs strategy places special emphasis on preventing drug misuse among young people and providing appropriate services to those who have or are at risk of developing drug-related problems. The national strategy defines three groups: children (aged 12 or less); young people (aged 13-17 years) and young adults (18-24 years). At the general population level, the following groups have been identified:

- school excludees and poor attenders at school;
- young people who are socially excluded;
young people who looked after by Local Authorities;
the young homeless;
young people living in environments with high levels of drug misuse;
young people involved in prostitution;
young people who have parents with a drug misuse problem; and
young people with a psychiatric disorder
young offenders

Adults

Within the broad adult population, several priority groups are identified.

Pregnant drug users should be specially targeted by services at an early stage. Since some pregnant users present to treatment precisely because of their pregnancy, this should be seen as an important opportunity to offer treatment and support. The importance of meeting the needs of young people also extends to issues of childcare. For example, crèche and nursery scheme facilities for drug users attending treatment services may not be commonly available.

People with co-morbidity are also increasingly targeted. There is currently no research and clinical evidence-base for the effective management and care of patients in psychiatric inpatient units with psychoactive substance misuse co-morbidity and this is an important development area. It is important to consider and plan for the possibility that people with drug misuse and severe mental illness will not respond well or comply with traditional care plans and arrangements.

People who are homeless. There is widespread concern about drug and mental health problems amongst homeless populations and drug misuse may be a risk factor for accommodation instability. Homeless people encompass those who use night shelters, temporary hostels and the accommodation of friends and acquaintances, as well as those “sleeping rough” on the streets. The most common health-related problems cited by people who sleep rough concern psychological issues, alcohol consumption and illicit drug use. Local Authority homelessness outreach teams and specialist service providers report that there is a substantial segment of this population who have unmet needs for drug misuse treatment and related support. It is important to recognise that some homeless people also have psychiatric and substance use disorder co-morbidity and may have complex treatment and support needs.

Minority ethnic groups. Overall, the UK population is characterised by considerable heterogeneity in its ethnic composition, particularly in London and the major cities. Variations in attitudes and beliefs concerning psychoactive drugs across ethnic minority populations are important influences on drug consumption.

It is critical that commissioners and service providers are sensitive to issues of race, culture and religion and that their particular needs are reflected in service agreements/contracts and specifications. In terms of ethnic groups, survey data suggests that drug use is distributed across different ethnic groups, with white respondents reporting the highest levels of cannabis and amphetamine use, followed by African-Caribbean respondents, Indian respondents and people from the Bangladeshi and Pakistani ethnic groups. Results from several studies have consistently shown that people from Asian communities are less likely to report drug use than white people or people from African-Caribbean descent. There is a perception that many drug users from ethnic minority populations are reluctant to approach substance misuse treatment services and that they constitute the most hard to reach of the priority groups (Abdulrahim, 1998). It is vital that treatment commissioners, purchasers and providers do not regard non-white drug misusers as a homogenous cultural group (Khan, 1999). Equally, it is important to recognise that risk and protective factors may be quite difference across cultural and minority groups.
**Drugs used**
The majority of individuals who present to primary care and specialist treatment facilities have primary problems with opiates (mainly illicit heroin). The use of multiple substances (polydrug use) is the norm rather than the exception, and many individuals with healthcare needs have multiple problems relating to the use of several types of drugs spanning the opioids, amphetamine-type stimulants, the benzodiazepines and alcohol.

**12.1(b) Political and professional choices and principles behind the approaches**

A central political and professional principle is that no one single commissioning agency or provider can meet the health and social cares needs of the drug misusing population in the UK. An effective response requires the combined efforts of all government departments to greater or lesser degrees. Balanced, joint service commissioning, appropriate joint purchasing between the health, social welfare and criminal justice agencies together with shared working between specialist and generic providers are key ingredients for a successful national response. The principles of a continuum of care and effective coordination of multiple treatments and support services are now being promoted across the country.

**12.2 Evaluation of the treatments**

**12.2(a) Research findings and used methodologies**

*The research evidence*

When considering the international research evidence it is important to note that there are often quite marked differences in the nature of the populations being treated and the structure and operation of the treatment services.

*Prescribing interventions*

*Inpatient programmes*

The main goal of an inpatient programme is to medically manage the detoxification of a patient and return them to physiologically normal levels of functioning in as safe and as comfortable manner as is possible. Detoxification should not be considered in itself a rehabilitative treatment for illicit substance dependence, but may be better seen as a first phase of those treatment programmes that are aimed at abstinence. On its own detoxification alone is seldom effective in leading to long-term abstinence. In patient programmes are important gateways into formal after-care counselling, and achieving a drug-free state is necessary to enter many residential rehabilitation programmes or receive opioid antagonist treatments. Currently, these programmes care for patients who are primarily dependent on opioids, with co-dependence on benzodiazepines and other substances likely.

In a recent comprehensive review of the international evidence base for opioid withdrawal using results from 218 studies (of which 27, 12% were conducted in the UK), Gowing, Ali & White (2000) concluded that heterogeneity in programme operation and outcome conceptualisation and measurement issues hamper systematic evaluation of the literature. They identified four major types of intervention to manage opioid withdrawal: reducing doses of an opioid agonist (predominantly methadone, although alternatives also feature); symptom amelioration using $\alpha_2$-adrenergic agonists (such as lofevidine or clonidine); symptom amelioration of acute withdrawal using the partial agonist, buprenorphine; and induction of withdrawal using opioid antagonists in conjunction with sedation or anesthesia.

Overall, Gowing, Ali & White calculated mean completion rates for inpatient treatment of 75% for tapered methadone, and 72% for $\alpha_2$-adrenergic agonists.

The first National Treatment Outcome Research Study in England has reported the following six-month post-discharge improvements in substance use amongst a sample of 95 patients treated in
inpatient programmes: heroin (70% at intake, 40% at follow-up) and injecting (66% - 39%)(Gossop et al., 1997). Improvements were also maintained at one-year follow-up (Gossop et al., 1999).

Community prescribing programmes
This category of treatment includes harm-reduction oriented substitution treatment using agonist or partial agonist medications; abstinence oriented substitution prescribing and relapse prevention antagonist pharmacotherapy.

Methadone maintenance
There is a well-established research and clinical evidence-base for substitution treatment with oral methadone in the UK (Farrell et al., 1994; Marsden et al, 1998; Ward, Mattick & Hall, 1992; 1998). MMT is associated with lower rates of heroin consumption, reduced levels of crime, and improved social functioning and methadone doses over 50mg/day is associated with lower rates of heroin use. Results from NTORS at 6 months, 1 year and 2 years following intake to treatment shown that methadone maintenance patients report a substantial reduction in their heroin involvement (Gossop et al., 1997, Gossop, Marsden, Stewart and Rolfe 2000b, Gossop, Marsden, Stewart and Treacy 2001). For example, on average patients who entered methadone maintenance treatment reported using heroin on 24 days in the previous three months at two-year follow-up (a reduction of 59% on pre-admission levels). A lower risk of premature mortality for maintained patients has been reported and substitution programmes have also contributed to the prevention the spread of HIV infection, by encouraging change in injection risk-taking practices.

Methadone reduction
Since methadone reduction treatment programmes in the UK contain a stabilisation or maintenance phase prior to a dose reduction, researchers have evaluated treatment outcomes using the same criteria as for maintenance treatment. The NTORS study has reported on the two-year follow-up outcomes from methadone reduction programmes (Gossop, Marsden, Stewart and Treacy 2001). On average patients who entered methadone maintenance treatment reported using heroin on 23 days in the previous three months at two-year follow-up (a reduction of 61% on pre-admission levels). However, the reduction programmes had somewhat poorer retention rates than maintenance programmes. Half of the reduction patients were also still receiving a reduction programme after one year, and almost a third of them were still in treatment after two years. In addition, the percentage of reducing methadone doses in the reduction programmes was found to be negatively correlated with heroin use at follow-up.

Community withdrawal treatments
Community detoxification has the same goal as inpatient detoxification with treatment staged at the patient’s home at a community treatment programme. From an intention to treat point of view methadone reduction is an abstinence oriented detoxification treatment. In the UK, methadone reduction is often delivered over a protracted period or many months and can therefore represent a de facto maintenance treatment.

Community detoxification
As discussed in the section on inpatient treatment, research has suggested that inpatient detoxification has higher completion rates – for those patient groups studied. Gowing, Ali & White (2000) calculated mean completion rates for community detoxification treatment of 35% for tapered methadone, and 53% for α2-adrenergic agonists. The reason for this reduction in completion detoxification is largely due to patients being unable to manage withdrawal symptoms and relapsing. This does not mean that all opioid dependent patients should be treated in an inpatient programme, and indeed there is only a limited capacity to do so in the UK. Those patients with stable, supportive home situation may well be able to complete detoxification in the community. It is also likely that younger patients with less chronic dependence will be better able to comply with a community detoxification, although at present there is no published evidence to support this assumption.
Counselling approaches and programmes

There have been no formal trials or cohort outcome evaluations of care planned counselling or structured day programmes in the UK. There is a substantial international literature, however, that has evaluated the application of counselling and psychotherapy approaches in the substance misuse treatment field and this literature has relevance for the delivery of these sorts of programmes in this country. Since counselling of one form or another is found in almost all treatment programmes for substance misuse the research evidence summarised in this section has a relevance to the review as a whole.

Residential rehabilitation.

Residential rehabilitation describes a planned and usually highly structured programme of counselling and other support services designed to make global changes in the addict’s lifestyle and facilitate long-term recovery. In the UK, there are three broad types of rehabilitation provision: therapeutic communities; 12-step programmes based on the Minnesota Model of addiction recovery treatment; general and christian houses promoting a less structured programme, which favours a more individually tailored package of care for each client. It is important to note that about half of all residential rehabilitation programmes provide medically supervised withdrawal to facilitate abstinence.

Residential rehabilitation originally was based around lengthy periods of stay. However, in the last two decades, short-term residential rehabilitation programmes have emerged. In terms of planned duration of the programme, two types of programme can be identified: short-term residential rehabilitation (STR) and long-term residential rehabilitation (LTR). STR programmes include a medically supervised detoxification programme (Inpatient programmes) as the first stage of a rehabilitation programme that has a planned duration of six to 12 weeks. The NTORS project studied four of these services in England (Gossop et al., 1999). LTR programmes generally do not provide medically supervised withdrawal services as a first treatment phase and the planned duration of the rehabilitation programme varies quite widely. The 12 LTR services in NTORS reported a planned duration of 12–52 weeks (Gossop et al., 1999).

For residential rehabilitation programmes, there is a strong body of international research showing positive psychosocial benefits for patients following treatment. NTORS has reported on one-year follow-up outcomes from patients admitted to 4 STR and 12 LTR programmes. Here, the reduction in rates of illicit substance use during the 90 days before intake and follow-up interview, were as follows: heroin (75%-50%); crack cocaine (37%-18%); other stimulants (71%-32%) and benzodiazepines (57%-28%).

12.2(b) Comparison between treatments and related approaches

No relative efficacy trials of treatment and related approaches have been undertaken in the UK to date.

12.3 Methodological issues

12.3(a) Limitations in data availability

There is a growing evidence base for the effectiveness of standard forms of treatment currently available, but less is known about the effective means of helping particular priority client groups. An effective treatment system, tailored to the needs of the local population, is based on principles of strategic alliance and partnership. Further work is required to extend and improve information and performance and outcome monitoring systems and to use more sophisticated needs assessment methodologies to guide strategic and service development.
12.3(b) **Future needs**

Good quality research on treatment and treatment outcomes is critical to inform the orientation and operation of treatment services. The RCT should be considered as the design of first choice for new treatments or treatments for specific groups. It is essential that where experimental studies of standard versus an enhanced or a new treatment are conducted, the potential for sub-group responses (client, treatment interactions) should be considered thoroughly before commencement of the trial. Observational studies are also required to examine the operation of the treatment system itself. Very little is known about how rehabilitation and aftercare processes operate after a period of health-care treatment has been completed. The evolving treatment and support needs of drug misusers should be studied systematically and this information used to cement inter-agency partnerships.

12.3(c) **Methodological proposal**

There has been some progress in the development of treatment outcome measures for the drug misuse population. The principle behind existing measures is to gauge treatment benefit in terms of a reduction of key problems. As a complement to these core measures, the following areas need to be developed:

- improved and more sensitive measures of progress in treatment;
- needs assessment protocols and measures for priority groups.

Treatment outcome researchers are increasingly encouraged to incorporate economic assessments in drug misuse service evaluations. Standard measures of economic effectiveness (e.g. adjusted life years gained) have not been devised with the drug misusing population in mind and there is a pressing need for health economists and drug misuse evaluation specialists to develop suitable indicators.
13. DRUG USERS IN PRISON

Introduction
Prison is one of the final frontiers for research into drug use. There has been more research into drug use in the community, even where offenders are concerned. For instance, drug use on the part of suspected offenders arrested by the police has been researched both through self-report interviews and by means of voluntary, anonymous testing under the NEW-ADAM programme and equivalent work carried out in Scotland (Bennett, 2000; McKeganey et al., 2000; NEW-ADAM stands for New English and Welsh Arrestee Drug Abuse Monitoring). This research has confirmed that offenders, traditionally heavy drinkers and smokers, are now more likely to be substantial consumers of prohibited drugs than is true of the general population (Bennett, 2000).

The vast bulk of the UK prison population is located in England and Wales (current prison population of over 65,000). There are separate prison populations for Scotland (current prison population 6,250) and Northern Ireland (with a much smaller prison population, just 900). The main focus of this chapter is on England and Wales.

As is increasingly true of European countries in general, UK prisons have for some years been implementing wide-ranging drugs strategies, influenced by national strategies for the country as a whole. In England and Wales, the Prison Service drugs strategy was set out in a 1998 policy document, Tackling Drugs in Prison. The drug strategy for prisons covers a wide spectrum including supply reduction, education for both prisoners and staff, support and advice before and, where possible, following departure from prison through CARATs, and a broad range of treatment (including substantial full-time programmes lasting up to a year or even longer, together with detoxification and some harm minimisation provision). The strategy is underpinned by both mandatory and voluntary drug testing of prisoners. The early indications from the emerging research suggest that the strategy is beginning to have an effect on the drug misuse and reoffending patterns of those prisoners who have engaged with the various services and interventions provided by the Prison Service.

13.1 Epidemiological situation: drug use before and within prison

13.1(a) Drug use before and within prison

A longitudinal study, not fully complete, has recently been adding to our knowledge of drug use before, during and after imprisonment in England and Wales. First, in spring 2000, the Criminality Survey covered a broadly representative sample of nearly 1,900 recently arrived sentenced male prisoners, focusing on their offending and drug use while still at large in the community (Lewis and Mhlanga, 2000). Taking this as the sample frame, the three stage Criminality Survey: Drugs Follow-up study re-interviewed three groups of those who had reported any use of drugs in the 12 months prior to their imprisonment: 302 inmates who were interviewed in prison about three months later (Part I); 227 short-term prisoners interviewed after release (Part II); and finally a re-interview of part of the sample of 302, after their release from prison (Part III).

Focusing on use within the last year, as a convenient pointer to relatively up-to-date patterns, cannabis was the most widely prevalent prohibited drug on the part of the offenders in the Criminality Survey, prior to their imprisonment. Of those aged 17-24, 80% had used it within the last year; for older prisoners, the equivalent figure was 59%. Ecstasy and cocaine prevalence rates were also relatively high; once again, younger respondents reported higher levels of use within the last year (for cocaine, figures were 37% for those aged 24 or less, compared with 28% for older offenders). Interestingly, prevalence rates for heroin did not vary much with age, being 32% and 31% respectively for younger and older offenders. While these figures are just for males, it is likely that equivalent pre-prison figures for females would be just as high, if not higher, to judge by other research among offenders (Bennett, 2000).
In the UK, while cocaine and crack have become increasingly important drugs for offenders at large in the community, heroin is still the drug most closely associated with offending against property. The heroin-crime connection, while not simple or straightforward, has been documented by English research as far back as the 1970s (Mott and Taylor, 1974). Together with cannabis, heroin is the other drug widely consumed on a regular basis: a quarter of respondents in the Criminality Survey reported consuming heroin at least once a day, prior to their imprisonment.

Among prisoners in England and Wales, cannabis and heroin are likewise the predominant drugs, although at lower levels than before their imprisonment. Just over half, 54%, of the respondents taking part in the Criminality Survey: Drugs Follow-up (Part I) said that they had used an illicit drug during their current sentence of imprisonment. Of these, 95% had used cannabis, 55% had used heroin and 28% had used tranquillizers. These figures represent 51%, 29% and 15% of all participants in the Drugs Follow-up (Part I). The prevalence of other drugs in the follow-up sample is much less common: 7% stated that they had used crack, 4% ecstasy and 3% cocaine.

Almost all (96%) of those in the Part I Follow-up sample were aged between 18 and 44. Relative levels of use of cannabis for different age groups mirror those of the Criminality Survey sample (focusing on pre-prison drug use), although in absolute terms there was less drug use in prison than previously. A high proportion (58%) of young inmates (18-24 years old) had used cannabis during their current sentence, while considerably fewer (43%) of the older age group (25–54) admitted to such use. Again (as with the original Criminality Survey) there was little variation in terms of age in the heroin prevalence rates among the prisoner follow-up group. The 18-24 year olds had a heroin prevalence rate since being in prison of 29%, compared with 32% for the 25–54 year old group. Almost all (97%) of the heroin users were White. Similarly, 89% of cannabis users were White, although there was a larger representation (10%) of Black prisoners among the cannabis users.

The use of drugs in prison was relatively infrequent: 68% of prisoners using cannabis did so on a less than weekly basis, 11% said that they used weekly, while only 10% stated that they used every day or nearly every day. The use of heroin was similarly infrequent: 64% of heroin users took it less than weekly and only 2 heroin users (2%) said that they used on a daily or nearly daily basis. Just one prisoner stated that he had injected a drug (heroin) while in prison.

13.1(b) Health status in prison, social and legal consequences

Offenders may arrive in prison with withdrawal symptoms, and can be in need of detoxification; they may also suffer from drug-related infectious diseases and other health problems. As discussed below (in 13.4), medical services are made available, as are treatment programmes. Following a successful pilot, disinfecting tablets, for cleaning injecting equipment, are now being made available in prisons across England and Wales. There are no needle exchanges.

Prisoners are not permitted to use or possess drugs. As mentioned above, the main method of deterring them is the regular programme of mandatory drug testing (MDT). Any prisoners whose urine tests positive are liable to be punished, typically by having their sentences lengthened by at least a few extra days. Prisoners who wish to show that they are free of drugs can also submit to voluntary drug testing (in addition to MDT). The mandatory testing programme is also discussed below (see 13.6).

16 There are no directly comparable data for drug use in Scotland. However, the available data indicates that, consistent with England and Wales, heroin and cannabis are also the most prevalent drugs in Scottish prisons.

17 See the Methodological comments section below for more details about the study and its sample composition.
13.2 Availability and Supply

13.2(a) Availability of illicit drugs in prison

As part of the first follow-up to the Criminality Survey, respondents were instructed to think about the prison they were in and asked, ‘which drugs would you say would be easily available if someone wanted to use drugs?’ Table 25 below summaries the responses.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Freq.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>246</td>
<td>82</td>
</tr>
<tr>
<td>Heroin</td>
<td>235</td>
<td>78</td>
</tr>
<tr>
<td>Tranquillizers</td>
<td>55</td>
<td>18</td>
</tr>
<tr>
<td>Crack</td>
<td>39</td>
<td>13</td>
</tr>
<tr>
<td>Cocaine</td>
<td>35</td>
<td>12</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>24</td>
<td>8</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>24</td>
<td>8</td>
</tr>
<tr>
<td>Steroids</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>Methadone or phypseptone</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>LSD</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Solvents</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Magic mushrooms</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Amyl nitrite (poppers)</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: Criminality Survey: Drugs Follow-up (Part I), 2000; n = 302.

The drug seen by the largest proportion of respondents, as being readily available was cannabis: 82% of the sample stated that cannabis would be easily available to someone who wanted to use drugs in the prison in which the respondent was held. A similar proportion, 78%, thought that heroin would also be easily available. Other drugs were far less commonplace: only tranquillizers (18%), crack (13%) and cocaine (12%) were highlighted as being easily available by more than 10% of the sample.

13.2(b) Smuggling into prison

There is currently little research evidence concerning the smuggling of drugs into prison. To redress this situation, the Home Office expects to commission research in this area in late 2001 to elicit the views of both staff and ex-prisoners about how drugs are brought in prisons.

However, administrative provision has been made to address the issue of drugs smuggling. The 1998 Prison Service drugs strategy for England and Wales (Tackling Drugs in Prison) was designed to produce a more integrated and balanced approach to tackling drug abuse and detailed a range of measures to treat prisoners, discourage drug use and reduce the supply of drugs. Measures to reduce supply include the following: improvements to perimeter security and to the security of visits; increased use of dogs to deter and discover drug smugglers and, from 1 April 1999, the banning of visitors caught smuggling drugs from making further visits for a minimum of three months, with another three months of visits in closed conditions.

13.3 Contextual information: prison environment and organisational culture

Implementation in prisons of the wide-ranging provisions of the drugs strategy is not entirely straightforward. For instance, the use of ex-addicts and ex-prisoners to help deliver treatment can be perceived critically by some prison officers as posing a security risk (Player and Martin, 1996). However, the same research also found that, in the main, prison staff believed that drug-free
parts of prisons were cleaner, quieter, less violent and easier to control. There is still a need for more comprehensive and up-to-date research to enhance our understanding of the implementation of the drugs strategy in prisons (see below, 13.6).

13.5 Demand reduction policy in prison

13.5(a) Drug user needs assessment in prison

Needs assessment work is widely carried out in UK prisons. In all prisons in England and Wales, there is provision for helping prisoners with drugs problems. This basic service is known as CARAT (counselling, assessment, referral, advice and through care). It is a multidisciplinary service provided under competitive contracts by organisations working outside prisons to help drug misusers; in addition, prison officers and probation and healthcare staff in the prisons may also be involved. CARAT staff can help prisoners in various ways. For instance, they may talk with newly arrived prisoners; they may offer counselling; they may carry out group-work. They can also refer prisoners with relatively serious drugs problems to full-time treatment programmes of different types and duration, as discussed in the next paragraph. Finally, CARAT workers can, where possible, help to ensure that treatment and support are available once prisoners are released back into the community.

13.5(b) Organisation of the drug services in prison

The Prison Service aimed to achieve accreditation by the independent Joint Prison/Probation Accreditation Panel for all programmes by March 2002. This target is now unlikely to be met as it was set before the requirements for accreditation were known. Progress is being made, however, in supporting programmes towards accreditation; guidelines on best practice and the accreditation process were issued in May 2001. So far, one programme, run by the charity Rehabilitation for Addicted Prisoners trust (RAPt), has been accredited and is running in seven prisons.

In December 2000, the Prison Service introduced a new standard for clinical services for substance misusers. This ensures that good quality detoxification services are available in all local and remand prisons to a level at least comparable with that in the community and to a standard set by the Department of Health. In 2000-01, there were 32,000 entrants.

13.5(c) Links with the community services outside the prison

As previously mentioned, CARAT workers help to ensure that treatment and support continue once prisoners return to their outside communities. Through care links of this kind have been shown by research to be vital in helping prisoners not to re-vert to problematic drug use and associated levels of offending (Burrows et al., 2001). This same research has also shown that it is not always easy to provide through care, given the multiplicity of organisations involved, all with their own priorities. There is however increasing interest, in policy terms, in providing more supervision and support for all short-term prisoners (whether drug users or not), which should provide additional impetus for the enhancement of through care (Halliday et al., 2001).

The Prison Service is leading an innovative pilot scheme to set up post release hostels for short term prisoners with histories of drug misuse. There will be up to five hostels in the pilot, one for women and four for men, planned to be open in summer 2002. The hostels will provide intensive support to this high risk group through the first few months following release from prison. The aim is to reduce re-offending by preventing return to drug misuse. Responsibility for this project will pass to the National Probation Directorate of the Home Office later this year when contracts to deliver and run the hostels are awarded.
The Prison Service is also currently working towards developing a central treatment model for rehabilitation and has agreed with the National Probation Directorate that it may adapt its ASRO (Addressing Substance-Related Offending) programme into a Prison Service model. This development of post-programme community links and linkage with the National Probation Directorate’s plans for “booster” community drug programmes will be considerably enhanced because of the similarity of the probation and prison models.

13.6 Evaluation of drug users treatment in prison

13.6(a) State of the art evaluation in prison

Development of treatment services in prison has been relatively rapid and recent, and research to evaluate it is still being developed and implemented, as a high priority. The level of future funding for drug treatment in prisons is likely to depend heavily on the extent to which programmes are shown both to reduce the drug use of ex-prisoners and to lessen their offending. There is an ongoing process of accreditation for treatment programmes in prisons, with accreditation being conditional on evidence of effectiveness.

13.6(b) Main findings and evaluation results

So far, the work of one major service provider, RAPt, has been evaluated (Martin and Player, 2000; RAPt stands for Rehabilitation for Addicted Prisoners Trust). This evaluation has shown that, on their release from prison, graduates from the RAPt treatment programme were twice as likely as non-graduates to avoid using drugs or to diminish their consumption substantially. Similarly, graduates were twice as likely as non-graduates not to be reconvicted in the 12 months following their release from prison.

13.6 Methodological issues

13.6(a) Limitations in data availability

There is a wealth of administrative data on the results of mandatory drug testing (MDT). The results of this programme, fully operational in all prisons in England and Wales, point to declining levels of positive tests for cannabis: down from about 20% in April 1998 to around 10% in March 2000; equivalent rates for heroin have remained broadly stable, at approximately 4%. As well as the Criminality Survey and its follow-ups, some other research has already been carried out which suggests that MDT results do not necessarily convey the full picture (Edgar and O'Donnell, 1998; Singleton et al., 1999). However, much of the existing research, including the Criminality Survey and its follow-ups, only involves relatively small numbers, which points to a need for caution in interpreting existing research, as well as for additional work.

13.6(b) Future needs

Further research, involving the Office for National Statistics, is already underway to shed additional light on drug use in prisons, and on ways in which this is affected by mandatory drug testing. This research, involving both self-report interviews and physical testing on a voluntary and confidential basis, should also help to explore a broad range of drug-related health issues.

Another need is for an overall evaluation of the effectiveness of the drug strategy. How well do its different components work, both individually and collectively? How neatly does the strategy dovetail with other work of the Prison Service? Here too, plans are actively being developed for new research in England and Wales.
13.6(c) **Methodological proposal**

In conclusion, there is a substantial amount of research now being planned or carried out, which should improve our understanding of drug use in prisons. Other on-going work includes evaluations of the effectiveness of treatment programmes, and of CARAT activity, together with an assessment of the particular needs of young prisoners, females and ethnic minorities. We have probably reached the stage where is no single type of research which needs to be developed from scratch, though new gaps are likely to be identified when current or planned work is completed. Research into drug use in prisons remains a challenging but important field.
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**Database and software used**

(a) *Alphabetical List of relevant databases/software used for National Report indicating:*

The database used was DrugScope’s information system – Inmagic database/DBTextworks version 4. It is a bibliographic database of more than 80,000 items relating to misuse of prescribed, illicit and over-the-counter drugs. The database covers literature on all aspects of drug misuse the has been written in the English language world-wide and is one of the foremost and most comprehensive collections of literature on drug use in Europe. It’s available to anyone worldwide. The contributing experts used a variety of systems and databases which are centred around the institution from which they are from.

(b) *Relevant internet address*

This is open to all in the UK via [http://www.drugscope.org.uk/library/home.asp](http://www.drugscope.org.uk/library/home.asp)
ANNEX

Drug monitoring system and sources of information

Synthetic description of monitoring systems at national level regional level and local level
(changes since last report)

Broadly speaking there are three forms of information within the drug strategy
(i) information about progress towards targets/objectives of the drug strategy, this information
being reported in the annual reports on the drug strategies of England, Wales, Scotland and
Northern Ireland;
(ii) information about performance in relation to Public Service Agreements which HM Treasury
has agreed with specific Departments;
(iii) research projects which develop new systems and sources to the point at which they may be
used for either of the two.

On (i), the objectives/targets of the UK drug strategies were not changed in late 1999 nor during
2000 (to our reporting date, November 2001). The relevant reports have been mentioned in
Section XX, above and electronic addresses are supplied in Section XX. On (iii), research, we list
current research in section (d) below.

a) Procedures for collecting information and processing

Varies with the particular target/objective or the particular research project. See list below.

b) Documentation centres

DrugScope remains the UK’s specialist drug information documentation centre, with an
interdisciplinary scope and customer base (see section above on References and Databases.
However, four factors - the increasing number of research specialisms relevant to drug strategies;
the increasing involvement of larger numbers of contractors in projects; political devolution; and
the increasing use of the internet for research purposes - mean that information sources are
widening beyond the traditional and specialised documentation centre.

c) Reporting system

Apart for the setting up of the Drug Strategy Directorate within the Home Office in the spring of
2001, there was no major change in the system of upward reporting from information/research
specialists to government.

d) Drug strategy research in England, Wales, Scotland and Northern Ireland

Drug strategy research in England

Key research project in 2001
Vulnerable groups research programme: Six projects looking at levels of drug use among young people at risk of developing drug problems in later life. Groups being researched include: young sex workers, young offenders, and young people in care.

Drug use and criminal offending: a programme of urine testing and interviews with arrestees across 16 police stations. The objective of this programme is to provide some insight into the links between drugs and criminal activity.


Evaluation of Arrest Referral Schemes: a series of projects assessing the impact of drugs outreach work based in police custody areas. The studies will assess the impact of referral into treatment on drug use and offending behaviour.

Evaluation of activities targeting drug markets: local initiatives seeking to reduce or eradicate drug markets in three sites across England will be appraised over a three year period. Initiatives include extra policing, changes in housing management and redesigning of buildings.

Drug strategy research in Wales

A substance misuse research and information strategy is under development. This strategy will outline arrangements for the monitoring of progress against key targets, the handling of information and the generation of research studies. It will guide the direction and commissioning of studies and information initiatives to support the Welsh substance misuse strategy. There will be common ground with the research programme devised for the UK drug strategy by the cross-departmental Research & Information (Working) Group and the information strategy work that has been developed in Scotland.

The finalised R&I strategy will be informed by the context, culture and priorities in Wales, as well as by the vision for health improvement described in the Better Health-Better Wales strategy.

Current or recently completed activities by strategic aims

Aim I: to help children, young people and adults resist substance misuse in order to achieve their full potential in society, and to promote sensible drinking in the context of a healthy lifestyle. Research projects include: the Schools Drugs Survey and drugs component of the British Crime Survey which covers Wales; the Youth Lifestyles Survey; analysis of the 1998/99 Youth Lifestyles Survey. The Initial results of this show higher rates of drug use across vulnerable groups, increasing with degrees of vulnerability and having potentially important interactions with gender. There is research examining the service needs of young people in the lower Teifi valley and the Institute of Rural Health is conducting a study examining adolescent substance misuse and focusing on geographical/spatial issues. There is also a local effectiveness study on peer education.

Aim II: to protect families and communities from antisocial and criminal behaviour and health risks associated with substance misuse. Research projects include the NEW-ADAM which covers England & Wales. The Dyfed Powys DAAT commissioned a hospital study in which Accident & Emergency staff are monitoring the nature of drug & alcohol related admissions. The Tackling Alcohol Related Street Crime (TASC) initiative in Cardiff has been subject to Home Office evaluation. The Substance Misuse Intervention Branch at the National Assembly has reviewed the progress of DTTOs in Wales and there is a study of substance misuse and homelessness.
Aim III: to enable people with substance misuse problems to overcome them and live healthy and fulfilling lives and in the case of offenders, crime free lives. Research projects include; the National Drug Treatment Monitoring System in which Welsh data is collected by the Substance Misuse Intervention Branch at the National Assembly; Welsh participation in UKATT. There is a two centre randomised controlled pilot study, led from Manchester University, one of the pilot sites being in South Wales regarding Dexamphetamine Substitution as a Treatment of Amphetamine Dependence. There is monitoring and evaluation of projects commissioned through the Welsh Drug & Alcohol Treatment Fund of which evaluation is conducted at both a national and local level; an audit/review of alcohol treatment services by University of Wales Cardiff & the Substance Misuse Intervention Branch, National Assembly; a project to develop rapid screening procedures for alcohol problems; research into needle fixation by Cardiff Community Addictions Unit; an assessment the prevalence of HCV and HBV amongst IDUs hidden to drug treatment services (University of Wales) Bangor; Iechyd Morgannwg Health commissioned a mapping exercise of treatment agencies to inform future service structure and development; a current Audit Commission study of the commissioning and management of drug treatment services includes one DAAT area in Wales;

Aim IV: to stifle the availability of illegal drugs on our streets and inappropriate availability of other substances. The Sizing the UK Drug Market & Drug Seizures and Offenders Statistical Series covers Wales.

Research cutting across more than one strategic aim includes needs assessment by Gwent DAAT and University of Glamorgan; training needs analysis commissioned by Gwent DAAT; Gwent DAAT conducting in-house research into evaluation methodology; needs assessment of minority ethnic groups in Cardiff (NewLink South Wales)

**Drug Strategy research in Scotland**

Scottish Executive – key research projects in drug misuse 2001

**Training and Employment Review**

A review of how best to support recovering drug users into employment, training and education has recently been completed. The report is now available at: [www.drugmisuse.isdscotland.org/goodpractice/EIU_movingOn.pdf](http://www.drugmisuse.isdscotland.org/goodpractice/EIU_movingOn.pdf)

**International Review of Treatment Effectiveness**

A systematic review of the international research literature on the effectiveness of drug treatment is underway using the methods employed by the Cochrane Collaboration. This review will be completed by May 2002.

**Survey of opioid treatments in Scotland**

A national survey of treatments for opiate dependents in Scotland began in October 2001. Telephone interviews will be conducted with key personnel in each DAT and Health Board area. This work will be completed in March 2001.

**Review of treatment services for young people**

This project includes a literature review, an examination of service provision across Scotland and qualitative work with young people. The work will be completed by March 2002.

**Prison transitional care evaluation**

Prison transitional care arrangements will begin in Scotland later this year. The Scottish Executive are now working with the Scottish Prison Service (SPS) to design the evaluation of this initiative.
Estimating the current prevalence of problematic drug use across Scotland
A prevalence study using the capture-recapture methodology has just been completed in Scotland that allows results to be disaggregated by Drug Action Team area. The report was published in November 2001.

Evaluation of Drug Testing and Treatment Orders
An evaluation of Drug Testing and Treatment Orders (DTTOs) has recently been completed in two pilot sites in Scotland.

Randomised controlled trial of methadone and dihydrocodeine
This RCT comparing methadone and dihydrocodeine began earlier this year and will be completed in 2003.

Follow-up of 1996 Glasgow cohort of methadone users
This project is systematically following-up individuals who were part of the Glasgow methadone evaluation in 1996. The project will be completed in 2003.

Drug Strategy research in Northern Ireland

Research and Information Programme
The drug and alcohol research unit is in the process of commissioning a researcher to undertake an analysis of the drug and alcohol data from the NISRA Omnibus Survey and the Young Person’s Behaviour and Attitudes Survey. The report will be published in March/April 2002.

The drug and alcohol research unit have appointed a researcher from the Queens University Belfast to review evidence and provide an assessment of the need for substitute prescribing for heroin users in Northern Ireland. The research will also provide an estimate of the number of heroin users in Northern Ireland. The final report is due in June 2002.

The drug and alcohol research unit are also taking forward a proposal to extend a UK survey of salivary antibodies to HIV, Hepatitis B and C in injecting drug users to Northern Ireland.

In October, the drug and alcohol research unit published a report entitled ‘Heroin Use in Northern Ireland: A Qualitative Study into Heroin Users’ Lifestyles, Experiences and Risk Behaviours’. The report is available on the departmental website at dhsspsni.gov.uk

In August, a report entitled ‘Drinking, Smoking and Illicit Drug Use Amongst 15 and 16 year old School Students in Northern Ireland’ was published. This report is also available on the departmental website.
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List of abbreviations used in the text

BCS  British Crime Survey
GP   General Practitioners
RTA  Road Traffic Accident
TDI  Treatment Demand Indicator
IDU  Injecting Drug Users
GHB  Gammahydroxybutyrate
RDMD Regional Drug Misuse Databases
HOAI Home Office Addicts Index
NDTMS National Drug Treatment Monitoring System
UK   United Kingdom
EMCDDA European Monitoring Center for Drugs and Drug Addiction
NEW-ADAM New English and Welsh Arrestee Drug Abuse Monitoring
DPAS Drugs Prevention Advisory Service
DATs Drug Action Teams
DAATs Drug and Alcohol Action Teams
CARATS Counselling, Assessment, Referral, Advice and Throughcare Service
DTTOs Drug Treatment and Testing Orders
EIU  Effective Interventions Unit
UKADCU United Kingdom Anti-Drugs Coordination Unit
ESPAD European School survey Project on Alcohol and other Drugs
SCS  Scottish Crime Survey
MSGD Ministerial Steering Group on Drugs
NGO  Non Government Organisation
UN   United Nations
CARA Criminal Assets Recovery Fund
CCTV Closed-Circuit Television.
DAFT Drug and Alcohol Treatment Fund
OFSTED Office for Standards in Education
NHSS National Healthy Schools Standard
PSHE Personal Social and Health Education
HMSO Her Majesty's Stationary Office
GMR  General Mortality Register
SMR  Special Mortality Register
ONS  Office of National Statistics
HAZ  Health Action Zone
DRD  Drug-Related Deaths
GROS General Register Office Scotland
ACMD Advisory Council on Misuse of Drugs
LEA  Local Education Authority
NPSAD National Programme on Substance Abuse Deaths
DfES Department for Education and Skills
NTORS National Treatment Outcome Research Survey
TRL  Transport Research Laboratory
VSA  Volatile Substance Abuse
CDSC Communicable Disease Surveillance Centre
SCIEH Scottish Centre for Infection and Environmental Health
CPR  Cardiopulmonary Resuscitation
NI  Northern Ireland
UAPMP Unlinked Anonymous Prevalence Monitoring Programme
CITA Council for Involuntary Tranquilliser Addiction
PHLS Public Health Laboratory Service
DRG  Drug Reference Groups
TB  Tuberculosis
MDT  Mandatory Drug Testing
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<td>National Crime Intelligence Service</td>
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<tr>
<td>HDA</td>
<td>Health Development Agency</td>
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<td>Youth Action Teams</td>
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<td>Health Advisory Service</td>
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<td>Drugs Prevention Advisory Service</td>
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