



European Monitoring Centre  
for Drugs and Drug Addiction



**UK Focal Point  
On Drugs**

**2007 NATIONAL REPORT (2006 data)  
TO THE EMCDDA  
by the Reitox National Focal Point**

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

**REITOX**

**United Kingdom drug situation: annual report to the European  
Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2007**

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## **The United Kingdom Focal Point on Drugs**

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

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

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

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

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## **The structure and content of this report**

The structure and content of this annual report are pre-determined by the EMCDDA to facilitate comparison with similar reports produced by the other European Focal Points. Ten chapters cover the same subjects each year, and three further chapters, giving in-depth information on selected issues, change from year to year.

Each of the first ten chapters begins with an **Overview**. This sets the context for the remainder of the chapter, describing the main features of the topic under consideration within the United Kingdom. This may include information about the main legislative and organisational frameworks, sources of data and definitions used, the broad picture shown by the data and recent trends.

The remainder of each chapter is concerned with **New Developments and Trends** that have not been included in previous annual reports. Generally, this covers developments that have occurred in the second half of 2006 or the first half of 2007. Relevant data that have become available during this period will also be discussed although these will often refer to earlier time periods.

This report, and the reports from the other European countries, will be used in the compilation of the EMCDDA's annual report of the drug situation in the European Union and Norway to be published in 2008.

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*The United Kingdom and its constituent countries*

The United Kingdom population was estimated to be 60.6 million in the middle of 2006 (ONS *et al.* 2007): 83.8 per cent (50.8 million) live in England, 8.4 per cent (5.1 million) in Scotland, 4.9 per cent (3.0 million) in Wales and 2.9 per cent (1.7 million) in Northern Ireland.

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## SUMMARY

### Main findings

#### 1. National policies and context

A new combined Northern Ireland alcohol and drug strategy was launched in October 2007. In both England and Wales there are to be new strategies in 2008. A consultation on the strategy for England ended in October 2007. This has been accompanied by a number of reports/critiques on current strategy.

New agreements for reducing the harm caused by drugs (and alcohol) were set in October 2007 placing responsibility on a number of Government departments to meet targets set by Government. Indicator measures which will drive action are: the percentage change in the number of drug users recorded as being in effective treatment; the rate of drug-related offending; and the percentage of the public who perceive drug use or dealing to be a problem in their area.

Methamphetamine has been reclassified as a Class A drug. The Advisory Council on the Misuse of Drugs has been asked by Government to undertake a further review of cannabis looking specifically at the potential mental health effects.

There have been two Departmental changes which have implications for drug strategy and policy. One affects all of the United Kingdom where a new Ministry of Justice has assumed some of the functions formerly undertaken by the Home Office. In England, two new departments have been created: the Department for Children, Schools and Families and the Department for Innovation, Universities and Skills, the first of which assumed many of the responsibilities of the former Department for Education and Skills takes lead responsibility for prevention and work with vulnerable young people.

*The Serious Crime Bill 2006-07* will introduce Serious Crime Prevention Orders, imposing restrictions on the activities of those involved in serious crime, and will have implications for drug trafficking.

There are proposals to expand the range of controlled drugs that can be prescribed independently by Nurse Independent Prescribers and to enable Pharmacist Independent Prescribers to prescribe some controlled drugs. Suboxone (buprenorphine/naloxone) has been licensed for use in the United Kingdom.

#### 2. Drug use in the population

Latest survey data on drug use amongst adults in England and Wales (2006/07) show that the fall in recent prevalence of drug use, first seen in 2004/05, has continued. This is mainly accounted for by a fall in cannabis use. Similar trends are seen in Northern Ireland. In Scotland, changes in the methodology of the 2006 survey mean that it is not possible to make any meaningful comparisons with previous surveys.

While prevalence amongst young people (aged 16 to 24) continues to be much higher than amongst the adult population as a whole, similar trends to those found in the wider group can be seen, with declining overall drug use and cannabis use. Use of cocaine, however, has continued to increase.

Amongst school children prevalence also continues to fall. The decrease is mainly attributable to a fall in the two most common drugs, cannabis, and, amongst this group, volatile substances. Cocaine use appears to be stable.

The first survey of primary school children's knowledge and use of drugs was carried out in Northern Ireland in 2006. Most had heard of drugs, most commonly cannabis and cocaine, but a very small proportion had been offered them, and it was extremely rare for them to have tried them.

The results of drug testing amongst servicemen/women are reported for the first time in the UK Focal Point report. Prevalence is low compared to the general population. Cannabis and ecstasy were the next most commonly detected drugs.

### 3. Prevention

A review of the evidence of the effectiveness of prevention programmes found that school-based drug prevention is effective, especially amongst low risk groups, and that programmes based on life skills show the most consistent effect. Parent education shows some evidence of effectiveness. The evidence for other universal interventions; primary school based drug prevention, peer education, family interventions, and mass media was less clear.

In Northern Ireland, a website for professionals involved in drugs prevention work was launched. A bilingual (Welsh and English) 24 hour helpline was launched in Wales.

A considerable amount of work in the field of drug, alcohol and tobacco education in schools has been undertaken in Scotland in the last year.

There has been a high focus on vulnerable young people. The National Institute for Health and Clinical Excellence has produced public health guidance on community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people. Toolkits for developing local profiles of drug use among vulnerable young people and for evaluating the effectiveness of interventions have been developed. The Advisory Council on the Misuse of Drugs has reported on the implementation of its recommendations on the children of drug using parents. There is now work underway to address the needs of children in the care of the Local Authority, in both England and in Scotland, including drug use.

### 4. Problem drug use

There are new estimates of problem drug use in England:

- 327,466 opiate and/or crack users (9.88 per 1,000 population);
- 281,320 opiate users (8.48 per 1,000 population);
- 192,999 crack users (5.70 per 1,000 population); and
- 137,141 injecting users (4.04 per 1,000 population).

Based on most recent research it is estimated that there are about 400,000 problem drug users and 164,000 injecting drug users in the United Kingdom.

In 2005/6, 128,446 presentations to treatment services were recorded through the Treatment Demand Indicator, this is an increase of nine per cent from the previous year (117,781). 49 per cent concerned drug users who sought treatment for the first time ever. Opiates remain the most reported primary drug, and cannabis the second most reported.

Among those who had not previously presented to treatment there is a slightly different pattern, with opiates accounting for a slightly lower proportion and cannabis accounting for a quarter of all presentations. The latter have increased both amongst all presentations and first treatment over the last three years.

A representative survey of arrestees found that 28 per cent had taken either heroin, crack, and/or cocaine in the last month. While it is difficult to draw firm conclusions cocaine users appear to be less likely to be dependent on the drug, to use less frequently, than users of heroin or crack. Cocaine users were also less likely to use either heroin or crack.

Based on the monitoring of all those in treatment and estimates of problem drug it is estimated that the treatment engagement rate in 2005/6 was approximately 42 per cent.

## 5. Treatment

There has been a continued process of improving the quality of treatment provision in the United Kingdom. Clinical guidelines are currently being revised. In England, there have been further reviews of the quality of treatment services through the Healthcare Commission and the National Treatment Agency, additional guidelines on aspects of treatment from the National Institute for Health and Clinical Excellence: on buprenorphine and methadone for the management of opioid dependence; on naltrexone for the management of opioid dependence; psychosocial interventions; and on opioid detoxification. There is revised guidance on good practice in care planning. A Treatment Outcomes Profile has been developed in England to monitor the outcomes of treatment.

The Scottish Government launched a wide ranging review of methadone programmes, concluding that methadone should continue to be the mainstay of the treatment system.

The results of evaluations of pilot psychostimulant services in Scotland and in England have been published; neither were able to verify their effectiveness.

## 6. Health correlates and consequences

The most recently published data show that in 2005 there was a total of 1,827 drug-related death in the United Kingdom, a majority relating to opiate use. There were 45 deaths associated with Volatile Substance Abuse in 2005 (47 in 2004), this is the lowest figure since 1981.

The overall prevalence of HIV among injecting drug users (IDUs) in 2006 was similar to that seen in recent years, but remains higher than that seen in the late 1990s, with an overall prevalence of 1.3 per cent in England, Wales and Northern Ireland. In Scotland, prevalence was 0.79 per cent. The annual number of HIV diagnoses among IDUs in recent years has been low and relatively stable, an average of 140 reports during the period 1998 to 2006. However, the prevalence of hepatitis C infection among IDUs remains high overall. In 2005 and 2006 overall hepatitis C prevalence in England was 43 per cent. Prevalence in Wales was 18 per cent and in Northern Ireland 29 per cent. Prevalence is not available for Scotland, but the incidence of hepatitis C among IDUs in many parts of Scotland remains high, in the range of 12 to 29 per cent. Overall, about one in five IDUs have had hepatitis B infection.

## 7. Responses to health correlates and consequences

In England, the Department of Health has updated its action plan on reducing drug-related harm. For drug-related death there are plans for a health promotion campaign, which will be targeted at risk groups such as homeless drug users, speedballers, and new injectors. Also included, is guidance on hepatitis C, the provision of needle exchange services and testing and treatment for blood-borne virus infections in prisons and the community.

The Scottish Government published a Hepatitis C Action Plan for Scotland in 2006. One aim is to improve the accessibility and effectiveness of needle exchange and other harm reduction services at a local level. In 2007, the Scottish Prison Service began piloting an in-prison needle exchange scheme. There are also plans to provide injecting paraphernalia to all prisoners leaving prison with an identified need by mid-2008.

Hepatitis B vaccine uptake has continued to increase, with up to 2/3 thirds now in England, Wales and Northern Ireland and it is expected to plateau at 80 per cent.

The Department of Health published new guidance on dual diagnosis in mental health inpatient and day hospital settings.

In England, updated guidelines on the management of pregnant drug misusers and neonatal care are in consultation. A new assessment tool to identify the prevalence of neonatal abstinence syndrome and delayed visual maturation in infants born to drug misusing parents has been launched in Scotland.

#### 8. Social correlates and consequences

Offences under the Misuse of Drugs Act 1971 recorded by the police show that of a total of 5,428,300 recorded in England and Wales in 2006/07 194,300 (4%) were drug crimes. This is an increase of nine per cent from the previous year (178,500). This is largely attributable to increases in the recording of possession of cannabis offences.

The first representative survey of drugs and crime amongst arrestees in England and Wales covers the period 1st October 2003 to 30th September 2004. The survey found that 57 per cent of arrestees had taken one or more drugs in the last month: 46 per cent reported taking cannabis in the last month; 18 per cent heroin; 15 per cent crack; and 10 per cent cocaine (powder). Results from the Offending, Crime and Justice Surveys of 2004 and 2005 reported significantly higher drug use amongst delinquent groups and youth offenders.

The economic and social costs of Class A drug use in England are estimated to have been around €22.3 billion in 2003/04. This equates to €63,940 per year per problematic drug user. The Scottish Government has commissioned research to produce an initial estimate of the economic and social costs associated with illicit drug use

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

In England and Wales, *Clinical Management of Drug Dependence in the Adult Prison Setting* sets out how clinical services should develop during the next two years so as to be consistent with services in the community.

There has been an increase in the number of drug using offenders entering treatment through the Drug Interventions Programme.

Drug testing on arrest is being piloted for a 2 year period in Scotland.

Peer led support is now seen as part of the aftercare package of support for prisoners.

## 10. Drug Markets

There were 189,032 seizures of drugs in the United Kingdom in 2005, a 42 per cent increase from the previous year. Increases are reported for all drugs, the largest being for herbal cannabis (74.2%), cannabis plants (44.6%), and cocaine (51.5%). There was a decrease in the quantity of seizures for a number of drugs including herbal cannabis, cannabis resin, cocaine, crack and heroin. The quantity of cannabis plants seized increased substantially, as did LSD and amphetamines.

The average price of amphetamines, crack, ecstasy and heroin fell in 2006, whilst cocaine and cannabis prices remained stable. The potency of cannabis resin and herbal cannabis fell. Purity of ecstasy, cocaine and crack dropped considerably in 2006 while there was a small drop in the mean purity of brown heroin.

New research suggests that the estimated the size of the illicit drug market in the United Kingdom was €7.7 billion (£5.3b) in 2003/04, with a wide margin of error of €5.8 billion (£4.0b) to € 9.6 billion (£6.6b).

### Most relevant developments and trends

#### Relevant trends: epidemiological indicators

In terms of epidemiological indicators the most relevant developments and trends are:

The continued fall in prevalence of drug use in the general population, including prevalence of cannabis. However, cocaine use has continued to increase.

The publication of problem drug use estimates for England.

The Treatment Demand Indicator shows the continued increase in treatment across the United Kingdom. This reflects a continued expansion in treatment availability. It is of note that while there has been a relative increase in opiate presentations, as a proportion of treatment demand presentations, opiates continue to fall. Cannabis presentations continue to rise, accounting for 25 per cent of all first ever treatment demands.

In 2005 drug-related deaths in the United Kingdom rose for the second year, after a previous fall. Deaths associated with volatile substances fell to their lowest figure since 1981.

The overall prevalence of HIV among injecting drug users (IDUs) remains stable, as does the prevalence of hepatitis C infection, though it remains high (43% in England). Overall, about one in five IDUs have had hepatitis B infection.

#### Relevant developments in policy and practice

Drug strategies have been, or are being, revised throughout the United Kingdom. A combined Northern Ireland alcohol and drug strategy was launched in October 2006. In England, the process of developing a new drug strategy is underway. This is also the case in Wales where there has been a broader substance misuse strategy incorporating alcohol, drug misuse and prescribed drugs since 2000.

A review of local partnerships, Alcohol and Drug Action Teams, in Scotland affirmed their value in delivering the drug strategy.

All parts of the United Kingdom are actively pursuing improvements in the quality of drug treatment. Important developments include the revision of clinical guidelines for the treatment of drug misuse, and in England an action plan on drug-related harms in

England and a strategy for hepatitis C in Scotland. Also, technological appraisals and clinical guidelines on aspects of drug treatment from the National Institute of Health and Clinical Excellence. All of these will have implications for improvements at the local level in treatment provision and on reducing drug-related harms. With respect to the latter there should also be major improvements in the provision of syringe exchange services.

In Scotland, a review of the place of methadone in drug treatment, found it to be the most appropriate treatment for heroin addiction; but it was noted that it should be seen as the minimum treatment, not the only treatment received. In addition, a review residential detoxification and rehabilitation services in Scotland was carried out to develop a comprehensive picture of the current position and help inform future policy and funding decisions.

In England, new Public Service Agreements indicators will govern action in the field of drug misuse. These are: the percentage change in the number of drug users recorded as being in effective treatment; the rate of drug related offending; and the percentage of the public who perceive drug use or dealing to be a problem in their area.

Throughout the United Kingdom there has been increased action in the area of vulnerable young people seen as being at high risk of drug misuse.

The work around accessing drug misusers into treatment through the criminal justice system continues.

#### Consistency between indicators

##### Opiates

Evidence from research into problem drug use shows that opiates continue to be the main problem drug in the United Kingdom. In England, latest estimates suggesting 261,320 users. The proportion presenting to treatment services with opiates as main drug has fallen, however actual numbers have increased, and the TDI continues to identify opiate use as accounting for the majority of presentations to services, around 65 per cent (77,580 in the United Kingdom). Most deaths continue to be associated with opiates (chiefly heroin and morphine), with 1,046 mentions on death certificates in 2005. Data on seizures for 2005 showed a 20 per cent increase from the previous year, although there was a fall in the quantity seized. The purity of heroin fell, though not by much and there has been no clear long-term trend since at least 1984. Price has fallen slightly.

##### Cocaine

Use of cocaine has continued to rise within the general population and is the second most used drug after cannabis. In England and Wales, data from the 2006/07 population-based surveys estimated there to be 828,000 recent and 396,000 current users of powder cocaine. No estimate could be given for problem cocaine users through research into estimating the number of PDUs for England. The TDI, to some extent, reflects trends (where data is available) seen in other indicators, with cocaine presentations continuing to rise, though they still only represent 6 per cent of presentations and 9 per cent of first ever presentations. There was also a 15 per cent increase in mentions of cocaine on death certificates (221) in 2005. Data on seizures for 2005 showed a 52 per cent increase from the previous year, although there was a fall in the quantity seized. The price of cocaine is stable. Purity of cocaine dropped considerably in 2006.



### Crack

Crack use has also been identified as problematic in the United Kingdom, estimates for 2004/05 suggesting that there were 192,999 problem crack users in England. Presentations to treatment where crack is the primary drug have continued to rise, though they still only represent 6 per cent of all presentations and 7 per cent of first ever presentations. Data on seizures for 2005 showed a 31 per cent increase in the number seized since the previous year, although there was a fall in the quantity seized. Price has remained stable. Purity of crack dropped considerably in 2006.

### Cannabis

Cannabis remains by far the most used drug in the general population in England and Wales, but use has declined significantly since 1998. The decline is seen particularly amongst 16 to 24 year olds though prevalence remains higher. Recent use of cannabis is also declining amongst school children. In contrast treatment presentations for cannabis have risen as a proportion of presentations over time, reported as the primary drug in about 16 per cent of all presentations making it the next most common drug after heroin and 25 per cent for first ever treatment presentations. It is the second most reported drug after opiates. Data on seizures for 2005 showed a substantial increase in the number of seizures, with a 74 per cent increase for herbal cannabis, a 13 per cent increase for cannabis resin and a 45 per cent increase for plants, although there was a fall in the quantity of seizures of cannabis resin and herbal cannabis. Price has remained stable. Potency of cannabis resin and herbal cannabis fell

### Ecstasy

Ecstasy remains the third most used drug in the general population, higher amongst young aged 16 to 24 (5%) though recent data shows no significant change from the previous year. In terms of treatment demand, numbers are very low (600 in the UK). There were, however, 114 ecstasy-related deaths in 2005, an increase of 15 per cent since 2004. Data on seizures for 2005 showed a very small increase in the number seized from the previous year, although there was a fall in the quantity seized. Price has fallen.

### Amphetamines

In the general population recent and current use amphetamines remains low in the general population. In 2005/0 there were 1,812 presentations to treatment, 4 per cent of all presentations. However, data on seizures for 2005 showed a 19 per cent increase from the previous year, and a 58 per cent increase in the quantity seized although there was a fall in the quantity seized. Price has fallen.



## **PART A: NEW DEVELOPMENTS AND TRENDS**

### **National policy and context**

#### **1.1 Overview**

The Misuse of Drugs Act 1971 divides controlled drugs into three classes (A, B and C) depending on their potential for harm. Drugs are placed in these three classes to reflect their relative harms and maximum criminal penalties for possession, supply and production are set accordingly. In January 2004 cannabis was reclassified from Class B to Class C; in January 2006 ketamine was brought under the control of the 1971 Act as a Class C drug and in January 2007 methamphetamine was reclassified from Class B to Class A. The Drugs Act 2005 amended sections of the Misuse of Drugs Act 1971 and the Police and Criminal Evidence Act 1984, strengthening police powers in relation to drug use.

A United Kingdom Drug Strategy was launched in 1998 (UKADCU 1998) setting four principal aims: preventing drug use amongst young people; safeguarding communities; providing treatment; and reducing availability, to be achieved through education, prevention programmes, expanded treatment, legal sanctions and the expansion of legal opportunities. The strategy was updated in 2002 with an increased emphasis on Class A drugs and problem drug users (DSD 2002). Government targets for the strategy are detailed in Public Service Agreements (PSAs). New agreements for reducing the harm caused by drugs (and alcohol) were set in October 2007 placing responsibility on a number of Government departments to meet the targets set. Each of the devolved administrations<sup>1</sup> (Northern Ireland, Scotland and Wales) has its own strategy, tailored to its individual circumstances (Scottish Office 1999; National Assembly for Wales 2000; DHSSPSNI 2006). The Scottish Government<sup>2</sup> is currently looking towards consensus across the drugs field (amongst service users, their families and local communities and the political community) regarding a long-term drugs strategy. In Northern Ireland a New Strategic Direction for Alcohol and Drugs was launched in October 2006 (DHSSPSNI 2006). In Wales a new substance misuse strategy will be published in May 2008. A three month consultation on the development of the new United Kingdom Drug Strategy closed in October 2007. The consultation proposed that the primary focus of the new strategy should be to: reduce the harms caused to the development and well-being of young people and families; bring the full force of law enforcement to bear on drug dealers at all levels; reduce the harms drugs cause to the health and well being of individuals and families; reduce the impact of drugs on local communities and reduce drug-related crime and associated anti-social behaviour.

In all four administrations, delivery is through local multi-agency partnerships.<sup>3</sup> In Scotland a stock-taking exercise of Alcohol and Drug Action Teams was recently undertaken and, as part of the process of developing consensus around a long-term drugs strategy, the Scottish Government are currently working to ensure that the right

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<sup>1</sup> Devolution is the delegation of power from the UK Parliament to the Scottish Parliament and Welsh and Northern Irish Assemblies in specific policy areas.

<sup>2</sup> The Scottish Government was referred to as the Scottish Executive between 1999 and May 2007.

<sup>3</sup> In England they are known as Drug Action Teams, or if they also take responsibility for alcohol, Drug and Alcohol Action Teams (referred to collectively here as DAATs). In Northern Ireland Drug and Alcohol Coordination Teams (DACTs), in Scotland Alcohol and Drug Action Teams (ADATs) and in Wales, Community Safety Partnerships.

local delivery structures are in place with associated accountability mechanisms. In 2007 a number of functions of the Home Office became the responsibility of a new Ministry of Justice; overall responsibility for the delivery of the United Kingdom Drug Strategy remains with the Home Office.

## 1. 2 Legal Framework

### 1.2.1 Laws, regulations, directives or guidelines

#### *The Serious Crime Bill*

*The Serious Crime Bill 2006-07* is currently before Parliament. It will introduce Serious Crime Prevention Orders, through which the courts will be able to impose restrictions on the activities of those involved in serious crime, and will lead to improvements to the law on encouraging and assisting crime, with implications for trafficking of drugs.<sup>4</sup>

#### *Changes to the way the Home Office licences controlled drugs*

Changes to the way the Home Office licences controlled drugs took effect from 1st December 2006 (Home Office 2006a). Under the new system, the issue of licences will continue to be based on the activity undertaken but will now provide coverage by schedule as opposed to individual drugs within a particular schedule. This will mean, for example, that a company currently licensed for morphine (a Schedule 2 drug) will also be licensed for other drug within the same Schedule. This will provide greater flexibility for companies and a resultant saving of time and costs by removing the need to apply to the Home Office for any variations to the licence. Also, licences will no longer be valid for periods of up to a year but will be open-ended. Licences will need to be returned, as before, if a company either ceases to trade or stops holding all drugs within a particular schedule. Companies are required to submit an annual statement of compliance.

#### *Licensing of buprenorphine/naloxone*

Suboxone, a combination of buprenorphine and naloxone has been licensed for use in the United Kingdom since December 2006. It has been introduced to discourage the injecting of buprenorphine, by means of the naloxone component which precipitates withdrawal effects.<sup>5</sup>

#### *Reclassification of methamphetamine*

On 18th January 2007, methamphetamine became a Class A drug (HMSO 2007).

#### *Review of cannabis classification*

The Government has announced another review of cannabis classification by the Advisory Council on the Misuse of Drugs (ACMD) reporting to the Government in Spring 2008. The Advisory Council will specifically look at the potential mental health effects of cannabis use and the availability of stronger strains.<sup>6</sup>

A consultation document was issued, by the Home Office, on the proposals to expand the range of controlled drugs that can be prescribed independently by Nurse Independent Prescribers and to enable Pharmacist Independent Prescribers to independently prescribe controlled drugs. It also asked for views on whether Nurse and Pharmacist Independent Prescribers should be allowed to prescribe specific Schedule 2 drugs to addicts for the management of their addiction (Home Office 2007a). The consultation was open for 12 weeks, and closed on 15 June 2007.

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<sup>4</sup> See: [http://www.publications.parliament.uk/pa/pabills/200607/serious\\_crime.htm](http://www.publications.parliament.uk/pa/pabills/200607/serious_crime.htm)

<sup>5</sup> For more information see: <http://www.smmgp.org.uk/html/newsletters/net017.php#Suboxone>

<sup>6</sup> For more information see: <http://www.downingstreetsays.org/archives/004476.html>

Nurse Independent Prescribers (formerly known as Extended Formulary Nurse Prescribing) are currently able to prescribe 12 Controlled Drugs<sup>7</sup> independently, including diamorphine and morphine, solely for specified medical conditions. The Advisory Council on the Misuse of Drugs will provide its final recommendation later this year and in light of responses to the consultation and subject to Ministerial agreement, change to the legislation will follow.<sup>8</sup>

#### *Changes to the Misuse of Drugs Regulations 2001<sup>9</sup>*

A consultation document was issued on a range of proposed changes to the 2001 Regulations. The consultation ran for eight weeks and closed on the 6th July 2007. Many of the proposals had already been the subject of informal consultation with key stakeholders, enabling legislative change to follow on 26 July (*The Misuse of Drugs and Misuse of Drugs (Safe Custody) (Amendment) Regulations 2007 Statutory Instrument 2007 No. 2154*)<sup>10</sup>. The implementation of the changes is staggered over a period of time to allow the sector to make preparatory steps to ensure compliance at the date it comes into force.

The changes continue to strengthen the regulatory and governance arrangements by which the handling of controlled drugs are managed by healthcare professionals, following the findings of The Shipman Inquiry.<sup>11</sup> They also reflect the need to recognise and to give authority to possess and supply controlled drugs to new health professionals, albeit ones that are regulated, highly trained and are subject to Standard Operating Procedures within their organisations, in this case Operating Department Practitioners. Changes have also been made to the form in which the Controlled Drugs Register— where all transactions for Schedule 2 controlled drugs must be recorded by a pharmacist – is kept.<sup>12</sup>

<sup>7</sup> Nurse Independent Prescribers are able to prescribe independently the following list of Controlled Drugs for the medical conditions indicated: buprenorphine (palliative care); chlordiazepoxide hydrochloride (treatment of withdrawal of alcohol); diamorphine hydrochloride (palliative care); diazepam (palliative care, treatment of withdrawal of alcohol, tonic-clonic seizures); fentanyl (palliative care); lorazepam (palliative care, tonic-clonic seizures); midazolam (palliative care, tonic-clonic seizures); morphine hydrochloride (palliative care, pain relief in respect of suspected myocardial infarction or for relief of acute or severe pain after trauma, including in either case post-operative pain relief); morphine sulphate (palliative care, pain relief in respect of suspected myocardial infarction or for relief of acute or severe pain after trauma, including in either case post-operative pain relief); and oxycodone hydrochloride (palliative care).

<sup>8</sup> For more information see: <http://www.homeoffice.gov.uk/documants/cons-2007-indpres>

<sup>9</sup> See <http://www.homeoffice.gov.uk/documents/misuse-drug-regulations.pdf>

<sup>10</sup> See <http://www.uk-legislation.hmso.gov.uk/si/si2007/20072154.htm>

<sup>11</sup> See: <http://www.the-shipman-inquiry.org.uk/home.asp>

<sup>12</sup> The main changes made to the 2001 Regulations by SI 2007 No. 2154 are as follows : (1) Re-scheduling of Midazolam from Schedule 4 to Schedule 3 (from 1 January 2008); (2) Introduction of new requirements for requisitions for human use used for the supply of Schedule 1-3 controlled drugs in the community (from 1 January 2008) ; (3) Authority to the Accountable Officer (introduced in the Health Act 2006) to authorise persons able to witness the destruction of controlled drugs (from 16 August 2007) ; (4) Authority to Operating Department Practitioners to possess and supply controlled drugs in certain settings (ward, theatre or other department) (from 16 August 2007); and (5) Removal of the requirement to maintain a Controlled Drugs Register in the prescribed form set out in Schedule 6 of the 2001 Regulations, replaced with a requirement to record designated fields of information in a Controlled Drug Register (from 1 February 2008).

### *Warning over benzyloperazine*

The Medicines and Healthcare products Regulatory Agency (MHRA) has issued a warning over the recreational use of benzyloperazine (BZP).<sup>13</sup> BZP acts as a stimulant. Potential health risks are reported as vomiting, dizziness and allergic reactions.

### 1.2.2 Laws' implementation

#### *Guidance for police on cannabis possession*

Guidance on how the police should deal with simple cannabis possession, produced by the Association of Chief Police Officers (ACPO), has been revised following changes to police powers of arrest as a result of the *Serious and Organised Crime and Police Act 2005*. Previous guidance advised officers to issue street warnings for most possession offences, arresting only in aggravating circumstances. New guidance recognises that different communities have different crime problems and therefore leaves provision for local police commanders to arrest rather than issue a cannabis warning if this was a proportionate response within their community (ACPO 2006a).

## 1.3 Institutional framework, strategies and policies

### 1.3.1 Coordination arrangements

#### *Redefined Home Office and new Ministry of Justice*

In May 2007 a number of the functions of the Home Office, which is responsible for the United Kingdom Drug Strategy, were transferred to a new government department, the Ministry of Justice<sup>14</sup>. The Home Office remains responsible for: counter-terrorism; drugs; crime; anti-social behaviour; securing borders; legal migrants and visitors; identity and citizenship; and for 'security, justice and respect that enable people to prosper in a free and tolerant society'.<sup>15</sup> The core components of the Ministry of Justice (MoJ) are the criminal justice services, including criminal law and sentencing, courts, prison and probation services (under the umbrella of the National Offender Management Service).

#### *Department for Children, Schools and Families*

From June 2007 a new Department for Children, Schools and Families (DCSF) became responsible for policy relating to children and young people, and coordinating and leading work across Government on youth and family policy. It takes on many of the functions of the former Department for Education and Skills (DfES) including the *Every Child Matters* programme and drug education in schools.<sup>16</sup>

### 1.3.2 National plan and/or strategies

The Northern Ireland alcohol and drug strategy, *New Strategic Direction for Alcohol and Drugs 2006-2011* (DHSSPSNI 2006) was officially launched in October 2006.

The current United Kingdom Drug Strategy covers a ten year period from 1998 and therefore, a new strategy will be introduced from 2008. As result of this, there have

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<sup>13</sup> See:

[http://www.mhra.gov.uk/home/idcplg?IdcService=SS\\_GET\\_PAGE&useSecondary=true&ssDocName=CON2030603&ssTargetNodeId=389](http://www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&useSecondary=true&ssDocName=CON2030603&ssTargetNodeId=389)

<sup>14</sup> For more information see:

<http://www.homeoffice.gov.uk/about-us/organisation/home-office-reform/>

<sup>15</sup> See: <http://www.justice.gov.uk/>

<sup>16</sup> See: <http://www.number-10.gov.uk/output/Page1488.asp>

been a number of commentaries and reports, particularly from civil society, as to what might be expected within a new strategy. In addition, in 2007 there have been a number of position papers and critiques of current drug policy; notably the Royal Society for the Encouragement of Arts, Manufactures and Commerce's (RSA) (2007) report on current policy, and a report from the newly established UK Drug Policy Commission (see below).

#### *Consultation document: Drug Strategy*

A consultation document, *Drugs: Our Community, Your Say* outlined proposals for a new Drug Strategy, to be implemented from April 2008 (HM Government 2007a).<sup>17</sup> The consultation ran from July to October 2007. An alcohol strategy was launched in June 2007<sup>18</sup> and, also, a new crime strategy (launched in July 2007).<sup>19</sup> In addition, a smoke-free law came into force in July 2007, making it an offence to smoke in enclosed public places.

It is proposed that the aim of the new Drug Strategy is to make further progress on:

- reducing the harms drugs cause to the development and well-being of young people and families;
- bringing the full force of law enforcement to bear on dealers at all levels;
- reducing the harms drugs cause to the health and well-being of individuals and families; and
- reducing the impact of drugs on local communities, reducing drug-related crime and associated anti-social behaviour.

The consultation document sets out the current approach and progress to date within five main themes: young people; education and families; public information campaigns; drug treatment, social care and support for drug-users in re-establishing their lives; protecting the community from drug-related crime and re-offending; and drug enforcement and supply activity. It asked focused questions within each theme to gather views and provide ideas to develop the next drug strategy.

#### *New crime strategy*

A new crime strategy has also been published (Home Office 2007b). It suggests that the use of drugs and alcohol continue to be among the biggest causes of crime and put some people at greater risk of offending, and of being a victim of crime. Reference is made to the drug strategy consultation document in addressing drug-related crime and the importance of tackling drug misuse as a key driver of crime and offending.

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<sup>17</sup> It is noted that the formulation and delivery of the drug strategy reflects the devolution of powers to the Assemblies in Wales and Northern Ireland and the Parliament in Scotland. The United Kingdom is responsible for setting the overall strategy and for delivery in the devolved administrations only for the areas where it has reserved power. Each devolved administration exercises its delegated powers to shape the strategy to address local circumstances. The areas of reserved power include policing and the criminal justice system (including all areas of offender management) within Wales. The work of the Serious Organised Crime Agency (SOCA) and HM Revenue and Customs in addressing drug supply covers the whole of the United Kingdom.

<sup>18</sup> See:

<http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Alcoholmisuse/index.htm>

<sup>19</sup> See: [http://www.policyhub.gov.uk/news\\_item/crime\\_strategy\\_07.asp](http://www.policyhub.gov.uk/news_item/crime_strategy_07.asp)



### 1.3.3 Implementation of policies and strategies

#### *Public Service Agreements on drug misuse*

New agreements for reducing the harm caused by drugs (and alcohol) were set in October 2007 placing responsibility on a number of Government departments to meet the targets set (HM Government 2007b). The Government's delivery strategy for reducing drug harms can be divided into four main strands:

1. Disrupt the supply of illegal drugs.
2. Intervene early to prevent and reduce the harms caused by substance misuse, particularly amongst the most at risk young people and families.
3. Provide effective treatment, social care and support to improve the health and well-being of young people and adults who are already using drugs in harmful ways and to help them re-establish themselves in the community.
4. Tackle crime and anti-social behaviour associated with drug misuse and reduce the harms caused by drugs to the community and use the criminal justice system to help offenders engage with treatment services.

The indicators that will measure progress against the new PSA are:

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

In addition, the new PSA Delivery Agreement is closely linked to several other PSAs which are crucial to reducing the harms caused by drugs. These are:

- The DCSF PSA to *Increase the number of children and young people on the path to success*;
- The Ministry of Justice PSA *Make Communities Safer* which deals with the level of serious acquisitive crime and re-offending;
- The Ministry of Justice PSA *Deliver a more effective, transparent and responsive Criminal Justice System for victims and the public* and particularly in relation to the recovery of criminal assets.

#### *Key Performance Indicators for substance misuse treatment services in Wales*

Key Performance Indicators for substance misuse treatment services in Wales are now published (for more information see Chapter 5.2.2).

### 1.3.4 Evaluation of policies and strategies

#### *The Impact of UK drug strategy*

In the last year there have been a large number of publications and statements about the United Kingdom Drug Strategy, anticipating the launch of the new drug strategy in 2008. Three major reports which consider the impact of the previous strategy are described in more detail below. Other notable reports include an examination of drug policies and their links with other policy areas such as prevention, health, the law and the criminal justice system by Hughes *et al.* (2006) and an examination of the criminalisation of drug policy by Duke (2006). More specifically, Roberts *et al.* (2006) consider the measurement of drug-related harm and Newcombe (2006) considers both the latter and Public Service Agreement (PSA) targets. In addition, the London Drug Policy Forum has also produced a strategy (LDPF 2007).

#### *Independent report on drug misuse by Royal Society for the Encouragement of Arts, Manufactures and Commerce Independent review of drug policy*

An independent report on drug misuse by the Royal Society for the Encouragement of Arts, Manufactures and Commerce (RSA) (2007) argues that: illegal drugs are by

no means always harmful any more than alcohol use is always harmful. It also argues that the implementation of policy is weighted towards the criminal justice system, and that current policy neglects other approaches such as those centred on individual health, public health, families, education, housing, social care and so forth. It concludes that policy should in future be pragmatic, directed at reducing harm rather than moralistic and with its means well adapted to its ends.

The RSA report recommends that:

- The *“lead department should be the Department of Communities and Local Government.”* (p.15)
- *“the Misuse of Drugs Act 1971 and the subsequent legislation associated with it be repealed and be replaced by a comprehensive Misuse of Substances Act. The new Misuse of Substances Act should acknowledge that, whether we like it or not, drugs are and will remain a fact of life. On that basis, the aim of the law should be to reduce the amounts of harms caused to individuals, their friends and family, their children and their communities.”* (p.15)
- *“serious consideration should be given to making local Drug Action Teams statutory bodies and to giving them enhanced status, authority and responsibilities. The lead role within them should probably be given to local authorities”* (p.15)
- *“DATs should be disentangled from Crime and Disorder Reduction Partnerships and represented on Local Strategic Partnerships in their own right.”* (P.20)

#### *An Analysis of UK Drug Policy*

In a review commissioned for the independent UK Drug Policy Commission (UKDPC)<sup>20</sup>, Reuter and Stevens (2007) suggest that harm reduction measures appear to have had a major impact on the HIV epidemic among injecting drug users, but have not prevented the rise of other blood-borne viruses such as hepatitis C. They also note the success in increasing the number of dependent drug users entering treatment will have led to substantial reductions in drug use, crime and health problems at the individual level, with positive benefits for drug users, families and potential victims of crime. However, they suggest that it is unlikely that these benefits will have been translated into a substantial impact on overall levels of dependent drug use and crime at the national level. With respect to prevention, they report that there is little to suggest that drug education and prevention have had any significant impact on drug use, and despite substantial increases in drug seizures and tougher sentences for drug offenders, the prices of drugs have decreased and there is no indication that tougher enforcement has succeeded in making drugs less accessible. Further, they argue that drug policy has limited ability to influence national trends in drug use and drug dependence and therefore, it is not appropriate to judge the performance of a country's drug policy by the levels of drug use in that country.

#### *The impact of policies and strategies in the last ten years*

In a report looking at the impact of crime reduction policies and strategies since 1997, Enver *et al.* (2007) reviewed drug misuse. The authors argue that despite apparent progress against a number of targets including: numbers in treatment; targets on drugs and young people; and reducing health harms, there is a degree of

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<sup>20</sup> The UK Drug Policy Commission was established in 2007. Its objectives are to: provide independent and objective analysis of drug policy in the UK; improve political, media and public understanding of the implications of the evidence base for drug policy; and improve political, media and public understanding of the options for drug policy. The Commission is supported by a charity, the Esmée Fairbairn Foundation for its support. For more information see: <http://www.ukdpc.org.uk/index.shtml>

disconnection between policies and targets and what might actually be happening in terms of real levels of drug use, availability and associated harms, for example where the number of arrests for young people using cannabis contribute to police targets on drug arrests.

#### *Policing cannabis as a Class C drug*

A research report on policing cannabis as a Class C drug considered the impact of the reclassification of cannabis (May *et al.* 2007).<sup>21</sup> The rationale for street warnings was that they would be both a proportionate response and a time-saving one, leaving the police more time to deal with serious offences. The study largely replicated an earlier study which examined the policing of cannabis as a Class B drug (May *et al.* 2002). The researchers concluded that the reclassification has had a smaller impact than advocates hoped or opponents feared; and that the use of street warnings is now an established police practice and one that appears to be working well, but that it is essential that police policies and procedures for dealing with cannabis offences are routinely monitored and exposed to some independent scrutiny.

#### *A rational scale for assessing drug harms*

Nutt *et al.* (2007) set out the feasibility of the use of a nine-category matrix of harm, with an expert delphic procedure, to assess the medical and social harms of a range of illicit drugs in an evidence-based fashion, as an alternative to the current drug classification system.<sup>22</sup> The ranking produced by this assessment of harm differed from that of the current regulatory system. It was found that, apart from heroin and cocaine (the two substances with the highest harm ratings) there was a poor

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<sup>21</sup> This study, conducted in four areas of England, revisited the four sites within the two police forces where the first study was conducted. Work in the case study areas involved observational work with operational police officers; interviews with 150 police officers; analysis of custody records and street warning data during the period May 2004 to April 2005; and interviews with 61 young people. An internet survey of 749 respondents was also conducted. Fieldwork data was supplemented by published statistics and all fieldwork was carried out during 2005. The study included an internet survey and a survey of young people. Neither sample was representative of the overall population, but they provide some indication of knowledge and attitudes.

<sup>22</sup> The matrix designed included all nine parameters of risk, created by dividing each of the three major categories of harm into three subgroups, as described above. Participants were asked to score each substance for each of these nine parameters, using a four-point scale, with 0 being no risk, 1 some, 2 moderate, and 3 extreme risk. An overall harm rating was obtained by taking the mean of all nine scores. The scoring procedure was piloted by members of the panel of the Independent Inquiry into the Misuse of Drugs Act. Once refined through this piloting, an assessment questionnaire was developed with guidance notes. Two independent groups of experts were asked to do the ratings, firstly the national group of consultant psychiatrists who were on the Royal College of Psychiatrists' register as specialists in addiction (replies were received and analysed from 29 of the 77 registered doctors) who were asked to assess heroin, cocaine, alcohol, barbiturates, amphetamine, methadone, benzodiazepines, solvents, buprenorphine, tobacco, ecstasy, cannabis, LSD, and steroids. Secondly, a group of experts with a wider spread of expertise in many areas of addiction, ranging from chemistry, pharmacology, and forensic science, through psychiatry and other medical specialties, including epidemiology, as well as the legal and police services. This second set of assessments was done in a series of meetings run along Delphic principles, a new approach that is being used widely to optimise knowledge in areas where issues and effects are very broad and not amenable to precise measurements or experimental testing, and which is becoming the standard method by which to develop consensus in medical matters.



correlation between a drug's classification<sup>23</sup> under the *Misuse of Drugs Act* and its harm as assessed by the matrix.

#### *The reclassification of cannabis: a post-structuralist analysis*

Acevedo (2007) undertook a post-structuralist analysis of the reclassification of cannabis in the United Kingdom (2004–2005) suggesting that the political decision regarding cannabis reclassification can be understood as part of the redefinition of the 'cannabis problem' and hence, the creation of a new type of 'cannabis user'.

### **1.4 Budget and public expenditure**

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

Expenditure figures for 2005/06 are the subject of a selected issue this year and are presented in detail in Chapter 11. These have been assembled on a different basis to the figures quoted in previous Focal Point reports and should not therefore be compared.

In Northern Ireland expenditure on drugs for 2007/08 is €11.44 million, a rise of 18 per cent from 2005/06. In Wales, for 2007/08 there will be a 32 per cent increase in spending from the previous year. The allocation to Community Safety Partnerships has increased from €2.9 million to €32.3 million over the past four years.

#### **1.4.2 Funding arrangements**

NO NEW INFORMATION AVAILABLE

### **1.5 Social and cultural context**

#### **1.5.1 Public opinions of drug issues**

The 2006 Scottish Crime and Victimization Survey (see Chapter 2) found that 76 per cent of respondents rated drug use as a "big problem", the same figure as in 2004. This is again a higher proportion than for any other social issue, with alcohol abuse and crime being rated a big problem by 65 per cent and 56 per cent of respondents respectively.

#### **1.5.2 Initiatives in parliament and civil society**

A number of consultation exercises have been undertaken. There have been a number of reports on current drug strategy and suggestions and recommendations have been made as to the new strategy (see section 1.3.2). Major reports have been referred to in sections 1.3.2 and 1.3.4. All guidance from National Treatment Agency (the NTA) is published in draft to allow comments from civil society.

The main opposition party's Social Justice Policy Group<sup>24</sup> has published its report, *Breakthrough Britain: Ending the costs of social breakdown* (Social Justice Policy Group 2007). The report defined five key 'paths to poverty': family breakdown; serious personal debt; drug and alcohol addiction; failed education; and worklessness and dependency, with the suggestion that they are all inter-connected. They propose policy reforms in the areas of treatment, harm prevention and child protection. Among these proposals are: more support for abstinence treatment;

<sup>23</sup> The current classification of an illicit drug is nominally based on an assessment of risk to users and society, advice on which is provided to the Government by the independent Advisory Council on the Misuse of Drugs.

<sup>24</sup> The leader of the Conservative opposition party in the UK commissioned The Social Justice Policy Group to establish the causes of poverty and inform their future policies.

dedicated drugs courts; raising treatment threshold and provision requirements; the reclassification of cannabis from Class C to B as part of a national action plan to discourage cannabis use; and the suggestion that government should tender for well designed, systematic, experimental trials of drug testing amongst school children, to be conducted in different parts of the country and across different school settings.

With respect to harm reduction, they argue that the best way to reduce harm is to prevent it in the first place through policies aimed at an overall reduction in consumption of both alcohol and drugs, proposing a renewed commitment to the control of the supply of drugs.

### 1.5.3 Mass Media Campaigns

See Chapter 3.

## 2. Drug use in the population

### 2.1 Overview

Estimates of the prevalence of drug use in the general population in England and Wales are provided by the British Crime Survey.<sup>25</sup> Similar surveys are undertaken in Scotland<sup>26</sup> and Northern Ireland.<sup>27</sup> Combining data from these surveys in 2005, it was estimated that just over a third of the adult population in the United Kingdom aged between 16 and 64 had used an illicit drug in their lifetime. In England & Wales, for which the most complete time series data are available, prevalence of recent (last year) use had been fairly stable at around 12 per cent from 1998 to 2003 but has subsequently fallen to 10 per cent.

Young adults under 35 are significantly more likely to use drugs, and amongst those who are under 25 years old, recent (last year) and current (last month) prevalence is higher still. In England and Wales, amongst these young adults, there has nevertheless been a steady decline in the recent use of any drug since 1998.

Amongst the school age population, surveys of drug use prevalence have been undertaken in each of the four administrations of the United Kingdom.<sup>28</sup> In England, for which the longest time series are available, drug use increased between 1998 and 2003, but has fallen since then.

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

Cannabis continues to be the most commonly used drug across all age groups, with prevalence rates close to those for use of any drug. Use of other drugs is considerably lower. Since the late 1990s the British Crime Survey shows that use of cocaine increased substantially and it is now the second most used drug amongst adults. However, there has been a corresponding decline in use of amphetamines, previously the second most used drug.

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<sup>25</sup> The British Crime Survey (BCS) is a crime and victimisation survey which gathers information about experience of crime, and is designed to provide a complementary measure of crime to police recorded crime statistics. It also asks respondents about their use of drugs. In 2002 it became a continuous survey.

<sup>26</sup> The Scottish Crime and Victimisation Survey (SCVS, previously the Scottish Crime Survey) is similar in scope and aims to the BCS. Surveys were carried out, as part of the British Crime Survey (BCS) in 1982 and 1988, as the independent Scottish Crime Survey in 1993, 1996, 2000, 2003 and as the SCVS in 2004 and 2006.

<sup>27</sup> The Northern Ireland Crime Survey is also similar to the BCS. Surveys were carried out in 1994/95, 1998, 2001 and 2003/4 and the survey has been continuous since January 2005. In addition, a Drug Prevalence Survey, based on the EMCDDA model questionnaire, was carried out in 2002/03 and a second such survey has been undertaken in 2007.

<sup>28</sup> Amongst the school age population, the main sources of information on drug use prevalence are surveys undertaken in schools. In England, a survey of the prevalence of smoking, drinking and drug use amongst young people (11 to 15 year old school children), has been undertaken annually since 1998. The *Young Person's Behaviour and Attitudes Survey* was undertaken in Northern Ireland in 2000 for the first time, and repeated in 2003. It will be run again in 2007. In Scotland, the *Scottish Schools Adolescent Lifestyle and Substance Use Survey* (SALSUS) is undertaken every two years. The *Health Behaviour in School Age Children Survey* (HBSC) provides data from Wales and is undertaken every four years with a two-year interim survey. The most recent survey, was conducted in 2006.

## 2.2 Drug use in the general population

Since submission of the 2006 United Kingdom Focal Point report, results have been published from the 2006/07 British Crime Survey (BCS), covering England and Wales, the 2006 Scottish Crime and Victimization Survey and the 2005 Northern Ireland Crime Survey.

### 2.2.1 England and Wales: the British Crime Survey

The latest findings from the British Crime Survey<sup>29</sup> show that ten per cent of 16 to 59 year olds had used drugs in the last year (Table 2.1). Cannabis was the most commonly used drug for all recall periods. For last year and last month use, it was followed by cocaine powder, ecstasy and amphetamines in that order. For lifetime use amphetamines and poppers<sup>30</sup> were the second and third most commonly used drugs. The only statistically significant change between 2005/6 and 2006/7 was a decline in magic mushroom use from 1.0 per cent to 0.6 per cent.

*Table 2.1: Percentage of 16-59 year olds reporting having used drugs in lifetime, last year and last month, England and Wales, 2006/07*

	Lifetime use			Last Year use			Last Month use		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug	41.9	29.3	35.5	13.2	6.9	10.0	8.2	3.8	5.9
Amphetamines	14.8	9.1	11.9	1.8	0.8	1.3	0.7	0.3	0.5
Cannabis	36.3	24.2	30.1	11.1	5.5	8.2	6.8	2.9	4.8
Cocaine powder	10.0	5.1	7.5	3.6	1.6	2.6	1.8	0.7	1.2
Crack	1.3	0.7	1.0	0.3	0.1	0.2	0.2	0.0	0.1
Ecstasy	9.8	4.8	7.3	2.6	1.0	1.8	1.2	0.4	0.8
LSD	7.8	3.0	5.4	0.4	0.1	0.2	0.2	0.0	0.1
Magic mushrooms	10.4	4.0	7.1	1.0	0.3	0.6	0.3	0.0	0.1
Opiates	1.1	0.5	0.8	0.3	0.1	0.2	0.2	0.0	0.1
Base	13,334	15,675	28,975	13,253	15,599	28,975	13,235	15,582	28,784

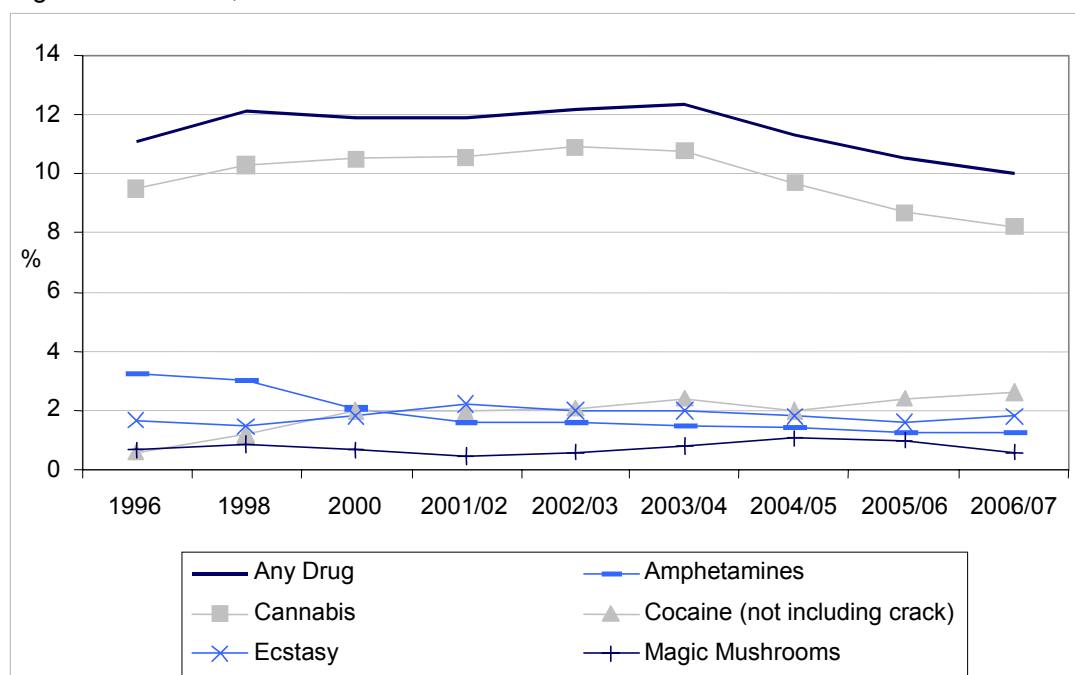
*Source: Murphy and Roe 2007*

Changes in last year prevalence since 1996 are shown in Figure 2.1. This shows a steady decline in overall drug use, and cannabis use, since 2003 and also, the increase in cocaine use and corresponding decrease in amphetamine use since 1996.

<sup>29</sup> 29,144 respondents completed the drugs module of the 2006/07 BCS and an extra 2,717 16 to 24 year olds were also interviewed as part of the 2006/07 BCS youth boost.

<sup>30</sup> Information on poppers (alkyl nitrites) is not asked for in the EMCDDA standard tables and has therefore been excluded from table 2.1. However, it is of note that 'poppers' has the third highest lifetime prevalence of drugs reported in the BCS (9.1%). Last year and last month prevalence were 1.4% and 0.5% respectively.

Figure 2.1: Percentage of 16 to 59 year olds reporting having used drugs in the last year in England and Wales, 1996 to 2006/07



Note that the first three time intervals in this graph are greater than a year  
Source: Nicholas et al. 2007

### 2.2.2 The Scottish Crime and Victimization Survey 2006

Findings from the 2006 Scottish Crime and Victimization Survey (SCVS) show that:

- 36.6 per cent of 16 to 59 year olds have ever used drugs;
- 12.6 per cent have used drugs in the last year; and
- 8 per cent have used drugs in the last month.

Cannabis is the most commonly used drug across all recall periods followed by cocaine for recent and current use. However, for lifetime use, amphetamines, ecstasy and amyl nitrate (poppers) (not a drug reported on to the EMCDDA) are more common than cocaine (Table 2.2).

Table 2.2: Percentage of 16-59 year olds reporting having used drugs in lifetime, last year and last month, Scotland, 2006

	Lifetime use			Last Year use			Last Month use		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug	42.5	30.9	36.6	16.2	9.1	12.6	10.4	5.6	8.0
Amphetamines	17.1	11.3	14.1	2.8	1.6	2.2	1.3	0.6	0.9
Cannabis	38.9	27.2	32.9	14.0	8.0	11.0	9.2	4.4	6.8
Cocaine powder	12.5	5.4	8.9	5.2	2.3	3.7	2.2	1.3	1.7
Crack	1.6	0.5	1.0	0.6	*	0.4	*	*	*
Ecstasy	13.5	6.5	9.9	4.6	1.9	3.2	2.2	1.0	1.6
LSD	11.0	4.6	7.7	1.1	0.1	0.6	0.5	0.1	0.2
Magic mushrooms	10.2	4.4	7.2	1.2	0.6	0.9	0.5	0.2	0.3
Opiates	1.9	0.6	1.3	0.9	0.2	0.6	0.8	0.2	0.5
Base	1,436	1,722	3,158	1,436	1,722	3,158	1,436	1,722	3,158

\* Less than 0.1%

Source: Standard table prepared for United Kingdom Focal Point from SCVS data;  
Brown and Bolling 2007

Men are significantly more likely to have used drugs than women with current and recent use almost double that of women.

Changes in the methodology of the 2006 SCVS from paper completion to CAPI appear to have an impact on reported drug use so it is not possible to make any meaningful comparisons with previous sweeps of the survey.

However, the new methodology is now similar to that of the BCS allowing comparison between the two surveys and showing reported drug use to be higher in Scotland than in England and Wales for all recall periods and for both men and women. (although this is without consideration of confidence intervals<sup>31</sup>).

#### *Frequency of use*

Almost half (47%) of those reporting current drug use in Scotland used drugs at least once a week with 21 per cent reporting use every day or almost every day.<sup>32</sup> Men were more likely than women to have taken drugs on at least a weekly basis in the last month (53% and 37% respectively).

### 2.2.3 The Northern Ireland Crime Survey 2005

Table 2.3 shows prevalence figures for last year use from the three most recent Northern Ireland Crime Surveys. Prevalence is generally lower than in England and Wales but shows similar patterns and trends with overall rates having fallen over the period covered by the surveys. Cannabis is the most commonly used drug followed by ecstasy. Prevalence has also fallen for both of these drugs. Use of cocaine powder increased between 2001 and 2005, although rates are lower than in England and Wales.

*Table 2.3: Percentage of 16 to 59 year olds reporting having used drugs in the last year, Northern Ireland, 2001 to 2005*

Drug	2001	2003/4	2005
Any drug	11.0	9.7	8.2
Amphetamines	1.2	0.9	1.0
Cannabis	7.3	6.4	5.8
Cocaine powder	0.5	1.1	1.0
Crack	0	0	*
Ecstasy	3.0	1.9	1.6
LSD	0.5	0	0.2
Magic Mushrooms	0.5	0.2	0.2
Base	2,037	2,121	2,381

\* Less than 0.1%

Source: McMullan and Ruddy 2006

As elsewhere in the UK, men are more likely than women to have used illicit drugs. Interestingly, the overall fall in prevalence of last year use between 2003/4 and 2005 is entirely accounted for by a considerable drop in the rate for women (from 8.1% to 4.5%). Prevalence amongst men actually rose slightly (from 11.5% to 12.4%).

### 2.2.4 Drug prevalence survey – Northern Ireland

Two bulletins containing further analysis of the 2002/03 Drug Prevalence Survey have been published. *Bulletin 5: Polydrug Use*, found that polydrug use involving illegal substances (alcohol, tobacco, any illegal drug) is low at around two per cent (NACD & DAIRU/DHSSPS 2007a). *Bulletin 6: Sedatives, tranquilisers or anti-depressants*, reported higher prevalence rates of use of these drugs amongst women

<sup>31</sup> Although using comparable methodologies, design effects and confidence intervals on the surveys vary.

<sup>32</sup> Since only a small number of respondents (n=279) reported last month drug use, a limited amount of sub-group analysis is possible.

across all recall periods and found that older respondents were more likely to have ever used than younger respondents (NACD & DAIRU/DHSSPS 2007b).

### 2.2.5 Study of factors contributing to frequency of cannabis use in England

In a study of 60 cannabis users in England<sup>33</sup>, Terry *et al.* (2007) found that external constraints were important factors in the reduction and increase of cannabis use. The most stated factor for increases in use was increased use by others (79%), followed by a change in circumstances, which provided more opportunities to use the drug (36%). Those who attempted to reduce their frequency of use commonly cited changed circumstances (55%) or negative effects of the drug (31%) as a factor. Periods of abstinence were best explained by a change in circumstances (73%) or concerns about the health consequences of use (31%).

## 2.3 Drug use amongst young adults

### 2.3.1 England and Wales: the British Crime Survey

Findings from the 2006/07 British Crime Survey show that 24.1 per cent of 16 to 24 year olds had used drugs in the last year (Table 2.4). Cannabis was the most commonly used drug followed by cocaine powder and ecstasy. The only statistically significant change between 2005/6 and 2006/7 was a decline in magic mushroom use (3.0% in 2005/06).

Table 2.4: Percentage of 16-24 year olds reporting having used drugs in lifetime, last year and last month, England and Wales, 2006/07

	Lifetime use			Last Year use			Last Month use		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug	49.3	40.1	44.7	29.5	18.8	24.1	18.6	10.0	14.3
Amphetamines	12.9	9.4	11.2	4.8	2.2	3.5	1.6	0.7	1.2
Cannabis	44.1	34.8	39.5	26.2	15.7	20.9	16.1	7.8	12.0
Cocaine powder	13.0	8.8	10.9	7.5	4.6	6.0	4.1	2.2	3.1
Crack	1.6	1.1	1.4	0.6	0.1	0.4	.	.	0.3
Ecstasy	13.1	7.6	10.3	6.5	3.1	4.8	3.6	1.4	2.5
LSD	4.6	1.8	3.2	1.4	0.2	0.8	.	.	0.3
Magic mushrooms	10.2	3.8	7.0	2.6	0.9	1.8	0.7	0.1	0.4
Opiates	0.9	0.5	0.7	.	.	0.2	.	.	0.2
Base	2,725	3,030	5,749	2,704	3,005	5,706	2,693	2,997	5,687

'.' Indicates that although the unweighted base under analysis was more than 50 there were insufficient drug users in the sample to enable robust drug group analysis.

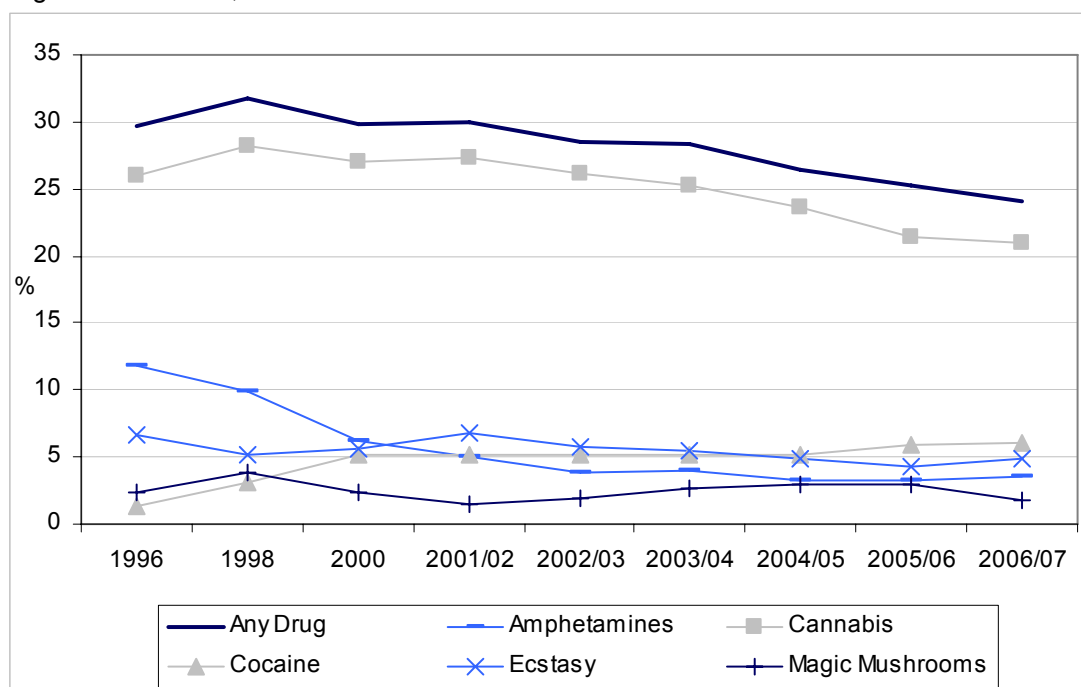
Source: Murphy and Roe 2007

Changes in last year prevalence since 1996 are shown in Figure 2.2. Prevalence of use of any drug, and of cannabis, has fallen steadily from a peak in 1998. An increase in cocaine use, particularly between 1996 and 2000, has been accompanied by a decrease in use of amphetamines.

<sup>33</sup> 60 individuals were identified from a previous survey of 190 cannabis users recruited using snowball sampling across England. Structured interviews lasting approximately 90 minutes were conducted over a period of 16 months.



Figure 2.2: Percentage of 16 to 24 year olds reporting having used drugs in the last year, England and Wales, 1996 to 2006/07



Note that the first three time intervals in this graph are greater than a year  
Source: Nicholas et al. 2007

### Frequency of Use

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

Table 2.5: Frequent use: percentage of 16 to 24 year olds (all respondents) who have used any drug more than once a month in the past year, England and Wales, 2002/03 to 2006/07

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

\*Statistically significant change 2002/03 to 2006/07

Source: Murphy and Roe 2007

### 2.3.2 The Scottish Crime and Victimization Survey 2006

Fifty-four per cent of young adults aged 16 to 34 reported lifetime use of any drug with half reporting lifetime use of cannabis (49.6%). This is slightly higher than lifetime use amongst 16 to 24 year olds (52.9% and 48.9% respectively).

For recent drug use the 16 to 24 year old age group has a higher prevalence than the 16 to 34 age group, 31 per cent compared to 23.7 per cent. This is mostly accounted for by lower drug use amongst females aged 25 to 34; 29 per cent of females aged 16 to 24 reported recent drug use compared to eight per cent aged 25 to 34. Table 2.6 shows that at age 16 to 19 there is little difference between males and females in the reporting of any drug use<sup>34</sup> but by age 30 to 34 males are four times more likely to report drug use than females.

<sup>34</sup> Although the prevalence for females appears higher, this is not a significant difference due to small base sizes.



Table 2.6: Percentage of respondents reporting last year use of drugs by age and gender, Scotland, 2006

Drug	16-19		20-24		25-29		30-34	
	Male	Female	Male	Female	Male	Female	Male	Female
Any drug	33.1	36.1	32.3	24.2	33.2	11.9	20.6	5.2
Amphetamines	6.4	6.1	4.9	5.3	5.9	3.2	1.4	0.6
Cannabis	29.8	33.0	26.8	20.9	27.0	9.4	19.5	4.3
Cocaine powder	10.6	10.2	14.5	8.2	12.8	3.1	4.8	0.9
Crack	-	1.4	1.3	-	0.7	0.6	1.3	*
Ecstasy	11.0	10.3	11.4	4.8	11.4	3.8	4.2	0.6
LSD	5.0	-	2.7	*	1.1	0.7	*	-
Magic mushrooms	1.4	2.6	3.7	2.1	1.5	1.2	1.8	-
Base	78	79	125	144	136	195	149	209

– indicates no responses; \* signifies less than 0.1%

Source: Standard table prepared for United Kingdom Focal Point based on SCVS data; Brown and Bolling 2007

As with adults, drug use is higher in Scotland than in England and Wales for the 16 to 24 age group. Last year use of any drug was reported by 31.0 per cent in Scotland compared with 24.1 per cent in the 2006/07 BCS. There were similar differences for each individual drug.

### 2.3.3 The Northern Ireland Crime Survey 2005

As elsewhere in the United Kingdom, last year prevalence is about two to three times higher for 16 to 24 year olds than for the adult population as a whole, both for use of any drug and for most individual drugs. The decline in last year use reported in the three recent surveys for this age group appears to have been particularly marked, the prevalence falling from 28.1 per cent in 2001 to 24.0 per cent in 2003/4 and 18.8 per cent in 2005.

## 2.4 Drug use in the school and youth population

In the last year new data have become available from surveys of secondary schoolchildren in England and Scotland. Results of a survey of primary school children in Northern Ireland have also been published. Section 2.6 discusses drug use amongst specific groups in the school age population.

### 2.4.1 England

The latest survey of smoking, drinking and drug use in England was undertaken in 2006 (Fuller 2007). Key findings are that:

- 17 per cent of 11 to 15 year olds had taken drugs in the last year and nine per cent had taken drugs in the last month;
- last year drug use increased with age from six per cent of 11 year olds to 29 per cent of 15 year olds; and
- the prevalence of last year drug use was similar for boys and girls but boys were more likely to be current drug users than girls.

Table 2.7 shows prevalence figures by drug. Cannabis was the most commonly reported drug for all recall periods followed by volatile substances and poppers<sup>35</sup>. Boys were more likely than girls to have used cannabis but girls were more likely to have used volatile substances and poppers.

<sup>35</sup> Poppers are not reported in EMCDDA standard tables. Lifetime, last year and last month prevalence were 6.2%, 4.2% and 1.8% respectively.

Table 2.7: Percentage of pupils reporting use of individual drugs in the last month, in the last year and in lifetime, by gender, England, 2006

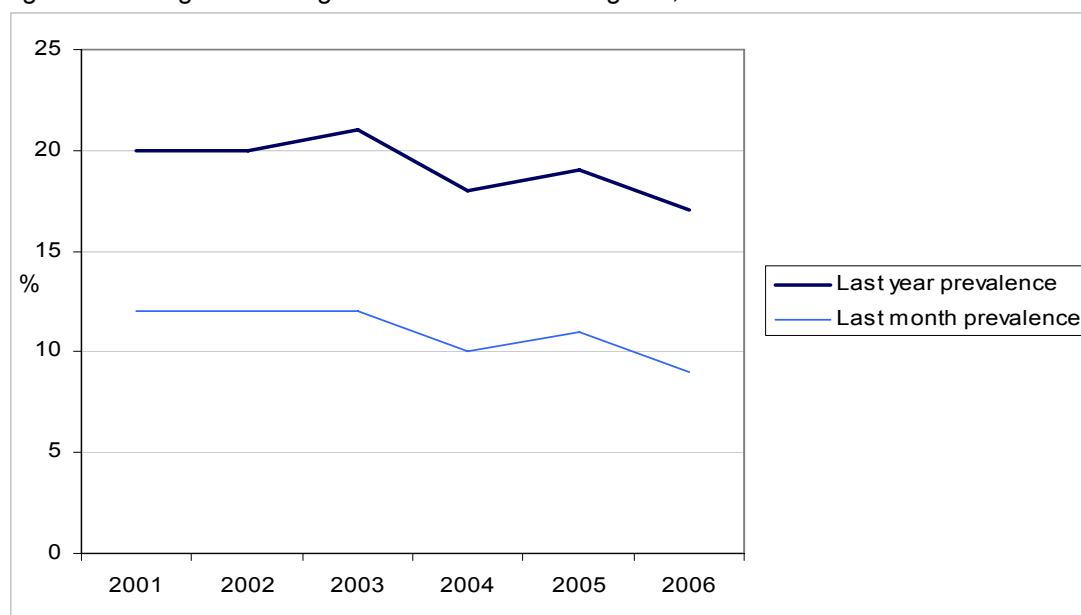
	Lifetime use			Last Year use			Last Month use		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug	24.4	23.7	24.0	16.8	16.3	16.5	10.2	8.5	9.3
Amphetamines	1.6	1.3	1.5	1.4	1.0	1.2	0.7	0.3	0.5
Cannabis	13.8	11.6	12.7	10.8	9.4	10.1	6.5	4.8	5.6
Cocaine	1.9	1.9	1.9	1.6	1.6	1.6	0.9	0.6	0.8
Crack	1.1	1.2	1.2	0.8	0.8	0.8	0.4	0.2	0.3
Ecstasy	1.9	2.0	1.9	1.5	1.7	1.6	0.8	0.7	0.7
LSD	1.2	0.9	1.0	0.9	0.6	0.7	0.5	0.3	0.4
Magic mushrooms	2.7	1.5	2.1	1.9	0.9	1.4	0.8	0.3	0.5
Opiates	1.1	1.0	1.0	0.7	0.6	0.7	0.4	0.2	0.3
Volatile substances*	10.0	12.2	11.1	4.6	5.6	5.1	2.3	2.3	2.3
Base	3,994	4,138	8,132	3,994	4,138	8,132	3,994	4,138	8,132

\*includes glues, gas, aerosols and solvents

Source: Fuller 2007

Last year prevalence amongst all school children has fallen considerably from 20.4 per cent in 2001 to 16.5 per cent in 2006. Last month prevalence has followed a similar pattern falling from 12 per cent in 2001 to 9 per cent in 2006 (Figure 2.3).

Figure 2.3: Drug use amongst school children in England, 2001 to 2006



Source: Fuller 2007

The decrease in last year drug use is mainly attributable to a fall in the two most common drugs, cannabis and volatile substances. Magic mushroom use has also decreased since 2003 but there has been an increase since 2001 in the use of cocaine (1.2% to 1.6%). However, the apparent sharp rise between 2004 and 2005 did not continue in 2006 when prevalence fell (Table 2.8). Recent use of other drugs has remained broadly stable.

Table 2.8: Percentage of pupils reporting use of individual drugs in the last year, England, 2001 to 2006

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

Source: Fuller 2007

The decline in recent use between 2005 and 2006 was seen across all ages covered by the survey.

#### Frequency of Use

The proportion of school children in England who report using drugs at least once a month declined from six per cent in 2005 to four per cent in 2006, far below 2003 levels (Table 2.9). This is largely due to a fall in frequent use amongst the older age groups, with the lowest age group reporting a stable level of frequent use. There is no difference between girls and boys overall.

Table 2.9: Frequency of use: Percentage of pupils who usually take drugs at least once a month by age, England, 2003 to 2006

Age	2003	2004	2005	2006
11 to 12 years	1	1	1	1
13 years	5	4	3	2
14 years	10	7	8	5
15 years	15	11	13	8
Total	7	5	6	4
Bases				
11 to 12 years	3796	3617	3225	2876
13 years	2087	1931	1841	1618
14 years	1945	1870	1831	1584
15 years	2205	2079	1887	1871
Total	10033	9497	8784	7949

Source: Fuller (2007)

#### 2.4.2 Scotland

The Scottish Schools Adolescent Lifestyle and Substance Use Survey<sup>36</sup> (SALSUS) was last carried out in 2006 and published in 2007. The key findings showed that:

- around a quarter of all 15 year olds (23%) and seven per cent of 13 year olds had used drugs recently;
- cannabis was the most commonly used drug for both age groups and across all recall periods; and

<sup>36</sup> SALSUS is a biennial survey carried out by schools across Scotland. The achieved sample in 2006 was 23,017 pupils in school years S(2) and S(4). The majority of pupils in S(2) were 13 years old (72%) but also included 12 year olds (27%) and 14 year olds (2%). The majority of pupils in S(4) were 15 years old (71%) but also included 14 year olds (28%) and 16 year olds (1%).

- boys were slightly more likely to have used drugs than girls in both age groups and across all recall periods.

Cannabis use accounts for most of the reports of lifetime drug use amongst 13 year olds (5.5%) and 15 year olds (24.5%). Boys, however, are more likely to have tried cannabis than girls at both ages (Table 2.10). The second most commonly used drug at age 13 is volatile substances (2.6%) but, by age 15, it is replaced by stimulant drugs, poppers (8%), ecstasy (5.4%) and cocaine (4.8%). At this age, girls are less likely to have used cocaine and amphetamines than boys, but report similar levels of ecstasy use.

*Table 2.10: Percentage of pupils reporting lifetime use of individual drugs individual drugs by age and gender, Scotland, 2006.*

Drug	13 years			15 years		
	Male	Female	Total	Male	Female	Total
Any Drug	9.0	7.7	8.5	28.6	26.2	27.4
Amphetamines	1.2	0.7	1.0	4.1	2.8	3.4
Cannabis	6.6	4.4	5.6	26.3	22.8	24.6
Cocaine	1.4	1.4	1.5	5.6	4.0	4.8
Crack	1.2	0.9	1.1	1.7	1.1	1.5
Ecstasy	1.2	1.1	1.3	5.5	5.3	5.4
LSD	0.9	0.8	0.9	2.6	1.5	2.1
Magic mushrooms	1.2	0.9	1.1	3.9	1.9	3.0
Opiates	0.8	0.5	0.7	1.1	0.7	0.9
Volatile substances	2.6	2.5	2.7	4.5	4.8	4.7
Base	5,473	5,564	11,037	6,034	5,946	11,980

Source: Standard table prepared for United Kingdom Focal Point based on SALSUS data

There were large decreases in prevalence between 2004 and 2006 with any drug use falling from 11 per cent to 6 per cent. However, caution must be exercised when comparing 2006 data, since changes to the fieldwork period may have influenced the findings.<sup>37</sup>

#### *Frequency of Use*

Results from SALSUS 2006 show that the majority of boys (83%) and girls (84%) had never taken drugs. The next most common reported frequency was having only taken drugs once (7%), with a further three per cent reporting that they used to take drugs but do not anymore. There is little gender difference at both ages, although 15 year old boys are more likely to report drug use at least once a week or most days than 15 year old girls (Table 2.11).

*Table 2.11: Frequency of use by school children in Scotland, 2006, as a percentage*

Frequency	Gender	
	Boys	Girls
Never taken drugs	83	84
Only taken drugs once	7	7
Used to take drugs but not now	3	3
A few times a year	3	2
Once or twice a month	2	2
At least once a week	1	1
Most days	2	1
Base	11,507	11,510

<sup>37</sup> The change in the fieldwork period should be taken into account when comparing results with 2002 and 2004. The 2006 survey was carried out in the Autumn term while the previous two surveys were conducted in the Spring term. This has resulted in a lower age profile for 2006 survey participants. As age has been identified as a key factor influencing the prevalence of drug use, caution should be taken when interpreting trends.

Source: ISD Scotland 2007

Pupils reporting drug use most days were much more likely to say they had ever felt they needed help because of using drugs, 12 per cent compared to two per cent of those who had tried drugs once, four per cent of those who used drugs once or twice a month and seven per cent of those who used at least once a week.

### 2.4.3 Wales

In Wales, the Health Behaviour in School Children (HBSC) survey is supplemented by questions relevant to the situation in Wales, and unlike the basic HBSC survey all questions are asked of all age groups in school. A survey was carried out in 2004 and a further survey began in 2006. No results relating to drug use are available at the time of writing.

### 2.4.4 Northern Ireland

The latest published survey of school children in Northern Ireland (DAIRU/DHSSPSNI 2004) is for 2003 and has been referred to in previous United Kingdom Focal Point reports. A school survey was carried out in 2007 and will be reported on in 2008.

#### *Survey of Primary school children in Northern Ireland*

The first ever survey of primary school children's knowledge and use of drugs was carried out in Northern Ireland in 2006 (DAIRU/DHSSPS 2007a). In a representative sample of 3,734 primary school children aged between 8 and 11, the survey found that:

- eighty-one per cent had heard of drugs before the survey, most commonly cannabis (77%) and cocaine (71%);
- the majority had heard about them from the news
- awareness increased with year group except for LSD; and
- boys were more familiar with drug names than girls.

Five per cent of those who had heard of drugs had been offered them, more than a quarter (26%) of these had been offered them by an adult they did not know. Less than two per cent of all primary school children surveyed reported they had tried drugs. The drugs most commonly tried by pupils were cannabis (31%) and solvents (27%). Eleven pupils (0.3%) reported current use.

#### Frequency of Cannabis Use among 14/15 year olds in Northern Ireland

In a survey of 3,919 year 11 pupils (aged 14 to 15) in Northern Ireland<sup>38</sup>, 36.8 per cent had used cannabis in the last year or in their lifetime (McCrystal *et al.* 2007a). Of these, 10 per cent (142) were daily cannabis users accounting for four per cent of the sample. 70.3 per cent of daily cannabis users were male and two-thirds (67%) belonged to the lowest socio-economic groups. Daily cannabis users reported high lifetime use of both legal and illegal substances and high frequency of drug use; almost half reported weekly ecstasy use compared to 2.5 per cent of low frequency users and 0.04 per cent of non-users. They accounted for almost all use of cocaine and heroin in the sample. Daily cannabis users also reported high levels of delinquency, antisocial behaviour and truancy.

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<sup>38</sup> The survey examined the drug using behaviours of 3919 year 11 pupils (aged 14 to 15 years old) attending 40 schools in three towns in Northern Ireland; Belfast, Ballymena and Downpatrick. All were participating in the fourth stage of the Belfast Youth Development Study (BYDS). Data were collected via a self-completion questionnaire by researchers with the assistance of school teachers.

## 2.5 Drug use among specific groups in the adult population

### 2.5.1 Armed Forces<sup>39</sup>

Compulsory drug testing in the Armed Forces was introduced by the *Armed Forces Act 1996*. Around 85 per cent of servicemen and women are tested annually (House of Commons Written Answers for 10 May 2006). The rate of positive tests increased in 2004 and again in 2005, falling in 2006. The proportion testing positive for Class A drugs increased considerably in 2005 (Table 2.12). In 2006, 55.5 per cent of positive tests contained traces of cocaine; 45.4 per cent for cocaine alone. Cannabis and ecstasy were the next most commonly detected drugs, 33.5 per cent testing positive for cannabis (28% cannabis alone) and 18.1 per cent testing positive for ecstasy (10% ecstasy alone). Detection rates for other drugs were less than five per cent.

Table 2.12: Drug tests and outcomes amongst Armed Forces personnel, 2000-2006

Year	No. tested	No. Positive	% Positive	No. Class A	Class A as % of positives
2000	107,142	760	0.71	323	42.5
2001	96,504	705	0.73	344	48.8
2002	89,585	567	0.63	255	45.0
2003	95,376	594	0.62	282	47.5
2004	88,747	705	0.79	273	38.7
2005	91,711	863	0.94	535	62.0
2006	129,888	844	0.65	480	56.9

Source : MOD 2006; House of Lords Written Answers Tuesday 17 April 2007

The Army has the highest rate of positive tests (0.74%) of all three services; Royal Navy (0.46%) and the Royal Air Force (0.14%). Junior ranks are responsible for almost all positive tests with, on average, one officer/cadet testing positive per year. Of the 844 military personnel who tested positive in 2006, 783 (92.7%) have been discharged (House of Lords Written Answers, Wednesday 25 April 2007).

### 2.5.2 Minorities

See Section 2.6.2 for schoolchildren from ethnic minorities

### 2.5.3 Sex workers

Jeal and Salisbury (2007) surveyed 71 sex parlour workers about their health needs and service use and compared the results to their previous findings for street sex workers.<sup>40</sup> The study highlighted differences in the drug use characteristics of street workers and parlour workers. Ninety-six per cent of street workers had used drugs every day in the last 30 days compared to 23 per cent of parlour workers. Eighty-seven per cent of street workers reported crack use and 85 per cent heroin use compared to seven per cent and six per cent respectively of parlour workers.

A report by Terrence Higgins Trust (2006), which questioned 37 sex workers in an English city, found similar differences between street-based and indoor sex workers. All street workers used drugs, with three quarters using heroin or crack while only 30

<sup>39</sup> EMCDDA reporting guidelines ask for information on conscripts. There is, however, no conscription (compulsory military service) in the United Kingdom.

<sup>40</sup> The study used an interviewer-administered questionnaire based on the same questionnaire used for the health needs assessment of street workers three years previously (Jeal and Salisbury 2004). Participants were female sex workers, whose current main city of work was Bristol and who worked in massage parlours



per cent of indoor workers used drugs, mostly recreational drugs such as ecstasy or cocaine.

#### 2.5.4 Gay men

Findings from the United Kingdom Gay Men's Survey 2005<sup>41</sup> show widespread recent drug use (Hickson *et al.* 2007). Amyl nitrite was the most commonly used substance in the last year (39.4%), followed by cannabis (27.7%). The majority of users were poly drug users (Table 2.13). Factors associated with higher current drug use included living in London, being aged 20 to 39 years old, mixed ethnicity and being HIV positive. Ethnicity, post 16 education, annual income and current religious practice affected which drug was used.

Table 2.13: Last year use of individual drugs amongst gay men in the United Kingdom, 2005

Drug	Last year use (%)
Amphetamines	7.2
Amyl nitrite/poppers	39.4
Benzodiazepines	4.1
Cannabis	27.7
Cocaine (powder)	16.8
Crack	1.4
Crystal Meth	2.8
Ecstasy	18.5
GHB	3.6
Heroin	1.0
Ketamine	9.1
LSD	2.8
Methamphetamine	2.8
Viagra	17.4

Source: Hickson *et al.* (2007)

## 2.6 Drug use amongst specific groups in the school age population

### 2.6.1 Truants and excludees

In the English Schools survey for 2006, 19 per cent of pupils reported past truancy and 12 per cent reported having been excluded from school.<sup>42</sup> Those who had truanted or been excluded from school were more likely to report frequent drug use (11%) than those who hadn't (1%) although there had been a decrease from 2005 (17%). Truants and excludees were also much more likely to report Class A drug use, 14 per cent compared to one per cent.

The SALSUS Schools Survey in Scotland found that current drug users were around three times more likely to report truancy in the past year than those who had never used drugs and were more likely to be frequent truants, 24 per cent of 13 year old current users had truanted more than ten times compared to two per cent of those who had never used drugs.

<sup>41</sup> The Gay Men's Sex Survey 2005 is an annual survey carried out by Sigma Research in partnership with 107 health promotion agencies across the United Kingdom. It uses a self-completion questionnaire distributed in booklet form by a range of Gay and HIV health promotion agencies. The survey is also available for completion online and heavily promoted by Gay commercial websites. The final sample included 16,426 men aged 14 years and over living in the UK who either had sex with a man in the last year and/or who expected or were not sure if they would do so in the future.

<sup>42</sup> Recorded levels of truancy and exclusion should be viewed with caution as they are based on self-reported data. In addition, regular truants and those excluded from school during the fieldwork period were almost certainly under-represented in the sample.

### 2.6.2 Ethnic minority school children

Jayakody *et al.* (2006) looked at ethnicity and drug use amongst 2,723 year 7 (11 to 12 years) and year 9 (13 to 14 years) school children in East London. When adjusted for socio-economic status, sex, year group and years lived in United Kingdom, Black Caribbean, Mixed ethnicity and White British children reported higher levels of cannabis use. Bangladeshi, Indian and Pakistani children were less likely to have used cannabis but more likely to have used volatile substances than other pupils. Around half of year 9 Bangladeshi pupils had tried paan<sup>43</sup> in their lifetime. Only two per cent of pupils had ever used class A drugs or amphetamines. The study found large differences between ethnicities commonly grouped together as 'black' (Table 2.14).

Table 2.14: Percentage of year 9 pupils (aged 13 to 14) reporting lifetime use of cannabis and volatile substances, by ethnicity and sex

Ethnicity	Cannabis		Volatile substance		Class A or amphetamines	
	Boys	Girls	Boys	Girls	Boys	Girls
White British	18.3	15.9	1.6	2.6	2.6	2.0
White other	9.5	12.4	0	3.0	3.0	0
Bangladeshi	12.1	4.5	2.2	5.7	3.7	1.2
Pakistani	8.0	2.3	4.5	6.2	0	2.0
Asian Indian	3.6	3.1	4.9	2.2	4.6	0
Black Carib'n	24.6	25.4	0	0	4.7	0
Black African	3.7	10.1	1.5	3.6	0	2.4
Black British	19.5	17.0	0	3.0	0	0
Mixed ethnicity	30.0	17.4	0	2.0	7.1	6.1
Other ethnicity	13.7	21.3	0	0	3.9	4.4
Total	13.5	10.9	1.9	3.4	3.1	1.6
Base	651	723	649	720	650	720

Source: Jayakody *et al.* 2006

### 2.6.3 Income and drug use

Analysis of the Belfast Youth Development Study<sup>44</sup> showed that higher income amongst year 10 (aged 13/14 years old) pupils was positively associated with levels of lifetime use for both licit and illicit drugs (McCrystal *et al.* 2007b). Two-thirds of those who received a weekly income of more than £60 (€86.74)<sup>45</sup> had used cannabis and more than one-third (36%) had used ecstasy compared with one-third and six per cent respectively of all study participants. Pupils who received no money were much less likely to have taken drugs, around 12 per cent had used cannabis and one per cent had used ecstasy.

### 2.6.4 Schoolchildren with a moderate learning disability attending special schools

Findings from 4 years of the Belfast Youth Development Study (BYDS) suggest that young people attending special schools are at a lower level of risk to drug use than those attending mainstream school (McCrystal *et al.* 2007c). Among a cohort of young people with a statement of special education needs attending a special school, cannabis use was the only illicit drug reported. Thirteen per cent of year 12 pupils attending the special school had tried cannabis compared to 47 per cent attending

<sup>43</sup> Paan is the nut of the *Piper betel*. It is commonly chewed for a period of about 20 minutes after which the fibrous residue is often spat out. The International Agency for Research on Cancer (IARC) suggest the betel nut is human carcinogen. People chewing tobacco in paan are over five times more likely to be at risk of oral cancer.

<sup>44</sup> Analysis based on 4,524 questionnaire responses from year 10 (13/14 years old) pupils in three secondary schools in Northern Ireland.

<sup>45</sup> Bank of England annual spot exchange rate 2003/04.



mainstream schools. The findings should be treated with caution as the sample size for special schools was much lower than the sample size for the mainstream schools.

#### **2.6.5 Looked after children**

The Department for Education and Skills (DfES) started collecting information on the number of looked after children identified as having a substance misuse problem in 2006. Of the 44,200 children looked after for at least 12 months, 2,300 (5.1%) were identified as having a substance misuse problem in the year to 30 September 2006 (DfES 2007a).

#### **2.7 Relationship with other indicators and trends in a wider context**

Consistency between indicators is discussed in the introductory section of this report and the relationship between general prevalence data, treatment demand data and problem drug use estimates is discussed in Section 4.5.1.

There appears to be no research that sheds light on the reasons for the recent declines in reported cannabis use, particularly among young people, and which are reflected in overall prevalence trends.

## 3. Prevention

### 3.1 Overview

Prevention of young people's drug use is a key element of drug strategies in the United Kingdom. In England, particular focus has been on a reduction of use of all Class A drugs, and the frequent use of any illicit drug particularly amongst vulnerable young people. Consultation on a new drug strategy, mostly relating to England (HM Government 2007a)<sup>46</sup> designates better education and intervention for young people and families (especially those most at risk) and better public information about drugs as priority areas.

Universal drug prevention initiatives are an important area of policy in the field of prevention. Communication programmes such as FRANK<sup>47</sup> in England and Know the Score<sup>48</sup> in Scotland provide information and advice to young people and their families. In Northern Ireland, the Health Promotion Agency develop public information campaigns for various target groups and settings<sup>49</sup> and in Wales, a Drug and Alcohol Helpline, Dan 24/7<sup>50</sup> was launched in 2006. Throughout most of the United Kingdom drug prevention is part of the national curriculum and most schools have a drug education policy and guidelines around dealing with drug incidents. Guidance on drug education recommends an approach that includes all psychoactive substances, including alcohol and tobacco, and places drugs education within the wider health and social education agenda.

More recently, drug prevention has become embedded in policy for children and young people aimed at enabling them to reach their full potential. In England the relevant programme is called Every Child Matters: Change for Children<sup>51</sup> and is described in Every child matters: change for children, young people and drugs (DfES, Home Office and DH 2005). There are similar documents in Scotland, Getting it Right for Every Child<sup>52</sup> and Delivering a Healthy Future An Action Framework for Children and Young People's Health in Scotland<sup>53</sup>; and in Wales in Children and Young People: Rights to Action (2004).<sup>54</sup> In Northern Ireland the latest drug strategy, New Strategic Direction for Alcohol and Drugs (2006-2011), identifies that at risk and vulnerable young people require specific targeting and Our Children and Young People – Our Pledge: A 10 year strategy for children and young people in Northern Ireland, 2006-2016<sup>55</sup> sets a framework for addressing the needs of young people;

In England action on young people and drugs is covered within DCSF's Public Service Agreement on increasing the number of children and young people on the path to success.

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<sup>46</sup> The areas of reserved power include policing and the criminal justice system (including all areas of offender management) within Wales. The work of the Serious Organised Crime Agency (SOCA) and HM Revenue and Customs in addressing drug supply covers the whole of the United Kingdom.

<sup>47</sup> See: <http://www.talktofrank.com>

<sup>48</sup> See: <http://www.knowthescore.info/>

<sup>49</sup> See: <http://www.healthpromotionagency.org.uk/work/drugs/publications.htm>

<sup>50</sup> See: <http://www.askdan.org.uk/>

<sup>51</sup> See: <http://www.everychildmatters.gov.uk/aims/>

<sup>52</sup> See: <http://childpolicyinfo.childreninscotland.org.uk/index/news-app?story=4989>

<sup>53</sup> See: <http://www.scotland.gov.uk/Publications/2007/02/14154246/12>

<sup>54</sup> See: <http://www.learning.wales.gov.uk/pdfs/children-and-young-people-e.pdf>

<sup>55</sup> See: <http://www.allchildrenni.gov.uk/tenyearstrategychildren1-2.pdf>

In England, the High Focus Area (HFA) initiative<sup>56</sup> supports progress on implementing *Every Child Matters: Change for Children – Young People and Drugs*. It aims to make an early and sustained impact on the drugs PSA target and develop better ways to capture learning from local areas to better understand ‘what works’ in interventions to prevent drug misuse and improve outcomes for young people.. Interventions focus on looking to address a range of potential harms, including drug use, by children themselves and by their families, which are viewed as putting children at risk. In England and in Wales, all local areas are expected to produce Children’s and Young People’s Plans for all local services for children and young people, including prevention and treatment. In both countries, a Common Assessment Framework (CAF) has been developed to help practitioners working with young people to determine their needs, including drug issues. All local areas are expected to have in place universal targeted and specialist support for young people around drug issues. In Scotland, an Integrated Children’s Services Planning framework<sup>57</sup> requires the development of a single plan agreed with all relevant agencies to deliver integrated services for all children and young people, including those who are vulnerable and at risk.

Current policy acknowledges that some groups of young people are more vulnerable to developing substance misuse problems than their peers and suggests more needs to be done for these young people. This is particularly highlighted in the consultation document on the Government’s new drug strategy.

Communities are provided with assistance through a range of initiatives to build the capacity to resist drugs, as well as being expected to have in place a range of prevention initiatives. Also, there are specific interventions targeting young people in deprived communities, for example, Positive Futures (PF), a sports-based social inclusion programme in England aimed at marginalised 10 to 19 year olds, with projects in some of the most deprived areas in the country, as identified by the Index of Multiple Deprivation.<sup>58</sup> Other projects to prevent drug harm and to ensure that all children and young people are able to reach their potential are running in ‘High Focus Areas’<sup>59</sup> in England which have high levels of crime and deprivation and/ or where drug misuse problems tend to be most prevalent. In Scotland, a number of projects are funded by the Scottish Government in partnership with Lloyds TSB Partnership Drugs Initiative (PDI), targeting children with, or at risk of, problem drug misuse, as well as those affected by familial drug use.

### 3.2 Universal prevention

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

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<sup>56</sup> See: <http://www.homeoffice.gov.uk/drugs/drugs-misuse/preventing-drug-misuse/>

<sup>57</sup> See: <http://www.scotland.gov.uk/Topics/Government/DataStandardsAndCare/ChildrenandFamilies/IAF>

<sup>58</sup> For more information see:

<http://www.communities.gov.uk/publications/communities/englishindices>

<sup>59</sup> The High Focus Area (HFA) Initiative was launched in England in April 2005 as part of a joint strategy between the Home Office, the Department for Education and Skills and the Department of Health, in 30 local authority areas to support faster and sustained progress in implementation of universal, targeted and specialist services as set out in strategic guidance *Every Child Matters: Young People and Drugs*, and to learn from their experience. The areas were selected on the basis of local need and levels of current service provision, including deprived/high crime areas where drug misuse problems are prevalent.

### 3.2.1 National drug strategy

With respect to universal prevention, the consultation document on the United Kingdom Government's new drug strategy states that the evidence suggests the importance of the role played by schools in drug prevention (HM Government 2007a) (see Chapter 1.3.2 for more information on this consultation document).

### 3.2.2 Universal prevention campaigns

In 2005/06 the FRANK website received 5.7 million hits from over 2 million visitors and the telephone helpline received approximately 1,350 calls per day; it is accessible in 120 languages. In 2006 its national television and radio advertising campaign had a particular focus on cannabis, including a 'Brain Warehouse' campaign. A future campaign focusing on cocaine is planned (Home Office 2007c).

In Northern Ireland, the Health Promotion Agency has developed a new website, DrugsAlcohol.Info, for professionals involved in drugs prevention work.<sup>60</sup>

In Scotland in 2006, the Know the Score website averaged over 14,000 visits per month and over the year received almost one million page hits from 171,000 visitors, with the pages on cannabis, cocaine and the drugs A - Z guide being the most popular. The Scottish Government published a qualitative post-campaign evaluation of the 2006 'Know the Score' anti-heroin media campaign (Scottish Executive 2007a), which reported high levels of campaign awareness. The evaluation focused on the impact it had on attitudes towards heroin use, and not on actual use of heroin. In 2007 the Scottish Government published a quantitative post-campaign evaluation of phase 3 of the 'Know the Score' anti-cocaine campaign. (Scottish Executive 2007b). The research focused on a primary audience of 16 to 26 year olds<sup>61</sup>. In general, the results were similar to those for earlier phases of the campaign, 58 per cent reported that the campaign had not altered their likelihood of taking cocaine.

The All Wales Drug and Alcohol Helpline, Dan 24/7, was officially launched in September 2006.<sup>62</sup> The helpline offers a bilingual service throughout Wales and is available 24 hours.

### 3.2.3 School

See above with respect to the Government's consultation on a new drug strategy.

#### An evaluation of Blueprint

The final evaluation report of Blueprint is due to be published in the autumn of 2007.<sup>63</sup>

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<sup>60</sup> See: <http://www.drugsalcohol.info/Home.aspx>

<sup>61</sup> A total of 443 interviews were conducted over the period 19th to 22nd December 2006 with a sample of young people aged between 16 and 26, who go out socialising once a week or more often and do not hold an anti-drugs attitude. Respondents were recruited on the street and invited into a central location. The interviews were carried out using a self completion multimedia CAPI (Computer Assisted Personal Interviewing) machine. Interviews were conducted in Dundee, East Kilbride, Edinburgh, Falkirk and Glasgow. This was the fourth wave of quantitative research have been conducted to evaluate the campaign. This wave evaluated the third phase of the campaign. For the purposes of analysis, respondents were split into one of the following four exposure groups based on the level of risk of encountering cocaine: *Cocaine users*, *high cocaine exposure* (but do not take cocaine), *high other drug exposure* (but not exposed to cocaine) and *low risk* (the remainder) <http://www.scotland.gov.uk/Publications/2007/08/03121046/0>

<sup>62</sup> For more information see:

<http://new.wales.gov.uk/news/archivepress/socialpress/socialpress2006/1085839/?lang=en>

### Drug, alcohol and tobacco education in schools in Scotland

An evaluation of the effectiveness of drug education in Scottish secondary schools (Stead *et al.* 2007)<sup>64</sup> reported that the vast majority of schools in Scotland provided drug education. It was suggested that while there is much good practice more can be done to enhance effectiveness, particularly through clearer guidance on evidence-based methods and approaches; continuity and progression; further training and support to boost teachers' knowledge, skills and confidence; and more attention to resources. Consideration will now be given by the Scottish Government, in conjunction with key stakeholders, to the implications of the research for policy and practice in the delivery of drugs education in Scottish schools.

In Glasgow, three schools piloted a consultancy service programme in 2004/05 to improve their curricular provision on drug and alcohol issues, in line with national best practice guidelines and Glasgow's health curriculum guidance. An evaluation<sup>65</sup> of this found that teachers and pupils felt that the project has led to recognisable improvements in the way staff and pupils experience drug and alcohol lessons (Fitzgerald 2006). The programme was extended to all other mainstream schools in Glasgow City in the 2005/06 academic year.

Primary schools in Scotland have been participating in a number of events, called *Choices for Life*, designed to promote healthy lifestyles and provide drug, alcohol, tobacco and mental health awareness. An evaluation suggested that they were successful in entertaining and stimulating pupils and in making them think about the issues relating to drugs, alcohol, tobacco and mental health; and in reinforcing children's existing negative attitudes about drugs. However, it was not possible to measure the impact on their behaviour (Menzies and Myant 2006).

*The Schools (Health Promotion and Nutrition) (Scotland) Act 2007* places a duty on Scottish Ministers and local authorities to endeavour to ensure that all schools are health promoting. Guidance will be issued to local authorities on health promotion and this will include drugs/alcohol and tobacco education.

### All Wales Schools Programme

A formative evaluation of the All Wales Police Schools Liaison programme was carried out by the University of Wales (Tregida *et al.* 2005)<sup>66</sup> focusing on processes

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<sup>63</sup> Blueprint is a five-year research programme that evaluates the effectiveness of drug prevention initiatives in schools and community settings. It involves 29 secondary schools in four LEA areas; 23 are adopting the Blueprint multi-component drugs education programme, while six continue with their existing drug education programme to act as a comparison sample.

<sup>64</sup> The research consisted of a literature review, a survey of schools, classroom observations and qualitative research with young people and was commissioned in response to the School Drug Safety Team's recommendation for research into the outcomes and process of educating young people on drug related issues.

<sup>65</sup> The evaluation was conducted between November 2005 and February 2006. The study had four elements: semi-structured interviews with a lead teacher; a survey of a sample of teachers delivering drug and alcohol education in the 12 schools; 10 focus groups with pupils; and a validation workshop with eight representatives from six of the 12 schools to present and discuss the findings and agree recommendations arising from the evaluation.

<sup>66</sup> The evaluation incorporated a mapping exercise; programme observation in schools and focus groups with young people; and stakeholder interviews. The mapping exercise was to consider matters of coverage and 'penetration'. While the Programme in Gwent was already well established, the Programme elsewhere in Wales had largely been operational only since the autumn of 2004 i.e. for just one school year at the time of evaluation in 2005. The aim was to establish how many schools had been 'reached' in that short time. For the observation in

rather than the actual outcomes in terms of whether the initiative reduces drug use. It was reported that whilst there had been good progress in implementing the programme nationally, it was noted that it was still at a relatively early stage of development and in future, needed to be more flexible in order to address any particular local issues for schools. The main consideration of future evaluations will be the effects of the programme on pupil's values, attitudes and behaviour. A second external evaluation is being undertaken, and is due to be presented to the Welsh Assembly Government by December 2007.

### Random Drug Testing in Schools

In England, the Department for Children Schools and Families (DCSF) is aware of three maintained<sup>67</sup> schools which have tested pupils for drugs<sup>68</sup>. There are no plans to introduce random and compulsory drug tests for all school children.

#### 3.2.4 Evidence review of drug prevention

In the Annual Review of Drug Prevention<sup>69</sup> Sumnall *et al.* (2006a) built on the findings of three previous National Collaborating Centre on Drugs Prevention (NCCDP) briefing papers: one on vulnerable young people (Edmonds *et al.* 2005); one on a tiered approach to prevention and treatment (Burrell *et al.* 2006); and one on universal prevention (Jones *et al.* 2006). Evidence was graded in terms of the following four star ratings:

Rating	Basis for evidence
*	based on experience of best practice by health professionals and expert groups;
**	only one medium quality study from the United Kingdom, two or more studies with inconsistent findings or studies of medium quality <sup>70</sup> outside the United Kingdom;

Schools/Focus Groups the evaluation focussed on secondary schools. Where possible, schools were visited when elements of the Programme were 'in action', but all visits to schools incorporated interviews with school staff, the relevant police Schools Liaison Officer (SLO), and pupils who had experienced the Programme. Stakeholder interviews were conducted after an analysis of documents relating to the Programme, active participation in schools, and observation of external events and in-school Programme delivery. This approach permitted a grounded inquiry into a range of issues on which stakeholders were encouraged to convey their perspectives. Interviews were conducted with a variety of stakeholders related to the Programme e.g. personal, health and social education (PHSE) co-ordinators and behaviour improvement officers in schools, substance misuse education workers, youth workers. The evaluation explored their awareness and understanding of the Programme and the contribution they believed it made. This methodology provided the data and basis for the subsequent analysis.

<sup>67</sup> In the United Kingdom, a state school that has voluntarily withdrawn itself from local authority support (an action called opting out), and instead is maintained directly by central government. The schools are managed by their own boards of governors.

<sup>68</sup> See:

<http://www.publications.parliament.uk/pa/cm200607/cmhansrd/cm070122/text/70122w0008.htm>

<sup>69</sup> In this review, drug prevention is defined as those interventions that prevent the onset, delay initiation, promote cessation and reduce the harms associate with drug use.

<sup>70</sup> Medium quality findings were defined as being based upon well conducted, non-randomised intervention studies (controlled non-randomised trial, controlled before-and-after, interrupted time series), comparative cohort and correlation studies with a low to medium risk of confounding, bias or chance. Good quality findings were defined as being based upon well-conducted meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a low to medium risk of bias. Findings that did not fall under these criteria were either excluded or only included as contextual information.



- \*\*\* one good quality study or consistent findings in two or more studies of medium quality or two or more good quality studies from outside the UK;
- \*\*\*\* consistent findings in two or more studies of good quality carried out within the UK and applicable to the target population.

An additional criterion was used to signify which prevention approaches warrant further research. Evidence was rated for school based prevention programmes, family based universal prevention programmes, community-based universal prevention programmes and generic universal prevention programmes. This was also applied to generic interventions for vulnerable or at-risk young people, peer-led education, specialised and alternative education provision, interventions for cared-for youth, family based interventions, interventions for young offenders and interventions for young people in BME (black and minority ethnic) communities.

#### Key findings:

- School-based drug prevention, for which the evidence was given a 3\* rating is shown to be effective, but most especially amongst low risk groups. Programmes based in life skills show the most consistent effect. Parent education, also given a 3\* rating shows some evidence of effectiveness;
- the evidence grading for other universal interventions; primary school based drug prevention, peer education, family interventions, and mass media, was given a 2\* rating; and
- it was suggested that community-based drug preventions warrant further research.

This review also refers to the economics of drug prevention, with a description of the four main types of economic analysis (described here as cost-effectiveness analysis, cost-utility analysis, cost-benefit analysis and cost-minimisation analysis). It is suggested that economic evaluation offers the opportunity to inform planners and prioritise finite resources. The key issues are introduced and discussed in a further report by Fordham *et al.* (2007).

#### 3.2.5 Reviews of policy on prevention

In the independent review, *Drugs – facing facts* (RSA 2007) (see Chapter 1.3.2) it is proposed that school drugs policy should be shifted, and concentrated earlier, in primary school and that prevention should also focus on the period immediately after leaving school. It is suggested that in the early years the first interventions in school may not tackle drugs issues directly, but instead aim at giving children the support, skills and strength that they might require in order to deal with problems they may encounter in the future. This report also argues that Government should acknowledge that there is no way of preventing all people from using all drugs. Further, it is suggested in their consideration of the three main drug prevention strategies in the United Kingdom (mass media campaigns; drug education in schools; and efforts to raise awareness and change attitudes towards drug taking amongst vulnerable and disadvantaged young people) that there are two main limits to the likely return on investment in all three of these strategies. The first is that research evidence suggests that prevention rarely leads to reduced drug use, and secondly, that even if it does reduce some drug use, this is unlikely to lead to major reductions in drug problems.

#### 3.2.6 Funding

The Young People's Substance Misuse Partnership Grant for England will total €81 million in 2007/08. This cross departmental grant is managed by the Home Office and is for the delivery of a range of local universal, targeted and specialist substance



misuse interventions for children and young people in line with strategic guidance issued in March 2005 to local Directors of Children's Services and Drug Action Teams, *Every Child Matters: Change for Children Young People and Drugs*.

### 3.2.7 Family

#### *Parenting programmes*

In a systematic review of parenting programmes for preventing use of drugs (as well as tobacco and alcohol) Petrie *et al.* (2007)<sup>71</sup> concluded that parenting programmes can be effective in reducing or preventing substance use. The most effective were those that shared an emphasis on active parental involvement and on developing skills in social competence, self-regulation and parenting.

### 3.2.8 Community

#### *Final report on Positive Futures*

The final case study research report draws out the key themes about both the contribution of Positive Futures and the lessons which will help to establish a benchmark for sport and activity based social inclusion programmes in the future (Crabbe *et al.* 2006). While there is a high level of confidence by agencies working with the programme of its effect in reducing drug use, there has been no evaluation of its actual impact in terms of reducing drug use.

#### *Community - level prevention in colleges*

*Let's Talk About Drugs* investigated the feasibility of a community-level drug intervention based upon the principles of motivational interviewing within a further education college. It aimed to create an environment that would stimulate interest in and awareness of drug use issues (as well as those around alcohol and tobacco consumption) with a harm reduction orientation. A pilot study was carried out with college students and found some qualitative evidence of attitudinal and environmental benefit to suggest that an intervention of greater duration may have the capacity to produce a greater impact (Newbery *et al.* 2006).

#### *Prevention in coastal and ex-mining areas*

Mentor UK (2007)<sup>72</sup> published the final report from its coastal and ex-mining areas pilot project for drug misuse prevention initiatives for young people. They researched and developed 12 pilot projects in order to address the issues of isolation, parenting and alcohol and drug misuse; and to support and engage young people and local agencies to develop and implement local projects to address those needs. This report describes their experiences and suggests how others working in those communities can learn from them. Amongst its recommendations, Mentor UK call on Drug Action Teams in these areas to regularly undertake an audit of local community organisations and create work-plans to engage and involve them in drug prevention. This project had not been externally evaluated for its effectiveness at the time of writing.

## 3.3 Selective prevention

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

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<sup>71</sup> The search looked at Cochrane Central Register of Controlled Trials, specialised Register of Cochrane Drugs and Alcohol Group, Pub Med, psych INFO, CINALH and SIGLE. Two reviewers independently screened studies, extracted data and assessed study quality. Twenty studies met the inclusion criteria.

<sup>72</sup> [http://www.mentorfoundation.org/uploads/UK\\_CEMA\\_Report.pdf](http://www.mentorfoundation.org/uploads/UK_CEMA_Report.pdf)

### 3.3.1 Recreational settings

#### Northern Ireland Safer clubbing campaign 2005 – 2007

The Health Protection Agency in Northern Ireland have re-issued a series of posters from the 2005 safer clubbing campaign that are displayed in the toilet areas of a range of pubs and clubs throughout Northern Ireland targeted at 18 to 30 year olds.<sup>73</sup>

### 3.3.2 At risk groups

#### *Drug strategy consultation*

The United Kingdom Government's new drug strategy consultation states that more can be done to reach out more effectively to the most vulnerable and the most at risk young people, suggesting that there is solid evidence showing that some groups of young people are more vulnerable to developing substance misuse problems than their peers. These groups include young offenders, looked-after children, young homeless people, children who truant or are excluded from school, young people who have been sexually exploited or who work in the sex industry and children whose parents misuse drugs or alcohol. (HM Government 2007a).

#### *Identifying and exploring young people's experiences of risk, protective factors and resilience to drug use*

A report from the Home Office (2007d) summarises and pulls together findings from two linked studies commissioned to explore methods of identifying groups and individuals 'at risk'. Firstly, a literature review was carried out of studies that have explored predictive factors of drug use and common factors arising from these studies were identified (Frischer *et al.* 2007). Following on from this, a further study explored young people's resilience to drug use. There were two stages to this research: the first was a multivariate analysis of the 2003 Offending, Crime and Justice Survey (OCJS) data; the second stage was a qualitative study of the views and experiences of a sample of these young people, exploring the nature of their resilience to drug use (Dillon *et al.* 2007).

The literature review found that the most extensive and consistent evidence relates to young people's interaction with their families and the key predictors of drug use are parental discipline, family cohesion, and parental monitoring. Further, some aspects of family structure such as large family size and low parental age are linked to adolescent drug use. There is also consistent evidence linking peer drug use and drug availability to adolescent drug use.

There is also evidence in the literature that the number of risk factors that a person is exposed to is a predictor of drug use, regardless of what those particular risk factors are: the more risk factors there are, the greater the likelihood of drug use.

The evidence indicates that risk and protective factors are context dependent and influence people for a variety of reasons. Some, such as gender and ethnicity, are fixed and cannot be changed. Others, such as parental discipline can be altered. Within these limits, improving the general social environment of children and supporting parents appear to be the most effective strategies for primary prevention of drug use. Evidence from studies of such interventions for parental monitoring and enhancement of social attachments and skills indicate that risk factors and resilience can be successfully altered. Studies exploring this type of intervention show promise but such interventions have been rarely implemented, or evaluated, within the United Kingdom.

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<sup>73</sup> See: <http://www.healthpromotionagency.org.uk/Resources>

*Guidance on vulnerable and disadvantaged children and young people*

The National Institute for Health and Clinical Excellence (NICE)<sup>74</sup> has produced public health guidance on community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people. It calls for anyone who works with young people to identify those who are vulnerable to drug problems and intervene at the earliest opportunity. It gives advice on stepping in and helping young people access the right support and services and outlines effective individual, family and group-based support, which can improve motivation, family interaction and parenting skills (NICE 2007a).

*Update of The National Service Framework for Children, Young People, and Maternity Services*

*The National Service Framework for Children, Young People, and Maternity Services* (Department of Health 2004a) is to be updated.

*Toolkit for developing local profiles of drug use among vulnerable young people*

A powerpoint toolkit has been developed to provide guidance and advice for practitioners and managers to help identify and deal with drug use in their area. This provides national data on drug use among vulnerable young people, showing the prevalence of use among different groups. It also explains how this data can provide a picture of probable need in an area if local data is not available (Home Office, DfES and TDA 2007).

*Evaluation toolkit*

The National Collaborating Centre for Drug Prevention (NCCDP) has developed a toolkit for practitioners to enable them to self-evaluate their drug prevention services. It has been designed to contain all the tools required by practitioners, managers and researchers to evaluate services that either they or others provide. The toolkit is currently being piloted by a number of services and an online version will be developed in the future.

*Children's Charities Working Together on Drug Prevention Project*

The Children's Charities Working Together on Drug Prevention Project brings together five national children's charities to work together on substance misuse: the National Children's Bureau (NCB)<sup>75</sup>, Barnardo's<sup>76</sup>, the National Society for the Prevention of Cruelty to Children (NSPCC)<sup>77</sup>, NCH<sup>78</sup>, and The Children's Society.<sup>79</sup> The project's aims are as follows: to develop the capacity of children's charities to deliver drug prevention support to those working with vulnerable children and young people; increase the influence and inter-agency working between national children's charities, Drug Action Teams (DATs) and children and young people's substance misuse services; increase access to, and communication between, charities and mainstream children's services for children and young people with substance misuse issues. The project is being evaluated by Mentor UK. Expected outcomes from the project include a greater recognition of the contribution the children's voluntary sector makes to the substance misuse agenda and that mainstream services have increased capacity to address substance misuse effectively.

<sup>74</sup> See: <http://guidance.nice.org.uk/PHI4/guidance/pdf/English/download.dspix>

<sup>75</sup> For more information see: [www.ncb.org.uk](http://www.ncb.org.uk)

<sup>76</sup> For more information see: [www.barnardos.org.uk](http://www.barnardos.org.uk)

<sup>77</sup> For more information see: [www.nspcc.org.uk](http://www.nspcc.org.uk)

<sup>78</sup> Previously known as National Children's Home. For more information see:

<http://www.nch.org.uk/>

<sup>79</sup> For more information see: [www.childrenssociety.org.uk/](http://www.childrenssociety.org.uk/)

### *FRANK (High Focus Areas)*

As part of its extra focus on vulnerable young people, FRANK increased its presence in the 30 High Focus Areas across England through street marketing activity and advertising. Adverts at bus stops and bus panels were used to extend the 'Brain Warehouse' theme used in the TV and radio adverts about cannabis. Also, in the autumn of 2006 FRANK launched its FRANK Lights up After Dark Campaign. The pack was intended to support High Focus Areas and other organisations to run their own FRANK Activity in the autumn/winter. It contains information on wider FRANK activity, as well as tips and advice for running peer-to-peer street marketing events.<sup>80</sup>

An evaluation of prevention initiatives in High Focus Areas is being carried out by the National Collaborating Centre for Drug Prevention (NCCDP).

### *Know the Score*

In Scotland, 'Know the Score' has run national campaigns which have involved penetrating more difficult-to-reach areas, both socially and geographically. These have utilised local radio campaigns, billboards and bus shelters and have been supported by editorials in local and national media. In 2006/7 'Know the Score' has piloted dedicated anti-cocaine awareness weekends in collaboration with local licensed venues across Scotland, utilising pub staff to help put the messages across. This campaign was also supported locally by the Association of Chief Police Officers Scotland (ACPOS), local voluntary groups, and Scotland's Alcohol and Drug Action Teams (ADATs).

### *Children of drug using parents*

The *Advisory Council on the Misuse of Drugs* has published a report which discusses the extent to which the 48 recommendations made in its 2003 report (ACMD 2003) have been implemented. It describes policy changes that have taken place since then, and also points to areas where work is still required (ACMD 2007a). It suggests that a key aspect of the initial report was the need for more integrated working between a range of services to identify and meet the needs of the children of drug using parents. It points to major programmes in the United Kingdom which seek to ensure all children are able to reach their potential (see Chapter 12). The Scottish strategy highlights the importance of safeguarding the welfare of the children of problem drug users and includes a specific performance target in relation to reducing the harm to this group of children. The new Northern Ireland strategy includes specific targets in relation to the implementation of *Hidden Harm* and the Welsh strategy highlights the importance of developing support for children of substance misusing parents, with the aim of "safeguarding their welfare". In England some progress is highlighted in embedding action to address the harm caused to children by parental drug misuse, including the requirement for new statutory Local Safeguarding Children Boards to develop specific arrangements and protocols to respond to parental substance misuse. It is noted that Northern Ireland is only recently working towards implementing the *Hidden Harm* agenda.

In Wales there are two specific initiatives to support the children of substance misusing parents:

- Option 2 is a family intervention service that is prompted by a crisis that could result in children having to be taken into care. The aim of the service is to develop and encourage new behaviours within the family so that they can move beyond the crisis; and
- an Early Parental Intervention Service Programme is being developed and piloted. The focus of the service is families where an adult's substance misuse

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<sup>80</sup> See: <http://www.homeoffice.gov.uk/materials/401478?view=Standard>

has been identified as having an impact on their parenting capacity. The aim is to deliver early preventative services in order to prevent a crisis that could result in children being taken into care.

#### *Family Drug and Alcohol Court*

A Family Drug and Alcohol Court is to be piloted from January 2008, its aim is to improve the engagement of adults in treatment services and increase their capacity to provide stable care for their children. The model will test out provision of intensive assessment, support, intervention and care plan coordination for families affected by parental substance misuse, whose children are in care proceedings. The pilot, which will be carried out in the Westminster, Islington and Camden areas of London, is to be evaluated.<sup>81</sup>

#### *Children in the care of the local authority*

In England, the Department for Children, Schools and Families sets out the steps the Department will take, together with local delivery partners, to improve outcomes for children and young people in care. Specific proposals are set out on including early identification of substance misuse issues within routine health assessments in the Green Paper *Care Matters: Time for Change* (DfES 2007b) (see Chapter 12).

In Scotland, a Ministerial Working Group, which ran from November 2005 to June 2006, considered what was required to improve educational and other outcomes for looked after children and care leavers. As a result, a report entitled *Looked After Children and Young People: We Can and Must Do Better* (Scottish Executive 2007c) raised many important issues and contains 19 action points across its five themes: working together; becoming effective lifelong learners; developing into successful and responsible adults; being emotionally, mentally and physically healthy and feeling safe and nurtured in a home setting. The action points and tasks contained in the report are not the responsibility of any one organisation or area; rather the document reflects the importance of partnership working. The need for positive Corporate Parenting is also highlighted throughout the report. An Implementation Board has been established (consisting of senior officials from within and outside of the Scottish Government) to oversee the implementation of the report, with a structure of eight working groups to take forward the specific tasks and actions.

#### 3.3.3 At risk families

There are already a number of generic early interventions for families and/or children, including those families where parental substance misuse is seen as placing children at risk. Increasingly, services are being developed to provide support to prevent children being taken from families where substance misuse has been identified as a problem.

The Department of Health in England has commissioned research to conduct an evaluation of the *Families First Project*, running in Middlesbrough from April 2006 to November 2008.<sup>82</sup> This is a multi-disciplinary service, incorporating adult and children's services, offering a comprehensive assessment, holistic intervention and family support package to families with problematic drug and/or alcohol use where there is a likelihood of children being removed from the family by the Local Authority. The support provided aims to reduce many of the 'risk factors' which research has

<sup>81</sup> For more information see:

<http://www.communitycare.co.uk/Articles/2007/05/15/104498/uks-first-specialist-drug-and-alcohol-court-to-start-next.html>

<sup>82</sup> Both quantitative and qualitative research methods are being used including interviews, focus groups and questionnaires.



shown children of drug using parents are susceptible to (including depression, social isolation and an increased risk of children using drugs in later life), by enforcing so called 'protective factors' against negative outcomes, such as parental drug stabilisation, school attendance and consistency in family routines. The package aims to enable families to make changes to their lifestyle which are necessary to ensure the safety and stability of the child within the home environment. The results of the evaluation and experiences of conducting it will also be used to develop the National Collaborating Centre for Drug Prevention (NCCDP) toolkit for assessment of young person outcomes in generic services. Results from the second interim report, produced by NCCDP researchers at Liverpool John Moores University<sup>83</sup>, showed that at the six month follow up stage none of the children receiving support from Families First had entered into a children's home or foster care (outside of the family), despite nine children having been under a care order at baseline interview; reported use of any illicit drug had halved amongst parents between baseline and sixth month follow up stages; and in terms of family conflict, there was a significant difference in the levels of arguing and fighting reported by parents over the six month period examined. The final report will be available in December 2008.

#### *The Bouncing Back! prevention programme*

The Bouncing Back! prevention programme aims to pilot and develop good practice, knowledge and expertise to engage vulnerable family members, carers and parents in drug education initiatives. The programme has recognised the links between positive parenting education and drug awareness (ADFAM 2007).

### **3.4 Indicated prevention**

These interventions are designed to prevent the onset of problem drug use in individuals who already are experiencing early signs of substance abuse and other problem behaviours, including children at risk of individually attributable risk factors such as Attention Deficit Hyperactivity Disorder.<sup>84</sup>

NO NEW INFORMATION AVAILABLE

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<sup>83</sup> See: <http://www.drugpreventionevidence.info/default.asp> Drug users in contact with specialist drug services

<sup>84</sup> Attention Deficit Hyperactivity Disorder AD(H)D, sometimes referred to as Attention Deficit Disorder (ADD) is a neurological condition which is estimated to affect approximately one per cent of children in the United Kingdom. It is characterised by pervasive inattention and/or hyperactivity-impulsivity, resulting in significant functional impairment. For more information see: [http://www.mind.org.uk/Information/Booklets/Understanding/Understanding+ADHD.htm#What\\_is\\_ADHD](http://www.mind.org.uk/Information/Booklets/Understanding/Understanding+ADHD.htm#What_is_ADHD)

## 4. Problem drug use

### 4.1 Overview

Estimates of problem drug use in the United Kingdom reflect the drugs identified as problematic following the methodology used<sup>85</sup>. Latest estimates for England are for 2004/05 for use of opiates and/or crack use (327,466), with additional estimates for opiate use (281,320), crack use (192,999), and injecting use (137,141). In Northern Ireland estimates are for 2004 for opiate and/or cocaine (including crack cocaine) use (3,303), with, also, an estimate for opiate use (1,395). In Scotland the estimates are for 2003 for opiate and/or benzodiazepine use (51,582). There are no recent estimates for Wales. Based on these, it is estimated that there are 398,845 problem drug users in the United Kingdom<sup>86</sup>.

The Treatment Demand Indicator (TDI)<sup>87</sup>; measures presentations to services by drug users, and data are provided for those in contact with general practitioners, outpatient (community-based specialist drug services) and inpatient services. Latest combined data for the United Kingdom are for 2005/06 when there were 128,446 new demands for treatment. Opiates, mostly heroin, were the main primary drug reported (65%). Cannabis was the second most reported primary drug (16%), and crack and cocaine accounted for six per cent each of primary drug reports. Presentations for cannabis have increased over time, and now represent a quarter of first ever presentations.<sup>88</sup> Current injecting was reported by 24 per cent; 52 per cent report having never injected. Twenty-two per cent were aged between 25 and 29. Amongst users of problem drugs, these characteristics have changed little over time.

### 4.2 Prevalence and incidence estimates of PDU

There is no information on incidence of PDUs.

#### 4.2.1 Prevalence estimates for England for 2004/05

Research published in 2006 provided estimates of problem drug use for the 149 Drug and Alcohol Action Teams (DAATs) areas in the nine Government Office Regions in England, as well as a national estimate for England for 2004/05 (Hay *et al.* 2006a). National estimates were derived from the sum of the DAAT estimates. Estimates are for persons aged 15 to 64. It was not possible directly to obtain estimates of those who only use crack (i.e. use crack but do not use opiates) or only use opiates (without also using crack). Estimates were provided for: problem drug users (defined as those who use opiates and/or crack), 327,466; opiate users, 281,320; crack users, 192,999; and for injecting opiate and/or crack users, 137,141. Drug treatment, probation, police and prison data were used to provide these estimates. Table 4.1 shows estimates, rates per thousand population and confidence intervals.

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<sup>85</sup> These are based on the capture-recapture method where possible, and where not, by the multiple indicator method.

<sup>86</sup> Estimates for Wales (18,402) are extrapolated from results for England.

<sup>87</sup> The TDI is one of the five epidemiological indicators established by EMCDDA to monitor the drug situation in the European Union. Currently it provides a measure of those presenting to treatment, for the very first time, or for the first time within the year. It does not include those who are already in treatment in that year. It can therefore best be described as a measure of treatment incidence.

<sup>88</sup> This could, in part be attributed to improved data reporting by young person's drug services.



Table 4.1: Problem drug users estimates and rates per 1,000 population aged 15 to 64 for the United Kingdom

Drug	Estimate	95% confidence interval		Rate	95% confidence interval	
Opiate and/or crack use	327,466	325,945	343,424	9.93	9.88	10.41
Opiate	281,320	279,753	292,941	8.53	8.48	8.88
Crack	192,999	188,138	210,763	5.85	5.70	6.39
Injecting	137,141	133,118	149,144	4.16	4.04	4.52

Source: Hay *et al.* 2006a

London has the highest prevalence of problem drug use, and of crack use, but is second to Yorkshire and Humberside in terms of prevalence of opiate use. Prevalence of injecting drug use is also highest in Yorkshire and The Humber (Tables 4.2 to 4.5).<sup>89</sup>

Table 4.2: Estimate of problem drug users aged 15 to 64 by Region in England 2004/05: rate per 1,000 population and number

Region	Rate per 1,000 population			Numbers		
	Estimate	95% CI		Estimate	95% CI	
East of England	6.48	6.18	7.11	23,081	22,029	25,313
East Midlands	8.23	8.00	9.04	23,142	22,516	25,442
London	14.35	13.86	15.68	74,417	71,845	81,299
North East	9.50	8.98	10.59	15,853	14,987	17,683
North West	11.43	10.39	12.45	51,110	46,455	55,653
South East	6.40	6.14	7.24	33,854	32,495	38,306
South West	9.44	9.16	10.21	30,455	29,536	32,936
West Midlands	10.62	10.17	11.45	36,834	35,276	39,726
Yorkshire and The Humber	11.74	11.43	12.40	38,720	37,708	40,911
England	9.93	9.88	10.41	327,466	325,945	149,144

Source: Hay *et al.* 2006a

Table 4.3: Estimate of opiate users aged 15 to 64 by Region in England, 2004/05: rate per 1,000 population and number

Region	Rate per 1,000 population			Numbers		
	Estimate	95% CI		Estimate	95% CI	
East of England	5.48	5.20	6.05	19,518	18,539	21,558
East Midlands	7.55	7.40	8.11	21,241	20,815	22,813
London	10.64	10.15	11.53	55,139	52,611	59,799
North East	8.22	7.85	9.38	13,729	13,099	15,657
North West	9.84	9.11	10.79	43,996	40,737	48,221
South East	5.43	5.15	5.98	28,727	27,267	31,648
South West	8.54	8.27	9.26	27,541	28,681	29,685
West Midlands	9.99	9.70	10.71	34,661	33,656	37,173
Yorkshire and The Humber	11.15	10.81	11.83	36,768	35,674	39,028
England	8.53	8.48	8.88	261,320	279,753	292,941

Source: Hay *et al.* 2006a

<sup>89</sup> Estimates for DAATs and the nine English Regions can be found in treatment plans for each team; see, for example: [http://www.nta.nhs.uk/areas/treatment\\_planning/treatment\\_plans\\_2007\\_08/trpl1\\_07\\_08\\_york\\_humber\\_northeast\\_northwest.aspx](http://www.nta.nhs.uk/areas/treatment_planning/treatment_plans_2007_08/trpl1_07_08_york_humber_northeast_northwest.aspx)

Table 4.4: Estimate of crack users aged 15 to 64 by Region in England, 2004/05: rate per 1,000 population and number

Region	Rate per 1,000 population			Numbers		
	Estimate	95% CI		Estimate	95% CI	
East of England	3.96	3.31	6.30	14,102	11,779	22,425
East Midlands	4.60	4.06	5.91	12,952	11,417	16,627
London	9.90	9.29	10.77	51,312	48,156	55,850
North East	4.42	3.38	6.53	7,376	5,636	10,899
North West	6.65	5.71	7.70	29,752	25,533	34,423
South East	3.64	3.04	5.02	19,261	16,097	26,554
South West	5.44	4.81	6.44	17,552	15,509	20,785
West Midlands	6.00	5.48	7.66	20,827	19,012	26,593
Yorkshire and The Humber	6.02	5.53	7.00	9,865	18,239	23,095
England	5.85	5.70	6.39	192,999	188,138	210,763

Source: Hay *et al.* 2006a

Table 4.5: Estimate of drug injectors aged 15 to 64 by Region in England, 2004/05. rate per 1,000 population and number

Region	Rate per 1,000 population			Numbers		
	Estimate	95% CI		Estimate	95% CI	
East of England	2.64	1.76	3.67	9,418	6,252	13,061
East Midlands	4.19	3.73	4.81	11,796	10,487	13,518
London	3.45	3.12	4.63	17,909	16,161	24,002
North East	5.37	4.57	6.35	8,959	7,638	10,597
North West	4.94	4.20	5.64	22,089	18,781	25,204
South East	2.60	2.28	3.36	13,778	12,044	17,802
South West	5.41	4.94	6.05	17,444	15,930	19,532
West Midlands	4.25	3.92	4.90	14,734	13,589	17,007
Yorkshire and The Humber	6.37	6.02	6.91	21,014	19,860	22,788
England	4.16	4.04	4.52	137,141	133,118	149,144

Source: Hay *et al.* 2006a

Estimates of problem drug use and opiate use were stratified by age group; from 15 to 24, 25 to 34 and 35 to 64 (Table 4.6), and by gender (Table 4.7). There was insufficient information to obtain age or gender-stratified estimates for crack use or drug injecting. Approximately a quarter of problem drug users or opiate users were female. For both estimates the greatest number of users is in the age group 25 to 34.

Table 4.6: Estimate of problem drug users and problem opiate users by age in England, 2004/05

Type of drug user	Age					
	15 to 24	%	25 to 34	%	35 to 64	%
Problem drug users	72,838	22.23	140,365	42.84	114,459	34.93
Problem opiate users	59,583	21.18	124,004	44.08	97,740	34.74

Source: Hay *et al.* 2006a

Table 4.7: Estimate of problem drug users and problem opiate users by gender in England, 2004/05

Gender	Problem Drug Users	Problem Opiate Users
Male	244,351	208,638
%	74.62	74.16
Female	83,116	72,712
%	25.38	25.84

Source: Hay *et al.* 2006a

The study is being carried out over a three-year period and will provide prevalence estimates at the end of each of the three study 'sweeps'. Estimates for 2005/06 are due to be published in the autumn of 2007.

#### *Estimating the national and local prevalence of problem drug use in Scotland*

The National Health Service (NHS) in Scotland has called for expressions of interest to carry out research to estimate the national and local prevalence of problem drug use in Scotland. These will use the 15 to 64 age range and will aim to provide estimates for opiate use as well as opiate and/or benzodiazepine use.

#### 4.2.2 Estimates of problem drug use in the United Kingdom

Revised estimates of problem drug use and of injecting drug use have been calculated using the most recent prevalence studies in the United Kingdom (Hay *et al.* 2004; Hay *et al.* 2006a; Hay *et al.* 2006b). These suggest an overall prevalence of 398,845 problem drug users (Table 4.8) and 164,036 injecting drug users. (Table 4.9).

*Table 4.8: Estimate of problem drug use in the United Kingdom: number and rate per 1,000 population*

Country	Estimate	95% confidence interval		Rate	95% confidence interval	
England	327,466	325,945	343,424	9.93	9.88	10.41
Northern Ireland	1,395	1,316	1,910	1.28	1.21	1.75
Scotland	5,1582	51,456	56,379	15.39	15.35	16.82
Wales	18,402	18,316	19,299	9.93	9.88	10.41
United Kingdom	398,845	397,033	421,012	10.15	10.11	10.72

Source: Table prepared by G. Hay 2007

*Table 4.9: Estimate of injecting drug use in the United Kingdom: number and rate per 1,000 population*

Country	Estimate	95% confidence interval		Rate	95% confidence interval	
England	137,141	133,118	149,144	4.16	4.04	4.52
Northern Ireland <sup>90</sup>	584	551	800	0.54	0.51	0.73
Scotland	18,737	17,731	20,289	5.59	5.29	6.05
Wales	7,707	7,480	8,381	4.16	4.04	4.52
United Kingdom	164,036	158,881	178,614	4.18	4.04	4.55

Source: Table prepared by G. Hay 2007

#### *Trends in prevalence of problem drug use*

It is difficult to consider estimates of prevalence in the United Kingdom as providing information which can be interpreted in terms of trends, as the methodology is to some extent reliant on the quality of monitoring systems by agencies; these have improved considerably over time, therefore allowing more reliable, and inevitably higher, estimates to be produced.

Millar *et al.* (2006) investigated whether hypotheses about trends in prevalence of problem drug use, prompted by capture-recapture based age specific prevalence

<sup>90</sup> This table makes the assumption that Northern Ireland shows the same proportion of injecting amongst the drug using population. This assumption may not be entirely appropriate and therefore the rate of injecting should not be used in isolation. However, it is an appropriate assumption for the United Kingdom given the size of the confidence interval.

estimates, are corroborated by estimates of trends in incidence.<sup>91</sup> The paper suggests that while estimates of prevalence of problem drug use are important they may not discern trends, even where there are comparable serial estimates and that information about incidence may provide a complementary approach to measuring and forecasting trends. The authors have used incidence estimation techniques used in AIDS epidemiology and show how results may be used to corroborate hypotheses about the current and future direction of changes in prevalence. Despite a number of caveats and assumptions the authors conclude that the method can be used to provide an evidence base that could help policy makers target resources more effectively.

#### 4.2.3 Problem drug use falling outside the EMCDDA definition

The available prevalence estimates for Scotland employ the case definition of opiate and/or benzodiazepine use. This is for historical reasons, in particular to achieve comparability with studies, such as the Dundee study (Hay and McKeganey 1996) where many drug users would be using benzodiazepines such as Temazepam or Diazepam when heroin was not readily available. Benzodiazepines are still used by problem drug users (who primarily use opiates) although this has perhaps lessened and it is thought that the PDU estimates for Scotland do not include any significant numbers of people who only use benzodiazepines; the estimates for Scotland may therefore be a good proxy for the prevalence of heroin use. TDI data for Scotland appears to verify this (Table 4.11).

#### 4.2.4 Problem drug use for which estimates are not available

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

### 4.3 Treatment Demand Indicator

In 2005/6, 128,446 presentations to treatment services were recorded through the Treatment Demand Indicator (TDI); this is an increase of nine per cent from the previous year (117,781). Of known cases, 48 per cent (49,625)<sup>92</sup> concerned drug users who sought treatment for the first time ever; in Northern Ireland first treatments accounted for 62 per cent of treatment presentations.

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<sup>91</sup> Lag correction techniques were used to provide incidence estimates adjusted for time-lag, between onset of drug use and its first recorded treatment for heroin users seeking treatment in three areas in the North West of England between 1986 and 2000.

<sup>92</sup> In 26,106 cases it is not known whether this is a first treatment or whether the presenting drug user has been in treatment previously.

### 4.3.1 Treatment centres

Reports to the TDI are based on structured treatment<sup>93</sup> only and in the United Kingdom do not include low threshold services or prison treatment. The vast majority of treatments are reported through outpatient services (94%)<sup>94</sup> (Table 4.10).

Table 4.10: Presentations by centre type in the United Kingdom, 2003/04 to 2005/06

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

Source: Standard Tables prepared for United Kingdom Focal Point by M. Donmall 2007

### 4.3.2 Profile of clients in treatment

#### Drugs used

Opiates (65%) remain the most reported primary drug amongst the TDI population and cannabis the second most reported primary drug (16%). Cocaine and crack were each reported by six per cent (Table 4.11). These are not significantly different from previous years (Table 4.16). There are some variations between parts of the United Kingdom. In Northern Ireland primary opiate use accounts for just 15 per cent of presentations, but primary cannabis use accounts for as much as 49 per cent. Also in Northern Ireland, 14 per cent of presentations were for primary benzodiazepine use, a problem previously regarded as relating to Scotland, but which as noted previously, although this is not reflected by the TDI. In England, seven per cent of presentations were for primary crack use, compared to one per cent throughout the rest of the United Kingdom, and these accounted for the majority of crack presentations (98%) across the country. While England also accounts for the majority of cocaine presentations (89%), Northern Ireland shows the highest proportion of primary cocaine users, at nine per cent, although still only accounting for 2 per cent of the presentations for cocaine in the United Kingdom.

Table 4.11: Number and percentage of drug treatment presentations by primary drug of use in the United Kingdom, 2005/06

Drug	England		Northern Ireland		Scotland		Wales		United Kingdom	
	n	%	n	%	n	%	n	%	n	%
Amphetamines	3,412	3.4	10	0.6	205	1.8	507	8.6	4,134	3.5
Benzodiazepines	1,200	1.2	233	14.0	672	5.8	192	3.2	2,297	1.9
Cannabis	15,504	15.5	821	49.3	1,588	13.7	880	14.9	18,793	15.8
Cocaine (powder)	6,122	6.1	150	9.0	476	4.1	142	2.4	6,890	5.8
Crack	6,705	6.7	4	0.2	68	0.6	80	1.4	6,857	5.8
Opiates	65,514	65.6	244	14.6	7,907	68.2	3,915	66.1	77,580	65.1
Other	1,422	1.4	204	12.2	709	6.1	205	3.5	2,540	2.1
Sub Total	99,879		1,666		11,625		5,921		119,066	
Not Known	2,801		0		2,051		4,503		9,355	
Total	102,680		1,666		13,676		10,424		128,446	
	79.9%		1.3%		10.6%		8.1%			

Source: Standard Tables prepared for United Kingdom Focal Point by M. Donmall 2007

<sup>93</sup> Treatment where a care plan should be provided.

<sup>94</sup> Most such services in the United Kingdom are specialist community based treatment services.

First treatment demands show a slightly different pattern (Table 4.12) with primary opiate use accounting for half (50%) of first treatment demands in England and the United Kingdom as a whole. Presentations with cannabis as primary drug accounted for a quarter of all first demands in the United Kingdom. The third highest number of first demands were for primary cocaine problems, although accounting for a much lower proportion (9%) than primary opiate or cannabis use.

*Table 4.12: Number and percentage of first drug treatment demands by primary drug of use in the United Kingdom, 2005/06*

Drug	England		Northern Ireland		Scotland		Wales		UK	
	n	%	n	%	n	%	n	%	n	%
Amphetamine	1,576	4.1	6	0.5	133	2.3	97	8.6	1,812	3.9
Benzodiazepine	586	1.5	204	17.0	306	5.2	57	5.1	1,153	2.5
Cannabis	9,567	25.1	672	56.0	1034	17.7	233	20.7	11,506	24.8
Cocaine (powder)	3,698	9.7	107	8.9	349	6.0	43	3.8	4,197	9.1
Crack	3,051	8.0	3	0.2	39	0.7	23	2.0	3,116	6.7
Opiates	18,873	49.5	73	6.1	3,450	59.0	625	55.5	23,021	49.7
Other	810	2.1	136	11.3	533	9.1	49	4.3	1,528	3.3
<i>Sub Total</i>	<i>38,161</i>		<i>1,201</i>		<i>5,844</i>		<i>1,127</i>		<i>46,333</i>	
Not Known	1,185		0		808		1,299		3,292	
Total	39,346 79.4%		1,201 2.4%		6,652 13.4%		2,426 4.9%		49,625	

Source: Standard Tables prepared for United Kingdom Focal Point by M. Donmall 2007

### Age

Forty-two per cent of all treatment presentations were for those aged between 25 and 34, and 29 per cent were under 25. As expected those presenting to treatment for the first time ever were considerably younger with 37 per cent under the age of 24 years (Table 4.13).

*Table 4.13: Age of drug users identified through TDI in the United Kingdom, 2005/06*

	Age							
	<25		25 to 34		34>		Missing	All
	n	%	n	%	n	%	n	n
All treatments	36,973	29	53,854	42	37,432	29	187	128,446
First treatments	18,596	37	17,910	36	13,106	26	13	49,625

Source: Standard Tables prepared for United Kingdom Focal Point by M. Donmall 2007

### Gender

Seventy-two per cent of clients were male and 28 per cent female (Table 4.14). There was no difference in those presenting to treatment for the first time (Table 4.15).

### Injecting status

Just over half of clients (52%) had never injected, but just under a quarter (24%) were currently injecting (Table 4.14). Males were slightly more likely to be currently injecting than females. Those who had never previously been in treatment (first ever treatment demands) were less likely to have injected, and less likely to inject currently (Table 4.15). This could reflect the higher number of first treatment demands using drugs such as cannabis which is not injected.



Table 4.14: Injecting status by gender in the United Kingdom, 2005/06; all treatment

Injecting status	Male		Female		Total	
	n	%	n	%	n	%
Ever injected, but not currently	16,658	24.4	6,598	25.0	23,256	24.6
Currently injecting (in last month)	16,844	24.6	5,445	20.7	22,289	23.5
Never injected	34,832	51.0	14,321	54.3	49,153	51.9
<i>Sub Total</i>	<i>68,334</i>		<i>26,364</i>		<i>94,698</i>	
Not known/missing	24,019		9,729		33,748	
Total	92,353 71.9%		36,093 28.1%		128,446	

Source: Standard Tables prepared for United Kingdom Focal Point by M. Donmall 2007

Table 4.15: Injecting status by gender in the United Kingdom 2005/06; first treatment

Injecting status	Age					
	Male		Female		Total	
	n	%	n	%	n	%
Ever injected, but not currently	4,486	14.8	1,567	13.7	6,053	14.5
Currently injecting (in last month)	5,105	16.6	1,561	13.7	6,666	16.0
Never injected	20,677	68.3	8,251	72.5	28,928	69.5
<i>Sub Total</i>	<i>30,268</i>		<i>11,379</i>		<i>41,647</i>	
Not known	5,697		2,281		7,978	
Total	35,965 72.5%		13,660 27.5%		49,625	

Source: Standard Tables prepared for United Kingdom Focal Point by M. Donmall 2007

#### 4.3.3 TDI prevalence trends in the light of other indicators

Table 4.16 shows the primary drug used by those presenting to treatment over the past three years. The proportion presenting with opiates as a primary drug has fallen, though actual numbers have increased, and the TDI continues to identify opiate use as accounting for the majority of presentations to services, at around 65 per cent. Cannabis, crack and cocaine have risen as a proportion of presentations over time. The TDI, to some extent, reflects trends seen in other indicators. PDU estimates also suggest opiate users account for the majority of problem drug users (Table 4.1)<sup>95</sup>; similarly, are implicated in the majority of drug-related deaths (see Chapter 6.2). First ever treatments offer the same picture, though the relative fall in the proportion of primary opiate users relative to the rise in primary cannabis presentations is even more accentuated (Table 4. 17). It is also of note that primary cocaine and crack users represent a higher proportion of first ever treatments, although with crack users the difference is very small.

<sup>95</sup> Note that the PDU estimates relate to opiate and/or crack use (England), opiate and/or cocaine use (Northern Ireland) and opiate and/or benzodiazepine use (Scotland).



Table 4.16: Number and percentage of drug treatment presentations by primary drug in the United Kingdom, 2003/04, 2004/05 and, 2005/06

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

Source: Standard Tables prepared for United Kingdom Focal Point by M. Donmall 2007

Table 4.17: Number and percentage of first drug treatment presentations by primary drug, in the United Kingdom, 2003/04, 2004/05 and, 2005/06

Drug	2003/04		2004/05		2005/06	
	n	%	n	%	n	%
Amphetamines	1,455	5.1	1,619	4.1	1,812	3.9
Benzodiazepines	675	2.3	1,226	3.1	1,153	2.5
Cannabis	5,289	18.6	8,653	22.1	11,506	24.8
Cocaine	1,683	5.8	3,016	7.7	4,197	9.1
Crack	1,722	6.0	2,589	6.6	3,116	6.7
Opiates	16,656	57.8	20,464	52.3	23,021	50.0
Other	1,329	4.6	1,525	3.9	1,528	3.3
<i>Sub Total</i>	<i>28,809</i>		<i>39,092</i>		<i>46,333</i>	
Not Known	1,056		3,405		3,292	
Total	29,865		42,497		49,625	

Source: Standard Tables prepared for United Kingdom Focal Point by M. Donmall 2007

Tables 4.6 (see 4.2.1 above) shows that in England 43 per cent and 44 per cent respectively of problem drug users and problem opiate users are estimated to be aged between 25 and 35. TDI data suggest similar proportions in this age group (43%) (see Table 4.13), with a higher proportion of the TDI being in the younger age group, aged under 25 (29%); PDU estimates suggesting 22 per cent of problem drug users and 21 per cent of opiate users in this group. This can be expected given that the TDI includes those who use cannabis as primary drug and PDU estimates do not.

In England, a 3:1 ratio of males to females is consistent from both TDI and PDU estimates. Also, in England PDU estimates suggest that 42 per cent of PDUs inject (see Table 4.5); this compares with the TDI estimate of 24 per cent currently injecting in the United Kingdom (Table 4.14), including primary cannabis users.

#### 4.4 PDUs from non-treatment sources

##### 4.4.1 PDU not seen in the TDI population

See 4.5.1 for estimates of penetration rates of PDUs in the treatment population.

##### *Northern Ireland, Drug Addicts Index*

In Northern Ireland, a Drug Addicts Index monitors those registered in concurrence with the *Misuse of Drugs (Notification of and Supply to Addicts) (Northern Ireland)*

*Regulations 1973* which requires any doctor to notify the DHSSPS in writing within 7 days, if they attend a patient who he considers to be, or has reasonable grounds to suspect, is addicted to any of the 14 named controlled drugs. Those included have not necessarily received treatment for drug misuse. In 2006:

- there were 288 registered addicts at 31 December 2006, an increase of 27 from the 31 December 2005 (261);
- there were 190 renotifications, compared to 182 in 2005, 100 new notifications, and 73 cases were removed;
- seventy-eight per cent were male (in 2005 72% were male);
- thirty-four per cent were aged 29 years and under in 2006 (37% in 2005);
- heroin was the most frequently reported drug (76%), with methadone (26%), and cocaine (8%);
- 42 per cent whose injecting behaviour was known reported currently injecting (36% in 2005); and
- 99 were registered within the last year, 125 had been registered between one and five years (DAIRU/DHSSPSNI 2007b).

### *Arrestee Survey*

Further information on problem drug users is available through the Arrestee Survey (see Chapters 8 and 9) (Boreham *et al.* 2006). The provides information on dependence (Table 4.18), frequency of use (Table 4.19), injecting status (Table 4.20), polydrug use (Table 4.21), ethnicity (Table 4.22), identifying treatment contact (Table 4.23) as well as education and employment. In this survey 57 per cent of arrestees reported having taken one or more drugs in the last month. Of these: 18 per cent reported heroin use; 15 per cent crack use and ten per cent cocaine use; 46 per cent reported taking cannabis. Based on the Severity of Dependence Scale 85 per cent of those who used heroin were dependent, 52 per cent of those would have used crack, but less than quarter (23%) who use cocaine (Table 4.18). Very little difference was shown by age. Heroin and crack users were more likely to use these drugs more often than cocaine users (Table 4.19). Those who used crack were more likely to also use heroin than cocaine (Table 4. 21).

### *Dependence*

*Table 4.18: Proportion of arrested users of heroin, crack or cocaine identified as dependent (Severity of Dependence Scale) in England and Wales, 2003-04 by age*

Drug	Age							
	17-24		25-34		35+		Total	
	17-24	Weighted base	25-34	Weighted base	35+	Weighted base	Total	Weighted base
Heroin	84	562	84	749	87	262	85	1,575
Crack	48	637	54	743	57	295	52	1,676
Cocaine	21	874	23	536	32	203	23	1,613

Source: Boreham *et al.* 2006.

### *Frequency of use*

The drug most frequently used was heroin (Table 4.19).

Table 4.19: Frequency of use of heroin, crack and cocaine by arrestees in England and Wales, 2003-04 as a percentage of all arrestees

Frequency of use	Drug		
	Heroin	Crack	Cocaine
5 or more days a week	13	7	2
3 or 4 days a week	1	2	1
1 or 2 days a week	1	3	3
1 or 2 days a month	2	3	5
A few times a year	1	2	5
Less often than once a year	0	0	0
Only ever taken once	2	3	5
Used to take, don't take now	8	12	21
Never taken	72	68	59
Weighted bases	7,465	7,454	7,440

Source: Boreham *et al.* 2006.

### Injecting

A third of those who had used drugs that could be injected had done so. The proportion was highest amongst those aged between 25 and 34 (Table 4.20).

Table 4.20: Proportion of arrestees who had ever injected drugs among those who had taken drugs that could be injected in England and Wales, 2003-04, by age

Ever injected drugs	Age			Total
	17-24	25-34	35+	
Yes	25	42	33	33
Weighted bases	1,784	1,561	788	4,134

Source: Boreham *et al.* 2006.

### Polydrug use

Those using heroin, crack and/or cocaine (HCC users) were asked about their combined use of all three drugs. Table 4.21 shows the largest groups were those who use heroin and crack, followed by those who used cocaine but neither heroin or crack, and those who used heroin, but not cocaine or crack. These results do not preclude use of other drugs.

Table 4.21: Polydrug use in the last month by age amongst arrestees using heroin, crack and/or cocaine in the last month in England and Wales, 2003-04 as a percentage

Polydrug use	Age			
	17-24	25-34	35+	Total
Heroin only	18	22	18	20
Crack only	6	8	17	9
Cocaine (powder) only	36	17	16	25
Heroin and crack	27	42	35	34
Heroin and cocaine (powder)	2	1	3	2
Crack and cocaine (powder)	4	3	3	3
Heroin and crack and cocaine (powder)	7	7	8	8
Weighted bases	859	868	349	2,077

Source: Boreham *et al.* 2006

### Ethnicity

Table 4.22 shows that amongst arrestees those of mixed race were more likely than other groups to be crack users, and both those of mixed race and those described as White more likely to be HCC users.

Table 4.22: Proportion of arrestees who had used drugs in the last month, by ethnicity in England and Wales, 2003/04

Drug	Ethnicity					Total
	White	Mixed	Asian	Black	Other	
Heroin	19	17	11	7	8	18
Crack	15	22	8	14	14	15
Cocaine(powder)	11	9	4	4	6	10
HCC	29	30	15	17	19	28
Any drug	57	69	32	56	42	57
Weighted bases	6,287	253	288	557	92	7,477

Source: Boreham *et al.* 2006.

### Education

The majority of arrestees said they had finished full-time education at the age of 16 or younger; 42 per cent being less than 16 and 37 per cent 16. Forty per cent had been excluded from school temporarily and 24 per cent permanently. Amongst HCC users (last year use) 58 had left school before they were 16, and 30 per cent when less than 16. Fifty-eight per cent had been temporarily excluded from school and 38 per cent permanently excluded.

### Employment

Among all arrestees 36 per cent were in paid employment, while 51 per cent were unemployed. Amongst HCC users 22 per cent were in paid employment, while 66 per cent were unemployed.

Other sources of information on drug users are available through interventions for young people under 18 arrested for acquisitive and other non-drug offences. These include those referred to arrest referral pilot schemes and showed that use of drug associated with problematic drug use was very low: cocaine used by four per cent, crack by one per cent and heroin by one per cent<sup>96</sup> (Matrix Research and Consultancy and Institute for Criminal Policy Research, Kings College 2007) (see Chapter 9.3.2).

Analysis looked at use of heroin and crack, and also cocaine, as an indication of problematic drug use, all being Class A drugs. This has proved difficult in considering this population with other indicators of problem drug use, in particular the PDU and TDI. However, the survey results do show that cocaine users are probably a different group from those who take heroin or crack.

Arrestees who had ever taken heroin, crack and cocaine were asked whether they had ever been offered treatment, had ever received treatment, had received treatment in the last twelve months and were currently receiving treatment. Table 4.23 shows that over half had been in treatment.

<sup>96</sup> 2,327 young people had contact with arrest referral between November 2003 and September 2005.

Table: 4.23: Lifetime use of heroin, crack and cocaine amongst arrestees who have been in contact with treatment services in England and Wales, 2003-04 as a percentage

Treatment status	Ever used drug		
	Heroin	Crack	Cocaine
Ever been offered treatment	58	13	4
Ever received treatment	52	7	2
Received treatment in the last twelve months	34	5	1
Currently receiving treatment	22	2	1
Treated in last 12 months , not currently receiving treatment	11	2	0
Treatment long ago	18	3	1
<i>Weighted base .</i>	<i>2,031</i>	<i>2,386</i>	<i>3,004</i>

Source: Boreham *et al.* 2006

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

See Chapter 6 for information on needle exchange schemes and drug related infectious disease testing.

### 4.5 Intensive or frequent patterns of use

#### 4.5.1 Frequency of use

By their very nature, estimates of problem drug use are concerned with intensive patterns of use. More sensitive information on frequency of use should be available when outcome monitoring becomes a part of treatment monitoring systems (see Chapter 5.4.3).

However, information on frequency of use of these problematic drugs is provided through the Arrestee Survey (see Table 4.13). With respect to heroin, crack and cocaine, heroin was the drug used most frequently, with very few arrestees reporting using cocaine more than once a week.

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

Most recent PDU estimates are available for England and Northern Ireland (the latter reported in the United Kingdom Focal Point report for 2006). Population survey data is based upon a very different population than that reflected in PDU estimates; the former identifying very low use of opiates and cocaine based drugs, though it is of note that cocaine use has increased within this population. In England, in 2005/06 the best estimate for the number of lifetime users of cocaine (powder) was 2,273,000; for recent use (in the last year) the number was 769,000, and for current use the number was 368,000. Despite these relatively high numbers, no estimate could be given for problem cocaine users through research into estimating the number of PDUs for England. Within the British Crime Survey the best estimate for opiate users was 272,000 for lifetime use, 47,000 for recent use and 35,000 for current use; the latter much lower than the number of estimated PDUs in England (281,320.) For crack users the best estimates were 270,000, 53,000 and 25,000; again, for recent and current use, much lower than the estimated number of PDUs (192,999).

Given the lack of comparable data on PDUs it is difficult to provide trend data and therefore not possible to consider any relationship between drugs identified through research estimating the prevalence of problem drug use and general population surveys. It is, however, of interest to consider the treatment population in relation to problem prevalence estimates.

In Northern Ireland, estimates of prevalence showed evidence of only opiates and cocaine as problematic drugs (though it should be noted that research was only conducted to establish prevalence of these drugs) and it can be seen that, relatively speaking, cocaine presentations reported through the TDI are slightly higher than elsewhere in the United Kingdom (9% in Northern Ireland compared to 5% in the United Kingdom as a whole).

The TDI distinguishes between all new presentations to treatment each year and first ever presentations (that is, first treatment demands). The number and profile of the first ever treatment demands reflects changes in the emergent population of drug users newly entering treatment, while the number and profile of all new presentations reflects the wider demands made on the treatment sector. For the future it is likely that EMCDDA will further develop the TDI to record information on all persons in treatment, including those in continuous treatment from year to year, so as to achieve a much better picture of the total treated population.

At present, TDI numbers cannot be used to consider treatment engagement rates as they do not take account of those individuals already in treatment prior to, and during, the reporting period. The National Drug Treatment Monitoring System (NDTMS) for England provides a better estimate of engagement, but totals relate to those in treatment contact rather than the numbers actually receiving treatment.

TDI data suggest that in England in 2005/06 there were 102,652 presentations, 72 per cent were problem drug users, using opiates and/or crack as a primary or secondary drug. Sixty-six per cent of presentations used opiates (as a primary or secondary drug) and 26 per cent used crack (as a primary or secondary drug) (Table 4.24).

*Table 4.24: Primary and secondary opiate users, crack users and opiate and/or crack users identified in TDI (England), 2005/06*

Problem drug users	Presentation	
	n	% (N =102,680)
Opiate and/or crack users (primary or secondary)	73,900	72
Opiate users (primary or secondary)	68,676	67
Crack users (primary or secondary)	26,272	26

Source: TDI data prepared by NDEC

NTMDS data show that, of those in treatment in 2005/06 (the same year as the latest TDI data, but a year on from the PDU estimates), 136,228 were problem opiate and/or crack users (Table 4.25), that is 42 per cent of problem drug users. The treatment figure for opiate users constituting 46 per cent (128,630) of the PDU estimate of opiate users, while the treatment figure for crack users constitutes 21 per cent (39,832) of PDU estimate for crack users.

*Table 4.25: PDU estimates, PDUs identified in TDI and PDUs identified through English treatment monitoring system (NDTMS)*

	PDU estimates (2004/05)	TDI (2005/06)		NDTMS (2005/06)*	
		n	%	n	%
Opiate and/or crack users	327,466	73,900	23	136,228	41.6
Opiate users	281,320	68,676	24	128,630	45.7
Crack users	192,999	26,272	13	39,832	20.6

\*2005/6 figures from NDTMS are provided by D. Cairns at the National Drugs Evidence Centre, 2005/6 figures from NDTMS are by NTA.

Source: Hay *et al.* 2006; Standard Tables prepared by M. Donmall 2007, NDEC



## 5. Drug-related treatment

### 5.1 Overview

United Kingdom drug strategies identify treatment as being effective in tackling problem drug use and, therefore, indicate a need to increase its availability and quality. An indicator measure for the new Public Service Agreements published in October 2007 is the percentage change in the number of drug users recorded as being in effective treatment.

*Drug misuse and dependence: guidelines on clinical management*, (updated in 2007) and, in England, *Models of care for treatment of adult drug misusers: update 2006* provide the basic framework for drug treatment, offering guidance around the structure and range of services to be commissioned in each area, as well as guidelines on clinical practice. The National Institute for Health and Clinical Excellence (NICE) also provides guidance in a number of areas. Treatment providers are expected to offer advice and information, care planned counselling, structured day care programmes, community prescribing, inpatient drug treatment and residential rehabilitation. In addition, drug misusers are to be offered relapse prevention and aftercare programmes; hepatitis B vaccinations; testing and counselling for hepatitis B and C and HIV; and needle exchange. Oral methadone maintenance is the most common method used in treating heroin addiction, buprenorphine, injectable methadone and heroin are also available.

Coordination and integration between a range of providers is seen as key in helping problem drug users reintegrate into society. While providing treatment remains a priority, the role of other service providers of housing, employment, education and training has also become important, leading to the concept of *Wraparound Services*.<sup>97</sup> This integrated approach is seen through the introduction of the Drug Interventions Programme (DIP) in England and Wales, and the establishment of Criminal Justice Intervention Teams which have been developed to improve referral into treatment through the criminal justice system and for those in prison (see Chapter 9).

Improving treatment for young people has been prioritised since 2005.

With access to effective treatment being a priority of the United Kingdom drug strategies, treatment capacity has increased substantially. This has been accompanied by significant financial investment. However, there remain concerns about workforce capacity, which are being addressed. Research initiatives are funded centrally to help improve the effectiveness of treatment, and there are also a number of other initiatives to increase the capacity and improve the effectiveness of treatment, for example nurse prescribing, guidance for pharmacists working with drug users, and continued encouragement to expand the role of general practitioners (GPs) in the treatment and care of drug misusers. The health and social outcomes associated with treatments have come to prominence in the last year, with attention given to measuring these in England and Wales. In Scotland political debate during the last year, about maintenance treatments, particularly methadone, seems to have been resolved with an acceptance of the value of this treatment.

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<sup>97</sup> See:

[http://www.drugmisuse.isdscotland.org/eiu/pdfs/eiu\\_litreviewsum.pdf#search=%22Wrap%20Around%20Services%20drug%20misuse%20%22](http://www.drugmisuse.isdscotland.org/eiu/pdfs/eiu_litreviewsum.pdf#search=%22Wrap%20Around%20Services%20drug%20misuse%20%22)



## 5.2 Treatment system

### 5.2.1 Numbers in treatment

In England the numbers in treatment, as well as those presenting to treatment, are monitored. In 2006/07 there were 195,464 individuals, this is a rise of 10 per cent from 2005/06 (177,055<sup>98</sup>). Elsewhere in the United Kingdom monitoring systems provide information on the numbers entering treatment rather than all those in treatment during the year (See Chapter 4).

#### *Welsh National Database for Substance Misuse*

The first annual report from the Welsh National Database for Substance Misuse was published in 2006 (WAG 2006a).

### 5.2.2 Quality in treatment systems

There has been a continued process of improving the quality of treatment provision in the United Kingdom. Clinical guidelines have been revised (see below). In England, there have been further reviews of local treatment through the Healthcare Commission and the National Treatment Agency (NTA) (see 5.2.3), additional guidance on aspects of treatment from the National Institute for Clinical Excellence (NICE) (see below), and revised guidance on good practice in care planning and work to measure treatment outcomes (see below). There has also been a strengthening of rehabilitation services mirroring comments in the consultation on the new national drug strategy (see below), ensuring that the right balance is achieved between treatment services that are able to maintain drug users in treatment, and services aimed at helping people become and remain abstinent from drug use. The NTA issued updated guidance on needs assessment for adult drug treatment. Also, treatment for young people under 18 years has been highlighted as requiring improvement; from 2007, the NTA will take lead responsibility for this (see below).<sup>99</sup>

#### *Treatment within the consultation document on a new national drug strategy*

The consultation on the new national drug strategy (see Chapter 1.3.2) states that drug treatment will remain a cornerstone of drug strategy, but needs to be more cost-effective and with more done to help drug users find employment and suitable housing. In addition, more needs to be done for those under 18. It is suggested that future policy should achieve the right balance between maintenance services and services aimed at helping people to become and remain abstinent from drug use altogether. The consultation seeks views on a number of questions with respect to treatment (HM Government 2007a).

#### *PSA Delivery Agreement*

New agreements for reducing the harm caused by drugs (and alcohol) were made in October 2007 placing responsibility on a number of Government departments to meet the targets set (HM Government 2007b). One indicator measure will be the percentage change in the number of drug users recorded as being in effective treatment.

#### *Treatment outcomes*

##### *Treatment effectiveness: retention in Treatment*

In England, retention in treatment for at least 12 weeks is a proxy measure for treatment effectiveness. In 2006/07 75 per cent were retained in treatment for 12 weeks or more. However, in order to provide a better indication of progress made by

<sup>98</sup> These figures are revised from those presented in the previous Focal Point Report, when they were given as 181,390.

<sup>99</sup> For more information see: [www.nta.nhs.uk](http://www.nta.nhs.uk)

those in treatment the need to understand and measure the outcomes of treatment was given priority in 2006 by the NTA.

#### *Outcome Tool*

A Treatment Outcomes Profile (TOP) has been developed in England to monitor the outcomes of treatment.<sup>100</sup> This tool will be used at the start of treatment and in care plan reviews and will be reported through the National Drug Treatment Monitoring System (NDTMS) every three months. Outcomes measured are drug and alcohol use; physical and psychological health; social functioning; and offending and criminal involvement. Available documentation includes the Treatment Outcome Profile Form (NTA 2007a); a manager's implementation guide (NTA 2007b); a Treatment Outcome Profile keyworker's guide (NTA 2007c); and a Treatment Outcome Profile service user's guide (NTA 2007d).

#### *Predicting drug treatment outcomes*

Gossop *et al.* (2007) reported on a study representing the first large-scale test of the capacity to predict illicit drug treatment outcomes from an instrument, the Stages of Change and Treatment Eagerness Scale (SOCRATES), purporting to measure processes underlying stages of change.<sup>101</sup> The main hypothesis was that 'taking steps' (making changes in behaviour) should be predictive of less frequent use of illicit opiates (heroin and non-prescribed methadone) at follow-up. Results did not support the hypothesis and a negative association was found with benzodiazepine misuse. While readiness for change measures were correlated with heroin use and psychiatric symptom scores at treatment intake, they were not associated with illicit drug use outcomes.

#### *Update of Drug misuse and dependence: guidelines on clinical management*

Departments responsible for health in the United Kingdom have updated *Drug misuse and dependence: guidelines on clinical management* (DH 1999). A draft was issued in June 2007 for a three month consultation.<sup>102</sup> The guidelines have been compiled by an independent working group of clinicians and others to consider the significant developments in clinical drug treatment since 1999, when the guidelines were last published. The new guidance was published in September 2007.

The guidelines include the following key principles underlying appropriate care of drug misusers are stated as:

- Drug misusers have the same entitlement as other patients to the services provided by the National Health Service.
- The General Medical Council's statement that: "It is ... unethical for a doctor to withhold treatment from any patient on the basis of a moral judgement that the patient's activities or lifestyle might have contributed to the condition for which treatment was being sought. Unethical behaviour of this kind may raise the question of serious professional misconduct."
- It is the responsibility of general practitioners to provide general medical services for drug misusers. Health Authorities, Primary Care Trusts in England and Wales, and Health Boards in Northern Ireland and Scotland all have a duty to provide

<sup>100</sup> For information see: [http://www.nta.nhs.uk/areas/outcomes\\_monitoring/](http://www.nta.nhs.uk/areas/outcomes_monitoring/)

<sup>101</sup> The sample comprised 1075 people seeking treatment for drug abuse problems in 54 treatment agencies in England. The study uses a longitudinal, prospective cohort design. Structured interviews were conducted at treatment intake and at 1-year follow-up. Data were collected about illicit drug use (frequency of use of heroin, non-prescribed methadone, cocaine and amphetamines, and non-prescribed benzodiazepines) and other problems.

<sup>102</sup> see:

[http://www.nta.nhs.uk/areas/clinical\\_guidance/clinical\\_guidelines/cgl\\_update0607/consultation.aspx](http://www.nta.nhs.uk/areas/clinical_guidance/clinical_guidelines/cgl_update0607/consultation.aspx)

treatment for drug misusers, to meet local population needs. This should include interventions to reduce drug-related harm such as hepatitis B vaccinations and needle exchange provision, together with evidence-based drug treatment.

- Every doctor must provide medical care to a standard which could reasonably be expected of a clinician in his or her position. An increasing number of clinicians are trained and supported to provide drug treatment under the terms of a contract negotiated with their local commissioners.

#### *National Institute for Health and Clinical Excellence Guidance*

The National Institute for Health and Clinical Excellence<sup>103</sup> (NICE 2007b; 2007c; 2007d; 2007e) published technology appraisals<sup>104</sup> and clinical guidelines<sup>105</sup> on a number of areas relating to treatment.

#### *Technology appraisal: buprenorphine and methadone for the management of opioid dependence*

This appraisal suggests that methadone and buprenorphine are both appropriate as substitute drugs for the management of opioid dependence with the dose varying depending on the individual. Supervised consumption is recommended at least for the first 3 months of treatment (NICE 2007b).<sup>106</sup>

#### *Technology appraisal: naltrexone for the management of opioid dependence*

It is recommended Naltrexone be used as a treatment option for people who have been opioid dependent but who have stopped using opioids, and who are highly motivated to stay free from the drugs in an abstinence programme (NICE 2007c). It is suggested that treatment should be for an initial period of 3 months, although extended treatment may be necessary.<sup>107</sup>

#### *Clinical Guidelines: on drug misuse: psychosocial interventions*

NICE suggests that psychosocial interventions are the mainstay of treatment for cannabis and stimulant misuse, and also form an adjunct to treatment for opioid misuse (NICE 2007d). It is suggested that the following interventions may be offered: brief interventions, self-help, behavioural couples therapy, cognitive behavioural therapy, contingency management and psychodynamic therapy.<sup>108</sup>

Contingency management, providing incentives, such as access to take home medication, for positive patient behaviour is not well developed in the United Kingdom (Weaver *et al.* 2007) and therefore, following the publication of the above guidelines the NTA is inviting expressions of interest for demonstration sites to deliver a range of contingency management approaches to expand the UK evidence base.<sup>109</sup>

<sup>103</sup> The National Institute for Health and Clinical Excellence advises on when and how drugs and other treatments should be used in the NHS in England and Wales.

<sup>104</sup> Technology appraisals are recommendations on the use of new and existing medicines and treatments, based on a review of clinical and economic evidence. The NHS is legally obliged to fund and resource medicines and treatments recommended by NICE's technology appraisals.

<sup>105</sup> Clinical guidelines are recommendations by NICE on the appropriate treatment and care of people with specific diseases and conditions within the NHS. They are based on the best available evidence. While clinical guidelines help health professionals in their work, they do not replace their knowledge and skills.

<sup>106</sup> For more information see:

<http://guidance.nice.org.uk/TA114/guidance/pdf/English/download.dsp>

<sup>107</sup> For more information see: <http://guidance.nice.org.uk/TA115/guidance/pdf/English>

<sup>108</sup> For more information see: <http://guidance.nice.org.uk/CG51/niceguidance/pdf/English>

<sup>109</sup> See: [http://www.nta.nhs.uk/areas/treatment\\_planning/needs\\_assessment.aspx](http://www.nta.nhs.uk/areas/treatment_planning/needs_assessment.aspx)

*Clinical guidelines: drug misuse: opioid detoxification*

NICE suggests that pharmacological approaches are the primary treatment option for opioid detoxification, with psychosocial interventions providing an important adjunct. Methadone or buprenorphine are recommended as the first-line treatments in opioid detoxification; though it is suggested that lofexidine may be considered, particularly for people with mild or uncertain dependence (including young people); clonidine and dihydrocodeine should not be used routinely in opioid detoxification (NICE 2007e). It is also recommended that ultra-rapid detoxification under general anaesthesia or heavy sedation should not be offered. Recommendations are also given on people who misuse benzodiazepines or alcohol in addition to opioids. Contingency management is suggested as the only psychosocial intervention with clear evidence for effectiveness as an adjunct to effective detoxification.<sup>110</sup>

*Draft Guidance on the Commissioning of Young People's Specialist Substance Misuse Treatment Services*

The NTA have issued draft Guidance on the Commissioning of Young People's Specialist Substance Misuse Treatment Services for consultation.<sup>111</sup> The commissioning guidance will link guidance on needs assessment and planning of young people's specialist substance misuse treatment services, which are currently under development by the NTA.

Young people's substance misuse services receive funding via the young people substance misuse partnership grant, which is a pool of budgets from the Department of Health, the Department for Children, School and Families, the Home Office and the Youth Justice Board. Funding for 2007/2008 will be €36.2 million. Where there is local need, additional funding for young people's treatment can also be met through the pooled treatment budget funding allocated to Primary Care Trusts.<sup>112</sup>

*Other guidance**Guidance on needs assessment for adult drug treatment*

The NTA has prepared new needs assessment guidance to assist commissioners and local partnerships; included are guidance on treatment mapping, gap analysis and understanding unmet need, as well as clarification of the role of assessing need within the annual commissioning cycle.<sup>113</sup>

*Guidance in commissioning Tier 4 services*

Two guidance documents have been published for inpatient services (Tier 4<sup>114</sup>) by the NTA. One offers guidance for local partnerships on the commissioning of Tier 4 services, and the second gives guidance and definitions on differing models of residential rehabilitation.<sup>115</sup>

*Guidance on good practice in care planning*

The NTA has also produced guidance on good practice in care planning (NTA 2007e). It is suggested that good performance in care planning is influenced by a number of factors including: having treatment systems which are responsive to user needs; good clinical governance and clinical leadership; effective local forums and meetings; integration with criminal justice and other treatment services; access to the

<sup>110</sup> For more information see: <http://guidance.nice.org.uk/page.aspx?o=256685&c=91523>

<sup>111</sup> For more information see:

[http://www.nta.nhs.uk/areas/young\\_people/guidance\\_commissioning\\_service\\_delivery.aspx](http://www.nta.nhs.uk/areas/young_people/guidance_commissioning_service_delivery.aspx)

<sup>112</sup> See: [http://www.nta.nhs.uk/areas/young\\_people/funding.aspx](http://www.nta.nhs.uk/areas/young_people/funding.aspx)

<sup>113</sup> See: [http://www.nta.nhs.uk/news\\_events/newsarticle.aspx?NewsarticleID=31](http://www.nta.nhs.uk/news_events/newsarticle.aspx?NewsarticleID=31)

<sup>114</sup> Tier 4 treatment services include inpatient assessment, stabilisation and assisted withdrawal services, residential rehabilitation services.

<sup>115</sup> See: [http://www.nta.nhs.uk/areas/tier\\_4/default.aspx](http://www.nta.nhs.uk/areas/tier_4/default.aspx)

full range of drug treatment services; good information sharing protocols; good systems for recording, sharing and monitoring care plans; regular audits of care planning; and integrated care pathways in place.

#### *DrugScope guidance*

DrugScope has launched a series of publications under the title of *The Essentials*, aimed at professionals working in the drug treatment sector. These are: *The Essential Drug and Alcohol Worker* (Morrison 2007); *The Essential Service Manager* (Robinson 2006); and *The Essential Drug Service Commissioner* (Hanton 2006).

#### *Models of residential rehabilitation for drug and alcohol misusers*

The draft document *Models of residential rehabilitation for drug and alcohol misusers* was reported in the 2006 UK Focal Point report (NTA 2006). The final version has now been published.

#### **Wales**

There is a thrust to improve services for drug users in Wales (internal communication from Welsh Assembly Government; personal) and key performance indicators have been published (see below). Access, availability and standards of care are key priorities of the Welsh Assembly Government and work is being undertaken to reduce waiting times and improve the quality of care. A Treatment Framework is being developed, to be updated each year. By April 2008 there will be a programme of external thematic reviews of treatment services to see what is happening in the field. This will be run through the Healthcare Inspectorate Wales. Its aim is to secure improvements and consistency and lead to new developments.

Also, the Welsh Assembly Government is currently giving consideration to measuring outcomes. A toolkit, the Wales Integrated Substance Misuse Assessment Toolkit, is being piloted in Dyfed Powys based on the NTORS domains. The use of the TOP form (see above) is also to be piloted.

There has been an audit of waiting times for Tier 3 services and there will be one for Tier 2 services. Guidance on good practice with respect to waiting times has been issued (internal communication from Welsh Assembly Government).

There is to be a review of Tier 4 services. Research is currently being undertaken on guidance for patient journeys, and there are also questions as to how Tier 4 is commissioned. There will be a national conference to highlight issues in December 2007.

There is an Action Learning Group looking at unit costs, and Local Health Boards are to be asked to account for substance misuse costs separately.

#### *Key Performance Indicators for substance misuse treatment services in Wales*

Key Performance Indicators (KPI) for substance misuse treatment services in Wales are now published and apply to alcohol, drugs and other substances (WAG 2006a). These are:

1. Increase local service capacity.
2. Reduce the number of incidences of unplanned ending of contact with services.
3. A waiting time of 10 days between referral and assessment.
4. A waiting time 10 days between assessment and the beginning of treatment.
5. Young people referred from a Young Offenders Team (YOT) to receive an assessment within five days.
6. Young people referred from a YOT to have a care plan no later than 10 working following assessment.



7. Reduce the number of incidences of reported acquisitive crime (defined as those listed as “trigger offences” for Drug Testing on Charge areas). The target is to achieve a reduction of 15 per cent against the baseline year 2003/04 (linked to the Home Office Public Service Agreement target 1: reduce crime by 15%).
8. All clients who are injecting to be offered information, counselling, screening and where appropriate, immunisation against Hepatitis B.

A new Drug and Alcohol Training Oracle website, sponsored by the Welsh Assembly Government, has been set up to increase the use of the Drug and Alcohol National Occupational (DANOS) standards in Wales by helping to identify the training needs of people working in the substance misuse field and to provide information about courses and other training opportunities that are available to help them meet these needs.

### *Scotland*

In Scotland, widespread political and media attention has been given to the current drug treatment system, focused more particularly on the effectiveness of methadone as a treatment. Concerns have, to some extent, been associated with a number of high profile incidents involving children such as the death last year of a two year old boy who drank his parents’ methadone. In response, the Scottish Government launched a wide ranging review of methadone programmes, which concluded that methadone should continue to be the mainstay of the treatment system, but included a number of recommendations to improve the quality of treatment (see 5.4.2).

As part of this review, in January 2007 a study of the long-term risks posed to Scottish society by drug and alcohol abuse was launched. The Scottish Parliament’s *Futures Forum* is to set out its research plan at a conference looking at ways that both illegal and legal addiction is affecting many families and communities.<sup>116</sup> As part of the debate it has been suggested that methadone programmes have been a failure because so few become drug free and only 20 per cent of those prescribed methadone do not continue to commit crimes (McKeganey *et al.* 2006). In February 2007, the Association of Directors of Social Work (ADSW) called for a Royal Commission to ‘settle’ what they describe as the row over methadone prescribing, suggesting that the debate over its use as a heroin substitute had become too politicised.<sup>117</sup>

There is also an interest in alternatives to methadone with funding for abstinence based treatment services and research suggesting the use of dihydrocodeine (see below).

### *National Quality Standards for Substance Misuse Services in Scotland*

The National Quality Standards for Substance Misuse Services have been published (Scottish Executive 2007a). There are 11 standard statements, which set out what substance misuse service users can expect from treatment services. It is expected that Alcohol and Drug Action Teams (ADATs) and commissioners will incorporate them into their monitoring arrangements.

### *Stocktake of Alcohol and Drug Action Teams in Scotland*

The remit of the Stocktake of Alcohol and Drug Action Teams (ADATs) in Scotland (Scottish Executive 2007e) was to consider the current performance of ADATs and their capability to deliver future Ministerial priorities on drugs and alcohol. Several

<sup>116</sup> For more information see: <http://www.scottish.parliament.uk/nmCentre/news/news-07/pa07-049.htm>

<sup>117</sup> For more information see: <http://www.theherald.co.uk/news/news/display.var.1204261.0.0.php>



fundamental questions were posed: is the partnership approach the best way to deliver real improvements in combating substance misuse in Scotland; and, if so, are ADATs the best model for this? The overwhelming conclusion was that a partnership approach was essential to address substance misuse effectively in Scotland. It was found that on the whole, ADATs do excellent work tackling some of the most challenging and complex societal problems that exist in Scotland today. However, in some there were serious shortcomings, including poor leadership, lack of commitment and an insufficient understanding of the strategic aims.

It was recommended that for ADATs to be more effective there must be greater clarity about what is expected of them and by whom. There should also be greater clarity and openness about the full extent of local expenditure on measures to prevent and reduce substance misuse so that ADATs can channel these resources more effectively. Also, composition and size of ADATs should be reviewed to take account of structural changes in the wider public sector environment and partnerships which have developed in recent years. And, support for ADATs should be strengthened and at the same time more should be expected of them. Performance management should be more robust at national and local levels so that all ADATs provide an equitable service. There should be greater consistency in the availability and delivery of local services across Scotland.

### 5.2.3 Reviews of the drug treatment system

#### *Improvement Reviews*

The aim of improvement reviews undertaken by the Healthcare Commission is to independently assess the quality of treatment services in each DAAT area to facilitate improvements in key aspects of these services.<sup>118</sup> The small number of organisations (approximately 10%) that receive the weakest assessment are provided with help to develop an action plan to improve their performance. In 2006/2007 the review assessed systems management and services for reducing harm.<sup>119</sup>

#### *RSA recommendations on evaluation of treatment*

The independent report by the Royal Society for the Encouragement of Arts, Manufactures and Commerce (RSA) (2007) (see Chapter 1.2.4) suggests there should be:

- a greater emphasis on drugs treatment as a health measure, with the demands of the criminal justice system exerting a lesser influence on the organisation, pattern and provision of treatment;
- availability of a range of different treatment options;
- easier access to treatment and more responsive services;
- better integrated services;
- more varied and flexible services for black and minority ethnic drug users, for women and for stimulant users;
- better 'wraparound' services;
- a better focused role for the criminal justice system in bringing people into treatment; and
- more humane and realistic ways of measuring the effectiveness of treatment.

<sup>118</sup> For more information see: [www.nta.nhs.uk](http://www.nta.nhs.uk)

<sup>119</sup> See:

<http://www.healthcarecommission.org.uk/serviceproviderinformation/reviewsandinspections/improvementreviews/substancemisuse2006-2007.cfm>

### 5.2.4 Funding

It was announced on 29 January 2007 that the 2007/08 Pooled Drug Treatment Budget for England is to increase from €550m to €569m. In addition, €14.7 million capital funding will also be distributed<sup>120</sup> and € 79.7 million in capital funding is to be made available to increase capacity for inpatient and residential (Tier 4) services in England in 2007/08 and 2008/09.

In 2005/06 €97.6 million was invested by the Scottish Government to tackle the drug problem across Scotland. €8.8 million a year was allocated for 2005/06 and 2006/07 to enable more people to enter treatment.<sup>121</sup> Of this, ADATs were allocated €5.8 million a year to establish or develop existing services aimed at increasing the numbers entering treatment, expanding the range of drug interventions and reducing waiting times. The remaining €3 million a year, earmarked for criminal justice interventions, was not allocated during 2005/06 and therefore for one year only, €2.5 million of funding has been allocated towards five abstinence based projects.

### 5.2.5 Drug treatment in custody

See chapter 9.3.1.

### 5.2.6 Pilot Treatment Projects / Trials

#### *The Randomised Injectable Opiates Treatment Trial*

A Randomised Injectable Opiates Treatment Trial (RIOTT) began in 2005; 150 patients are to be recruited. Participants receive one of three prescriptions at random: injectable diamorphine; injectable methadone and oral methadone. The trial aims to assess the effectiveness of injectable diamorphine and injectable methadone treatment in England through a system of daily supervised consumption. The results will be reported towards the end of 2008. (Department of Health – internal communication).

#### *Pilot study: protocol for a randomised controlled trial comparing dihydrocodeine and buprenorphine for opiate detoxification*

Sheard *et al.* (2007) report on a randomised controlled trial methodology to be undertaken to compare the open use of buprenorphine and dihydrocodeine for opiate detoxification, given in the context of routine care, within Her Majesty's Prison (HMP) Leeds.<sup>122</sup> The primary outcome measure is abstinence status at five days post detoxification, as determined by a urine test. Secondary outcomes during the detoxification and then at one, three and six months post detoxification will be recorded. The reducing regimen of both dihydrocodeine and buprenorphine (over less than 16 days) will be at the discretion of the prescribing doctor.<sup>123</sup>

#### *Pilot cluster-randomised trial of adjunctive motivational interviewing to reduce crack-cocaine use*

Mitcheson *et al.* (2007) report on a pilot trial to explore the effectiveness of an adjunctive single session of motivational interviewing to reduce crack cocaine use in

<sup>120</sup> See: <http://www.drugs.gov.uk/news-events/latest-news/2901?version=1>

<sup>121</sup> See: <http://www.scotland.gov.uk/News/Releases/2006/10/18152439>

<sup>122</sup> Randomisation will be random block size, which will be administered centrally in the Academic Department of Psychiatry and Behavioural Sciences, University of Leeds. Opaque consecutively numbered envelopes will be prepared. If a prisoner is both eligible and agreeable the next envelope will be opened and the intervention allocated.

<sup>123</sup> Also see: Wright, N.M.J., Sheard, I., Tompkins, C.N.E., Adams, C.E., Allgar, V.L. and Oldham, N.S (2007) Buprenorphine versus dihydrocodeine for opiate detoxification in primary care: a randomised controlled trial. *BMC Family Practice*, **8**

a methadone maintenance treatment population.<sup>124</sup> It is reported that the intervention had a modest, but not statistically significant, impact on one crack cocaine measure. However, a large, and statistically significant, reduction in heroin use amongst those in receiving motivational interviewing was observed. The authors suggest that the study demonstrated it was feasible to incorporate a psychosocial intervention within a busy outpatient methadone maintenance programme and the findings support the value of undertaking a larger trial.

#### *Methadone tolerance testing in drug misusers*

Bakker and Fazey (2006) argue that providing new patients with too low a dose of methadone does not eliminate mortality associated with starting treatment and may not be sufficient to alleviate withdrawal symptoms, thus discouraging addicts from entering or staying on treatment. They suggest that testing methadone tolerance, which uses an initial dose that approximates the patient's usual opioid intake, provides a better solution and they describe the rationale behind this method, their experience of its effectiveness, and safeguards against methadone toxicity.

#### *Supervised methadone*

In a study of factors associated with outcome variables for supervised methadone (Bloor 2007) it was found that pharmacy supervised methadone schemes were seen as positive by the majority of users, pharmacists, prescribers and policy makers.<sup>125</sup> However, the issues of privacy, confidentiality and flexibility were a concern. The study also investigated drug-related mortality in the context of supervised methadone consumption schemes and found schemes were associated with a reduction in death related to methadone; those methadone-related deaths which did occur were most often in association with use of a combination of drugs including benzodiazepines.

#### *Methadone versus dihydrocodeine: a controlled trial*

Robertson *et al.* (2006) reported on a study designed to define the efficacy of dihydrocodeine as an alternative to methadone in the maintenance treatment of opiate dependence.<sup>126</sup> The primary outcome measure was retention in treatment. Eight secondary outcomes included: total illicit opiate use; reported crime; physical health; mental health; injecting drug use; overdoses; selling drugs; and being in education or work. Measures were compared over 42 months follow-up. No significant difference in outcomes was found between randomised groups over time. Compliance with randomised treatment differed by randomised group and was affected by experiences in custody during follow-up. Those randomised to dihydrocodeine were more likely to switch treatments. It was concluded that these results provide evidence that dihydrocodeine is a viable alternative to methadone as a maintenance treatment for opiate dependence.

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<sup>124</sup> Twenty-nine participants were cluster randomised by a clinician to motivational interviewing or a crack information control condition as part of treatment as usual.

<sup>125</sup> The project compared four different services which have introduced supervised methadone schemes. The study included the following methodologies: epidemiological study; service review and evaluation; structured questionnaires; narratives; semi-structured interviews; structured case vignette; focus groups; and quantitative and qualitative analysis. Nine hundred users were sent questionnaires (response rate 38.9%); 166 community pharmacists (response rate 68.8%); 497 GPs (response rate 26.3%) and 29 specialist prescribers (response rate 69%). Semi-structured interviews were carried out on 14 drugs users, six community pharmacists, four GPs and three specialist prescribers. The number of participants in the focus groups were three, four, ten and five respectively.

<sup>126</sup> This was a pragmatic open-label randomised controlled study of patients recommended for opiate maintenance treatment to test equivalence of the two treatment options with follow-up continuing for up to 42 months after recruitment. Two hundred and thirty-five subjects (168 male, 67 female) were recruited. Patients were randomised to receive either methadone mixture 1 mg/ml or dihydrocodeine, 30 mg or 60 mg tablets.

### *Pilot projects in Scotland*

In 2006 the Scottish Government funded a number of pilot projects which address clients' wider needs in addition to their addiction and include alternatives to substitute prescribing. These are all being independently evaluated.

#### *Community based intensive support, Edinburgh - LEAP*

Existing treatment provision within the NHS in Edinburgh is being extended to include a 12 week recovery programme, using activities and techniques often used in residential rehabilitation, adapted for use in a community setting. In addition to comprehensive healthcare, the treatment provided includes proven interventions such as counselling, training in life skills, anger management and grief issues, parenting skills and exercise. There is also provision for aftercare, linked with housing services and training and employment services.

#### *Detoxification and extensive support, Forth Valley – FV-TOX*

Following extensive consultation with drug users in the area, an opiate detoxification programme has been extended in Forth Valley based in Alloa, attracting drug users for whom maintenance treatment was neither suitable nor desired. This offers more drug users a choice of treatment, and increases the number of clients who can be accommodated at any one time. The treatment involves three stages: preparation; detoxification; and support and lasts for an average of 3 months.

#### *Alternative options for rural drug misusers, Dumfries and Galloway*

Abstinence as a treatment option for rural drug misusers coming from a defined geographical area is being piloted. The programme involves three phases: preparation; detoxification; and follow-up support. While preparatory work and clinical supervision will be done through existing services, the project is supplying intensive community support required by those who enter. Outcomes monitored include not only the level of abstinence achieved but also other social indicators such as housing, employment, education and relationships.

#### *Additional 'SMART Recovery' therapy for released prisoners, Inverness*

An existing peer support regime based on the SMART Recovery Inside Out Programme has been in use in Inverness prison for the last four years. Is being extended for prisoners who wish to continue it on release into their communities. This pilot links prisoners up via an innovative secure computer system called Distance Therapy and a SMS phone service to provide a more holistic, integrated and cost effective throughcare plan.

#### *Intensive support project for female ex-prisoners, Cornton Vale*

This pilot is an additional support mechanism for drug addicted women leaving Cornton Vale prison. It is designed to strengthen the support systems around them and help establish and prolong engagement with drug services for a period of up to 6 months post-release. It is also helping female ex-prisoners to make and sustain connections with existing services such as accommodation providers, money advice services, child care and further education/employment services. Project staff provide practical support, exploring behaviours that seek to address difficulties and provide non-offending options.

### 5.2.7 Other research studies on drug treatment

#### *Attribution of drug use and model of treatment*

Newham and Davies (2007) looked at attributions of drug use by three groups of users, those involved with Narcotics Anonymous (n = 5), those from a residential rehabilitation unit (n = 6) and students (n = 12). The study showed that the two former groups gave attributions consistent with addiction, while students gave

unstable and controllable attributions. They suggest that adoption of the attribution 'addiction' can be detrimental, increasing self-assessed powerlessness and creating a self-fulfilling prophecy whereby users perceive themselves to not be in control, whereas when addicts see themselves as in control, they are better able to prevent relapse.

#### *Drug user involvement in treatment decisions*

Fischer *et al.* (2007) suggest that whilst user involvement has become a key principle in the delivery of health and social care services, implementation is not easy. Their research explores a range of related issues: the nature and extent of involvement; the desire for involvement amongst practitioners and service users; likely constraints on involvement; and the impact and relative importance of involvement on treatment users.<sup>127</sup> It found variations in concepts of involvement between clients, referrers, agency staff and residential staff and that user involvement can be limited by users' deference to staff expertise. There were differences in power relations between staff and their clients; while many practitioners were highly committed to involving their clients in referral decision making, service users' choice of treatment could be constrained by limited resources, administrative procedures and agency policies regarding client suitability. It is suggested that willingness on behalf of staff and service users to communicate and negotiate with each other appears to be the cornerstone of effective user involvement. The report contains a number of recommendations for facilitating user involvement based on early analyses of the data, refined through a closed email Delphi group involving practitioners, policymakers and service users.

#### *'Treatment experienced' and 'treatment naive' drug agency clients*

A comparison of drug users entering treatment who had had previous experience of treatment and those who had not, found that at treatment intake, the former had worse drug use and life problems than treatment novices (Neale *et al.* 2007a).<sup>128</sup> Multivariate analysis showed that three variables; ever injected, ever overdosed, and index type, were independently associated with being treatment experienced rather than treatment naive. It is therefore suggested that new drug treatment clients who have a prior treatment history seem particularly likely to need advice and support with injection-related problems and overdose prevention. Also, that prison-based services can anticipate more treatment experienced drug users than community-based services. It was concluded that there was no evidence that those who are treatment experienced have worse drug use outcomes than those who are not.

#### *Perceptions and experiences of health and social care professionals*

The aim of the study by McLaughlin *et al.* (2006) was to explore the perceptions that a sample of health and social care professionals have of illicit drug users in Northern

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<sup>127</sup> The research is based on an in-depth investigation of drug service users' and practitioners' experiences of user involvement in four specialist treatment agencies: two community prescribing agencies and two residential rehabilitation centres, in England and Scotland.

<sup>128</sup> The study was based upon the DORIS cohort of drug users entering treatment in Scotland. The DORIS study is a prospective follow-up study of a cohort of 1007 individuals starting a new episode of drug treatment in Scotland in 2001/2002. These 1007 drug users were recruited from 33 drug treatment agencies located across rural, urban, and inner-city areas of Scotland. Entry criteria for the study were (i) having a primary dependence on illicit drugs; (ii) being able to give contact details for follow-up interviews; and (iii) attending one of the study's 33 recruitment agencies for the first time ever or for the first time in the last 6 months, providing a systematic comparison of treatment experienced and treatment naive drug users. Six hundred and fifty-three clients were interviewed on four separate occasions; at treatment intake, 8 months, 16 months, and 33 months, using structured questionnaires. 85.5% (558) had had some form of previous treatment, many reporting multiple previous treatments, most commonly substitute drugs.



Ireland.<sup>129</sup> The findings from this study show many of the professionals who participated held entrenched negative views of people that use illicit drugs. These same professionals admit to having little knowledge or skills to assist users with their problems. This finding supports results from other studies in the UK that highlighted the negativity and paucity of professional preparation to deal with this client group.

#### *User involvement in the recruitment of staff for drug services*

Foster *et al.* (2007) report on two case studies of user involvement in the recruitment of staff for drug services, suggesting that participation in staff recruitment may be a practical and meaningful performance indicator for drug services with respect to user involvement.

#### *Time taken to heroin dependence*

Coomber and Sutton (2007) investigated how rapidly heroin users take to become physically dependent<sup>130</sup> and suggest that the period from first use to addiction, and regular use to daily use, may be longer than many assume. The range reported reliably on the temporal transition from regular use to daily use being from one day to six years. The mean was 7.4 months (221 days) and the median, three months (90 days). The data suggest that more frequent initial heroin use resulted in a faster transition to feeling dependent.

#### *How do heroin users spend their spare time?*

Research based on DORIS<sup>131</sup> looked at leisure activity amongst heroin users (Neale *et al.* 2007b).<sup>132</sup> It was found that 59 per cent (359) had at least one leisure interest on entering treatment and 86 per cent (521) had at least one interest 33 months after entering treatment. Sport was the most common interest while others included reading, writing, poetry, music and photography. It is suggested that this research provides further evidence that many problem drug users participate in ordinary daily activities.

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<sup>129</sup> A survey methodology was used. Community settings across Northern Ireland were accessed. Focus groups and face-to-face interviews were used as data collection methods. Thirty-five health and social care professionals took part in this study.

<sup>130</sup> Information was extracted using quantitative data from their qualitative study of a sample of 'street' heroin users. The study comprised individuals who were, at the time of interview, dependent—or had recently been—on heroin and had become so in a natural (i.e. not in a therapeutic) setting. Recruitment took place between August 2000 and March 2001 through five nonresidential treatment/walk-in drug centres in central and South East London. Data collection took the form of semi-structured interviews and was designed to elicit narratives from the participants that explored their transitions from first use through to dependent use. Seventy-two users were interviewed.

<sup>131</sup> The Drug Outcome Research in Scotland (DORIS) study is based at the University of Glasgow's Centre for Drug Misuse. It examines the effectiveness of Scotland's drug treatment services and how evidence of what works can be incorporated into treatment. The researchers have recruited 1,007 drug users who are starting a new drug treatment episode from across Scotland. For more information see:

<http://www.gla.ac.uk/centres/drugmisuse/DORIS.html>

<sup>132</sup> 606 heroin users (70% males; 30% females) were interviewed using structured questionnaires at treatment entry and again 33 months later. Univariate analyses were undertaken using chi-square tests and independent t-tests. Multivariate analyses were undertaken using stepwise logistic regression.



*Case reports of conversion from dextromoramide to other opiates within addiction maintenance treatment*

In light of interruption to the supply of pharmaceutical opiates (see 5.4.2),<sup>133</sup> Strang *et al.* (2006) reported on patients who switched to dextromoramide (an opioid analgesic structurally related to methadone and used in the treatment of severe pain). It was found that dose conversion ratios varied greatly between patients, with up to a threefold variation. With no rigid formula for conversion, and in the absence of pre-existing guidance, wide diversity of practice occurred. It is suggested that clinicians should exercise caution in of the process of dose conversion.

*Remission of psychiatric symptoms after treatment*

Gossop *et al.* (2006), investigating changes in psychiatric symptoms after treatment<sup>134</sup> found reductions in a range of psychiatric symptoms, with reductions occurring rapidly and maintained at follow-up.

*Developing a method for conducting needs assessments for drug treatment: A systems approach*

Best *et al.* (2007a) reported on a method for analysing the extent of need for drug treatment in a local area, based on estimated prevalence of problem drug use and treatment uptake. The aim of the project was to develop a method that could be replicated in each DAAT in England to assess treatment need among groups both in contact with, and out of, treatment. Data used were derived from national monitoring systems for drug treatment and for drug interventions in the criminal justice system. These were used in three areas, supplemented by group work with managers and staff from treatment providers, service commissioners and other key informants. The analysis led to two types of treatment maps, one an assessment of treatment uptake, and the second, a visual representation of service configuration that assessed the flow of clients into and through the local drug treatment system.

**5.3 Drug-free treatment**

See NICE clinical guidelines on psychosocial interventions (5.2).

*Evaluations of drug free treatment**Evaluation of pilot psychostimulant service*

An evaluation of a pilot psychostimulant service, Incite, in Aberdeen, commissioned by the Scottish Government suggested that the effectiveness of the project could not be verified (Human Factors Analysts Ltd 2007).

*Evaluation of crack cocaine treatment and outcome study: England*

The report of the crack cocaine treatment and outcome study (NECTOS), commissioned in 2003 and designed to evaluate a series of established specialist crack services, was published in 2007 (NTA 2007f).<sup>135</sup> It found that while there was a demand for all of the services, there were high rates of attrition prior to assessment and at the start of treatment. The assessment of treatment outcomes undertaken

<sup>133</sup> The methodology was through case report and clinical audit, we report on the opiate switch and dose conversion strategies with 14 patients previously receiving dextromoramide (Palfium\_) as opiate addiction maintenance treatment.

<sup>134</sup> 662 drug –dependent adults recruited at admission to treatment in residential rehabilitation programmes, outpatient methadone treatment programmes. Data were collected by structured interview at intake, one month, and six months.

<sup>135</sup> Initially ten specialist crack services were to be evaluated, however two services withdrew from the evaluation and subsequently three more services closed. Therefore, the evaluation was conducted in five service settings, four of whom provided Tier 3 (structured community-based services) day services (two of these services also provided Tier 2 interventions) and one service provided Tier 4 residential care and was subject to a separate evaluation.

was limited. However, analysis suggested that among clients who were retained in treatment at 30 days and 90 days, there were large and statistically significant reductions in both the frequency of crack use and the amount clients spent on crack. There were also observed increases in the proportions of clients who were abstinent from crack; however, these latter differences were not statistically significant.

#### *Supervising crack-using offenders on Drug Treatment and Testing Orders*

Turnbull and Webster (2007), in research into treatment services provided to crack-using offenders given Drug Treatment and Testing Orders, found that the numbers of primary crack users who had received a DTTO were low, limiting the ability to identify best practice in how to engage and retain crack-using offenders in treatment. It was found that 16 per cent (11/70) completed their DTTOs, compared with a national figure of 28 per cent.

#### 5.3.1 Inpatient treatments

See reviews of residential rehabilitation and *Models of residential rehabilitation for drug and alcohol misusers* in 5.2 above.

#### *Review of Residential Drug Detoxification and Rehabilitation Services in Scotland.*

As part of the review of treatment in Scotland, consideration was given to residential drug detoxification and rehabilitation services (Scottish Executive 2007f). This included the availability, decision-making processes, use and cost of existing residential detoxification and rehabilitation services in Scotland. Alcohol and Drug Action Teams (ADATs) were asked to submit information on their local services. It was found that:

- there are 352 beds available for drug treatment in Scotland, situated across 22 services;
- thirty-one beds are dedicated for use by drug misusers only; most are for drugs and / or alcohol misusers;
- approximately 160 individuals were reported to be on waiting lists;
- all 22 ADAT areas have support services for clients waiting to enter residential treatment, largely specialist community services; and
- a total of €13.3 million was spent on residential detoxification and rehabilitation services in 2005/06. Of this, 68 per cent (€9m) came from local authority budgets while 32 per cent (€4.3m) came from NHS Boards.

The review also found considerable variation as to who ultimately refers and authorises funding for a client to enter residential drug treatment, from senior social workers to Directors of Public Health. There is also little communication or partnership working between residential and community based services, leading to a possible risk of clients being left in limbo between the two.

#### *Detoxification in Rehabilitation*

Best *et al.* (2007b) compared self-reported treatment provision in 87 residential rehabilitation services in England, 34 of whom (39.1%) reported that they offered detoxification services within their treatment programmes. It was found that although there were no differences in self-reported treatment philosophies, residential rehabilitation services that offered detoxification were typically of shorter duration overall, had significantly more beds and reported offering more group work than residential rehabilitation services that did not offer detoxification. Outcomes were also different, with twice as many clients discharged on disciplinary grounds from residential rehabilitation services without detoxification facilities. The authors question the United Kingdom classification of residential drug treatment services as either detoxification or rehabilitation and suggest that there is a need for greater

research focused on the aims, processes and outcomes of this group of treatment providers.

### 5.3.2 Outpatient treatments

NO NEW INFORMATION AVAILABLE

## 5.4 Pharmacologically assisted treatment

See section 5.2 regarding opioid detoxification and NICE guidelines on buprenorphine, methadone, and naltrexone for the management of opioid dependence.

### *GP prescribing of opioids to opiate-dependent patients*

A secondary analysis of data collected by the NTA on substitute opioid prescribing, first published by Strang *et al.*<sup>136</sup> in 2005, explores various aspects of the previous study (Hunt and Strang 2007). In the original analysis, it was found that there was much activity among GPs in relation to both seeing opiate misusers (half of the sample) and prescribing (half of those who attended an opiate misuser). However, there are serious concerns, with a widespread lack of confidence among GPs about providing services to opiate misusers, geographical variability in the type of prescribing, level of shared care involvement and low dose dispensing, and widespread extensive reliance on weekly take-home prescriptions.

This secondary analysis found that GPs who were in contact with opiate misusers differed demographically to those who did not: doctors who were in contact were younger; had been qualified and working as GPs for less time; were more likely to be male; and more likely to be working in an urban practice. The provision of payment to GPs for prescribing methadone was associated with greater involvement by GPs in seeing opiate misusers; where it was offered, GPs saw on average twice as many opiate misusers. Remunerated GPs rated their services as more appropriate and reported feeling more confident. Nearly 80 per cent of GPs in contact with opiate misusers were satisfied to some extent with their local community drug team, whereas only just over half of those who did not treat an opiate misuser were satisfied. Among those who saw opiate misusers, those who rated the local community drug team (CDT) as either very poor or very good had a higher mean patient caseload than those who were more ambivalent to the service. The policies of the practice also determined whether GPs prescribe. GPs were more likely to prescribe where there was a policy for the management of opiate misusers, where there was a limit on the number of opiate misusers who were patients at the practice and where there was a limit on the hours during which opiate misusers can be seen by a doctor.

### 5.4.1 Withdrawal treatment

See above (5.2)

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<sup>136</sup> In mid-2001, a ten per cent random sample (3,023) of the 30,000 GPs across England and Wales was sent self-completion postal questionnaires; a 66 per cent response rate was achieved (1,999 out of 3,023). GPs reported data on whether they had seen an opiate misuser in the previous four weeks, whether GPs had prescribed substitute drugs to at least one misuser who had been treated in the previous four weeks, prescribing, dosing and shared care arrangements.

#### 5.4.2 Substitution treatment

##### *Statistics from the Northern Ireland Substitute Prescribing Database*

Statistics from the Northern Ireland Substitute Prescribing Database (SPD), relating to individuals referred up to and including the 31<sup>st</sup> March 2006, were published in October 2006 (DAIRU/DHSSPSNI 2006a). This is the first bulletin reporting information collected on the SPD since it was established in April 2004. During 2005/06:

- 419 individuals were in contact with treatment services; and
- 77 individuals discontinued treatment.

On 31 March 2006:

- 284 individuals were receiving substitute medication;
- 259 of those had been stabilised;
- the same proportion were stabilised on methadone (48%) and buprenorphine (48%), the remainder (4%) were stabilised on dihydrocodeine;
- 226 had been subject to at least one review;
- almost a quarter (24%) reported heroin as their main problem drug at review stage, compared to more than four in five (83%) when first assessed for substitute prescribing treatment; and
- of those who injected, 16 per cent had injected in the four weeks prior to their review, compared to over half (53%) who had injected in the four weeks prior to assessment.

##### *Suboxone launched in United Kingdom*

Suboxone, a combination of naloxone alongside buprenorphine, was launched in early 2007 as an alternative treatment to methadone and buprenorphine. The formulation is designed to limit the potential for misuse, as well as lowering its street value. It is used for maintenance treatment of opioid dependence.<sup>137</sup>

##### *Continued limited supply of diamorphine*

Limited supply of diamorphine, reported in the previous UK Focal Point Reports, continues although there has been substantial improvement.<sup>138</sup>

##### *Evaluation of methadone prescribing*

Dickinson *et al.* (2006) reported on changes in prescribing practice at a specialised substance misuse service in the United Kingdom which have occurred since the introduction of national guidelines on the management of drug misuse (DH 1999). The research explored a possible link between the length of time spent in methadone maintenance therapy (MMT) and the dosage prescribed. It found that the guidelines had a measurable effect on prescribing practice.<sup>139</sup>

##### *Review of methadone in Scotland*

The following reviews of methadone prescribing in Scotland have been published.

##### *Reducing harm and promoting recovery: a report on methadone treatment for substance misuse in Scotland*

A report from the Scottish Advisory Committee on Drugs Misuse (SACDM) methadone group (2007a), aimed at advising ministers on the place of methadone in the treatment of substance misuse in Scotland, agreed that methadone replacement prescribing remains the main treatment for opiate dependency and should be

<sup>137</sup> See: <http://www.nelm.nhs.uk/Record%20Viewing/vR.aspx?id=575267>

<sup>138</sup> See: <http://news.bbc.co.uk/1/hi/health/6376713.stm>

<sup>139</sup> A retrospective analysis of a computerised prescription database between 1996 and 2002 obtained from Sheffield Care Trust Substance Misuse Service was performed.

available within the framework of services across all areas in Scotland. This, it is suggested, reflects the evidence base which supports its effectiveness in the face of little current credible evidence to support other approaches, though it was suggested that prescribing could be improved significantly in terms of consistency and quality of practice and process of care delivery. Recommendations included integrating methadone replacement prescribing into a coherent planned care package and improving accountability, performance management, the quality of information and the effectiveness and commissioning of services.

#### *A review of methadone treatment in Scotland: views of carers and users*

The Scottish Drugs Forum (SDF) were commissioned to consult those directly affected by or working in the field of substitute prescribing<sup>140</sup> on the use of methadone and found only a very small number were critical of it (SDF 2007). Otherwise, methadone was identified as helping individuals gain stability and reduce the chaos in their lives; improve relationships, including improved ability to care for dependent children; improve their financial position; assist with the move into training, education and employment; and gain or regain self-respect. However, it was also recognised that the effectiveness and impact of clinical prescribing could be significantly improved through the provision of consistent standards of high quality care; a needs-led rather than service-led help; co-ordinated services which meet the full range of needs; swifter access to services; and increased resources. Lack of consistency and the variable quality of services came out strongly across all those consulted. Also, there was a reported need for services to move away from providing the kind of help designed to suit their particular working practices, to one which was truly responsive to the individual needs of service users. This was viewed as an issue of critical importance in improving the impact of treatment by all those consulted, with choice, flexibility and information mentioned consistently.

#### *Review of Methadone in Drug Treatment: Prescribing Information and Practice*

A further review by the Scottish Executive (2007g) sought information, primarily from NHS Boards in relation to methadone prescribing practice. It was found that in 2006:

- 22,224 people were receiving methadone treatment for drug misuse in Scotland, 1,093 of which were in prison;
- at least 12,236 people were on a daily supervised consumption regime; and
- at least 6,752 people who receive methadone have children living with them all or part of the time.

The review also considered the implementation of national guidelines (DH 1999) and local guidelines on methadone prescribing. It found that:

- despite evidence of local interpretation, national guidelines provide the broad basis from which NHS Boards and partner agencies have developed local guidance on the clinical management of drug misusers;
- there is some evidence, however, that policy may not be being implemented in practice (e.g. submission of SMR data by GPs);
- some, but not all Boards have provided evidence that national and local guidelines are monitored actively; and
- methadone is likely to remain the prescribers' drug of choice for maintenance therapy for some time; only four Health Boards currently offer buprenorphine as an alternative to methadone for maintenance prescribing.

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<sup>140</sup> The views of 250 individuals were taken into consideration



*The effect of national guidelines on substitute prescribing in England 1995-2005*

A study by Strang *et al.* (2007a)<sup>141</sup> found that positive changes in prescribing for opiate addiction had occurred in six out of the seven United Kingdom national guidelines issued between 1995 and 2005. This included greater numbers of opiate prescriptions; the increased use of buprenorphine as an opiate substitute; higher dose methadone prescribing; a large increase in methadone prescribed in oral linctus/syrup formulation, more frequent dispensing; and a larger proportion of supervised methadone consumption. The only negative change in relation to the increased involvement of GPs was that the proportion of opiate prescriptions to opiate patients from GPs fell from 41 per cent in 1995 to 30 per cent in 2005, although there was a 50 per cent increase in patients receiving methadone prescriptions from GPs.

*The impact of advanced substance misuse training on GPs' attitudes, behaviour and knowledge*

Strang *et al.* (2007b) reported on a randomised trial to discover the difference that advanced training in drug misuse makes for GPs in England<sup>142</sup>. Using a control group of general practitioners on the waiting list for training, the study found greater improvements in attitudes and behaviour amongst the group assigned a training place although only 'role security' and 'situational constraint' reached statistical significance. A further analysis, undertaken after a subgroup of the control group managed to secure training outside of the trial allocation, found that those who had attended training showed markedly greater improvements in knowledge, attitudinal and prescribing confidence measures and remained more actively involved in treating drug misusers than GPs who remained on the waiting list.

**5.4.3 Other medically assisted treatment***Neuro-Electric Therapy (NET)*

Neuro-Electric Therapy (NET) has been promoted in Scotland recently with television programmes following twelve patients, six men and six women, undergoing a week of therapy. The study involving the six men was terminated when it was discovered that they had been able to smuggle heroin into the study location. Five of the women were still off drugs a few weeks later. Promoters of NET have explored the possibility of conducting a larger trial with the Scottish Government and others. Discussions have focussed on the need to ensure that evidence of effectiveness is gathered in a scientifically credible fashion.<sup>143</sup>

<sup>141</sup> A repeat national survey (1995 and 2005) using random one-in-four samples of all community pharmacies in England, 1,847 (75% response rate) in 1995 and 2,349 (95% response rate) in 2005. Data were obtained on 3,732 (1995) and 9,260 (2005) prescriptions dispensed in the preceding month from the 936 and 1,463 pharmacies who were currently dispensing.

<sup>142</sup> A two-group randomised trial with training and waiting list control comparison. The trial comprised of 112 GPs working in primary care practices in England who applied for an over-subscribed, Department of Health funded place on the 6-month Certificate –level training course on Drug Misuse from the Royal College of General Practitioners. GPs were randomly assigned to each group with 63 in the training group and 49 in the waiting list control group. An initial questionnaire on attitudes, prescribing practices and behaviour was completed by both groups before random allocation. After six months a knowledge questionnaire was completed on the first day and last day of training for those in the training group and at a similar time by post by the waiting list group. A subgroup of the waiting list group secured funding from elsewhere and attended the course and subsequently, further analysis was undertaken on this group.

<sup>143</sup> See: <http://www.scottish.parliament.uk/business/pqa/wa-06/wa0707.htm> and <http://scotlandonsunday.scotsman.com/index.cfm?id=262972007>



## 6. Health correlates and consequences

### 6.1 Overview

The United Kingdom submits two sets of tables to the EMCDDA based on each of three definitions of drug-related death (DRD); each is slightly different. The EMCDDA definition refers to those deaths that are caused directly by the consumption of one or more illegal drugs and generally occurring shortly after the consumption of the substance(s)<sup>144</sup>. The definition used by the Office for National Statistics (ONS) was established earlier and so provides the longest time series, but is a much wider definition than that used by the EMCDDA and includes legal drugs.<sup>145</sup> DRDs, according to the United Kingdom Drug Strategy, are where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances scheduled under the *Misuse of Drugs Act 1971* were involved. This definition has been adopted by the General Mortality Registers (GMRs) across the United Kingdom. The Drug Strategy definition is a subset of the ONS definition, with the main differences lying in the fact that only controlled drugs are identified.

Based on General Mortality Registers (GMR), DRDs in the United Kingdom rose steadily from 1996 until 2000, then fell until 2003, but have since risen.<sup>146</sup> However, the most up to date data, from the Special Mortality Register (SMR), for 2006 shows a fall from the previous year. Males are more likely to suffer DRDs than females, by over 4:1 with the difference closing over the last decade. Overall, the average age at death fell in 2001 and 2002 to 34.0, rising in 2003, 2004, and again in 2005 when it was 36.4 years. Males were approximately four years younger than females at death (35.6 years and 39.9 years respectively). Males are more likely to die at a younger age of accidental poisoning, drug dependence, or non-dependent abuse of drugs, and females by means of intentional/undetermined poisoning. Most deaths are associated with opiates, chiefly heroin/morphine and methadone, often in combination with other drugs and/or alcohol. Mentions of opiates and morphine rose by seven per cent in 2005. In Scotland, diazepam is more likely to be involved than elsewhere in the United Kingdom; for example, in 2005 it was involved in 27 per cent of DRDs.

Data from the SMR show that most male accidental poisoning and overdose deaths occur amongst young age groups who consume illicit drugs, whereas typically it is older females who overdose deliberately on antidepressants and (opioid) analgesics. Those who have a history of drug use/abuse die from a drug-related death at a much

<sup>144</sup> These deaths are known as 'overdoses', 'poisonings' or 'drug-induced deaths'. This definition was agreed by the EMCDDA group of national experts: see methodological notes 'Drug-related death EMCDDA definition' in the 2005 statistical bulletin and DRD standard protocol v3.0.

<sup>145</sup> The ONS definition uses ICD-10 codes equivalent to F11-F16, F18, F19, X40-X44, X60-X64, Y85, Y10-Y14 from 2000, prior to that IC9 codes 292, 304, 305.2-9, E858-8, E950.0-.5, E980.0-.5, E962.0.

<sup>146</sup> There are two main types of source in the UK for information on 'acute' deaths: three General Mortality Registers (GMRs - the General Register Offices for England and Wales (GRO), Scotland (GROS), and Northern Ireland (GRONI)) and one Special Mortality Register (SMR - the National Programme on Substance Abuse Deaths or np-SAD) based at St George's Hospital Medical School, University of London. The General Mortality (GMR) data are derived from medical death certificates. Whilst the GMRs for England and Wales, and Scotland have established special databases to monitor DRDs, this has not yet happened in Northern Ireland. The UK-wide use of ICD-10 in coding DRDs provides consistency in approach.

younger age than those without such a history. However, the average age at death (of whatever cause) of drug addicts has risen over time (from 31.2 years in 1997 to 35.4 years in 2006). Between two-fifths and a half of those who die are unemployed. Two-fifths live alone, and about one in twenty has no fixed abode. Socio-economic determinants play a large part in the geographical distribution of DRDs both nationally and locally. There are differences in the types of drug and mode of administration, not only between but within regions.

HIV<sup>147</sup> prevalence among injecting drug users (IDUs) in the United Kingdom has been at around one per cent since the mid-1990s, although in London it has been higher, at or near, four per cent. There is emerging evidence that suggests a possible increase in transmission in recent years. There were an estimated 2,000 people living with HIV infection acquired through injecting drug use in 2004, of whom 600 were thought to be undiagnosed. Prevalence of hepatitis C (HCV) has been much higher at around 40 per cent of IDUs, and there is evidence of increased incidence. Prevalence of antibodies for hepatitis B (anti-HBc) declined in the early 1990s, and has levelled off at around 20 per cent. Outbreaks of other infections among IDUs have been increasingly declared,<sup>148</sup> following reported increases in injecting risk behaviour. Data for 2006 suggests that prevalence remains stable, though HIV is slightly lower than in the previous year, when it increased a little, but prevalence remains higher than it was in 2000. There has been little change in the prevalence of hepatitis C in the last year, however, prevalence is again higher than at the beginning of the decade.

Prevalence and attribution of dual diagnosis remain difficult to estimate. Depression, anxiety disorders, personality and psychotic disorders are commonly reported, although prevalence varies with setting and specific sub-populations. It has been suggested that from 1993 to 1998 there were at least 195,000 co-morbid patients and 3.5 million general practitioner (GP) consultations involving such patients in England and Wales. The level of co-morbidity is increasing at a higher rate among younger patients, which indicates that co-morbidity may increase in future years. Approximately one-third of psychiatric discharges involve a supplementary rather than a main diagnosis of drug use. In these cases, the most common diagnoses were schizophrenia, mood (affective) disorders and alcohol misuse.

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<sup>147</sup> Data on the prevalence of blood borne infectious diseases amongst injecting drug users (IDUs) are provided by a number of sources. The Unlinked Anonymous Prevalence Monitoring Programme's (UAPMP) surveys of IDUs in contact with drug services in England, Wales and Northern Ireland (Hope *et al.* 2001; Unlinked Anonymous Steering Group 2002); the Centre for Research on Drugs and Health Behaviour's surveys of IDUs recruited from community settings in England (Hunter *et al.* 2000); and the Scottish Centre for Infection and Environmental Health's (SCIEH) surveys of IDUs attending community and drug agency settings in Glasgow (Taylor *et al.* 2000). SCIEH also holds anonymous epidemiological data on all those who have had a named HIV antibody test in Scotland since 1989 (on the HIV Denominator Database). All collect behavioural data and oral fluid for testing for antibodies to hepatitis C (anti-HCV). The main sources of information on newly diagnosed HIV/AIDS infections are from voluntary cases reporting from laboratory reports of newly diagnosed infections by microbiologists and clinicians. For England, Wales and Northern Ireland, reports are made to the Health Protection Agency's Communicable Disease Surveillance Centre (CDSC) whilst new diagnoses in Scotland are reported to Health Protection Scotland. Laboratory report data for England and Wales, Scotland, and Northern Ireland are available from the following websites: <http://www.hpa.org.uk> for England and Wales; <http://www.hps.scot.nhs.uk/> for Scotland; and <http://www.cdscni.org.uk> for Northern Ireland.

<sup>148</sup> Methicillin resistant *Staphylococcus aureus* (MRSA) as a cause of IDU-related sepsis (CDR Weekly 2003) and other serious Clostridial infections acquired through contaminated drugs have been reported (Jones *et al.* 2002; McGuigan *et al.* 2002).

Evidence of the extent of other physical health problems associated with problem drug use<sup>149</sup> are not readily available. In January 2007, the Department of Health issued a health warning after reports of herbal or skunk cannabis contaminated with small glass beads came to light.<sup>150</sup> It was suggested that whilst the exact potential health harm from this contamination is not yet fully determined, inhaling hot glass into the mouth, throat, or into the lungs should clearly be avoided. This was updated in May 2007<sup>151</sup>, suggesting contaminated cannabis is found in approximately 5 to 10 per cent of herbal cannabis seizure cases examined by the Forensic Science Service.

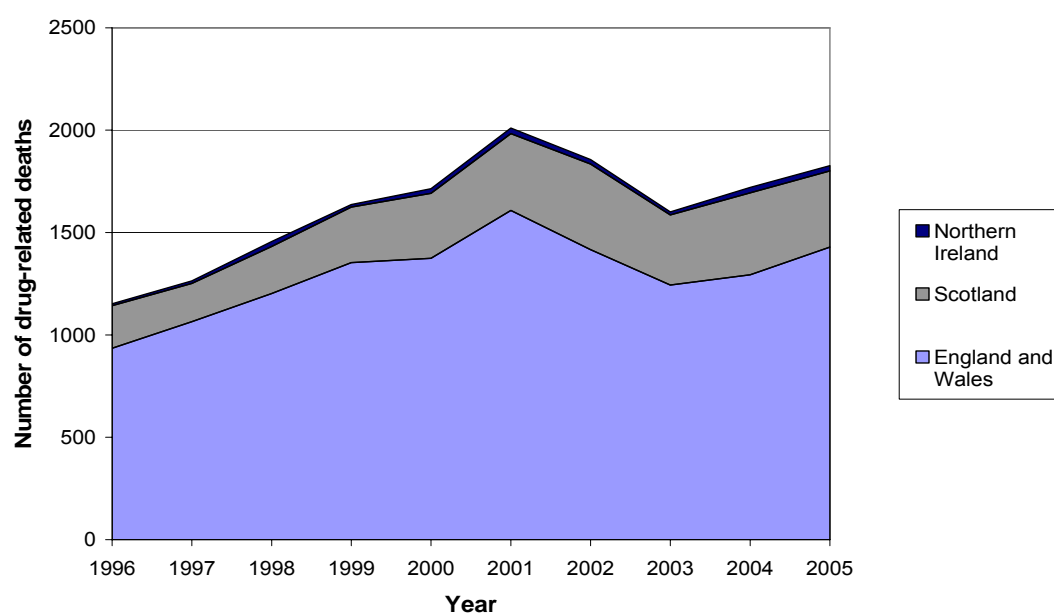
The impact of maternal drug use on unborn children is well known as is the fact that babies are affected by withdrawal from maternal drug use. In the United Kingdom, there is little evidence of HIV transmission to babies through maternal infection specifically associated with drugs, but there is a risk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

## 6.2 Drug related deaths and mortality of drug users

### 6.2.1 Direct overdoses and indirect drug-related deaths

Using the EMCDDA definition of drug related death, the total number of deaths in the United Kingdom in 2005 was 1,827 (Figure 6.1), an increase of six per cent since 2004 (1,721). The number of deaths per 100,000 population was 3.03. Differences exist between parts of the United Kingdom; in Scotland the rate was 7.30, in England and Wales 2.68 and in Northern Ireland 1.51.

Figure 6.1: Number of deaths using EMCDDA DRD standard definition by country, United Kingdom, 1996-2004



Source: Compiled by J Corkery with data obtained from General Mortality Registers 2007

<sup>149</sup> These includes thrombosis, blood clots and gangrene as well as health problems that are associated with problem drug users' lifestyles including poor diet.

<sup>150</sup> See:

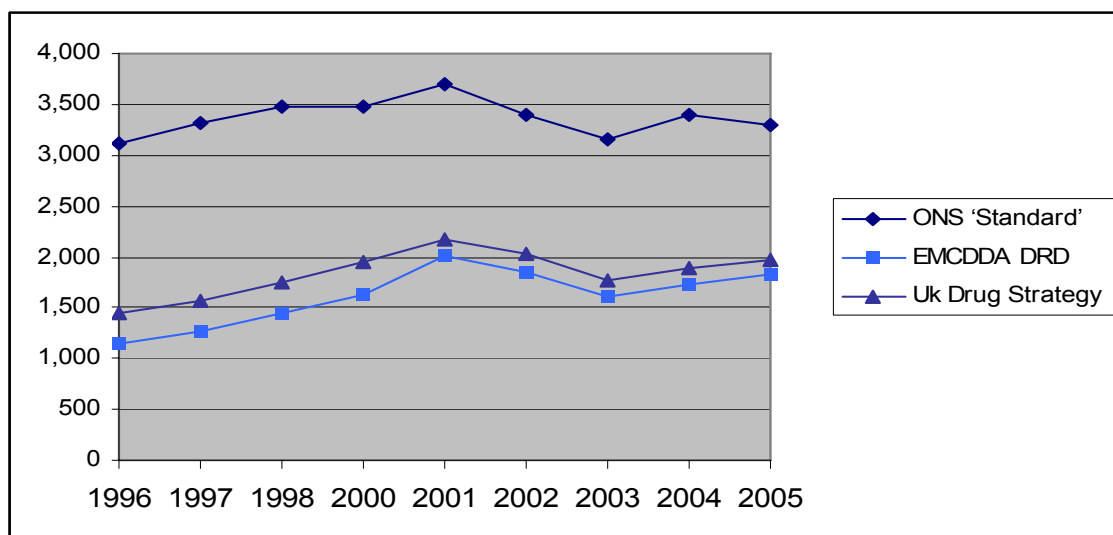
<http://www.info.doh.gov.uk/doh/embroadcast.nsf/vwDiscussionAll/297D9740D0412C9D802572650050A4A0?OpenDocument>

<sup>151</sup> See:

<http://www.info.doh.gov.uk/doh/embroadcast.nsf/vwDiscussionAll/B62F8B2DD75DEA08802572DE0036E4FF>

The slightly different United Kingdom Drug Strategy definition, which measures the impact of the strategy, shows the number of deaths in 2005 was 1,979, higher than the EMCDDA definition. The total number of deaths in 2005 using the ONS definition was 3,301, a fall of 2.7 per cent the previous year (3,392); 2004 saw a rise in deaths having steadily fallen since 2001 (ONS 2007). Differences between the three definitions are shown in Figure 6.2.

Figure 6.2: Comparison of total number of deaths using three definitions, United Kingdom 1996 – 2005

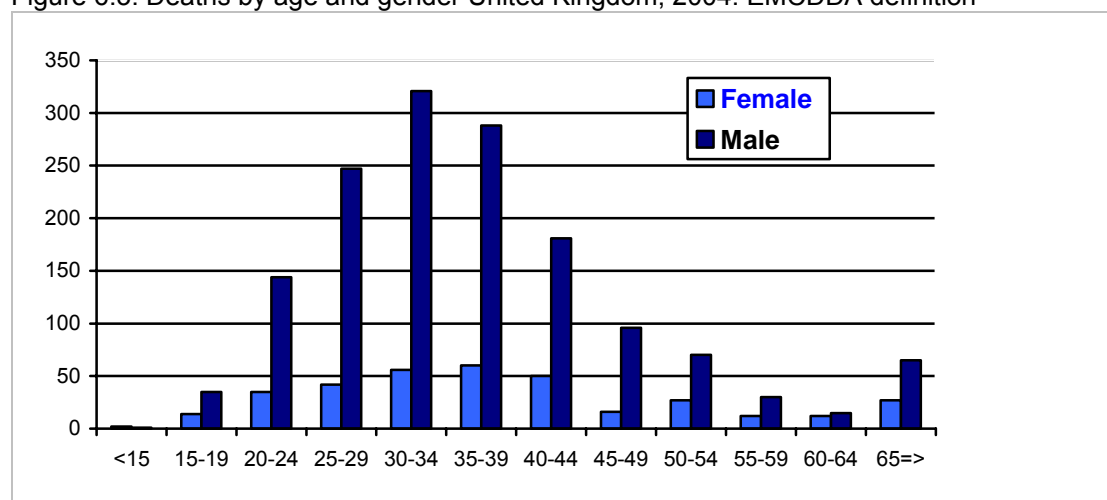


Source: Compiled by J Corkery with data obtained from General Mortality Registers 2007

### Age and Gender

Based on the EMCDDA definition, 79.6 per cent (1,454) of deaths involved males and 20.4 per cent (373) females. The average age of those dying in 2005 was 36.4 years (SD 11.2), with males (35.6 years, SD 11.2) tending to be about four years younger than females (39.9 years, SD 15.4) (Figure 6.3). Age of death is therefore continuing to increase over time (35.6 in 2004). Age at death tended to be higher in Northern Ireland than in the rest of the United Kingdom. Overall, the highest number of deaths occurred in the 30-34 age group; this was true for both males and females. In Scotland, however, the average age was higher. Figure 6.3 shows the number of deaths by age group and gender.

Figure 6.3: Deaths by age and gender United Kingdom, 2004: EMCDDA definition



Source: Compiled by J Corkery with data obtained from General Mortality Registers 2007

*Drugs mentioned on death certificates in the United Kingdom*

Most deaths continue to be associated with opiates (chiefly heroin/morphine and methadone), often in combination with other drugs and alcohol. Table 6.1 shows that mentions of heroin and morphine on death certificates increased by 6.7 per cent in 2004, having declined between 2002 and 2003. There was also an increase in mentions of cocaine (by 14.5%) and ecstasy (by 15%). Methadone deaths remained stable.

Table 6.1: Drug mentions on death certificates in the United Kingdom, 2002 to 2005

Drug	Year				
	2001	2002	2003	2004	2005
Heroin/ Morphine	1,204	1,120	873	980	1,046
Methadone	314	297	289	300	293
Cocaine	117	160	158	193	221
Ecstasy	102	114	98	99	114
Diazepam	284	357	286	222	206
Temazepam	103	92	106	87	55

Source: Compiled by J Corkery with data obtained from General Mortality Registers 2007

*DRD in Scotland 2006*

Numbers of deaths in 2006 is available for Scotland only. Figures published by GROS (2007) show that DRDs in Scotland rose to record levels in 2006 (to 421 from 336 in 2005). Most of this was accounted for by heroin/morphine, although there was also an increase in the mentions of methadone. By contrast, there was a fall in the number of deaths in which cocaine was mentioned. Most of this increase occurred in the Greater Glasgow and Clyde NHS Board area.

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

Data from the SMR (np-SAD) database are broadly consistent with those from ONS. The np-SAD Annual Report for 2007 (Ghodse *et al*, 2007) shows that in 2006:

- there was a decrease of about one per cent over number of recorded by the same sources for 2005 (from 1,382 to 1,366);
- the demographic profile remains consistent with previous reports. The majority of cases were males (76%) and under the age of 45 years (71%), and White (96%);
- about two-thirds of cases had a history of drug abuse or dependence and on average, death was 14 years earlier than for those without such a history (this was the case throughout the period 1997 to 2006);
- seventy per cent of cases died in a defined residential address, 23 per cent in hospital, and seven per cent elsewhere (e.g. a public place);
- forty-eight per cent of those who died were unemployed. Forty-three per cent lived with others, compared to 42 per cent who lived alone, whilst four per cent were of no fixed abode;
- opiates/opioids (i.e. heroin/morphine; methadone; other opiates/opioid analgesics), alone or in combination with other drugs, accounted for the majority (68%) of fatalities. Heroin/morphine alone or in combination with other drugs, accounted for the highest proportion (46%) of fatalities.
- deaths involving methadone were more likely to be the result of illicit rather than prescribed drugs (62% or more);
- there was an increase in the number of cases involving methadone from 198 to 217;
- the proportion of cases involving methadone increased from 12 per cent to 17 per cent;
- the proportion of cases involving alcohol-in-combination increased from 26 per cent to 32 per cent; and



- the proportion of cases involving heroin/morphine decreased from 46 per cent to 44 per cent.

### 6.2.3 Death associated with Volatile Substance Abuse

There were 45 deaths associated with Volatile Substance Abuse in 2005 (47 in 2004). This is the lowest figure since 1981 and compares with the all-time peak of 152 in 1990 (Field-Smith *et al.* 2007).

### 6.2.4 AIDS

Deaths of IDUs (including IDUs who have sex between men) with AIDS accounted for 8.4 per cent (1,333/15,914) of the total number of AIDS deaths in England and Wales up to the end of March 2007. In Northern Ireland the figure was 5.1 per cent (4/79), but in Scotland it was 51 per cent (718/1,408). The decline in the number of deaths of IDU with AIDS seen in recent years has levelled off. The United Kingdom figure of 69 for 2005 (63 in 2004) is about 33 per cent of the peak level in 1995 (212). By the end of March 2007, 46 deaths had been reported for 2006; the number is likely to increase. (Personal communication to John Corkery from Health Protection Agency, 8 May 2007)

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

#### *The National Treatment Agency (NTA) studies on DRD*

The NTA has recently published a series of studies of drug-related deaths and methods of investigating them. Oliver *et al.* (2007a) used a matched case-control design to estimate the relative risk of fatal opioid overdose associated with benzodiazepine and cocaine use. A group of individuals who died from a heroin overdose (the cases) were matched on age and gender to a similar group of living heroin users (the controls). They then compared each pair's recent use of benzodiazepines and cocaine using urinalysis data. A parallel study was conducted for methadone overdose fatalities. Three hundred and fifty heroin-related cases were randomly selected, together with all 260 methadone-related ones, from a database held by the University of Sheffield containing toxicological findings from around 1,300 opioid-related deaths occurring throughout England and Wales during 1991–2004. Two control groups were obtained from the Sheffield Primary Care Clinic for Drug Dependence (PCC). The control group for the heroin overdose fatalities were patients who had recently been referred for assessment, while the control group for the methadone overdose cases were a group of methadone maintenance patients who had been in treatment for at least three months. The findings support the status of benzodiazepine use as a significant risk factor for opioid overdose, especially for methadone-related death in which a near ten times increase in risk of fatal overdose was observed. Benzodiazepines appear to have the potential, in terms of pharmacological interaction, of increasing the respiratory depressant effects of opioids. The use of cocaine by opioid-dependent individuals is widespread and has previously been associated with poorer treatment outcomes, more chaotic drug use and more severe psychopathologies. Despite this, positive cocaine detections are, in comparative terms, rarely seen in fatal opioid overdoses.

In another study, Oliver *et al.* (2007b) examined 15,000 toxicology reports produced by the Department of Clinical Chemistry at the Royal Hallamshire Hospital Sheffield for various coroners throughout England and Wales, covering the period between 1991 and 2004. A database search resulted in 1,586 potential heroin cases and 553 potential methadone cases. Levels of methadone and heroin in the blood, along with levels of associated drugs, were extracted. Alcohol was the most commonly detected substance in heroin-related fatalities, found in approximately 50 per cent of cases, followed by diazepam (34%) and temazepam (13%). Over 75 per cent of



heroin fatalities involved one or more of these substances, with 37 per cent involving at least one benzodiazepine. During the last ten years this pattern has remained fairly stable with the exception of temazepam, which after peaking in 1995 has reduced in recent years. In cases of methadone overdose, diazepam was the most commonly detected drug (44%), followed by alcohol (33%), morphine (28%) and temazepam (21%).

The purpose of a study undertaken by Oliver *et al.* (2007c) was to adapt and describe the psychological autopsy methodology to investigate the psychosocial antecedents of opiate misuse deaths both as a research tool and as a standardised method for services to investigate such fatalities. A case-control study was conducted in which data from a control group of living heroin users, recruited from local drug services, were compared to opiate overdose decedents in order to identify psychological and social risk factors associated with fatal opiate overdose. Cases for the study were a consecutive sample of individuals who died from an acute non-deliberate, opiate-related overdose and on whom an inquest was held between April 2004 and May 2005 at the two South Yorkshire coroners' courts. During the study period 32 opiate-related inquests took place at the two coroner's courts. Of these, 26 fulfilled the criteria for study inclusion. Being in a relationship was a protective factor for fatal non-deliberate opiate overdose; 87 per cent of cases were single compared to 33 per cent in the control group. More generally, a higher proportion of cases lived alone and experienced an isolated or disrupted social network. The majority of the study group met ICD-10 criteria for substance misuse; however, more individuals fulfilled these criteria in the control group (93% compared to 64%). This suggests that some of the overdose fatalities were less experienced users and that incomplete tolerance or opiate naivety played a role, though the selection of the control group from predominately treatment settings may also be relevant. Overdose fatalities were more likely to have been currently diagnosed with a mental health problem and be in receipt of a prescription for psychoactive medication. Despite this, following the psychological autopsy interview there was little difference between those who died and the control group with respect to meeting the criteria for an ICD-10 psychiatric diagnosis not related to substance misuse.

#### *The relationship between fatal poisonings and other factors*

Morgan *et al.* (2006a) examined the relationship between fatal poisonings in England and Wales from heroin and methadone; seizures of illicit heroin and diverted methadone; methadone prescriptions and treatment provision between 1993 and 2004. Direct age-standardised mortality rates for males were similar for both drugs, increasing from approximately five to 15 per million. Mortality rates for heroin continued to increase until 2000, subsequently decreasing from 30 to 20 per million by 2003, and rising again to 24 per million in 2004. In contrast, mortality rates for methadone decreased between 1997 and 2004 to just above 1993 levels. Among females the mortality rate for both drugs was lower than for males throughout the study period, remaining relatively stable. Methadone deaths per 1000 patient years remained similar between 1993 and 1997, after which they fell by three quarters. For both heroin/morphine and methadone, deaths were strongly associated with seizures.

#### *Supervised consumption of methadone*

Bloor (2007) led a study into the practice of supervised consumption of methadone in Staffordshire and Shropshire, exploring the beliefs and attitudes of professionals involved and also those of services. All respondent groups believed supervised methadone reduced the amount of illicit methadone. There was no consensus on the effectiveness of supervised methadone in reducing drug-related deaths other than those directly related to methadone. The majority of users saw supervised

methadone in a positive way. Data from Staffordshire and Shropshire showed that, in the 3 years since introduction of supervised methadone, there have been no methadone-related deaths in the treatment population, compared to four in the three years prior to supervised methadone and ten in the three years prior to that. The National Programme on Substance Abuse Deaths (np-SAD) database was used to provide data on deaths for the North Staffordshire and Shropshire areas. The available data for 1999 to 2003 did not show any fall in drug-related deaths following the introduction of supervised methadone. Analysis of the deaths due to drug toxicity in patients known to treatment services in Staffordshire and Shropshire showed that the majority were males (93%) and that the mean age of the group at death was 27.6 years. Deaths related to methadone were more likely to occur at weekends (42.8%) compared with death from other drugs (22.7%).

#### *Daily patterns of death*

Morgan *et al.* (2006b) examined the daily pattern of deaths in 3,098 cases in England and Wales between 1993 and 2003 where methadone was mentioned on the coroner's certificate of death registration after inquest. Initially, there was a marked excess of deaths occurring on Saturdays. The rate of decline from 1997 was greatest for deaths occurring on Saturdays. As a result, the Saturday peak disappeared.

#### *The pharmacological, epidemiological, clinical and social issues related to smoking methamphetamine*

Schifano *et al.* (2007) recently commented on the pharmacological, epidemiological, clinical and social issues related to smoking methamphetamine as opposed to either its injection or ingestion. Furthermore, they provided data related to amphetamine/methamphetamine consumption, treatment demand, seizures, related offences and deaths in the United Kingdom (1990-2002). Peak rates for most indicators were reached at the end of the 1990s, declining in the following years. The only indicator which did not show a decline was the number of deaths, an issue possibly related to a more general increase in stimulant death rates recently observed in the United Kingdom.

#### *Audit of 148 drug overdose deaths involving heroin, methadone, dihydrocodeine, cocaine, amphetamine or MDMA*

Hickman *et al.* (2007a) carried out an audit of 148 drug overdose deaths (involving heroin, methadone, dihydrocodeine, cocaine, amphetamine or MDMA) investigated by London coroners during 2003. Poly or multiple drug use was detected in the majority of deaths (with at least 69 different combinations), including 66 per cent for heroin and 42 per cent for cocaine. Six categories of death were identified: involving an opiate (100, 68%); cocaine (14, 9%); other controlled drug (five, 3%); mixed drug overdose (18, 12%); other prescribed drug (five, 3%); and other causes (seven, 5%). A witness was present and the death was not instantaneous in 92 (61%) cases, although evidence in the coronial file suggested that in the majority of cases the overdose went unnoticed until too late to intervene. In all, 15 (one in 10) of the deceased were released from prison within 3 months of death; and 37 (one in four) were reported to be receiving a methadone prescription.

#### *Paracetamol poisoning*

Paracetamol poisoning is the leading cause of acute liver failure in the United Kingdom. The government introduced legislation in 1998 limiting the pack size of paracetamol sold in shops. Several studies have reported recent decreases in fatal poisonings involving paracetamol. Morgan *et al.* (2006a) calculated directly age-standardised mortality rates for paracetamol poisoning in England and Wales from 1993 to 2004. There were about 2,200 deaths involving paracetamol. The age-standardised mortality rate rose from 8.1 per million in 1993 to 8.8 per million in

1997, subsequently falling to about 5.3 per million in 2004. After the regulations were introduced, deaths dropped by 2.69 per million ( $p = 0.003$ ). Trends in the age-standardised mortality rate for paracetamol compounds, aspirin, and antidepressants were broadly similar to paracetamol, increasing until 1997 and then declining. Non-drug poisoning suicide also declined during the study period, but was highest in 1993. Segmented regression models showed that the age-standardised mortality rate for compound paracetamol dropped less after the regulations ( $p = 0.012$ ) but declined more rapidly afterward ( $p = 0.031$ ). However, age-standardised rates for aspirin and antidepressants fell in a similar way to paracetamol after the regulations. Non-drug poisoning suicide declined at a similar rate to paracetamol after the regulations were introduced. The question still remains as to whether the decline in paracetamol deaths was due to the regulations or was part of a wider trend in decreasing drug-poisoning mortality. The authors found little evidence to support the hypothesis that the 1998 regulations limiting pack size resulted in a greater reduction in poisoning deaths involving paracetamol than occurred for other drugs or non-drug poisoning suicide.

#### *The role of substance use in non-drug related deaths*

A study of individuals in contact with drug treatment services in 2003/04 showed that 103 (0.4%) were confirmed as having died during the year<sup>152</sup>. The majority of these deaths (70.6%) were classified as non-drug related within current definitions. However, the main cause of death was the likely result of substance use in two-thirds (65.3%) of non-drug related deaths. These causes of death included 16 deaths due to infection (seven of which were various forms of pneumonia), seven due to alcohol related liver disease and at least seven through intentional self harm, in addition to individual cases of cellulitis, deep vein thrombosis, cerebral and myocardial infarctions, asthma and volatile substance inhalation. Those classified as dying from non-drug related deaths were significantly older than those within the category of drug related deaths ( $p = 0.004$ ). The study concludes that significant numbers of drug users die due to poor health as a direct or indirect result of prolonged drug use. Not only are these deaths not included within current drug related death statistics but in some cases, these deaths are potentially preventable (Beynon and McVeigh 2007).

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

Information on infectious disease is based on *Shooting Up: Infections among injecting drug users in the United Kingdom 2006* (HPA et al. 2007).

#### **6.3.1 HIV**

The overall prevalence of HIV seen among IDUs in 2006 was similar to that seen in recent years, and remains higher than that seen in the late 1990s. The Unlinked Anonymous Prevalence Monitoring Programme (UAPMP) survey of current and former IDUs in England, Wales and Northern Ireland indicates an overall HIV prevalence of 1.3 per cent in 2006. In London, the prevalence was four per cent, whilst elsewhere in England it was 0.66 per cent. Combining data for 2005 and 2006, the prevalence of HIV infection among IDUs in the UAPMP agency survey in Northern Ireland was 1.9 per cent and in Wales was 1.1 per cent.

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<sup>152</sup> A cross-sectional study of 27,810 individuals in contact with drug treatment services in the North West of England during 2003/04. Death certificates, verdict of the inquest (where appropriate) and causes of death (in accordance with the World Health Organization International Classification of Disease Register version 10 were provided by the Office of National Statistics for 103 drug treatment clients that were confirmed as having died in 2003/04.

In Scotland, the prevalence of HIV among IDUs is monitored through the surveillance of people undergoing voluntary confidential HIV testing. This found a HIV prevalence of 0.79 per cent among IDUs undergoing testing during 2006; this compares with prevalences of 1.4 per cent to 3.2 per cent in the early to mid-1990s and 0.5 per cent to 0.9 per cent during the period 1998 to 2005.

The annual number of HIV diagnoses among IDUs in recent years has been low and relatively stable, at an annual average of 140 reports during the period 1998 to 2006. By the end of June 2007, 156 HIV diagnoses, where infection was thought to have been acquired through injecting drug use, have been reported in the United Kingdom for 2006 (72 in London, 16 in Scotland, and 68 elsewhere). This figure is like to rise further as further reports are received for 2006. Of the 156 new diagnoses in 2006, probable country of infection was reported for 67 per cent (104). Where reported, 52 per cent (54) of infections were probably acquired within the United Kingdom and 48 per cent (50) outside of the United Kingdom, mostly in Southern Europe.

In 2006, 1,038 HIV-infected IDUs were seen for HIV-related treatment or care in England, Wales and Northern Ireland, a 19 per cent increase since 2000 when 870 IDUs were seen for care. In Scotland, 387 HIV-infected IDUs were seen for HIV-related treatment or care in 2006, an 11 per cent decrease since 2000 when 436 IDUs were seen for care.

### 6.3.2 Viral hepatitis

The prevalence of hepatitis C infection among IDUs remains high overall. Of the (current and former) IDUs participating in the UAPMP agency survey in 2006, two fifths (41%) had antibodies to hepatitis C<sup>153</sup>, which is similar to that seen in recent years (2005, 42%). The overall hepatitis C prevalence in England was 43 per cent, however, there were very marked regional variations from 22 per cent in the North East to 57 per cent in London and 60 per cent in the North West (data from 2005 and 2006 combined). The prevalence in Wales and Northern Ireland were lower than most of the English regions: combining data from 2005 and 2006, hepatitis C prevalence in Wales was 18 per cent, and in Northern Ireland it was 29 per cent.

Those IDUs participating in the UAPMP survey who had ever been homeless were more like to have antibodies to hepatitis C (45%) than those who had not (28%).

Amongst current IDUs participating in the UAPMP survey the prevalence of hepatitis C has increased since the beginning of the decade, from 33 per cent in 2000 to 42 per cent in 2006. There were higher prevalences of hepatitis C infection among several sub-groups of current IDUs. Those who reported injecting crack-cocaine in the past four weeks were more likely to have hepatitis C (59%) than those who had not (34%). Higher prevalence was also associated with the use of some injection sites: those who had injected into their groins in the past four weeks were more likely to have hepatitis C (54%) than those who had not (37%) and those who injected into their legs were also more likely to have hepatitis C (49%) than those who had not (41%).

The main aim of the National Public Health Service for Wales (NPHSW) cohort study of IDUs conducted in South Wales in 2004 was to estimate the incidence of hepatitis C among IDUs. It recruited 700 IDUs and followed up 400 of these over approximately one year. The estimated hepatitis C incidence was approximately 6.5 per 100 person-years, whilst the prevalence of hepatitis C among all the IDUs

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<sup>153</sup> The sensitivity of the oral fluid test used in the UAPMP agency survey is approximately 93 per cent.

recruited at the start of the study was 26 per cent.

A recent review of epidemiological studies showed that the incidence of hepatitis C among IDUs in many parts of Scotland remains high (in the range of 12 to 29 per 100 person-years).

Overall about one in five IDUs have had hepatitis B infection. In 2006, 21 per cent of the current and former IDUs who took part in the UAPMP survey in England, Wales and Northern Ireland had antibodies to hepatitis B core antigen (anti-HBc, a marker of previous or current hepatitis B infection)<sup>154</sup>; this was similar to the level seen since 1995.

### 6.3.3 Sexually transmitted infections

NO NEW INFORMATION AVAILABLE

### 6.3.4 Tuberculosis

NO NEW INFORMATION AVAILABLE

### 6.3.5 Other infectious morbidity

Cases of wound botulism continue to occur among IDUs in the United Kingdom. In 2006, 22 suspected cases were reported, fewer than in each of the previous two years, with 28 cases reported in 2005 and 40 in 2004.

In 2006, one of the three cases of tetanus reported to the HPA in England was known to have been an IDU, no cases of tetanus were reported for the rest of the United Kingdom. Whilst in 2005, four of the six cases of tetanus reported in the United Kingdom were in IDUs, indicating that tetanus continues to affect IDUs, albeit at lower numbers than in 2003 and 2004.

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

## 6.4 Psychiatric co-morbidity (dual diagnosis)

### 6.4.1 Prevalence

Data on psychiatric discharges in Scotland shows that in 2004/05, six per cent of cases had a diagnosis of drug misuse (as either a main or supplementary diagnosis).

The majority of cases which reported drug misuse as a main diagnosis did not record a supplementary diagnosis. In cases where a main diagnosis of drug misuse and also a supplementary diagnosis were recorded, the most common supplementary diagnoses were mood (affective) disorders (in 16% of those cases) and personality disorders (15%). Where drug misuse was a supplementary diagnosis, the most common main diagnosis was schizophrenia (29%) followed by mood (affective) disorders (20%) (ISD 2006).

These 2004/05 figures are provisional (due two areas having incomplete information) at the time of writing and may therefore, be subject to revision.

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<sup>154</sup> The sensitivity of the oral fluid test used in the UAPMP agency survey is approximately 75 per cent.



A study in a semi-rural location in South-East England<sup>155</sup> found that 16 per cent of patients attending Community Mental Health Teams reported use of illicit drugs in the past year, most commonly cannabis. This is three times the prevalence of the general population, but below the prevalence rates found in inner city studies of psychiatric co-morbidity (Trathen *et al.* 2007).

Another study, carried out in Cambridge and South Cambridgeshire found that lifetime substance use among individuals with first episode psychosis was double that of the general population of a similar age<sup>156</sup>. Class A drug use was much greater, 55 per cent of participants reported lifetime use compared to 13 per cent of the general population. Cannabis use was reported by 80 per cent of participants with half meeting DSM-IV criteria for cannabis abuse or dependence (Barnett *et al.* 2007).

#### 6.4.2 Personality disorders

##### *The relationship between cannabis use and mental health*

A systematic review published in the Lancet<sup>157</sup> looked at the evidence relating to cannabis use and psychotic or affective mental health outcomes. It found that individuals who had ever used cannabis were at increased risk of a psychotic outcome (pooled adjusted odds ratio=1.41, 95% CI 1.20-1.65). The evidence for affective disorders was less consistent. Although the authors concede that a causal link is unlikely to be discovered, they believe there is enough evidence to necessitate increased public education about the dangers of cannabis use (Moore *et al.* 2007).

##### *Predictions of future trends in schizophrenia*

Hickman *et al.* (2007b) used modelling techniques to predict future trends in schizophrenia assuming a causal link between cannabis use and schizophrenia<sup>158</sup>. The study concluded that between 2000 and 2010 the impact of cannabis on the prevalence and incidence of schizophrenia should be observable at least amongst men. It suggests that by 2010, cannabis would have caused 25 per cent of incident cases amongst men or 13 per cent if a causal link is assumed to exist only amongst heavy users. Projections for women are slightly lower. However, the report notes that recent epidemiological studies have found stable or falling levels of schizophrenia incidence despite increasing levels of cannabis use. It warns that other risk or protective factors may mask the impact of cannabis and that the full lifetime risk of young users will not yet have been observed.

##### *Khat use and mental illness: A critical review*

Warfa *et al.* (2007)<sup>159</sup> looked at the evidence of a causal relationship between khat use and mental illness finding a weak association between the two. They suggest

<sup>155</sup> A cross-sectional prevalence survey of 1808 patients in a semi-rural area of South East England. Interviews with patient's key workers were conducted and a screening questionnaire completed.

<sup>156</sup> The study looked at 123 people referred consecutively to Cameo, a specialist early intervention service for people who experience a first episode of psychosis between June 2002 and June 2005.

<sup>157</sup> 35 studies were identified that met the inclusion criteria; 11 studies of psychosis and 24 for affective outcomes.

<sup>158</sup> Trends in cannabis use were estimated using the Offending Crime and Justice Survey and incidence of schizophrenia was derived from surveys in three English cities 1997-99. The model used multiple scenarios and was defined for different birth cohorts. It was run separately for men and women.

<sup>159</sup> The authors searched relevant databases using known terms for the drug khat and various terms in addition to 'mental illness'. Searches were limited to quantitative studies and clinical



that khat use exacerbates psychological problems caused by pre-existing stressors but call for more robust studies taking into account cross-cultural differences and confounding factors.

#### *Ethnic minorities*

A study looking at ethnic differences amongst a community cohort of people with dual diagnosis<sup>160</sup> found that individuals describing themselves as Black-British were more likely to misuse cannabis and have been compulsorily hospitalised or involved in violence in the past 18 months than White individuals (Afuwape *et al.* 2006). The authors emphasise the need for interventions tailored to the needs of different ethnic groups.

#### 6.4.3 Depression

NO NEW INFORMATION AVAILABLE

#### 6.4.4 Anxiety

NO NEW INFORMATION AVAILABLE

#### 6.4.5 Affective disorders

NO NEW INFORMATION AVAILABLE

### 6.5 Other drug-related health correlates and consequences

#### 6.5.1 Somatic co-morbidity

##### *Abscesses*

Symptoms of a possible injecting site infection would appear to be common among IDUs, as 35 per cent of IDUs participating in the UAPMP survey in 2006 reported they had experienced either an abscess, sore or open wound, possible symptoms of an injecting site infection, during the previous year. The reporting of such a symptom was associated with having been homelessness in the last year, with 36 per cent of those homeless during the last year reporting a symptom compared with 30 per cent of those not homeless during the last year.

##### *Sepses*

Connolly *et al.* (2006) identified 20 cases of renal amyloidosis<sup>161</sup> in intravenous drug users in two London hospitals; two during 1990 and 1994, five during 1995 and 1999 and 13 between 2000 and September 2005. All patients were long-term intravenous drug users (mean 18.9 years) and had a history of recurrent soft tissue infection. Sixty-five per cent (13) required dialysis within one month of diagnosis and of the remaining seven, four developed end-stage renal failure between six and 30 months later. Of 17 patients who underwent chronic dialysis, the median overall survival was 25 months. There were nine deaths within five years, all due to sepsis.

##### *Endocarditis*

NO NEW INFORMATION AVAILABLE

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case reports written in English from 1946 to 2006. Out of an initial 450 identified papers, 24 met the full criteria for inclusion.

<sup>160</sup> The caseloads of case managers in four adjacent South London Boroughs were screened, firstly to find those with clinical diagnoses of a psychotic disorder and then for substance misuse. 213 individuals met the inclusion criteria, 55 per cent were White, 8 per cent Black Caribbean, 10 per cent Black African and 26 per cent Black British. 146 client interviews were conducted with information for the remainder collected through case managers.

<sup>161</sup> Renal deposits of amyloid, especially in glomerular capillary walls, may cause albuminuria and the nephrotic syndrome. The condition is associated with renal failure. Treatment options are limited and the outcome for such patients on renal replacement was poor.

*Dental health*

NO NEW INFORMATION AVAILABLE

**6.5.2 Non-fatal drug emergencies**

Data are collected for England through Hospital Episode Statistics<sup>162</sup> but it is difficult to monitor trends in non-fatal drug emergencies as classification is based on ICD10 codes and the subjective views of the recording clinician. In 2005/06 there were 920 inpatient episodes due to a primary diagnosis of acute substance intoxication. Eighty-five per cent were classed as emergencies and the most commonly recorded drug was multiple or other psychoactive substances (35%).

There were 9,968 finished episodes of poisoning by narcotics and psychodysleptics in 2005/06. This figure has risen by almost 50 per cent since 2002-03, with the largest increase for those affected by 'other opioids'. Cocaine poisonings have also increased from 262 episodes in 2000/2001 to 807 in 2005/07 and, despite a drop in heroin poisonings until 2003/04 there have been large increases in the past couple of years to 1,908 finished episodes in 2005/06.

In Scotland, data are collected on acute inpatient discharges with a diagnosis of drug misuse as a factor in treatment<sup>163</sup> (ISD 2006). In 2005/06 there were 5,015 general acute hospital discharges with a diagnosis (main or supplementary) of drug misuse, 78 per cent of which were emergencies.

In Wales during 2006/07 there were 160 inpatient episodes due to a primary diagnosis of acute substance intoxication

The Welsh Assembly Government are looking at effective ways of monitoring non-fatal drug emergencies.

**6.5.3 Other health consequences**

Golding *et al.* (2007) studied cognitive performance in light current users and ex-users of ecstasy and a control group.<sup>164</sup> The study concluded that current light users show a small but significant cognitive impairment, which is no longer detectable in ex-users who had not used ecstasy for six months.

**6.5.4 Driving and other accidents**

In a sample of 1,185 fatal vehicle accidents between 1994 and 2005, Clarke *et al.* (2007) found that four per cent involved drugs, the most common being cannabis. Drivers who were found to be using drugs had a younger average age than non-drug drivers, 28 years compared to 40 years. The report authors warn that this is likely to be an underestimate as toxicology reports were not available in all cases.

Interviews with 26 individuals drawn from the Drug Outcome Research in Scotland (DORIS) explored experiences and management of drug driving. All had been

<sup>162</sup> Hospital Episode Statistics (HES) is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. See: <http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/HospitalEpisodeStatistics/index.htm>

<sup>163</sup> This is not comparable with England as it includes supplementary diagnosis as well as primary diagnosis and also includes detoxification treatment.

<sup>164</sup> Sixty subjects comprising 20 current light users, 20 ex-users and 20 non-users of ecstasy were tested on an extensive battery of cognitive tests.

addicted to heroin and admitted to drug driving.<sup>165</sup> Strategies for managing risks included attempting to limit their drug intake to their tolerance level; delaying driving after taking a drug until they felt safe; stopping driving if they felt unsafe while behind the wheel; and avoiding driving altogether under the influence of certain drugs. The study suggests that media campaigns or more effective means of detection would impact on behaviour and that education on the risks and consequences of drug driving should be incorporated into drug rehabilitation programmes (McIntosh *et al.* 2007).

An insight gathering exercise among 14 to 17 year olds by Road Safety Scotland, published in July 2007, found widespread belief that the ability to drive under the influence of drugs would be dependent on the drugs taken and the reaction of the individual to the effects of the drugs (TNS System Three 2007). There was some acceptance of drug driving, with some young people knowing others who regularly drove after smoking cannabis in the belief that it had a calming effect on their driving. There was confusion about the law on drug driving; all knew it was illegal to take drugs and reasoned that drug driving would also be illegal, although they had not received messages about this issue before. The research also found a lack of awareness of how someone would be caught drug driving and of the penalties involved.

#### 6.5.5 Pregnancies and children born to drug users

Hospital Episode Statistics show that, in England, during 2005/06, there were 170 cases of fetus and newborn affected by maternal drugs of addiction (ICD10 code P04.4) and 1,276 cases of neonatal withdrawal symptoms from maternal use of drugs of addiction (P96.1). Table 6.2 shows the change from 2003/04 to 2005/06.

Table 6.2: Effect of maternal drugs of addiction in England 2003/04 to 2005/06

Primary diagnosis	2003/04	2004/05	2005/06
Fetus and newborn affected by maternal use of drugs of addiction	205	262	170
Neonatal withdrawal symptom from maternal use of drugs of addiction	1,096	1246	1276

Source: The Information Centre (2007a)

In Scotland in 2004/05 there were 493 maternities for which drug misuse was recorded (Table 6.3). Of births recording drug misuse, 18 per cent were pre-term compared to eight per cent of all births and only 69 per cent were recorded as full-term normal birth weight compared to 90 per cent of all births.

There were 300 recorded cases of foetus and newborns affected by maternal drugs of addiction and/or neonatal withdrawal symptoms from maternal use of drugs of addiction (ISD 2006). Changes to recording of drug misuse in pregnancy over this period mean that comparison of the figures is not appropriate; earlier figures are likely to underestimate the number of maternities where drug misuse was an issue and improved data recording from April 2003 will have had an impact on these figures.

<sup>165</sup> Clients were selected randomly from those who reported that they had driven under the influence of drugs at stage 4 of the DORIS study, a prospective cohort project. Semi-structured interviews were conducted in an open ended way.

*Table 6.3: Diagnosis in Scotland, 2000/01 to 2004/05*

Diagnosis	2000/ 01	2001/ 02	2002/0 3	2003/0 4	2004/0 5
Maternities recording drug misuse	237	241	339	440	493
Fetus and newborns affected by maternal use of drugs of addiction or neonatal withdrawal symptom from maternal use of drugs of addiction	329	258	281	320	300

Source: ISD Scotland (2006)

A study carried out in the Grampian area of Scotland between June 2002 and December 2003<sup>166</sup> found that 75 of the 110 babies born to substance misusing mothers had Neonatal Abstinence Syndrome (NAS) symptoms, an incidence of 68.2 per cent (Scottish Executive 2006b). Of the 26 babies recruited to the study who were initially asymptomatic, 12 developed delayed onset NAS and seven required treatment. The majority of treated infants recruited to the study had ceased treatment at 20 weeks although almost a quarter (24.4%) required longer treatment and follow-up (12/49 infants).

Twenty-two per cent of babies born to substance misusing mothers were premature compared to 9 per cent of all births. Of those recruited to the study, 26 per cent failed an eye test and 11 per cent were diagnosed with eye problems.

In Wales during 2006/07 there were 22 cases of foetus and newborns affected by maternal drugs of addiction and 77 cases of neonatal withdrawal symptoms from maternal use of drugs of addiction (Internal communication - Welsh Assembly Government).

<sup>166</sup> Opiate using mothers fulfilled the criteria for recruitment to the study. Eligible mothers were identified by their referrers, their own admission of substance misuse, urine screening or by clinical diagnosis in the baby. Once identified the Study Nurse carried out recruitment. Of the 110 mothers identified, 72 infants were recruited to the study and assessed by the family health visitor using a modification of the Finnegan score at 2, 4, 8, 12 and 24 weeks.

## 7. Responses to health correlates and consequences

### 7.1 Overview

Drug-related deaths (DRDs), infectious diseases, co-morbidity and other health consequences are key policy issues within the United Kingdom drug strategies (Scottish Office 1999; National Assembly for Wales 2000; DSD 2002; DHSSPSNI 2006).

A strategy for England and Wales was published in 2001, focusing on promoting treatment, with service providers expected to provide information and advice on how to reduce DRD, to educate drug users and their families on resuscitation, educate prisoners on the risk of overdose on release from prison, and training of paramedical and Accident and Emergency (A&E) staff. This has been updated in 2007 with the publication of a new *Reducing Drug-related Harm: An Action Plan*. In Scotland a strategy and action plan to reduce DRD was published in 2005.

Throughout the United Kingdom there is information about volatile substances available on drug information websites. The Scottish Government and the Health Promotion Agency in Northern Ireland ensure that young people, parents and retailers are aware of the dangers of abusing products such as cigarette lighter refills, aerosol sprays and glue. In Scotland 90 per cent of Scottish schools include advice on the risks from volatile substance abuse.

In the 1980s, United Kingdom drug policy was led by a public health approach aimed at containing HIV transmission. The subsequent action, involving harm reduction measures, is regarded as having been successful in containing HIV amongst injecting drug users (IDUs); providing free needles and syringes, promoting the safe disposal of used equipment, information campaigns on safer sex and safer injecting; and HIV/AIDS counselling, support and testing. The *Hepatitis C Action Plan for England* was developed in 2004, prioritising prevention of infection and disease progression. Treatment for infectious diseases is provided as part of the National Health Service (NHS), including the provision of anti-retroviral treatment for HIV and HCV. Treatment for wound infections is available through primary care, Accident and Emergency (A&E) departments, and in some areas, through needle exchange schemes and specialist drug services. Those in prison have access to HIV and hepatitis testing, and vaccination against HBV. In England, *Reducing Drug-related Harm: An Action Plan*, also focuses on infectious disease.

Standards of care for problem drug users with mental health problems were agreed in 2001 (HAS 2001). Guidance on good practice (DH 2002a) and the provision of services were developed in England. The Department of Health highlighted the need for generic health services to work in partnership with other agencies, such as drug services (DH 2002b). Local Implementation Teams (LITs) implement the policy requirements described in the guidance, and work in partnership with Drug and Alcohol Action Teams (DAATs). The Scottish Government is to publish a report setting out a series of recommendations for change and improvement on awareness and for the development of support and service provision for people with co-occurring substance misuse and mental health problems.

Maternity services are expected to provide appropriate facilities for the needs of pregnant women drug users and their babies, although the approach varies across the country. The Advisory Council on Misuse of Drugs (ACMD 2003), in its *Hidden Harm* report, highlighted concern about the consequences for children of parental

drug use. Since then a number of initiatives have been undertaken to address problems identified throughout the United Kingdom, including a Scottish Government Action Plan.

## 7.2 Prevention of drug-related deaths

### 7.2.1 Overdose prevention

The consultation draft of the updated guidelines on clinical management of drug misuse and dependence (DH *et al.* 2007) sets out actions for the prevention of drug-related deaths by:

- providing education and training to drug users and their families on the risks of overdose and how to respond effectively;
- advising drug users on the dangers of combining drugs, especially alcohol and benzodiazepines;
- contributing to effective care pathways between prisons and the community
- educating new drug misusers that the use of methadone, outside its medical purpose, is extremely dangerous;
- educating new patients starting on methadone and buprenorphine on the risks of loss of tolerance;
- using supervised consumption in the early stages of methadone and buprenorphine treatment;
- requiring that patients moving on to take-home methadone and buprenorphine provide details of satisfactory home storage arrangements and recording these in the patient's notes, especially when children are in the home;
- making use of local specialist support and referral in complex cases, e.g. cases of polypharmacy requiring specialist review; and
- conducting or arranging for mental health assessments in patients who present a suicide risk.

### *Preventability of drug-related deaths*

In an audit of drug-related overdose deaths in London during 2003, Hickman *et al.* (2007a) found poly-drug use in the majority of cases although opiates were identified as the major contributory drug in 68 per cent of cases. Evidence from coronial files showed that, in 61 per cent of cases, a witness was present and death was not instantaneous. However, the authors conclude that three-quarters of these deaths would have been difficult to prevent due to a number of factors including the intoxication of the witness. They recommend encouraging a 'duty of care' amongst drug users to increase capacity for identifying and responding to overdoses. The study also supports other research findings that substitute prescribing and loss of tolerance after prison release are key protective and risk factors associated with drug overdose deaths. The National Treatment Agency (NTA) published a more in-depth report on the findings including qualitative statements from witnesses (Hickman *et al.* 2007c).

### *Psychosocial factors*

In the study described above (Hickman *et al.* 2007c), the authors found that, in the majority of deaths, significant health or social events were noted, which may have contributed to the subsequent fatal overdose. Similarly, a study by Oliver *et al.* (2007c) using a control group found that the occurrence of negative life events in the past week was more common among those who died from an overdose than among the control group<sup>167</sup>. The authors conclude that there is evidence to suggest that

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<sup>167</sup> The study used a matched case-control design to evaluate a number of psychosocial risk factors for acute non-deliberate fatal opiate overdose. Cases were matched to controls on sex and age but were not achieved on treatment history. There were 15 subjects in each group



psychosocial factors play a role in fatal non-deliberate opiate-related overdoses and that traditional educational forms of prevention should be expanded to include a more proactive monitoring of the psychosocial wellbeing of heroin users.

The Scottish Government has commissioned a qualitative study looking at why those present at illicit drug over doses may not contact the emergency services.

#### *Safer use training*

The NTA's Action Plan includes the provision of training and guidance to service users on how to minimise harm associated with drug use (DH and NTA 2007).

An evaluation of the Peer to Peer Project in Merseyside found that participants' knowledge about safer injecting techniques, prevention of blood borne viruses, what actions to take in an overdose situation and other health issues improved after training. The level of confidence and willingness to pass on this information to peers increased greatly. The report recommended the strategic development of the project for future expansion (Shaw *et al.* 2007a).

#### *First aid training*

NO NEW INFORMATION AVAILABLE

#### *Consumption rooms*

A systematic review (see 7.3) found little evidence of the effectiveness of drug consumption rooms.

#### *Antagonists*

The clinical guidelines mentioned above (DH *et al.* 2007), suggest local piloting of take-home naloxone with appropriate training for users, relatives and carers and highlight the need for further research to establish its effectiveness in the prevention of overdose-related deaths.

In a qualitative study with homeless drug users<sup>168</sup>, Wright *et al.* (2006) found that the majority of participants would be willing to administer naloxone provided they were trained in an appropriate manner. Concerns about how to properly administer naloxone precludes its provision "over the counter" but the authors conclude that distribution by drug treatment services and a programme of peer training could result in public health benefits.

Suboxone was launched in early 2007, as being potentially of value in reducing death through overdose (see Chapter 5.4.2).

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

In May 2007, the Department for Health (DH) and the National Treatment Agency (NTA) published *Reducing Drug-related Harm: An Action Plan* (DH and NTA 2007). One of its aims is to improve delivery by issuing guidance on reducing drug-related harm to commissioners, service users, carers and those working with drug users. This includes guidance on hepatitis C, the provision of needle exchange services and testing and treatment for blood-borne virus infections in prisons and the community. The Action Plan also contains plans for a health promotion campaign, which will be

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recruited from areas covered by coroner's courts in South Yorkshire. Key informants were interviewed for the case group, most often partners or parents.

<sup>168</sup> In depth face-to-face interviews with 27 drug users (19 men and 8 women) were conducted in 2002-2003 with homeless drug users across three sites providing services to drug users (one primary care centre and two non-statutory organisations) in a large city.

targeted at risk groups such as homeless drug users, speedballers<sup>169</sup> and potential or new injectors. €2.8 million is being made available in 2007/08 for investing in the Action Plan.

In September 2006 the Scottish Government published the *Hepatitis C Action Plan for Scotland: Phase 1*, which will run until August 2008 (Scottish Executive 2006a). The prevention strand of the Action Plan focuses on transmission of the virus among injecting drug users (IDUs). One of the aims is to improve the accessibility and effectiveness of needle exchange and other harm reduction services at a local level. The Scottish Government has provided NHS boards with additional funding of €5.9 million over the two years of the Action Plan, some of which may be spent on prevention. In April 2007, the Scottish Prison Service began piloting an in-prison needle exchange in HMP Aberdeen, which will be reported on in 2009. There are also plans to provide injecting paraphernalia to all prisoners leaving prison with an identified need by mid-2008.

A systematic review<sup>170</sup> of the evidence for the effectiveness of primary prevention interventions for Hepatitis C among injecting drug users found that needle exchanges reduce the prevalence of HCV although prevalence remains high. The authors found limited evidence evaluating the effectiveness of drug consumption rooms and concluded that methadone maintenance is only marginally effective at reducing HCV. They warn against over-reliance on one harm reduction intervention and the need for expansion of the evidence base (Wright and Tompkins 2006).

The National Public Health Service for Wales (NPHS Wales), with the support of Welsh Assembly Government, is developing a costed 'Blood Borne Viral Hepatitis Action Plan for Wales'.<sup>171</sup> The key aims of the Action Plan include:

- reducing the transmission of hepatitis infection in Wales;
- increasing the diagnosis of current infection; and
- improving the provision of treatment and support to infected individuals.

Later this year the Scottish Government will publish a report on safety, health risks and outcomes for injecting drug users using injecting paraphernalia (personal communication Scottish Government).

### 7.3.1 Prevention

The Royal College of General Practitioners (RCGP 2007) has published guidance for its members on the prevention, testing, treatment and management of hepatitis C in primary care. It recommends ensuring that all drug users have access to local needle and syringe services as well as other paraphernalia and that GPs issue advice on safer snorting, smoking and how to move away from injecting. The guidance also suggests running a needle exchange in GP surgeries.

#### *Vaccination*

The consultation draft of the updated clinical guidance for drug misuse and dependence in England states that Hepatitis B vaccination should be carried out as soon as possible after presentation to all drug users regardless of injecting status. To increase take up, the guidance suggests the use of accelerated courses and possible incentives such as the issuing of vouchers (DH *et al.* 2007). NICE clinical guidelines on psychosocial interventions also recommends using material incentives

<sup>169</sup> Injecting heroin and crack together.

<sup>170</sup> A systematic review of the major electronic databases in 2002 identified 1007 abstracts with 18 papers meeting the final inclusion criteria.

<sup>171</sup> See: <http://www2.nphs.wales.nhs.uk/icds/page.cfm?pid=519>

such as £10 (14.6 Euros) shopping vouchers to encourage Hepatitis B vaccination (NICE 2007d).

A study of hepatitis B vaccination among injecting drug users in England, 1998 to 2004,<sup>172</sup> found that reported uptake rose significantly from 27 per cent to 59 per cent (Hope *et al.* 2007). However, the study also found that prevalence of antibodies to hepatitis B remained stable at 21 per cent. Prisons (38%) were the most common source of vaccination followed by drug services (28%), GPs (17%) and needle exchanges (14%). The authors conclude that, while there have been considerable improvements in vaccine uptake, further improvements are necessary including the targeting of recent IDUs and wider coverage of vaccination efforts.. A complementary paper based on the same study suggests that the risk of HBV infection varies between regions and identifies the need for greater evidence establishing the effectiveness of vaccination in reducing hepatitis B infection (Judd *et al.* 2007).

The proportion of IDUs in the UAPMP who have taken up an offer of the hepatitis B vaccination has increased markedly over time, rising from 25 per cent, in 1998 to 65 per cent in 2006 (self-reported data<sup>173</sup>). Self-reported vaccination uptake varied by region and country (combining 2005 and 2006 data), and in Wales was 47 per cent and in Northern Ireland 76 per cent (HPA *et al.* 2007).

Sixty per cent of DAATs have on-site hepatitis B vaccination, according to the NTA's 2005 survey of needle exchanges with significant differences by region ( $p < 0.001$ ) (NTA 2007g). The NTA's Action Plan contains plans for a campaign on hepatitis B vaccination targeted at drug users most at risk of contracting an infectious disease.

In Wales, in a study of 500 current and recent injectors<sup>174</sup>, just under half (49%) had received one or more hepatitis B vaccinations with 72 per cent of these having completed the course. The most common venue for receiving the vaccination was in prison (48%), followed by GP surgery (23%) and drug service (19%), although there were regional variations with around half of those from North East Wales and Mid and West Wales receiving vaccination from drug services (Smith 2006).

A survey of the 22 Community Drug Teams (CDT) in Wales<sup>175</sup> found that, of the 14 that responded only six provided Hep B vaccination on site, with a further six referring clients to a local genito-urinary medicine departments (GUM) or GP. Two CDTs had no written protocol to ensure users were vaccinated (Smith and Lyons 2006).

#### *Syringe provision programmes*

Northern Ireland is the only country in the United Kingdom with a national syringe exchange database monitoring activity in the nine pharmacies that offer syringe exchange. In 2005/06:

<sup>172</sup> The study combined results from the annual national voluntary unlinked anonymous survey of injectors in England (Agency survey) and a survey of IDUs recruited from community settings in late 2003 and during 2004 (Community survey). Oral samples were taken in the Agency survey and dried blood spot samples in the community survey.

<sup>173</sup> Vaccination uptake data should be interpreted with caution as they are based on self-reports.

<sup>174</sup> 500 valid face-to-face interviews were conducted with ex and current drug users opportunistically recruited from various localities across Wales. A community needs assessment questionnaire tool was developed to provide quantitative data.

<sup>175</sup> A short questionnaire was sent to all 22 Community Drug Teams in Wales. A response rate of 64% was achieved.

- there were 8,797 visits to participating pharmacies by users of the scheme, an increase of 18 per cent on 2004/05,
- 85,801 syringes were issued,
- the proportion of visits involving the return of used equipment fell from 54 per cent in 2004/05 to 44 per cent in 2005/06,
- the rate of return varied greatly across the four health boards, and
- four per cent of visits were by clients reporting themselves to be new users of the needle and syringe exchange scheme (DAIRU/DHSSPSNI 2006b).

A national monitoring scheme for needle exchange is currently being developed in England (NTA 2007g).

The Welsh Assembly Government has set up a National Needle and Syringe Information Group and are developing a database to improve the collection of information on needle and syringe exchange programmes (Welsh Assembly Government – personal communication).

A qualitative study with 49 injecting drug users in Wales found that the main source of needles and syringes in the previous four weeks was non-pharmacy syringe exchange schemes (58%) followed by pharmacy-based schemes (16%). Twenty-two per cent of those interviewed reported sharing a needle or syringe in the last four weeks. Availability was generally good in larger towns and cities but IDUs in one market town reported occasions when the pharmacy had run out of equipment and the lack of an alternative accessible facility. The report recommends more mobile and outreach services and consultation on introducing vending machine facilities (Rhodes and Lyons 2006).

The study by Smith (2006), referred to earlier in this section, with 500 current and ex injecting users found that:

- eighty-eight per cent of current users used a local needle exchange locally;
- the general perception was that needle exchanges provided a basic service; and
- twelve per cent reported sharing needles and syringes in the past 4 weeks.

#### *Paraphernalia and condom provision*

A study by Turning Point (see Chapter 7.3.2) found that nearly half of IDUs (46.4%) reported sharing spoons, filters or water and over a third called for a wider range of equipment to be made available (Turning Point 2007).

#### *Information materials*

NO NEW INFORMATION AVAILABLE

#### *Educational approaches*

NO NEW INFORMATION AVAILABLE

### **7.3.2 Counselling and testing**

In England, increasing the proportion of IDUs who are aware of their infection status through improved uptake of voluntary confidential testing is one of the aims of the *Hepatitis C Action Plan for England* (DH, 2004). Of those IDUs taking part in the 2006 UAPMP survey<sup>176</sup>, 76 per cent reported having undertaken a voluntary confidential test, compared to 29 per cent in 2000 and 67 per cent in 2004. Fifty-four per cent of those infected with hepatitis C were aware of their status, compared to 52 per cent in the previous year's survey and 40 per cent in 2000 (HPA *et al.* 2007).

<sup>176</sup> Drug users in contact with specialist drug services.

Of UAPMP participants from Wales 45 per cent reported never having a voluntary confidential test for hepatitis C in 2005/06, with over half of those with hepatitis C were unaware of their infection. Less than one in ten (8.6%) of the participants from Northern Ireland in 2005/06 reported not having been tested for hepatitis C, and just over one quarter the participating IDUs with hepatitis C in the province were unaware of their hepatitis C infection (HPA *et al.* 2007).

In England, increasing the proportion of IDUs who are aware of their infection status through improved uptake of voluntary confidential testing is one of the aims of the *Hepatitis C Action Plan for England* (DH 2004b). Of those IDUs taking part in the 2005 UAPMP survey, 71 per cent reported having undertaken a voluntary confidential test, compared to 29 per cent in 2000 and 67 per cent in 2004. Fifty-two per cent of those infected with hepatitis C were aware of their status, compared to 51 per cent in the previous year's survey and 40 per cent in 2000 (HPA 2006).

A survey<sup>177</sup> carried out by the social care organisation Turning Point found that 22.2% of respondents had never been tested for hepatitis C and 23.1% had never been tested for hepatitis B. The study included three focus groups with current and former IDUs in different locations across England. Participants suggested that tests offered on a drop-in or rapid access basis would increase uptake. The report also recommended investigating further the option of dried blood spot testing as a means to increase uptake (Turning Point 2007).

The NTA's 2005 survey of needle exchanges in England (NTA 2007f) showed that 54.5 per cent of DAATs had at least one service that provides on-site hepatitis B testing and 51 per cent had at least one service providing hepatitis C testing. There were, however, significant differences by region in the provision of on-site hepatitis B and hepatitis C testing ( $p < 0.001$ ).

In the study of 500 current and recent injectors in Wales, only 47 per cent had ever had a hepatitis C test, although this varied by region. Fourteen per cent of those tested did not receive their results and 24 per cent tested positive. Of those testing positive, 84 per cent had notified their GP but only 31 per cent had been referred to a specialist doctor or hepatitis clinic, all of whom had yet to receive an appointment (Smith 2006).

### 7.3.3 Infectious disease treatment

NO NEW INFORMATION AVAILABLE

## 7.4 Interventions related to psychiatric morbidity

The Department of Health published new guidance to improve the care for people with concurrent mental health problems and substance misuse. *Dual diagnosis in mental health inpatient and day hospital settings* recommends that all clinical staff in mental health services should have the skills to assess and manage patients with a substance misuse problem. It makes clear that substance misuse and mental health services must become more integrated and provides ideas and guidance for front-line managers to help them improve services. It also contains guidance on service planning for groups with different needs such as women and black and minority ethnic groups (DH 2007).

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<sup>177</sup> The questionnaire was distributed in 10 Turning Point needle exchanges between December 2006 and March 2007 to people who had injected illegal drugs in the last four weeks. The results are based on 874 responses.



The Department of Health also launched a resource to help professionals raise the issue of cannabis use with patients and assist in reducing cannabis use. *How cannabis can affect people with mental health problems - Information for patients and practitioners* contains information materials in different formats.

In Scotland, a report to issue by the Scottish Government before the end of 2007, sets out a series of recommendations for change and improvement on awareness and for the development of support and service provision for people with co-occurring substance misuse and mental health problems.<sup>178</sup> This report supports the model of lead agency responsibility as set out in the 2002 Department of Health Guidance (DH 2002b). It builds on earlier policy developments, in particular *Mind the Gaps – Meeting the Needs of People with Co-occurring Substance Misuse and Mental Health Problems* (Scottish Executive 2003a). The report will not be prescriptive about the particular structure of services that needs to be in place to deliver good outcomes. Instead it proposes models of approach designed to inform change, focusing on the key aspects that needs to be in place at each point in the journey of care so that all involved in that care can be clear about what needs to be done and by whom. The 2007 NHS Quality Improvement Scotland standards for Integrated Care Pathways for specific mental health conditions will reinforce this message.

#### *Capability framework*

A capability framework setting out core competencies required for the delivery of care services to people with combined substance use and mental health problems has been published. The framework concentrates on three main strands: values and attitudes; utilising knowledge and skills; and practice development (Hughes 2007).

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

#### **7.5.1 Somatic co-morbidity**

The 2005 survey of needle exchanges in England found that less than half (46.6%) of services provide care for minor infections and dressings (NTA 2007g). In Wales, only 14 per cent of Community Drug Teams that responded to a survey provided in-house wound care with the remainder referring to a GP or Accident and Emergency department (Smith 2006).

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

NO NEW INFORMATION AVAILABLE

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

The consultation draft of the updated guidance for clinical management of drug misuse and dependence addresses the issue of driving while deemed to be drug dependent or a drug misuser (DH *et al.* 2007). It sets out the responsibilities for disclosure of information to the Driver and Vehicle Licensing Authority (DVLA) and guidelines for clinicians on how best to inform patients of these responsibilities. The guidance also provides clinicians with risk assessment information and advises how best to tackle non-compliance including confidential disclosure to the relevant authority.

#### **7.5.4 Other activities to reduce health consequences**

NO NEW INFORMATION AVAILABLE

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<sup>178</sup> This follows a consultation process, see:  
<http://www.scotland.gov.uk/Publications/2007/06/29120532/4>



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

Guidelines on the management of pregnant drug misusers and neonatal care have been published (DH *et al.* 2007). They highlight the need for joint working and coordination across agencies and recommend a written policy on drug-misusing parents. The need to engage early on in pregnancy is emphasised, as are ways to stabilise drug use during pregnancy, including substitution treatment.

A project in Scotland described in section 6.5.5 used a new assessment tool to identify prevalence of neonatal abstinence syndrome (NAS) and delayed visual maturation in infants born to drug misusing parents. The health visitors interviewed as part of the project believed the tool increased their awareness of NAS and established more open communication with parents; they were less sure about the vision screen test. Parents, who participated in the study were found to be appreciative of the improved service. The results from the study will be used to produce local recommendations for service development (Scottish Executive 2006b).

#### *Maternity Services update*

The 2003 *Hidden Harm* report (ACMD 2003) recommended ways to improve services for pregnant drug users and their babies. *Hidden Harm Three Years On* presents information on local responses gathered by the 'Hidden Harm' Working Group<sup>179</sup> including improvements to maternity services (ACMD 2007b).

Responses to a snapshot questionnaire sent to DAATs in England<sup>180</sup> show that 60 per cent reported having protocols for the management of neonatal withdrawal. The majority also reported having specialist posts or provision to support drug misusing mothers and their babies during and after pregnancy including specialist midwives, obstetricians and clinics (ACMD 2007a).

In Scotland, in the majority of ADATs, protocols exist for the management of pregnant drug users and neonatal withdrawal. There are similarly specialist posts and provision as in England. The Scottish Government is also funding a project to improve delivery of services for children and families affected by drug misuse. As part of the Inequalities Sensitive Practice Initiative in NHS Greater Glasgow and Clyde, the project will develop specific guidance to improve how mainstream health services, such as maternity services, cater for those affected by inequalities including substance misusers.

#### *Data collection on maternal drug use*

The update on *Hidden Harm* (ACMD 2007a) sets out the current efforts across the UK to improve data collection in maternity services. In Northern Ireland and Wales, data on children of those in treatment are routinely collected but there is no maternity record. It is reported that there is a new minimum maternity data set currently being developed for routine data collection with the aim of linking with child records and efforts are being made to ensure questions meet the recommendations of *Hidden Harm*. In Scotland, the ACMD report that the maternity record and neonatal discharge record includes an optional field for information about the use of drugs in pregnancy. NHS Health Scotland, however, has commissioned an audit of practices and opinion on the recording of data on maternal drug use to recommend improvements.

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<sup>179</sup> The group was set up to monitor and promote the implementation of the Hidden Harm recommendations and first met in February 2004.

<sup>180</sup> Forty seven DAATs returned the snapshot questionnaire, representing just under a third of all DAATs. Three regions were not represented in the snapshot.

The Scottish Government has commissioned externally an evaluation of the impact and outcomes of the Dundee outreach services for children and families affected by substance use.

## 8. Social correlates and consequences

### 8.1 Overview

A number of studies in the United Kingdom have shown that there is a strong association between problem drug use and social exclusion; drug problems are most serious in those communities where social exclusion is acute. Established drug markets are an impediment to regeneration, damaging community confidence and adding to the poor reputation of the area. In some parts of the United Kingdom over 90 per cent of problem drug users are unemployed, a high proportion of the homeless are problem drug users (evidence suggesting up to 80 per cent) and lacking educational qualifications (studies suggest up to 40 per cent lack any GCSEs<sup>181</sup>). Also vulnerable young people (those in care, the homeless, truants, school excludees and young offenders) are more likely to use drugs, use more often, and use a wider range of drugs.

Drug use *per se* is not a crime in the United Kingdom, but possession, dealing and trafficking are specific offences under the *Misuse of Drugs Act 1971*. The number of persons dealt with has continued to rise since 2001 in the UK. The main drug concerned is cannabis.

General criminal offences routinely recorded by the police do not contain information on the offenders' drug habits, neither do specific drug law offences. It is therefore not possible to provide an accurate estimate of the number of offences that are drug related, but there is substantial research evidence of the link between drug use, particularly use of heroin and crack cocaine, and acquisitive crime. Around three quarters of the users of these drugs admit to committing crime to support their habit. Over two-thirds of those in custody are reported to be problematic drug users. However, acquisitive crime, to which drug related crime makes a substantial contribution, has continued to fall in recent years.

The economic and social costs of Class A drug use in England are estimated to have been around €22.3 billion in 2003/04. This equates to €63,940 per year per problematic drug user. The associated confidence range is between €22.1 billion and €23.3 billion. The Scottish Government has commissioned research to produce an initial estimate of the economic and social costs associated with illicit drug use.

### 8.2 Social exclusion

#### 8.2.1 Homelessness

The Scottish Government has commissioned research into homelessness and substance misuse, in terms of the services provided and whether they are achieving the desired outcome.

#### 8.2.2 Unemployment

NO NEW INFORMATION AVAILABLE

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<sup>181</sup> GCSEs (General Certificate of Secondary Education) are the principal means of assessing pupil attainment at the end of compulsory secondary education in England, Northern Ireland and Wales; see: <http://www.dfes.gov.uk/qualifications/mainSection.cfm?sld=1>. The equivalent in Scotland is the Standard Grade; see : <http://www.scotland.gov.uk/Publications/2007/03/20130930/1>.

### 8.2.3 School drop out

In England, in 2005/06 there were of a total of 7,990 permanent exclusions, of which six per cent (450) were for drug and alcohol related issues, and of 343,840 fixed period exclusions 8,360 (2%) were for drug and alcohol related issues (DfES 2007c).

In the survey on *Smoking, drinking and drug use among young people in England* for 2006 pupils were asked whether they had ever truanted or been excluded from school<sup>182</sup> (Fuller 2007). Eleven per cent of those who had ever truanted, or been excluded reported using drugs at least once a month, compared with one per cent of those who had never truanted.

### 8.2.4 Financial problems

A literature review of the association between drugs and poverty commissioned by the Scottish Drugs Forum (SDF)<sup>183</sup> suggested that although there appears to be no direct causal link between drug-related problems and poverty, there is a strong association (Shaw *et al.* 2007b).

It is concluded that although relative poverty by itself is not the cause of Scotland's drug problem, narrowing a range of social and economic inequalities should contribute significantly to a reduction in high levels of damaging drug use. Furthermore, policies focusing on reducing poverty, exclusion and inequalities, *per se*, should help clarify more realistic boundaries for health, social care and criminal justice responses to individuals.

### 8.2.5 Social network

NO NEW INFORMATION AVAILABLE

## 8.3 Drug-related crime

### 8.3.1 Drug offences

#### *Recorded drug crimes*

Offences under the *Misuse of Drugs Act 1971* are recorded by the police. Statistics show that of a total of 5,428,300 recorded crimes in England and Wales in 2006/07 194,300 (4%) were drug crimes (Nicholas *et al.* 2007). This is an increase of nine per cent from the previous year (178,500). Nicholas *et al.* suggest that increases in recent years have been largely attributable to increases in the recording of possession of cannabis offences. From 2005/06 to 2006/07 the offence of possession of cannabis increased by nine per cent, which followed an increase of 36 per cent over the previous year. It is also noted that these increases coincided with a rise in the number of formal warnings for possession of cannabis issued by the police and that in 2006/07 the rise was nearly double the increase in the number of offences of cannabis possession and indicates the greater use of this method of disposal by the police. The increase in the offence of possession of other drugs was 12 per cent in 2006/07 in comparison with the previous year.

In Northern Ireland a total of 121,144 offences were recorded during 2006/07 compared with 123,194 in 2005/06; a decrease of 1.7 per cent. Of these 2,411 were drug offences, a reduction of 18.1 per cent since the previous year (2,944) (PSNI 2007).

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<sup>182</sup> For methodology used and further details see Chapter 2.

<sup>183</sup> The Scottish Drugs Forum (SDF) is the national non-government drugs policy and information agency. For more information see: <http://www.sdf.org.uk>

Latest information on recorded crime in Scotland is for 2005/06 (Scottish Executive 2006c). The total number of crimes recorded by the police in 2005/06 was 417,785, five per cent less than in 2004/05. Recorded drugs crimes increased by six per cent from 41,823 in 2004/05 to 44,247 in 2005/06.

### *Convictions*

NO NEW INFORMATION AVAILABLE (Information on convictions and disposals for drug offences for 2005 will be available in late 2007).

### 8.3.2 Other drug-related crime

There are a number of surveys and monitoring programmes which have measured drug use amongst individuals within the criminal justice system, and surveys amongst the general population reporting the relationship between self-reported drug use and crime amongst those questioned. As part of the Government's monitoring of the success of its drug strategy reductions in crimes are seen as positive indicators.

### *Property crimes*

*Crime Statistics* is a quarterly update which combines the reporting of police recorded crime and the results of the British Crime Survey<sup>184</sup> (BCS) (Taylor *et al.* 2007). Results from the British Crime Survey (from April to September 2006) showed that overall crime remained stable; as did domestic and vehicle thefts. Recorded Crime Statistics showed total recorded crime to be down three per cent from the previous quarter. A number of crime associated with drug users decreased: domestic burglary was down by down three per cent; other burglary down by seven per cent; vehicle crime down four per cent; and other thefts down five per cent. However, robbery was up one per cent and drug offences up nine per cent (Taylor *et al.* 2007).

### *Arrestee Survey*

The first representative survey<sup>185</sup> of drugs and crime amongst arrestees in England and Wales covers the period 1<sup>st</sup> October 2003 to 30<sup>th</sup> September 2004 (Boreham *et al.* 2006). The survey found that 57 per cent of arrestees had taken one or more drugs in the last month:

- 46 per cent reported taking cannabis in the last month;
- 18 per cent heroin;
- 15 per cent crack; and
- 10 per cent powder cocaine.

Reported use of some drugs decreased with age:

- 57 per cent of 17 to 24 year olds reported cannabis use in the last month compared with 28 per cent of those aged 35 years or over;
- 14 per cent of 17 to 24 year olds reported use of powder cocaine in the last month compared with five per cent of those aged 35 years or over.

Eighteen per cent had injected drugs at least once in their lifetime:

<sup>184</sup> The British Crime Survey (BCS) only covers England and Wales. The first BCS (1982) included lowland Scotland as did the fourth (1988), but since 1993 Scotland has ran its own, separate survey.

<sup>185</sup> The survey was carried out in a sample of 60 custody suites, within each of which interviewers worked six hour shifts and attempted to interview as many eligible arrestees as possible. Eligible arrestees had to be over 17 years of age, and arrested for committing any offence. In total 7,535 arrestees were interviewed. The interview consisted of a 20-minute computerised interview with a substantial self-completion section, which contained questions about offending behaviour, drug and alcohol use and treatment for drugs. In addition, arrestees were asked to provide an oral fluid sample for analysis of recent drug use.

- 25 to 34 year olds were most likely to have done so (30%); and
- 14 per cent of those aged 17 to 24 years and 12 per cent of those aged 35 years or over reported having injected.

Dependence was measured using the Severity of Dependence Scale (SDS), which uses five questions to measure dependence. Dependence on heroin was greater than on crack or powder cocaine:

- eighty-five per cent of those who had taken heroin in the last year were dependent; and
- equivalent figures for crack and powder cocaine were 52 per cent and 23 per cent respectively

Other characteristics of those who had used heroin, crack and/or cocaine (HCC) in the in the 12 months prior to arrest were:

- sixty per cent were unemployed (compared with 51% who had not used HCC);
- eighty-two per cent lived in a house (compared with 92% who had not);
- nineteen per cent arrestees had slept rough in the 4 weeks prior to arrest (compared with 8% who had not);
- eighty-nine per cent were White (compared with 84% who had not used HCC);
- fifty-three per cent had left school before they were 16 years of age (compared with 35% who had not);
- twenty-six per cent had spent some time in a foster home, children's home or a young person's unit (compared with 13 per cent who had not);
- for 57 per cent the reason for arrest was have committed an acquisitive crime<sup>186</sup> (compared with 28% who had not).

#### *Prolific and other priority offenders*

An impact assessment of the Prolific and other Priority Offender (PPO) programme<sup>187</sup><sup>188</sup> (Dawson and Cuppleditch 2007) (see Chapter 9.3.2) all but one of the 48 PPOs interviewed had used illegal drugs.

#### *Offending, Crime and Justice Survey 2004*

In a report from the 2004 Offending, Crime and Justice Survey (OCJS) delinquent youth groups and offending behaviour was examined (Sharp *et al.* 2006).<sup>189</sup> The

<sup>186</sup> Defined as an offence is committed to obtain money or goods in the last 12 months.

<sup>187</sup> The programme is premised on an understanding of a total offending population of around one million, only approximately 100,000 offenders (10% of all active offenders) were responsible for half of all the crime committed in England and Wales. Every Crime and Disorder Reduction Partnerships (CDRP) (or Community Safety Partnership in Wales) is responsible for setting up and implementing its own PPO scheme. The key criteria for selecting PPOs were outlined as follows: the nature and volume of the crimes they are committing; the nature and volume of other harm they are causing (e.g. as a consequence of their gang leadership or anti-social behaviour); and local criteria, based on the impact of the individuals on their communities.

<sup>188</sup> The PPO programme is comprised of three complementary strands: *Prevent and Deter* - aimed at those young offenders who are most at risk of becoming the next generation of prolific offenders; *Catch and Convict* - the goal being to prevent PPOs from offending by apprehension and conviction through licence enforcement and by ensuring a swift return to the courts for those PPOs continuing to offend; and *Rehabilitate and Resettle* - which aims to rehabilitate PPOs who are in custody or serving sentences in the community through closer working between all relevant agencies and continued post-sentence support.

<sup>189</sup> The Offending, Crime and Justice Survey (OCJS) was a longitudinal, self-report offending survey for England and Wales. The aim was to examine the extent of offending, anti-social behaviour and drug use among the household population. Eighty-two per cent of those first interviewed in 2003 were interviewed in again in 2004 giving a total 'panel' sample of 3,489 people (3,363 were aged ten to 25 at the time of the 2004 interview).



report pointed out that while the NEW ADAM (Bennett and Holloway 2004) study found that last year use of cannabis was significantly higher in current gang members compared with non-gang members, gang members were no more likely than non-gang members to have used any of the other drugs asked about. Rather, they were significantly less likely to have used heroin and to have injected a drug in the last 12 months. The report also noted, conversely, that studies carried out in the US (on a sample of school students and school dropouts) have found that more serious forms of drug use were more common in gang members than non-gang members (this included heroin and cocaine use) (Fagan 1996). Sharpe *et al.* suggest that these two very different results may be related to differences in the samples used in these studies.

In the report from the OCJS it was found that 45 per cent of young people in delinquent youth groups had used an illegal drug in the last year and 11 per cent had used a Class A substance. This was significantly higher than for non-members (15% for any drug and 3% for Class A drugs). Also, the most common delinquent group activity carried out together was using drugs; half (51%) of those belonging to a delinquent youth group said their group had used drugs together in the last year. Given this high proportion, they suggest that it is useful to know the proportion of individuals belonging to delinquent youth groups whose group delinquent activity is based only around drug use and no other behaviour. Overall, 13 per cent fell into this category and a further 38 per cent had used drugs and committed at least one other behaviour. Almost half (49%) had not used drugs but had engaged in the other behaviours. It is noted that although drug selling and weapons are often considered a feature of 'gangs', the OCJS shows that these were relatively uncommon among the groups measured in the survey. Just under a fifth of those belonging to a delinquent youth group reported that their group had actually sold drugs (18%).

#### *Young People and Crime: Findings from the 2005 Offending, Crime and Justice Survey*

Analysis of the 2005 Offending, Crime and Justice Survey (OCJS) focused on levels and trends in youth offending, anti-social behaviour and victimisation amongst young people aged 10 to 25 living in the general household population in England and Wales (Wilson *et al.* 2006). Selling drugs was one of 20 core offences which respondents were asked about.

The most commonly reported offence categories reported as having been committed in the last 12 months included drug selling; by four per cent (other offences were assault, committed by 16%, other thefts, by 11%; criminal damage, by 4% and vehicle-related thefts, by 2%). Repeat offending was particularly common for the selling of drugs. Among the four per cent of young people who said they had sold drugs in the last 12 months, 82 per cent had done so more than once, with 41 per cent reporting having done so six or more times.

It was found that young people who took drugs in the last 12 months were significantly more likely to have committed an offence than those who did not. Selling non-Class A drugs being most common at 16% of all offences. For both 10 to 15 year olds and 16 to 25 year olds, factors that were independently strongly associated with committing anti-social behaviour included taking any drug (also committing an offence in the last 12 months; having friends/siblings in trouble with the police; and perceiving parents to have poor parenting skills).

### *Evaluation of Drug Interventions Programme pilots for children and young people: drug testing and arrest referral schemes and Testing Requirements*

The evaluation of the drug testing and arrest referral pilot schemes for children and young people under 18 years old (Matrix Research and Consultancy and Institute for Criminal Policy Research, Kings College 2007)<sup>190</sup> found that young people in contact with arrest referral reported using a range of substances, the most common of which were cannabis (30%), tobacco (30%) and alcohol (23%) (for results of the evaluation see Chapter 9.3.2).<sup>191</sup> The frequency of use of the latter was high; over half of those who reported using each of these substances did so either daily or weekly. However, reported use of cocaine (4%), crack (1%) and heroin (1%) was low. Similarly, very few of the young people tested after charge were found to have used Class A drugs, with approximately five per cent testing positive.<sup>192</sup>

### *The concept of drug-related crime*

In a discussion paper Stevens (2007) suggests that the concept of drug-related crime, which he argues is a socio-political construction, has dominated recent developments in UK drug policy, and it has been assumed that the perceived overlap between known offenders and drug users is also present among the much larger groups of unknown offenders and drug users. This assumption, he argues, is methodologically suspect and has led to inflated claims of scale, precision and causality in political discussions of the link between drugs and crime.

### *Illegal prostitution*

As part of the Drug Interventions Programme (DIP), individuals arrested for loitering or soliciting for the purposes of prostitution can be drug tested under Inspector's Authority in DIP intensive areas. Data collected between June 2006 and June 2007 indicates that, of the 368 women who were tested, 90 per cent tested positive for heroin and/or crack cocaine.

### *Prescription offences*

NO NEW INFORMATION AVAILABLE

### *Violence under the influence*

Results from the British Crime Survey for 2006/07 suggests that victims of violent crime believed the offender to be under the influence of drugs in 17 per cent of incidents, a decrease from 23 per cent in 2005/06 (Nicholas *et al.* 2007).

### *Driving offences*

The Association of Chief Police Officers (ACPO) Christmas for December 2006 show that, of 666 Field Impairment Tests conducted, 251 drivers were arrested for drink or

<sup>190</sup> The research took place over ten sites and included stakeholder interviews, interviews with young people, analysis of monitoring data, analysis of Youth Offending Team (YOT) Asset data in pilot and comparator sites and analysis of cost data collected from various sources. The evaluation comprised two distinct phases of field research. During the first phase, research was undertaken in all ten sites to review the development and early implementation of arrest referral and drug testing. In the second phase, field research focused on the five sites that piloted DT(T)Rs. For the purpose of this report, research is reported only for the five sites involved in all parts of the evaluation. Monitoring data were collected by the Home Office for all ten sites throughout the pilot.

<sup>191</sup> This pilot was undertaken to see if pilot drug testing and arrest referral schemes for young people are an effective means of identifying young people at risk of becoming problem drug users and then referring them on to appropriate help to reduce drug use and crime.

<sup>192</sup> Approximately 1,500 individuals were tested 2,000 times between August 2004 and October 2005 across five sites, with the vast majority being tested only once.

drug impairment offences (37.7 per cent). The number testing for drugs rather than alcohol is not reported.<sup>193</sup>

### *Date rape*

#### *Operation Matisse: Investigating Drug Facilitated Sexual Assault*

A report from the Association of Chief Police Officers (ACPO)<sup>194</sup> concluded that there is no evidence to suggest widespread use of the so called 'date rape drug' Rohypnol. In most cases, the alleged victims had consumed alcohol voluntarily and in some cases, to dangerous levels (ACPO 2006b).

#### *Toxicology findings from a three year study*

A report from the Forensic Science Service describes the toxicological findings in 1,014 instances of alleged drug facilitated sexual assault for the period 2000 to 2002 (Scott-Ham and Burton 2006). This study found that alcohol, alone or with an illicit drug and/or medicinal drug, was present in 46 per cent of cases and illicit drugs were detected in 34 per cent; cannabis (26%), cocaine (11%) and MDMA (ecstasy) (5%) were the most common. Gamma-hydroxybutyric acid (GHB) was detected in 2 cases.

#### *Advisory Council on the Misuse of Drugs report: drug facilitated sexual assault*

In a report by the Advisory Council on the Misuse of Drugs (ACMD)<sup>195</sup>, which considered the two reports mentioned previously, it is suggested that drug facilitated sexual assault, including rapes in which drugs are mixed with alcohol, is a significant problem (ACMD 2007b). The Council recognises two forms of sexual assault:

- *Proactive drug facilitated sexual assault* involves the covert or forcible administration of an incapacitating or disinhibiting substance, by an assailant, for the purpose of sexual assault; and
- *Opportunistic drug facilitated sexual assault* involves sexual activity, by an assailant, with a victim who is profoundly intoxicated by his or her own actions to the point of near or actual unconsciousness, and thus lacks the capacity to consent.

However, it is suggested that the incidence of drug facilitated sexual assault is unclear, with many victims failing to report the incident and, where victims do report the incident, the elapsed time may be too long for drugs to be reliably detected in blood or urine. This particularly applies to alcohol and GHB. Further, they suggest that the most common weapon used in drug facilitated sexual assault, whether proactive or opportunistic, is probably alcohol.

<sup>193</sup> For more information see :

[http://www.acpo.police.uk/pressrelease.asp?PR\\_GUID={9A7F8325-C3BB-4C75-83EF-0A8CB09B2D66}](http://www.acpo.police.uk/pressrelease.asp?PR_GUID={9A7F8325-C3BB-4C75-83EF-0A8CB09B2D66)

<sup>194</sup> Operation Matisse was a twelve month study into the nature of drug-facilitated sexual assault (DFSA) in England conducted by the three main services engaged in evidence collection for sexual offences: ACPO; the Forensic Science Service (FSS); and Sexual Assault Referral Centres (SARCs). Participants in the study were 120 police-referred victims who reported to the police that they had experienced or suspected a drug-facilitated sexual assault within the previous 72 hours. Blood and urine samples were collected and stored. A questionnaire detailing drug, alcohol and food consumption was specifically designed for use in this study. Fieldwork was conducted between 1/11/2004 and 31/10/2005.

<sup>195</sup> The ACMD is established under the Misuse of Drugs Act 1971 to keep under review the drug situation in the United Kingdom and to advise Government Ministers on measures that they feel should be taken for preventing the misuse of drugs or for dealing with the social problems connected with their misuse.

## 8.4 Drug use and prison

### 8.4.1 Drug use in prison

#### *England and Wales*

From April 2006 to March 2007, 8.6 per cent Mandatory Drug Testing (MDT) were positive, indicating a continued fall in positive tests in prisons in England and Wales (10.3% in the previous year) (HM Prison Service 2007).

#### *Scotland*

Of 903 Addictions Testing Measure (ATM)<sup>196</sup> tests carried out in 2005/06, 24 per cent were positive for drug misuse which had occurred while in prison (ISD Scotland 2006). A further 10 per cent were positive tests where the prisoner may have misused the drugs for which they tested positive before entry to prison. These data are not comparable with MDT results previously reported.

In Scotland, an annual Prisoner Survey is undertaken. Results in 2007 (10<sup>th</sup> Prisoner Survey) showed that seven out of ten prisoners (69%) reported that they used illegal drugs in the year before coming into prison (ISD Scotland 2006). Half of the prisoners (51%) reported that they had used drugs in prison at some point in the past. The majority of those individuals (82%) reported that their drug use had changed during their current period in prison with most of these prisoners (74%) reporting a decrease in drug use in prison.

Less than a third (30%) reported that they had used illegal drugs in the month immediately prior to survey completion. A small minority of prisoners (3%; 100) reported injecting drugs in prison in the last month. Of this minority, most (80%) stated that they had shared injecting equipment.

The Scottish Prison Service (SPS) also undertook a Pre-release Survey in 2006/07 in an attempt to measure progress against Offender Outcomes. This was conducted following a survey of all those prisoners who had been sentenced to six months imprisonment. Each prisoner was contacted prior to release and asked to complete a short questionnaire to assess the impact of their imprisonment in terms of the Offender Outcomes. Results in relation to substance misuse and future offending showed that:

- two in five respondents (40%) reported that they were not a drug user;
- of those who indicated that they were drug users, in response to the question: "My drug taking has decreased in prison during this sentence.", 83 per cent indicated that their drug use had decreased, 14 per cent that it had remained at a similar level, and 4 per cent that it had increased; and
- in response to the question: "My chances of not coming back into prison in the next twelve months have improved during this prison sentence", two-thirds (63%) expressed the view that their chances of not coming back into prison had improved during this prison sentence (Internal communication ISD Scotland 2006).

<sup>196</sup> An Addictions Testing Measure (ATM) was introduced in 2005, replacing Mandatory Drug Testing (MDT) in Scotland. ATM is carried out on five per cent of the prison population, three times a year. The results are anonymous and cannot be attributed to the individual tested. This contrasts with the previous system of MDT for which tests were carried out monthly on 10% of the prison population and were attributable to specific prisoners, with penalties for positive results. By making the results of the new measure anonymous prisoners who had taken drugs did not attempt to conceal the fact. This measure is designed to better inform the interventions required for prisoners, rather than penalising them. Participation in the ATM tests is voluntary for all prisoners. For these reasons the results of ATM are not comparable with previous figures published which were obtained through MDT.

### *Northern Ireland*

Mandatory Drug Testing (MDT) has not been implemented. However, voluntary drug testing (VDT) is carried out in each establishment. Of 3,811 VDTs carried out between 1 December 2005 and 31 November 2006, 79.09 per cent were negative.<sup>197</sup>

### **8.5 Social costs**

An updated estimate of the economic and social costs of Class A drug use in England and Wales is €22.26 billion in 2003/04, equating to €63,940 per year per problematic drug user (Gordon *et al.* 2006).<sup>198</sup> The associated confidence range is between €22.1 billion and €23.3 billion. It is suggested that problematic Class A drug use accounts for most of the total costs (99%, or €22.1 billion). Drug-related crime accounts for the largest proportion of cost (90%, or €20.1 billion).

The Scottish Government has commissioned research to assess the scale and impact of illicit drugs in Scotland, the research will produce an initial estimate of the economic and social costs associated with illicit drug use.

Reuter and Stevens (2007) in their report on drug policy in the UK suggest that estimates used to provide crime costs are in fact debatable, as they are extrapolated from a relatively small number of highly criminally active drug users in the National Treatment Outcome Research Study (NTORS) sample to the much larger population of problematic drug users.

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<sup>197</sup> See: [http://www.niprisonservice.gov.uk/module.cfm/opt/14/area/Drug%20Report/page/drugs\\_eizures/](http://www.niprisonservice.gov.uk/module.cfm/opt/14/area/Drug%20Report/page/drugs_eizures/)

<sup>198</sup> Since the original estimates were first published in 2000, a number of methodological and data improvements have been made to estimate the economic and social costs of Class A drug use. These relate to the inclusion of additional health harms, criminal justice system costs of drug-related crime, victim costs of drug-related crime and the more up to date and estimates of the prevalence of problematic drug use. It is suggested that given these changes, total cost estimates in 2000 and 2003/04 are not comparable.

## 9. Responses to social correlates and consequences

### 9.1 Overview

Social reintegration is a key element of the drug strategies in the United Kingdom. Responsibility for responding to the social correlates and consequences discussed in Chapter 8 rests with a number of Government departments and agencies. There are various programmes to help drug users. The Supporting People Programme, introduced in 2003, provides housing related support to vulnerable groups generally, including people with drug problems. Progress2work (p2w), initiated in 2002 supports those who are drug free or stabilised, in gaining employment. The Building Safer Communities Fund aims to build communities that are resistant to drugs. Social inclusion programmes such as Positive Futures can bridge the gap between universal and targeted services (see Chapter 3).

The Drug Interventions Programme (DIP) was established in England and Wales in 2003 to reduce drug-related crime. DIP is a major programme designed to ensure that offending problem drug users access not only treatment services, but also other services addressing other needs, for example accommodation and employment, to assist in reintegration. In Scotland drug testing on arrest is being piloted and also, Drug Treatment and Testing Orders; each designed to help access drug users into treatment.

In prison a balance is struck between deploying robust security measures and supporting the rehabilitation of offenders. Measures to prevent drugs entering prison include: clearly-defined searching procedures covering all possible routes; passive and active drug dogs with passive dogs available to all prisons; CCTV surveillance of all social visits areas and low-level fixed furniture in Category C (low security) prisons and above; comprehensive measures to tackle visitors who smuggle or attempt to smuggle drugs, including closed visits, visit bans and police arrest. Since April 2006, in England and Wales, responsibility for prison health services has been fully devolved to the National Health Service, and an Integrated Drug Treatment System (IDTS) has been developed to improve the availability and quality of drug treatment in prison, bringing it on a par with treatment in the community. For the first time in the United Kingdom a syringe – exchange programme is currently being piloted in one Scottish prison.

Current attention is also focused on the impact of the parental drug use on children (see Chapters 3 and 13). In addition, there is a growing number of responses to neighbourhood problems associated with problem drug use, including drug dealing. For example, the *Anti-Social Behaviour Act 2003* seeks to stop the use of premises for drug dealing. Also, there is guidance to tackle the inappropriate disposal of drug paraphernalia.

### 9.2 Social reintegration

The Social Exclusion Task Force, based in the Cabinet Office, has invited researchers to contribute to its Families-At-Risk Review. This call for evidence is seen as an opportunity to help identify key lessons from practice and research that will be used to inform the direction of the review, and improve outcomes for some of the most excluded children and families. The review covers all services for adults.<sup>199</sup>

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<sup>199</sup> See:

[http://www.cabinetoffice.gov.uk/social\\_exclusion\\_task\\_force/publications/families\\_at\\_risk/](http://www.cabinetoffice.gov.uk/social_exclusion_task_force/publications/families_at_risk/)



In an article on drugs, crime and social exclusion, Seddon (2006) suggests that the drug-crime link should be understood as being underpinned by the processes of social exclusion.

### 9.2.1 Housing

It is noted in the consultation document on the new Drug Strategy that the support drug users need to re-establish their lives (including housing, employment and education) is not always readily available (HM Government 2007).

In a research paper by Clare (2006), housing is seen as a commodity in demand amongst a group of people for whom accommodation may be problematic, insecure or non-existent. Consequently it has an exchange value and can be bartered for other commodities or services, including drugs, sex, money or goods.

#### *Comprehensive Rent Deposit Model*

A second quarterly progress update and two seminar reports produced in July 2006 and March 2007 about the Comprehensive Rent Deposit Model reported in the previous United Kingdom Focal Point report are available on CD-ROM and the [www.drugs.gov.uk](http://www.drugs.gov.uk) website. Whilst funding ended March 2007, practice and learning continues to be promoted.

#### *Preventing Homelessness*

Working in partnership with Communities and Local Government (a Government Department), the Ministry of Justice, the Department of Health, the National Treatment Agency and the Home Office, the Drug Interventions Programme has been able to:

- Continue to promote practice and learning from the implementation of the Comprehensive Rent Deposit Model in 13 DAT areas. Quarterly progress updates and seminar reports produced in July 2006 and March 2007 are available on CD-ROMs and the [www.drugs.gov.uk](http://www.drugs.gov.uk) website.
- Gain agreement of the use of common housing terminology to be used to describe housing/accommodation status. This has been adopted in the revised Drug Interventions Record (DIR) used from April 2007.

### 9.2.2 Education, training

NO NEW INFORMATION AVAILABLE

### 9.2.3 Employment

NO NEW INFORMATION AVAILABLE

### 9.2.4 Basic social assistance

#### *Families of drug misusing offenders*

A consultation, *Partners in Reduction: Engaging and Involving Families in the Reduction of Substance Related Problems in Prison*, published in 2005, and a review report published by the National Offender Management Service (NOMS) Prison Service Drug Strategy Unit, identified gaps in provision and support for families of drug misusing offenders at points in the criminal justice system, particularly around arrest and on release. *Around Arrest, Beyond Release: the experiences and needs of families in relation to the arrest and release of drug using offenders*, was subsequently commissioned by DIP to further inform what provision may be needed to support families of drug using offenders. This report was circulated to stakeholders in July 2006.

See also DIP, below.

### 9.3 Prevention of drug related crime

#### 9.3.1 Assistance to drug users in prison

In England and Wales the Drug Interventions Record (DIR), which is used with many drug-misusing offenders to improve continuity of care, has been reviewed. The revised form introduces a requirement for a follow-up assessment.<sup>200</sup>

##### *Prevention*

See Mandatory Drug Testing in England and Wales, and the Addictions Testing Measure in Scotland (Chapter 8.4). In Northern Ireland, while legislative authority for Mandatory Drug Testing (MDT) has been provided by Parliament it has not been implemented. Voluntary drug testing (VDT) is carried out in each establishment to act as a deterrent to prisoners.

##### *Harm reduction*

See section on treatment in prison below.

##### *Treatment*

In 2006 the Home Office was taken to court over their failure to offer any treatment to prisoners suffering opiate withdrawal on the grounds that this was damaging to prisoners' welfare and possibly a factor in 'self-destructive behaviours'. These cases concern action against medical practice in prison which dates back to the early 1990s. The Home Office agreed to compensate six prisoners.<sup>201</sup>

##### *Clinical Management of Drug Dependence in the Adult Prison Setting*

In England and Wales, new guidance recognises the need for more humane drug treatment for prisoners, better coordinated with any treatment they may already have been receiving and better preparation for their release. *Clinical Management of Drug Dependence in the Adult Prison Setting* (DH 2006a) describes how clinical services should develop during the next two years as increasing resources permit. It is formulated as a treatment model, covering reception up to and beyond 28 days thereafter. It sets out the key components: reception screening; assessment; clinical management and psychosocial interventions. It is suggested that while detoxification may remain the preferred method of clinical management, a range of clinical treatment options are required to manage the varied and complex needs of this patient group.

*Guidance on the delivery of drug treatment services to meet the prisons needs of black and minority ethnic prisoners.*

Roy *et al.* (2007) have published guidance to support those responsible for the development and delivery of drug treatment services, which meet the needs of Black and minority ethnic prisoners. The guidelines were commissioned by the National Offender Management Service for England and Wales.

##### *Social reintegration*

See Drug Interventions Programme in section 9.3.2 below with respect to England and Wales.

The Home Office suggests that there is growing evidence supporting the benefits of involving families of drug misusers in the treatment process. Initial findings from the *Partners in Reduction: Engaging and Involving Families in the Reduction of*

<sup>200</sup> For more information see:

<http://www.drugs.gov.uk/drug-interventions-programme/guidance/DIR>

<sup>201</sup> For more information see:

[http://www.politics.co.uk/news/public-services/prisons/prison-rehabilitation/prisoners-compensated-over-cold-turkey-treatment-\\$457586.htm](http://www.politics.co.uk/news/public-services/prisons/prison-rehabilitation/prisoners-compensated-over-cold-turkey-treatment-$457586.htm)

*Substance Related Problems in Prisons* (NOMS 2005) consultation, and a review report produced by NOMS Prison Service Drug Strategy Unit (DSU), identified gaps in provision and support for families of drug misusing offenders at points in the criminal justice system, particularly around arrest and on release. *Around Arrest, Beyond Release: the experiences and needs of families in relation to the arrest and release of Drug using offenders* (Home Office 2007d) was subsequently commissioned by the DIP team at the Home Office to further inform what provision and support may be needed to support families of drug using offenders. This report was completed and circulated to stakeholders in July 2006.

#### *Community links*

See Drug Interventions Programme in section 9.3.2 below with respect to England and Wales

### 9.3.2 Urban security policies in the prevention of drug related crime

#### *The Drug Interventions Programme (DIP)*

It is reported by the Home Office that since the onset of DIP in 2003 recorded acquisitive crime, to which drug related crime makes a significant contribution has fallen by 20 per cent (Home Office internal communication).

There has been a large increase in the number of drug-misusing offenders entering treatment through DIP; currently there are over 3,000 drug misusing offenders a month entering treatment, compared with just over 400 in March 2004. It is reported that this number has increased markedly since April 2006 when testing on arrest and required assessment was introduced. The target to engage 1,000 offenders per week in treatment by March 2008 has been exceeded. As at January 2007, over 75,000 drug misusing offenders had entered treatment through DIP since the programme began.

Since 1 April 2007, there have been two parts to the required assessment: the initial and the follow-up assessment. Sanctions exist, and will be enforced, against those who fail to attend and remain for either part without good cause. The Home Office publication *Rebalancing the Criminal Justice System in favour of the law abiding majority* (2006) included a commitment to align the Prolific and Priority Offenders (PPO) Programme more closely with the Drug Interventions Programme. Good practice guidance for partnerships was drawn up and published following widespread consultation with practitioners and a series of regional stakeholder events.

By June 2007, over 96 per cent of Prolific and Priority Offender schemes had successfully aligned with DIP, with plans to do so in.

It is also suggested that there is some evidence that offenders who completed Drug Treatment and Testing Orders (DTTOs), the predecessor of the Community Order with a Drug Rehabilitation Requirement (DRR), have greater reductions in offending and drug use than those who failed to complete. Numbers of offenders starting and completing DRRs are rising. Numbers starting DTTOs/ DRRs have increased from about 6,000 in 2000 to nearly 16,000 in 2007. Completions have increased from about 28 per cent to 44 per cent in the same period. Latest data (Sept 07) indicates that 84 per cent of offenders on DRRs are retained in treatment for at least 12 weeks. Courts appear to have confidence in the DTTO/DRR. They are made in over 90 per cent of cases where they have been proposed in pre-sentence reports. (Home Office internal communication).

*Evaluation of the Restriction on Bail Pilot*

An evaluation of the Restriction on Bail (RoB) Pilot<sup>202203</sup> found that it was successful in terms of channeling defendants into drug treatment, but its impact on drug use and offending is less clear (Hucklesby *et al.* 2007).

*Evaluation of Drug Interventions Programme pilots for children and young people*

An evaluation of pilot drug testing on charge and arrest referral schemes<sup>204</sup> for young people aged 18 years and younger considered the effectiveness of such programmes as a means of identifying young people at risk of becoming PDUs and referring them for appropriate help to reduce drug use and crime (Matrix Research and Consultancy and Institute for Criminal Policy Research, Kings College 2007).<sup>205</sup> The evaluation also considered Drug Treatment and Testing Requirements (DT(T)Rs).

The research found that in the drug testing on charge schemes few young people used Class A drugs (5%).<sup>206</sup> A higher proportion of those who tested positive were older (10% of 17 year olds compared to 3% of 14 year olds).

Amongst those involved in arrest referral schemes, self-reported use of Class A drugs was also low, cocaine (4%), crack (1%) and heroin (1%).<sup>207</sup> However, use of alcohol (23%), tobacco (30%) and cannabis (30%) was high and over half of those who reported using each of these substances did so at least weekly. Drug offences formed a low proportion of the arrests. Arrest referral schemes identified and addressed a broad range of issues beyond offending and substance misuse and were effective in offering referrals for those who were not already in contact with services and also for those who were at an early point in their substance misuse. However, no change in subsequent offending was identified.

<sup>202</sup> The report drew on monitoring data collected in the pilot sites, reconviction and treatment data, court observations and interviews carried out with 61 defendants and 124 staff and stakeholders. 1,315 defendants had RoB imposed.

<sup>203</sup> Restriction on Bail forms part of the Government's Drug Interventions Programme and provides for defendants who have tested positive for a specified Class A drug to be granted conditional bail if they have agreed, when offered, to undergo an assessment and participate in any proposed follow-up, including treatment. The RoB condition was piloted in three areas (Manchester, Nottingham and Salford) between May 2004 and October 2005.

<sup>204</sup> Arrest referral schemes for children and young people (10 to 17 year olds) were piloted in ten areas; all were operational from August 2004. On-charge drug testing of 14 to 17 year olds under Section 5 Criminal Justice Act (CJA 2003), piloted in five areas, has been operational from August 2004. Statutory powers to test young people at the pre-sentence stage and while on licence also exist under the CJA 2003 but were not enacted during the evaluation period.

<sup>205</sup> The research took place over ten sites and included stakeholder interviews, interviews with young people, analysis of monitoring data, analysis of Youth Offending Team (YOT) ASSET data (The ASSET form is a tool used to assess why the young person has committed a crime and how to prevent them offending again) in pilot and comparator sites and analysis of cost data collected from various sources. The evaluation comprised two distinct phases of field research. During the first phase, research was undertaken in all ten sites to review the development and early implementation of arrest referral and drug testing. In the second phase, field research focused on the five sites that piloted DT(T)Rs. For the purpose of this report, research is reported only for the five sites involved in all parts of the evaluation. Monitoring data were collected by the Home Office for all ten sites throughout the pilot.

<sup>206</sup> Approximately 1,500 individuals were tested 2,000 times between August 2004 and October 2005 across five sites, with the vast majority being tested only once.

<sup>207</sup> 2,327 young people had contact with arrest referral between November 2003 and September 2005.

The evaluation found insufficient evidence to roll out drug testing for under 18s. Due to the low number of DT(T)Rs issued during the research period there was insufficient evidence to support a wider roll out of DT(T)Rs and be able to draw any firm conclusions on their impact.

#### *Citizen participation*

NO NEW INFORMATION AVAILABLE

#### *Drug Treatment and Testing Orders in Scotland*

Drug Treatment and Testing Orders (DTTOs), superseded in England and Wales by Drug Rehabilitation Requirements (DRRs), continue to be applied in Scotland. Currently they are only handed down by the courts for high-tariff offenders, largely those convicted of large amounts of acquisitive crimes, but are to be extended to lower tariff offenders. As the number of courts able to DTTOs has been extended to all Scottish courts, with the exception of District Courts, the number of orders imposed has increased to approximately 600 per year. An evaluation of the pilot schemes pointed to DTTOs having had a positive and dramatic impact on drug use and offending which was sustained for at least 6 months into the orders. Offenders reported marked reductions in drug use and drug-related offending since being placed on a DTTO, with an average weekly expenditure of €84 on drugs six months into a DTTO compared to a weekly expenditure of €719 before being given an order.<sup>208</sup>

#### *Drug testing on arrest in Scotland*

In June 2007, the Police, Public Order and Criminal Justice (Scotland) Act 2006 launched mandatory drug testing and referrals for all those brought to custody aged 16 and over. Three pilot schemes have been set up in Glasgow, Edinburgh and Aberdeen. Post conviction measures also exist.<sup>209</sup>

#### *Multi-agency collaboration*

See DIP above.

#### *Throughcare and aftercare*

See DIP above.

#### *Peer Led Support*

There is a growing understanding that the gains made in health, improved social circumstances and reduction in offending, which arise from successfully completing drug treatment in the community or prison, may be lost if ongoing support is not provided to drug users. Peer led support is seen as part of the aftercare package of support. Currently, it is provided in a variety of different ways across England and Wales. *Peer-led approaches for ex-drug users to meet diverse needs: A Practice Guide* (Home Office 2006b) suggests a clear pathway from treatment into peer led support should be identified and that good practice and differing approaches should be shared more consistently.

#### *24/7 Client Phone Line for DIP clients*

The 24-hour, single point of contact phone numbers are now available to support DIP clients in 93 per cent of DAAT areas (140) in England, and in Wales.<sup>210</sup>

<sup>208</sup> For more information see: <http://www.scotland.gov.uk/News/Releases/2001/09/160>

<sup>209</sup> For more information see: <http://www.scotland.gov.uk/News/Releases/2006/10/12103849>

<sup>210</sup> See: <http://www.drugs.gov.uk/drug-interventions-programme/strategy/throughcare-aftercare/>



### *Prolific and other priority offenders*

An impact assessment of the Prolific and other Priority Offender (PPO) programme (Dawson and Cuppleditch 2007) examined the implementation, interventions and outcomes of the first cohort of prolific and priority offenders who entered the PPO programme in 2004 (See Chapter 8.3.1 for information on methodology).<sup>211</sup> All but one of the 48 PPOs interviewed had used illegal drugs. . The preceding *Early Findings from the Prolific and Other Priority Offenders Evaluation* (Dawson 2005) examined Offender Assessment System (OASys) reports to identify factors linked to offending. This found that the PPO cohort presented higher levels of most criminogenic needs than the OASys sample, including those around drug misuse. Sixty-one per cent of the PPO cohort had needs relating to drugs misuse, compared to 26 per cent of the OASys sample.

It was found that:

- in the 17 months following entry onto the programme there has been a 43 per cent reduction in offending ;
- in this time there was a reduction of 62 per cent in the overall level of convictions;
- the average rate of offending fell from 0.51 convictions per month per PPO in the 12 months prior to entry onto the scheme, to 0.39 for the 12 months following entry, a reduction of 24 per cent; and
- there was a marked decrease in the number of days between committing their offence and being sentenced in court in the year following entry on the programme.

However, researchers concluded that it is not possible to state the extent to which the reduction in offending observed in the PPO cohort was solely attributable to the PPO intervention.

### *Victim support interventions*

NO NEW INFORMATION AVAILABLE

### *Prostitution*

The Government's coordinated strategy on prostitution (published in January 2006) recognised the need to reform the offence of loitering or soliciting for the purposes of prostitution, in order to meet the needs of those involved in prostitution and to address directly the factors that keep them tied to the street. Provisions in the *Criminal Justice and Immigration Bill* (published in June 2007) include proposals to introduce a new penalty for those convicted of this offence. The new penalty, which will be available as an alternative to a fine, will require the offender to attend a series of three supervised sessions to begin to address the reasons behind their involvement in prostitution, which could include sessions with a drug treatment agency.

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<sup>211</sup> A number of complementary research methods were used which, when taken together, aimed to provide a reasonable indication of the impact of the PPO programme. The methods used were a combination of offender interviews, PPO staff interviews, an analysis of the offending of PPOs prior to and following their entry onto the PPO programme, and an attempt to draw comparisons between any changes in PPO offending with an appropriate control group identified using a statistical technique called Propensity Score Matching (PSM). A total of sixty interviews were undertaken with PPOs from PPO schemes in each of the ten Government Office regions. Forty-eight interviews were with PPOs currently on the scheme at the time of the interviews, whilst 12 had been deselected. Fifty-two interviews were undertaken with key PPO staff (representing police, probation and Crime and Disorder Reduction Partnership representatives) from one PPO scheme in each of the ten Government Office regions.



The Scottish Government recently published *Guidance for Local Authorities and their Community Planning Partners on Tackling Street Prostitution* (Scottish Government 2007). This focuses on five key elements of a comprehensive strategy to address street prostitution:

- challenging attitudes which lead to a demand for prostitution;
- preventing vulnerable young people from becoming involved in prostitution;
- minimising the harm and risk encountered by women who are involved in street prostitution;
- assisting women to leave prostitution; and
- enforcing the law, disrupting street sex markets and protecting communities affected by the presence of street prostitution.

*The Prostitution (Public Places) (Scotland) Act 2007*, which come into force in October 2007 will provide Scotland with the toughest legislation on kerb crawling in the UK and sends an unequivocal message to those who create the demand for street prostitution.<sup>212</sup>

### Rape

In their report on drug facilitated sexual assault Advisory Council on the Misuse of Drugs (ACMD 2007b) (See Chapter 8.3.) recommended that:

- the Association of Chief Police Officers (ACPO) enhance evidence gathering so that the forensic science services can test for date rape drugs;
- the Department of Health ensure hospitals have early evidence kits to allow for similar tests;
- the Government seek advice on whether the *Sexual Offences Act* should be strengthened;
- drug facilitated sexual assault should be part of the British Crime Survey (BCS)<sup>213</sup> and be recorded by police; and
- schools and other educational establishments should alert people to take common sense measures, such as minding drinks, to avoid being a victim.

To avoid being a date rape victim the ACMD is encouraging people to:

- avoid going to a club, pub or party alone;
- not accept a drink from strangers;
- not share or exchange drinks;
- not leave your drink unattended even when going to the toilet; and
- be a friend by watching out for others, and be aware of any changes in their behaviour.

The Scottish Government's Know the Score information and media campaign, developed with the Scottish Crime and Drug Enforcement Agency (SCDEA), *Who's Keeping an Eye on your Drink*<sup>214</sup> campaign, has been complemented by local police force initiatives, including the *Get Real* DVD which includes information about drug assisted sexual assault (DASA). The DVD is used by police officers in their work with schools. SCDEA are working with partners who provide support and advice to victims and to obtain better data on Scottish trends and frequency.

<sup>212</sup> See: <http://www.scotland.gov.gov/Publications/2007/09/prostitutionact2007>

<sup>213</sup> The British Crime Survey is a continuous victimisation survey in which a representative sample of adults aged 16 or over living in private households are asked about their experience of crime.

<sup>214</sup> This campaign has run repeatedly since winter 2003/4, usually in the run-up to the Christmas

An independent assessment of the sensitivity and specificity of two commercially available 'drug-facilitated sexual assault' drug detector kits highlighted concerns regarding their use by the general public<sup>215</sup> (Beynon *et al.* 2006). Neither of the tested kits demonstrated high levels of sensitivity, specificity or utility under laboratory conditions. For example, the kits correctly identified the presence of a drug in only 69 per cent of cases. The authors concluded that the use of these kits by the public in the night-time environment needs further investigation as they may create a false sense of security (false negatives) and undue concern (false positives) among kit users.

#### *Interventions for drug-using offenders in the courts, secure establishments and the community: Cochrane Systematic Reviews*

In a systematic review of interventions for drug-using offenders in the courts, secure establishments and the community, Perry *et al.* (2006)<sup>216</sup> concluded that there was limited evidence of the effectiveness of drug treatment programmes for drug-using offenders in the courts or the community. However, it was found that therapeutic communities with aftercare showed promising results for the reduction of drug use and criminal activity in drug using offenders. The lack of evidence is reported to be partly due to broad range of studies and the wide range different outcome measures presented. It was suggested that standardised outcome measures and costing methodology would help improve the quality of research conducted in the area.

#### *Analysis of drug policy*

Reuter and Stevens (2007) in their analysis of the United Kingdom drug strategy argue that given that there are many other influences on crime in addition to drug use, including "*unemployment, inequality, demographics, fashion, the availability and price of consumer goods, detection and imprisonment rates and the use of locks and other situational crime prevention measures*", and given the lack of correlation between British crime rates and the prevalence of Class A drug use it is difficult to discern the effect of drug policy on overall crime rates and "*therefore, changes in crime rates are not directly indicative of the effectiveness of drug policy.*"

They further suggest that, given that the link between drugs and crime is much more complicated, it is unlikely that drug treatment can achieve the reductions in overall crime rates that have been claimed for it.

McSweeney *et al.* (2006) reporting findings from their pan-European study of coerced treatment suggest that, increasingly, measures are being introduced that coerce drug users, identified through the criminal justice system, into treatment, through provisions of the *2005 Drugs Act* and the 'Tough Choices' agenda (both reported in the previous United Kingdom Focal Point report), in particular, the Drug Rehabilitation Requirement. It is noted that pan-European research on clients entering treatment through the courts report significant and sustained reductions in drug use and offending and also improvements in other areas of social functioning, as did those entering treatment through non-criminal justice routes. However, it is argued that coerced treatment, particularly given high expectations of offenders, may not always be appropriate.

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<sup>215</sup>Standard drug doses of GHB, ketamine, temazepam, flunitrazepam were added to solutions of cola, beer, 'alcopop' and distilled water. Testing was undertaken in accordance with instructions on the packaging of each kit. Each kit was tested 10 times for each drink/drug or placebo combination. Two independent raters scored each test result (presence/absence of drug) according to the kit instructions.

<sup>216</sup> Twenty four studies, 8,936 participants, met the inclusion criteria of Randomised Controlled Trials designed to reduce, eliminate or prevent relapse in drug using offenders for the review.

### *Diversity manual*

A diversity manual has been issued by the Home Office<sup>217</sup>, this is to be employed by regional crime and drug teams and local partnerships to assist in:

- understanding the legislation requiring public sector bodies to eliminate discrimination and promote equality;
- identifying key tasks relating to diversity;
- identifying the needs of all local communities;
- engaging local communities; and
- delivering services appropriate to the needs of specific communities.

### *Expressions of interest for drug detection using low angle x-ray scatter*

The Home Office has called for expressions of interest in research to investigate whether low angle x-ray scatter has the potential to be able to detect illicit drugs, quickly, in an operational environment. The basis of the work, with reports and data forming the majority of the deliverables, includes:

- the population of a database containing diffraction profiles of illicit drugs, cutting agents, packaging and other pertinent substances;
- development of a model for detection of illicit drugs;
- investigation of the statistical quality of the data;
- refinement and testing of the developed model;
- investigation into defeating mechanisms; and
- system design, identifying components and practicality of use.

It is required that prototype design be finalised within two years.<sup>218</sup>

### *Review of the reporting of crime statistics*

An independent review has made recommendations on changes that should be made to the production and release of crime statistics<sup>219</sup> suggesting a shift from the publication of aggregate national figures to a system of communication which encompasses data at local level between police and their neighbourhood communities (Home Office 2006c). Amongst a number of recommendations was that the British Crime Survey sample frame should be extended to include those under 16 and those living in group residences as soon as practical after taking the advice of those with relevant expertise and piloting the changes.

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<sup>217</sup> For more information see: <http://drugs.homeoffice.gov.uk/publication-search/drug-strategy/DiversityManual>

<sup>218</sup> For more information see: <http://scienceandresearch.homeoffice.gov.uk/hosdb/drug-detection/>

<sup>219</sup> These are police recorded crime statistics and the British Crime Survey.

## 10. Drug markets

### 10.1 Overview

*The United Kingdom Threat Assessment of Serious Organised Crime 2006/07 report* suggests that, "The United Kingdom is one of the most lucrative markets in the world for traffickers in Class A drugs (heroin, cocaine powder, crack cocaine, ecstasy)". The overall picture is one of ready availability throughout the United Kingdom (SOCA 2006).

**Heroin:** Most identified supply chains to the United Kingdom follow well-established trafficking routes. The primary trafficking route is overland from Afghanistan to Europe, transiting from Iran to Turkey, where the majority of opiates are processed before being moved to the Balkans, and then overland to Europe. In addition, a large amount of Afghan heroin arrives directly by air routes from Pakistan, via couriers and parcels.

**Cocaine:** The Iberian Peninsula, predominantly Spain, and the Netherlands, continue to be the main entry points into Europe for shipments of cocaine from the South Americas (primarily Colombia and Venezuela). Shipment routes transiting the Caribbean and West Africa are also common with organised crime groups. It is believed cocaine enters the United Kingdom via ports in the South East of England.

**Ecstasy:** Almost all of the ecstasy consumed in the United Kingdom is manufactured in the Netherlands or Belgium, and commonly enters by sea through Harwich, Felixstowe and Dover. A greater number of sites making up tablets have been found than laboratories, mostly in the North of England. Synthetic drug production in the Netherlands and Belgium relies heavily upon precursor chemicals made in China, obtained through criminal networks from Chinese companies.

**Cannabis:** Cannabis is imported into the United Kingdom from Europe in bulk by serious organised criminals, sometimes in mixed loads alongside Class A drugs, and in smaller amounts for sale and for personal use. In addition, there are indications that intensive hydroponic cultivation of cannabis is occurring in the United Kingdom.

The overall picture of United Kingdom drugs distribution appears increasingly complex and diverse. However London, Birmingham and Liverpool continue to be important centres for the distribution of all types of drugs to all areas of the United Kingdom. Dual supply of heroin and crack cocaine are now well established in most parts of the United Kingdom and not solely at street level. In Scotland, the main source of heroin from Liverpool via the Glasgow area. Crack cocaine seizures have risen, particularly in Aberdeen and Edinburgh; however there is a lack of intelligence that supports the existence of 'crack houses' in Scotland.

In general the quantity of seizures has been rising in the United Kingdom; cannabis being the most seized drug. However, SOCA reports that arrests and seizures mainly in Class A drugs have achieved short-term disruptions rather than a sustained reduction in the size of the United Kingdom drugs market.

The most recent estimate of the size of the illicit drug market in the United Kingdom is £5.3 billion (€7.7 billion) in 2003/04, with a wide margin of error of £4.0 billion to

£6.6 billion<sup>220</sup>. The Scottish Government has commissioned research to assess the scale and impact of illicit drugs in Scotland. One part of this will aim to produce an initial estimate of the size/value of the illicit drug markets in Scotland.

## 10.2 Availability and supply

### 10.2.1 Availability in the general population

Given the prevalence of drug in the population (see Chapter 2), questions on drug availability are not reported for the adult population.

### 10.2.2 Availability amongst school children

The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) (see Chapter 2) asks questions on whether pupils had ever been offered drugs and ease of obtaining drugs. In 2006:

- 53 per cent of 15 year olds had ever been offered drugs, a fall from 63 per cent in 2004;
- The most common drug to have been offered was cannabis (44%) followed by ecstasy (18%), poppers (16%) and cocaine (13%);
- 48 per cent of 15 year olds believed it was very easy or fairly easy to obtain drugs compared to 58 per cent in 2004; and
- Only 27 per cent of those who had never tried drugs thought drugs were easy to obtain compared to 88 per cent of those who took drugs each day.

The survey also asked where pupils had obtained their drugs from the last time they had used them. Seventy-four per cent of 15 year olds who had taken drugs obtained them from a friend (the same age or older), four per cent from a brother or sister and one per cent from parents. Amongst 13 year olds who had taken drugs, six per cent had obtained them from a brother or sister and eight per cent from a parent (including step parent) (ISD Scotland 2006).

### 10.2.3 Production, sources of supply and trafficking patterns within the country and some from and towards other countries

Research suggests that the overall picture of United Kingdom drugs distribution is increasingly complex and diverse. London, Birmingham, Bristol, Nottingham, Glasgow and Liverpool are important centres for the distribution of all types of drugs to all areas of the United Kingdom. Dual supply of heroin and crack cocaine is now well established in most parts of the United Kingdom and not solely at street level (Government internal communication).

The Home Office has commissioned research involving interviews with convicted drug traffickers and dealers to understand how high level drug dealers operate and how markets for illicit drugs work. The results are due to be published in autumn 2007.

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<sup>220</sup> The study used a survey-based demand side approach to estimate market size. Data from the Schools Survey 2003, the Offending Crime and Justice Survey 2003 and the Arrestee Survey 2003-04 were analysed to estimate the prevalence of drug use, frequency of use quantity used and expenditure on drugs by juveniles, the general adult population and adult arrestees. Estimates of price and quantities were compiled from a number of sources including NICS price data and FSS purity data. The estimate was based on data sources for England and Wales and extrapolated to the United Kingdom as a whole.

### 10.3 Seizures

Latest information on seizures in the United Kingdom is for 2005 and provided information for all law enforcement agencies except for customs data for Scotland. There were 189,032 seizures of drugs in the United Kingdom in 2005, a 42 per cent increase from the previous year. Increases are reported for all drugs, the largest being for herbal cannabis (74.2%), cannabis plants (44.6%), and cocaine (51.5%). There was a decrease in the quantity of seizures for a number of drugs including herbal cannabis, cannabis resin, cocaine, crack and heroin (Table 10.1).

*Table 10.1: Number of seizures of drugs by law enforcement agencies in the United Kingdom, 2003 to 2005*

Drug	2003	2004	2005	% change from 2004
Amphetamines	6,952	7,254	8,656	+ 19.3
Cannabis – herbal	36839	42,814	74,575	+ 74.2
Cannabis – resin	60,068	52,218	59,204	+ 13.4
Cannabis plants	2,904	2,995	4,331	+ 44.6
Cocaine	7,707	8,763	13,272	+ 51.5
Crack	4,814	4,974	6,479	+ 31.3
Ecstasy type substances	7,577	7,388	7,539	+ 2.0
Heroin	12,965	13,674	16,402	+ 20.0
LSD	131	152	229	+ 50.7

Source: compiled from Standard Table by J. Corkery

The quantity of cannabis plants seized increased substantially, as did LSD and amphetamines (Table 10.2).

*Table 10.2: Quantity of seizures of drugs by law enforcement agencies in the United Kingdom, 2003 to 2005*

Drug	Unit measure for quantities	2003	2004	2005	% change from 2004
Amphetamines	Kg	1,626	1,389	2,330	+ 57.7
Cannabis – herbal	Kg	29,412	21,496	20,650	- 3.9
Cannabis – resin	Plant	65,379	64,920	50,395	- 22.4
Cannabis plants	Kg	83,972	95,103	212,971	+ 124.0
Cocaine	Kg	7,773	4,644	3,862	- 16.8
Crack	kg	253	135	58	- 57.0
Ecstasy type substances	tablet (000s)	7,435	4,991	3244	- 35
Heroin		2,732	2,260	1,970	- 12.8
LSD	dose (000s)	50	23	131	+ 469.6

Source: compiled from Standard Table by J. Corkery

In Scotland, police have closed more than 66 cannabis factories in the last 12 months. Each drug factory, set up in either homes or business properties, was capable of housing up to 1000 plants and producing around €150,000 worth of cannabis (Internal communication September 2007, The Scottish Crime and Drug Enforcement Agency).

#### Research

Morgan *et al.* (2006a), looking at the association between availability of heroin and methadone and fatal poisoning in England and Wales between 1993 and found that trends in fatal heroin poisoning closely track heroin seizures. They suggest that this lends support for the thesis that seizure data may be indicators of drug availability.



## 10.4 Price/purity

### 10.4.1 Price of drugs at street level

Drug prices in the United Kingdom come from a number of sources. Law enforcement agencies<sup>221</sup> collect national data on drug prices while the Independent Drug Monitoring Unit (IDMU)<sup>222</sup> survey festival goers. DrugScope conduct a random snapshot of drug prices in different areas of the United Kingdom but do not compile a national average<sup>223</sup>.

Pudney *et al.*'s (2006) report on estimating the size of the illicit drug market suggests that price data in the United Kingdom is underdeveloped and that there is a need for more systematic monitoring of prices.

#### *Mean price of illicit drugs in the United Kingdom*

Data from law enforcement agencies show that the average price of amphetamines, crack, ecstasy and heroin fell in 2006, whilst cocaine and cannabis herb prices remained stable (Table 10.3)

*Table 10.3: Law enforcement agencies: Mean price of illegal drugs in the United Kingdom, 2003 to 2006*

Drug (price per gram)	2003	2004	2005	2006
	Exchange rate: €1.4246* = £1	Exchange rate: € 1.4401* = £1	Exchange rate: € 1.4725* = £1	Exchange rate: € 1.486* = £1
Amphetamines	£9.00	£8.00	£10.00	£9.00
	€12.82	€11.52	€14.73	€13.37
Cannabis herb	£2.54	£2.54	£2.64	£2.68
	€3.62	€3.66	€3.89	€3.98
Cannabis resin	£2.32	£2.00	£1.94	£2.12
	€3.31	€2.88	€2.86	€3.15
Cocaine	£55.00	£51.00	£49.00	£49.00
	€78.35	€73.45	€72.15	€72.81
Crack (per 0.2g)	£19.00	£18.00	£19.00	£18.00
	€27.07	€25.92	€27.98	€26.75
Ecstasy**	£5.00	£4.00	£4.00	£3.00
	€7.12	€5.76	€5.89	€4.46
Heroin	£62.00	£55.00	£54.00	£52.00
	€88.33	€79.21	€79.52	€77.27
LSD	£3.00	£3.00	£3.00	£3.00
	€4.27	€4.32	€4.42	€4.46

\*Conversion rates are the monthly rates quoted by the Bank of England (December monthly averages – spot exchange rate) Euro to Sterling. The source data in pounds (£) are provided in whole pounds.

\*\* Average price per tablet

Source: Law Enforcement Agencies

<sup>221</sup> Seizures by police and HM Customs and Revenue

<sup>222</sup> IDMU is an independent commercial research organisation conducting research including surveys of drug users. They estimate drug prices by distributing random questionnaires at pop festivals combined in recent years with a web-based survey.

<sup>223</sup> Information collected by journalists from Druglink, the organisation's magazine, who call drug services and police forces in 20 areas of the United Kingdom.

Average prices from the IDMU show similar trends with cannabis and LSD prices having remained stable and amphetamine and ecstasy prices falling. Cocaine prices, however, continued to fall in 2006 (Table 10.4)

Heroin and crack prices are difficult to estimate accurately as they are often sold in 'bags' or 'rocks', which have been estimated to weigh 0.2g. However, gram sale prices of crack reported by a small number of individuals in the IDMU survey are considerably lower than those based on bag or rock prices; the average price for a gram of crack in 2006 in rock prices is €131.81 compared to €68.60 for a gram sold as a gram. This suggests that a rock of crack may be greater than 0.2g and is supported by laboratory analysis estimating the average weight to be around 0.3g (L. King personal communication).

*Table 10.4: Independent Drug Monitoring Unit: Mean price of drugs at street level 2004 to 2006*

Drug (price per gram)	2004	2005	2006
	Exchange rate: € 1.4401* = £1	Exchange rate: € 1.4725* = £1	Exchange rate: € 1.486* = £1
Amphetamines	£10.19	£9.37	£8.97
	€14.67	€13.80	€13.33
Cannabis herb***	£5.69	£5.92	£5.74
	€8.19	€8.72	€8.53
Cannabis resin	£2.83	£2.70	£2.62
	€4.08	€3.98	€3.89
Cocaine	£45.27	£46.24	£43.18
	€65.19	€68.09	€64.17
Crack (per g)	£83.52	£145.66	£89.85
	€120.28	€214.48	€133.52
Ecstasy**	£3.59	£3.44	£3.03
	€5.17	€5.07	€4.50
Heroin	£54.74	£69.08	£54.99
	€78.83	€101.72	€81.72
LSD	£3.95	£3.90	£3.74
	€5.69	€5.74	€5.56

\*Conversion rates are the monthly rates quoted by the Bank of England (December monthly averages – spot exchange rate) Euro to Sterling. The source data in pounds (£) are provided in whole pounds.

\*\*Average price per tablet

\*\*\*sinsemilla

Source : Independent Drug Monitoring Unit

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

Information on the purity of drugs and composition of tablets is from the Forensic Science Service Ltd, covering most of England and Wales. Latest data are for 2006 and are shown in Table 10.5. Potency of cannabis resin fell to 2004 levels after a rise in 2005 and potency of herbal cannabis fell close to 2003 levels. The purity of heroin fell, though not by much and there has been no clear long-term trend since at least 1984. Purities rise and fall almost randomly over short (months) and longer periods (1 to 2 years) with the long-term mean around 40 to 45 per cent for heroin (L. King - personal communication in 2006). Purity of ecstasy, cocaine and crack dropped considerably in 2006 while there was a small drop in the mean purity of brown heroin.

Research suggest states that while average purity of cocaine seized by police has fallen, purity of cocaine seized by HM Revenue and Customs has remained stable,

suggesting increased adulteration within the United Kingdom (Government internal communication).

Table 10.5: Street level mean percentage purity of drugs in the United Kingdom, 2003 to 2005

Drug*	Year			
	2003	2004	2005	2006
Amphetamines	10.8	9.0	10.1	10.6
Cannabis resin	9.8	3.4	5.3	3.3
Cocaine	51.2	42.4	42.7	34.5
Crack	69.6	63.7	64.8	49.5
Ecstasy	64.5	66.7	66.3	48
Herbal Cannabis	10.7	12.7	13.5	11.3
Heroin (brown)	32.7	39.9	46.5	43.5
Heroin (white)	-	50.0	-	

\*For cannabis products the % THC content is shown; for ecstasy mg of MDMA base per tablet/unit is shown; and for other illicit drugs the % of pure substance is shown.

Source: Forensic Science Service Ltd 2006

#### 10.4 Estimating the size of the United Kingdom illicit drug market

A study by Pudney *et al.* (2006) estimated the size of the illicit drug market in the United Kingdom to be £5.3 billion (€7.7 billion<sup>224</sup>) in 2003/04, with a wide margin of error of £4.0 billion (€5.8 billion) to £6.6 billion (€9.6 billion)<sup>225</sup>. The estimate was based on six categories of illicit drugs; cannabis, amphetamines, ecstasy, powder cocaine, crack and heroin. It found that:

- crack and heroin accounted for the largest expenditure share, 28 per cent and 23 per cent respectively;
- cannabis and cocaine accounted for about a fifth each; and
- in volume terms the cannabis market was by far the largest, 20 times the volume of the heroin market.

The authors estimated that 59 per cent of the market (by expenditure) is attributable to adult arrestees, 32 per cent to other adults and nine per cent to juveniles. Cannabis, cocaine and ecstasy were dominant in the general adult population whilst crack, heroin and amphetamines were common amongst the arrestee population.

The Scottish Government has commissioned research to assess the scale and impact of illicit drugs in Scotland. One part of this will aim is to produce an initial estimate of the size/value of the illicit drug markets in Scotland.

<sup>224</sup> Bank of England annual spot exchange rate, 1 April 2003 – 30 March 2004.

<sup>225</sup> The study used a survey-based demand side approach to estimate market size. Data from the Schools Survey 2003, the Offending Crime and Justice Survey 2003 and the Arrestee Survey 2003-04 were analysed to estimate the prevalence of drug use, frequency of use quantity used and expenditure on drugs by juveniles, the general adult population and adult arrestees. Estimates of price and quantities were compiled from a number of sources including NCIS price data and FSS purity data. The estimate was based on data sources for England and Wales and extrapolated to the United Kingdom as a whole.

## **PART B: SELECTED ISSUES**

### **SUMMARY**

#### **Public expenditures**

Labelled expenditure on drugs in the United Kingdom is collected at a national level and provides a good indication of government spend. However, much of the expenditure data is aggregated at programme level and, without a detailed interrogation of local expenditure documents, it is difficult to classify using broad headings. In 2005/06, labelled expenditure in the United Kingdom is estimated at €1.5 billion. Using a number of sources, it is possible to identify and estimate attributable proportions of unlabelled expenditure across multiple government functions such as health, public order and safety, social protection and education. Estimated unlabelled expenditure for 2005/06 is €7.3 billion, two-thirds of which is public order and safety expenditure with almost a quarter (24%) spend on child and family social work. Estimated overall expenditure is €8.7 billion which amounts to 0.48% of GDP or €144.43 per capita.

#### **Vulnerable groups of young people**

There is a wealth of evidence to suggest that vulnerable young people, including looked after children, children of drug using parents, homeless youth, young offenders, school excludees and truants, those involved in commercial sex work and those from some black and minority ethnic groups, are more likely to use drugs than those not described as vulnerable. As in the general population cannabis remains the most used drug, and amongst the very young, volatile substances. While such young people are also at higher risk of being problematic drug users, evidence suggests use of heroin, crack and cocaine remains low. Drug use is often one of many problems associated with vulnerable youth, many of whom belong to more than one group. Therefore, while current drug strategies in the United Kingdom focus on the needs of these young people, policies on drug misuse are linked to wider programmes to meet the needs of the young, and to ensure that they are provided with appropriate interventions. These are focused around integrated working between services at the local level to plan interventions, and the development of a common framework for assessing need, used by all professionals in contact with the young. Early intervention strategies are becoming more common, particularly those that target families, rather than the child in isolation.

#### **Drug-related research**

An underlying principle of drug strategy in the United Kingdom is that it should be evidence based. The overwhelming majority of drug research is funded through Government. Examples of research informing drug policy by providing an evidence base predate current strategies, for example, the Task Force responsible for the a review of the effectiveness of drug treatment commissioned a number of pieces of research, which led to an understanding of the effectiveness of treatment and the major policy initiative to substantially increase treatment capacity. Research is often undertaken to address specific gaps in knowledge, such as research into estimating the number of problem drug users. Research into the effectiveness of prevention programmes has been funded and one of the largest education research programmes ever run aims to design, deliver and evaluate school prevention (Blueprint).

## Chapter 11 Public expenditures

This chapter has been written to provide information to the EMCDDA on a basis which will be as consistent as possible with that obtained by the other European National Focal Points. The aim of this is to enable the EMCDDA to report on drug-related expenditure across Europe in a document to be published in 2008. The chapter therefore follows, as far as practicable, detailed guidelines established by the EMCDDA. A full and comprehensive study obtaining, for example, information from local agencies would be beyond the resources of the UK Focal Point. The figures presented should therefore, in many cases, be taken as indicative estimates and not definitive. Furthermore, they do not necessarily represent the most appropriate way of presenting the information for national purposes.

The chapter distinguishes between labelled and unlabelled expenditure. Labelled expenditure is spend included in budget and/or year-end reports that is drug-specific, and is proactive in that it is linked to the achievement of specific policy aims. Unlabelled expenditure, conversely, is often reactive with spend arising as a consequence of drug use. This includes policing, prison accommodation and some health consequences. However, unlabelled spend can also be proactive such as expenditure related to providing drug education in schools. For the purposes of this chapter, labelled spend relates to drug-related expenditure with a departmental budget line that is drug specific while unlabelled spend relates to non-drug specific expenditure where a proportion may be attributable to drug use. The distinction between proactive and reactive spend, used in previous United Kingdom cost research, is not made in this chapter.

### 11.1 National estimates of LABELLED drug-related expenditures

In the United Kingdom, responsibility for the drug strategy lies with a number of departments with the Home Office providing the overall lead. Devolution of powers to the administrations in Northern Ireland, Scotland and Wales means it is increasingly difficult to produce a United Kingdom estimate of drug-related expenditure. This is compounded by devolution of spend to the local level across the United Kingdom.

Her Majesty's Treasury breaks down government spend using the Classification of the Functions of Government<sup>226</sup> (COFOG) categories (see 11.2.1). However, no information is available on how each individual drug-related expenditure item (listed in Table 11.1) is classified using COFOG. The monitoring of United Kingdom drug-related expenditure is often linked to programme expenditure which presents difficulties when trying to disaggregate programme components into COFOG categories. This is also true of attempts to categorise expenditure using Reuter's classification of drug-related programmes as primarily enforcement, harm reduction, prevention or treatment programmes (Reuter 2006).

#### 11.1.1 Results and analysis of national drug-related expenditure

Table 11.1 presents national labelled drug-related expenditure for the United Kingdom financial year 2005/06. This covers the period from 1st April 2005 to 31st March 2006. As mentioned above, expenditure is monitored for individual programmes and funding streams. Consequently it is difficult to combine data from across the United Kingdom to provide a simplified table of drug-related expenditure.

<sup>226</sup> For further information see: <http://unstats.un.org/unsd/cr/registry/regcst.asp?Cl=4>

Table 11.1 shows that in 2005/06 labelled drug-related expenditure amounted to €1465.1million (£1001.5m).

*Table 11.1: Labelled drug-related expenditure in the United Kingdom, 2005-06 classified by COFOG and Reuter*

Expenditure	€m	£m	COF OG	Reuter
<b>England</b>				
Local Mainstream Funding	298.4	204	07.2	Treatment
Pooled Treatment Budget (includes 23.1m transfer to YPSMG)	437.4	299	07.2	Treatment
National Treatment Agency central costs	15.9	10.9	01.1	Treatment
YPSMPG (Young People Substance Misuse Partnership Grant)	63.6	43.5	07.2	Prevention
High Focus Areas	1.8	1.2	10.7	Prevention
Drug strategy administration (HO)	13.0	8.9	01.1	
Blueprint	1.8	1.2	09.7	Prevention
Drugs Intervention Programme (DIP) (including capital)	209.2	143.0	03.6	Treatment/Harm reduction
FRANK	9.1	6.2	09.5	Prevention
Drug Prevention Advisory Service Dowry	7.0	4.8	09.5	Prevention
Partnership Support Funds	16.5	11.3	01.5	Prevention
Pompidou Group	0.3	0.2	01.1	Harm reduction
Positive Futures	8.5	5.8	10.7 10.9	Prevention
Home Office programme management. & capacity building	1.5	1.0	01.5?	Prevention
Research & Monitoring	8.9	6.1	01.5	
Prison area co-ord/HQ staff	2.2	1.5	03.4	Enforcement
Prison capital	1.0	0.7	03.4	Enforcement
Prison clinical services	16.5	11.3	03.4	Treatment
Prison treatment	28.4	19.4	03.4	Enforcement
Prison CARATS (Counselling, Assessment, Referral, Advice and Throughcare Services)	39.1	26.7	03.4	Treatment/Harm Reduction
Voluntary testing in prisons	15.2	10.4	03.4	Enforcement
Supply reduction in prisons	9.1	6.2	03.4	Enforcement
Drug testing on license	1.6	1.1	07.2	Enforcement
Drug Treatment & Testing Orders/ Drug Rehabilitation Requirement	61.4	42.0	07.2	Treatment
Prospect programme	4.5	3.1		Enforcement
Youth Justice Board custody	10.2	7.0	03.4	Enforcement
Youth Justice Bd. Resettlement Prog.	18.3	12.5	03.4	Treatment
Overseas drug-related assistance	8.8	6.0	01.2	Enforcement
<b>England total</b>	<b>1309.3</b>	<b>895.0</b>		
<b>Northern Ireland</b>				
Allocation to DACTs	1.0	0.7		Treatment/Prev'n
Allocation to regional projects	2.3	1.6		
Allocation to Local Action Plan Projects	2.6	1.8		Treatment/Prev'n
Substitute prescribing allocation	1.3	0.9	07.1	Treatment
Policy development/research	0.3	0.2	07.5	
Public information campaigns	0.3	0.2		Prevention
Needle and Syringe Exchange Scheme	0.1	0.1	07.4	Harm reduction
Youth counselling services	0.9	0.6		Harm Reduction
Dual diagnosis	0.3	0.2	07	Treatment
Other expenditure	0.6	0.4		
<b>Northern Ireland total</b>	<b>9.8</b>	<b>6.7</b>		



<b>Scotland</b>				
Treatment Programmes	34.7	23.7	07.2	Treatment
GP Training on Drugs	0.6	0.4		Treatment
Research & Statistics	0.9	0.6		
Education	1.3	0.9	09.5	Prevention
Arrest Referral	0.7	0.5		Enforcement
Drug Courts	2.8	1.9	03.1	Enforcement
DTTOs	10.5	7.2	07.2	Treatment
Time Out drug centre for women drug offenders	2.5	1.7		Treatment
DAT Association and Support	2.3	1.6		
Scottish Crime and Drug Enforcement Agency	37.3	25.5		Enforcement
Scottish Drug Forum	0.7	0.5	07.1	Treatment
Scotland Against Drugs	2.2	1.5		
<b>Scotland total</b>	<b>97.6</b>	<b>66.7</b>		
<b>Wales</b>				
Revenue allocations to Community Safety Partnerships	13.6	9.3		Treatment/Prevention/Harm Reduction/Enforcement
Capital allocations to CSPs	4.4	3.0		
Central initiatives/pilot projects	3.5	2.4		Treatment/Prevention/Harm Reduction/Enforcement
Policy development, implementation & training	1.2	0.8		
Local Health Board ring-fenced funding	13.0	8.9	07.2	Treatment
Drug Interventions Programme	7.3	5.0		Treatment
Social Housing Grant Programme	2.9	2.0	10.6	Harm Reduction
Drug testing on charge	1.2	0.8		Enforcement
Operation Tarian	1.3	0.9		Enforcement
<b>Wales total</b>	<b>48.4</b>	<b>33.1</b>		
<b>United Kingdom total</b>	<b>1,465.1</b>	<b>1,001.5</b>		

\* Bank of England annual average spot exchange rate 1 April 2005 to 31 March 2006 1.4629

Source: Figures provided by government departments

Drug misuse services often do not stand in isolation and form part of many publicly funded programmes including education and crime reduction and other services that could provide support to problem drug users. In recognition of the need to resource these programmes to respond to drug misuse, the Government has made specific contributions towards national budgets for public services. For example, in England, the 2001 Budget allocated €28.9 million (£20m) additional funding for 2003/04 in recognition of the need for extra support for job seekers who are problem drug users (Cabinet Office 2001). While this activity continues, there is no requirement to report how much of the Jobcentre Plus expenditure is directed exclusively towards meeting the needs of problem drug users and therefore we are unable to include the figures in the analysis of labelled spend above.

This means that comparison with drug expenditure figures reported in previous Focal Point reports (i.e. a total of £1,483 million (€2,169 million) for 2005/06) is difficult as the current analysis relates only to labelled drug-specific expenditure identified as such in departmental accounts. Furthermore, in addition to expenditure such as the Jobcentre funding above and similar funding such as regeneration monies, Table 11.1 excludes estimated expenditure of €549 (£380m) (figure for 2003/04) for proactive supply reduction activities by United Kingdom enforcement agencies

(Cabinet Office 2001). This is due to the fact that drug-related work by enforcement agencies is often part of wider objectives and the drug-related expenditure is not always readily identifiable within departmental accounts.

#### *COFOG classification*

Where possible labelled drug-related expenditure has been classified using COFOG categories. The majority of expenditure is categorised under COFOG 03 Public order and safety and COFOG 07 Health but there is also significant spending under the 1<sup>st</sup> level categories of 01 General Public Services (mainly research & development), 09 Education and 10 Social Protection.

As expenditure is often programme or funding stream based, it can be categorised under a number of headings. For example the Young People's Substance Misuse Partnership Grant (YPSMPG) in England is funded by the Home Office, Department of Health, Department for Children, Schools & Families (formerly known as the Department for Education and Skills), and the Youth Justice Board and funds activities such as prevention, education, support and advice services and treatment. Monies are distributed amongst local partnerships throughout England and can be used by them to finance a number of activities to address local needs.

Similarly in Wales national expenditure is recorded at the level of allocations to Community Safety Partnerships (CSPs). CSPs are responsible for tackling substance misuse and delivering substance misuse local action plans (including alcohol). Spending is determined at a local level and the classification of drug-related expenditure is only possible by examining budgetary documents at a local level, far beyond the resources available to the UK Focal Point for completion of this chapter. Similar problems are encountered when examining spend in Northern Ireland.

See 11.1.2 for discussion of local spending by partnerships.

#### *Reuter classification*

Using Reuter's classification where possible (Reuter 2006), the majority of drug-related expenditure is for treatment followed by enforcement, prevention and harm reduction. Although harm reduction features less explicitly than the other classification, it is often part of programmes or funds with other primary aims.

Similar difficulties to the COFOG categorisation are encountered using Reuter's taxonomy of drug-related spend. Local Action Plan expenditure in England contains elements of treatment, prevention and harm reduction, which are difficult to disaggregate. Furthermore, some expenditure such as research and information, policy and strategy and overseas drug-related assistance cannot be classified under the four programme division without detailed examination of each project.

#### **11.1.2 Breakdown of local expenditure**

National spend is often grouped by programme or funding stream making it difficult to disaggregate the different elements. As expenditure is based on local needs and priorities, a substantial amount of programme expenditure is delegated to a local level where agencies have discretion over expenditure decisions and monitoring requirements are kept to a minimum wherever possible. This means that collation of a detailed breakdown of labelled spend by COFOG categories or by Reuter's drug programme divisions would only be possible by placing additional burdens on local agencies.

*England*

In England local Drug and Alcohol Area Team (DAAT) partnerships are required to provide expenditure documents to the National Treatment Agency (NTA), who are responsible for performance management issues. These documents are not publicly available and, at a national level, spend is assumed to be equal to allocation. While it is possible to break down monies allocated under the pooled treatment budget (PTB) to the level of treatment type, data on local mainstream funding spend is not available centrally. Some DAATs may publish financial breakdowns at their own discretion. For example a breakdown of 2005/06 spend by Staffordshire County DAAT appends the Staffordshire Police Authority Reform and Management Committee Report (Staffordshire Police Authority 2006). This contains expenditure broken down to include pharmacy fees, education costs, needle exchange costs and user involvement costs. Given the level of aggregate in the national data we are placing the entirety of the expenditure against COFOG 07.2 and Reuter "Treatment" but this example illustrates some of the limitations of the analysis we are able to prepare in the United Kingdom.

*Scotland*

Each local Alcohol and Drug Action Team (ADAT) partnership is required to submit to the Scottish Executive an annual plan for tackling drug misuse in their area. These corporate action plans are available on the Drug Misuse Information Scotland website<sup>227</sup> and contain previous year's expenditure broken down under three headings: drug services; alcohol services; and drug and alcohol services. By examining these local documents it is possible to allocate expenditure more accurately to the COFOG or Reuter classifications.

*Wales*

In April 2003, a ring-fence for substance misuse services was introduced at 0.4 per cent of the Local Health Board's (LHB) discretionary allocation. An Audit Commission Review of NHS Substance Misuse Treatment Services encountered difficulties in discovering the actual expenditure of LHBs on substance misuse. The final report recommended the introduction of a formal framework to identify substance misuse expenditure (WAG 2004a). As yet this has not happened and the figure contained in Table 11.1 refers to the value of the 0.4 per cent ring-fenced allocation. However, there are wide variations in substance misuse spending, with some LHBs spending much more than 0.4 per cent and some possibly less (WAG 2004b). The requirement to account for LHB substance misuse spending will possibly be resurrected following a change of government.

## **11.2 Attributable proportion definitions of NON-LABELLED drug –related expenditure**

### **11.2.1 Overall national health and law enforcement expenditures**

HM Treasury collects annual data on government expenditure by COFOG functions (HM Treasury 2007) and makes it publicly available on the HM Treasury website.<sup>228</sup> Data are presented at both 1<sup>st</sup> and 2<sup>nd</sup> level, however the level of detail required for 2<sup>nd</sup> level health expenditure is not available. Data in Table 11.2 are from 2005/06.

<sup>227</sup> See <http://www.drugmisuse.isdscotland.org/dat/cap/dat.htm>

<sup>228</sup> See [http://www.hm-treasury.gov.uk/economic\\_data\\_and\\_tools/finance\\_spending\\_statistics/pes\\_publications/pespub\\_pesa07.cfm](http://www.hm-treasury.gov.uk/economic_data_and_tools/finance_spending_statistics/pes_publications/pespub_pesa07.cfm)

Table 11.2: Total government expenditure in the United Kingdom, 2005/06 by COFOG functions 3: Public Order and Safety and 7: Health

COFOG Function	€m	£m
3. Public order and safety	42,862	29,299
3.1 Police services	2,693	1,841
3.3 Law courts	9,074	6,203
3.4 Prisons	5,234	3,578
7. Health	129,791	88,722

Source: HM Treasury (2007)

### 11.2.2 Attributable proportions of non-labelled drug-related expenditure – Public order and safety

By looking at various data sources and research, it is possible to provide a rough estimate of some of the expenditure by government on drugs and the consequences of drug use.

#### *Police services*

Since 2003/2004, it is mandatory for each police force in England and Wales to submit annual Activity Based Costing (ABC) data to the Home Office<sup>229</sup>. This uses the financial overrun for any year and sets it against activity data and management information. The data can give an indicative estimate of both the direct and indirect cost of policing drugs. During 2005/06, the direct cost of drugs offences using ABC data is estimated at €539.7 (£368.9m).

The indirect police costs of drug-related crime are more difficult to estimate but are, nevertheless, important as they account for a large amount of government expenditure related to drugs. Furthermore, such crimes act as a trigger for spend related to labelled costs, such as probation orders with treatment conditions, for example Drug Treatment and Testing Orders or Drug Rehabilitation Requirements (DTTOs/DRRs).

Using the ABC data, which lists expenditure against incident codes, in combination with survey data that provides evidence of the link between drugs and crime, an estimate of the indirect costs of policing drugs can be generated. The main surveys used are:

- Arrestee Survey 2003/04: the proportion of those arrested for each type of offence that reported taking heroin, crack or cocaine in the last 12 months (Boreham *et al.* 2006).
- NEW-ADAM: the proportion of those arrested for each type of offence that reported taking heroin, crack or cocaine in the last 12 months (Holloway and Bennett 2004).
- British Crime Survey 2005/06: the proportion of victims that believed the offender to be under the influence of drugs (Walker *et al.* 2006).

Where survey data is not available, subjective judgements by a senior member of the Association of Chief Police Officers (ACPO) have been provided. Table 11.3 sets out the proportions against incident and provides the source of the estimate.

<sup>229</sup> For further information see: <http://police.homeoffice.gov.uk/finance-and-business-planning/index/> and [http://police.homeoffice.gov.uk/news-and-publications/publication/finance-and-business-planning/ABC\\_Manual\\_of\\_Guidance\\_v2\\_21.pdf?view=Binary](http://police.homeoffice.gov.uk/news-and-publications/publication/finance-and-business-planning/ABC_Manual_of_Guidance_v2_21.pdf?view=Binary)

Table 11.3: Estimates of the proportion of criminal activity that is drug-related in England and Wales

Incident	% Drug-related	Source
Violence against the person – S20	23	BCS 05/06
Violence against the person – S47	23	BCS 05/06
Sexual offences	9	Arrestee Survey 03/04
Burglary - dwelling	63	Arrestee Survey 03/04
Burglary - commercial	63	Arrestee Survey 03/04
Robbery	35	NEW-ADAM survey
Theft of/or from motor vehicle	26	NEW-ADAM survey
Deception/fraud	28	NEW-ADAM survey
Theft other	41	Arrestee Survey 03/04
Criminal damage	27	Arrestee Survey 03/04
Other crime	34	Arrestee Survey 03/04
RTC fatal/serious	5	Subjective estimate
RTC minor injury/damage	5	Subjective estimate
Public disorder	29	Arrestee Survey 03/04
Sudden/suspicious death	5	Subjective estimate
Complaint/nuisance	10	Subjective estimate
Prostitution	60	Subjective estimate
Intelligence research/analysis	50	Subjective estimate
Maintaining and developing partnerships	20	Subjective estimate
Community involvement	20	Subjective estimate
Domestic dispute	10	Subjective estimate

This puts the indirect costs of drug-related police work in England at €2.3 (£1.6 billion). Added to the direct costs, the overall police expenditure for 2005/06 is an estimated €2.9 (£2.0 billion).

In Scotland, grant aided expenditure (GAE) for police spend in 2005/06 was €1.5 billion (£1 billion) (Scottish Executive 2006d). In a review of expenditure in Scotland (Scottish Executive, 2000) anecdotal police reports estimated that 30 per cent of all recorded crime was drug-related. This appears to be consistent with England and Wales and will be used here as an estimate of the direct and indirect costs of drug-related police work. This puts estimated expenditure at €440.5m (£301.1m).

In Northern Ireland during 2005/06 total revenue spend was €1,254.9m (£857.8m) (PSNI 2006). No national estimates of drug-related police costs are available and, given the relatively large spend by the police force and the lower estimates of problem drug use, it would be inappropriate to use the same method for estimation as for Scotland or to extrapolate from England and Wales.

The total estimated unlabelled police expenditure for the United Kingdom is €3.4 billion (£2.3 billion).

#### Law courts

Her Majesty's Court Service (HMCS) is responsible for managing the magistrates' courts, the Crown Court, county courts, the High Court and Court of Appeal in England and Wales. The Scottish Court Service and the Northern Ireland Court Service are responsible for the administration of courts in Scotland and Northern Ireland respectively. It is not possible to estimate expenditure by looking at annual accounts for these agencies as there is a lack of information on which to base assumptions.

In 1999, however, the Home Office published research on the cost of criminal justice which estimated the average cost per person proceeded against in the courts (including sentence). This figure includes costs to all criminal justice agencies such as the Legal Aid Board and Crown Prosecution Service (Home Office 1999). Up-rating for inflation<sup>230</sup>, it gives a cost of €4,794 (£3277) for 2005/06.

Using the proportion of crime attributed to drugs (as above) and data on receptions to prisons, a rough estimate can be made. This is likely to be a large underestimate as it includes only those found guilty and receiving a custodial sentence. Table 11.4 shows that, in 2005/06, there were 35,679 receptions in the United Kingdom that may be attributable to the use or selling of drugs. Assuming all receptions have a court case attached, estimated expenditure on courts is €171m (£116.5m) for 2005-06.

Table 11.4: Receptions to prison attributable to drugs in the United Kingdom, 2005-06

Country	Receptions to prison
England and Wales	30,846
Scotland	4,291
Northern Ireland	542
Total	35,679

Source: Home Office (2006d), Scottish Executive (2006d), NIO (2006b)

### Prisons

Data on the average daily adult prison population by offence is available across the United Kingdom. Table 11.5 shows expenditure in 2005/06 on adult prisoners sentenced for drug offences using the annual cost of a prisoner place. Data from England and Wales and Scotland is a cross-sectional analysis of those in custody at 30<sup>th</sup> June 2005 assuming the proportion remains similar throughout the year. Data from Northern Ireland uses the average daily population in 2005. The total expenditure for 2005/06 is estimated at €535.9m (£366.3m).

It is not possible to estimate expenditure based on annual receptions to prison and average sentence length although these data are available. This would require detailed information on date of reception and historical data on prisoners possibly dating back a large number of years.

Table 11.5: Expenditure on accommodating drug offenders in prison in the United Kingdom, 2005-06

Prison population	Cost (€)	Cost (£)
<b>England and Wales</b>		
Sentenced	414,471,397	283,321,756
Remand	68,925,768	47,115,844
<b>Scotland</b>		
930 custody x £30,338	41,274,758	28,214,340
472 fine x 10 days at £83.25 per day	57,486	39,296
<b>Northern Ireland</b>		
57 custody and 31 remand x £85, 935	11,062,859	7,562,280

Source: Home Office (2006d), Hansard 8<sup>th</sup> May 2007 Column 87W, Scottish Executive (2006e), Scottish Prison Service (2006), NIO (2006a; 2006b)

<sup>230</sup> Using HM Treasury's GDP deflator. See: [http://www.hm-treasury.gov.uk/economic\\_data\\_and\\_tools/gdp\\_deflators/data\\_gdp\\_fig.cfm](http://www.hm-treasury.gov.uk/economic_data_and_tools/gdp_deflators/data_gdp_fig.cfm)



The proportion of non-drug offences attributable to drugs has been calculated using the same data sources for police costs (see above). While these data sources relate to England and Wales, the same proportions have been used to calculate expenditure in Scotland and Northern Ireland.

In England and Wales expenditure on prison places for those convicted/suspected of non-drug offences which can be attributed to drug use is €784.3 (£536.1m). This assumes an average of 18,819 prisoners throughout the year. In Scotland the estimated expenditure is €64.5m (£44.1m), while in Northern Ireland the figure is €31.9m (£21.8m). The total United Kingdom expenditure for non-drug offences is €880.7m (£602m).

The total estimated figure for prison expenditure attributable to drugs is €1,416.5m (£968.3m).

### 11.2.3 Attributable proportions of non-labelled drug-related expenditure – Health

#### *Medical products, appliances and equipment*

Expenditure on injecting paraphernalia in Northern Ireland is labelled while spend in England and Wales is decided locally and can be funded by local Primary Care Trust (PCT) mainstream funding, LHB ring-fenced funding and additional NHS monies. In Scotland in 2005/06, €12.3m (£8.4m) was supplied for blood-borne virus prevention work, which could include needle exchanges but spend is not broken down further and additional monies could be spent<sup>231</sup>. The spend on Hepatitis B and C vaccination and testing are not available.

Methadone prescribing costs are included in the PTB for England. In Scotland for 2005-06 expenditure on methadone prescribing was €17.8m (£12.2m).

#### *Primary care services*

Godfrey *et al.* (2002) estimate the cost of GP visits by problematic drug users using data from the National Treatment Outcomes Research Study (NTORS). However, the study does not determine whether the visit was drug-related nor does it compare the figure with the average GP visit by non-drug users. Therefore estimates of GP costs are not included here.

#### *Outpatient services*

Expenditure for outpatient service use as a consequence of drug misuse are not available.

#### *Acute inpatient hospital services*

Hospital statistics for inpatient episodes<sup>232</sup> are collected for England, Northern Ireland, Scotland and Wales by diagnosis using the International Classification of Diseases 10<sup>th</sup> revision (ICD-10)<sup>233</sup> codes. However, data is published differently for each country. Data for Northern Ireland were provided by DHSSPSNI and for Wales by Health Solutions Wales.

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<sup>231</sup> See: <http://www.scottish.parliament.uk/business/pqa/wa-07/wa0222.htm>

<sup>232</sup> Caution must be taken when interpreting these statistics as one patient may have a number of episodes attached to their hospital stay.

<sup>233</sup> See: <http://www.who.int/classifications/apps/icd/icd10online/>

Data presented here are likely to be an underestimate of the true costs to the health service of drug use as they relate only to inpatient stays.

#### *Drug misuse diagnosis*

Hospital episode statistics (HES) in England are published on the HES website<sup>234</sup> and provide data on primary diagnosis at four digit code level. Data also include information on emergency admissions and the number of bed days. Admissions due to drug misuse are recorded using ICD-10 codes F11 to F19 (excluding F17). Table 11.6 shows that in 2005/06 there were 4,905 finished episodes where drug misuse was the primary diagnosis resulting in 92,875 bed days, an average of 5.3 per episode. The data excludes codes ending .2 as these are likely to be treatment inpatients and may be funded by labelled expenditure. A unit cost of €342 (£234) per bed day and €113 (£77) for a lower cost A&E entry (Curtis and Netten 2006) for those admitted as an emergency gives an overall estimated cost of €32.2 million (£22m). This is likely to be a large underestimate as it includes only those whose primary diagnosis is drug misuse and would exclude, for example, a patient presenting with a wound infection caused by intravenous drug use.

*Table 11.6: Finished hospital episodes with a primary diagnosis of drug misuse in England 2005/06*

Primary diagnosis	Finished episodes	Emergency	Bed days
Mental & behavioural disorders due to psychoactive substance use			
F11 Opioids	846	63%	8,680
F12 Cannabinoids	976	83%	22,104
F13 Sedatives or hypnotics	106	80%	1,429
F14 Cocaine	329	91%	1,788
F15 Other stimulants	404	76%	5,818
F16 Hallucinogens	104	91%	770
F18 Volatile substances	23	87%	613
F19 Multiple drugs or other	2,117	80%	51,673

Source: The Information Centre (2007a)

Data from Scotland provide information on episodes with a diagnosis of drug misuse in any position at the three digit code level and could therefore include those in hospital for drug treatment. In 2005/06 there were 5,015 inpatient discharges with a diagnosis of drug misuse (ISD Scotland 2006). Using available cost data for speciality group cases<sup>235</sup>, estimated expenditure for 2005/06 is €15.1m (£10.3m).

<sup>234</sup>

<http://www.hesonline.org.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=537>

<sup>235</sup> See: <http://www.isdscotland.org/isd/costs-book-detailed->

[Tables.jsp?pContentID=3601&p\\_applic=CCC&p\\_service=Content.show&](http://www.isdscotland.org/isd/costs-book-detailed-Tables.jsp?pContentID=3601&p_applic=CCC&p_service=Content.show&)

See:

*Table 11.7: General acute inpatient discharges with a diagnosis of drug misuse by type of admission in Scotland, 2005/06*

Type of admission	Discharges
General medicine	2,831
Cardiology	71
Communicable diseases	240
Respiratory medicine	99
General surgery	296
General surgery (excl. vascular)	315
A & E	227
Anaesthetics	106
Orthopaedics	385
Plastic surgery	45
Gynaecology	46
Other	354
Total	5,015

Source: ISD Scotland (2006)

In Wales, data are available at only the three digit ICD-10 code level and consequently could include treatment episodes covered in labelled expenditure. The data covers all mentions of drug misuse using codes F11 to F19 (excluding F17). In 2005/06 there were 2,136 discharges with a diagnosis of drug misuse with a total of 20,130 bed days, an average of 10.6 per episode. Using English unit costs of €355.5 (£243) per bed day (Curtis and Netten 2006), the total cost is €7.2m (£4.9m). No information on emergency status is available.

In Northern Ireland there were 254 episodes with any diagnosis of drug misuse, a total of 974 bed days. No data, however, is available on the type of admission or the unit cost per bed day.

The total estimated expenditure for the United Kingdom is €54.4m (£37.2m).

#### *Maternity costs*

In England in 2005/06 there were 170 fetus and newborn affected by maternal use of drugs of addiction (ICD-10 code P04.4) and 1,276 recorded with the primary diagnosis of neonatal withdrawal symptom from maternal use of drugs of addiction (ICD-10 code 96.1), with a total of 17,597 bed days (The Information Centre 2007a). At a cost of €629 (£430) per bed day (Curtis and Netten 2006), the overall estimated expenditure for 2005/06 is €11.1m (£7.6m).

In Wales for the same period, there were 22 and 76 respectively with a total of 1,451 bed days at an overall cost of €0.9m (£0.6m) using unit costs at the same level as England. Data for Scotland are for 2004/05 and show 300 neonatal discharges with a diagnosis of ICD-10 codes P04.4 or P96.1. Using average number of bed days and cost data for England, expenditure is estimated to be €1.6m (£1.1m).

Scottish data show that in the period 2004/05 there were 493 maternities for which drug misuse was recorded but there is no cost data on which to base estimates of expenditure consequences for maternity services. This is true across the United Kingdom and consequently expenditure by maternity services is probably an underestimate.

In Northern Ireland in 2005/06 there were six episodes relating to neonatal withdrawal symptom from maternal use of drugs of addiction at a unit cost of €887 (£606) (DHSSPSNI 2007a), giving a total of €5,319 (£3,636).

The total estimated expenditure for the United Kingdom is €13.6m (£9.3m).

### *Poisoning*

Data from England show that in 2005/06 there were 9,968 episodes of poisoning by narcotics or psychodysleptics (ICD-10 code T40), with 98 per cent being emergencies (The Information Centre 2007a). At a reference cost of €667 (£456) per episode (DH 2006b) and assuming emergency cases required paramedic services at €473 (£323) per patient journey, overall expenditure for 2005/06 is €11.3m (£7.7m). In Wales there were 1,256 T40 episodes, with no information available on the proportion that were emergencies, giving an estimated expenditure of €0.9m (£0.6m).

Data from Northern Ireland show that there were 847 episodes with any T40 diagnosis mention, 97 per cent of which were emergencies. Using an average cost of €554 (£379) (DHSSPSNI 2007a) and paramedic costs from English unit cost data, the overall expenditure is €0.9m (£0.6m).

No data are currently available for Scotland.

The total estimated expenditure for the United Kingdom is €13m (£8.9m).

### *Hepatitis C costs*

Estimates in England suggest that 88 per cent of individuals with hepatitis C are current or former IDUs (HPA 2006). Using this proportion, in 2005/06 there were 3,081 inpatient episodes due to chronic viral hepatitis C (ICD-10 code B18.2) and 818 due to acute hepatitis C (B17.1) (The Information Centre 2007a). Using reference costs data and adjusting for different costs for elective and non-elective (calculated as percentage emergencies) total expenditure amounts to €12.4m (£8.5m). In addition, €31.5m (£21.5m) was spent on drugs to treat hepatitis C issued by hospitals (NICE 2007f).<sup>236</sup>

In Wales there were 206 episodes of acute hepatitis C and 462 episodes of chronic viral hepatitis attributable to intravenous drug use assuming 90% of infections were in IDUs (HPA 2006). This puts estimated expenditure at €1.8m (£1.2m) for 2005/06 using reference costs for England.

In Northern Ireland, the proportion of new infections that were IDUs was reported to be 93 per cent in 2005 (HPA 2006). Data from DHSSPS shows that, in 2005/06 there were 128 acute hepatitis C episodes and 54 chronic. Using the same cost adjustments as for England, the overall expenditure is €0.3m (£0.2m) (DHSSPSNI 2007a). There are no data from Scotland.

In 2005/06 there were 60 liver transplants where the primary liver disease was hepatitis C. Using proportions for England (88%) and a Department of Health reference cost of €34,827 (£23,807) (DH 2006b), total expenditure amounts to €2.5m (£1.7m).

Total estimated expenditure for the United Kingdom is €48.4m (£33.1m).

<sup>236</sup> Calculated for 2005/06 using data for 2006 and percentage change on previous year.

### Costs associated with treating HIV-infected individuals

Data on HIV-infected individuals are provided by the Survey of Prevalent HIV Infections Diagnosed (SOPHID)<sup>237</sup> (HPA 2006b). In 2005 there were 1,366 HIV-infected individuals seen for care in the United Kingdom who were current or past IDUs. Research carried out by the British HIV Association (BHIVA) estimates the cost of treating a HIV-infected individual to be €23,406 (£16,000) per year (Aidsmap 2006).<sup>238</sup> This gives an estimated cost of €32m (£21.9m).

#### 11.2.4 Attributable proportions of non-labelled drug-related expenditure – other categories

While much government expenditure is related to health or law enforcement, there are also other important areas of spend such as education and social protection.

### Education

In England, the most recent estimates of teacher time spent on drug education in primary and secondary schools are from 2002 (Ofsted 2002). Using data on the number of pupils and average class sizes, Table 11.8 calculates the total time spent on drug education in England during 2005/06. The estimated cost of teacher time is €0.85 (£0.58) per minute (Jones *et al.* 2007) meaning the total estimated expenditure on drug education in England for 2005/06 amounts to €102.7m (£70.2m)

Table 11.8 Calculation of teacher time spent on drug education in England 2005/06

Year	Nos	No. classes*	Hours spent	Total time spent (hrs)
Reception	800,200	30,426	4	121,704
Year 1	543,600	20,669	5	103,345
Year 2	559,200	21,262	5.5	116,941
Year 3	564,600	21,468	5.5	118,074
Year 4	579,300	22,027	6	132,162
Year 5	544,500	20,703	7	144,921
Year 6	558,100	21,221	9	190,989
Year 7	613,000	28,512	8	228,096
Year 8	573,000	26,651	7	186,557
Year 9	592,700	27,567	9.5	261,887
Year 10	594,400	27,647	8	221,176
Year 11	578,900	26,926	6.5	175,019
Year 12 & 13	188,200	8,753	2	17,506
<b>Total</b>				<b>2,018,377</b>

\*Based on average school size of 26.3 for primary schools and 21.5 for secondary school  
Source: Ofsted (2002); DfES (2006a), (2006b)

In Scotland data sources provide information on the number of pupils per year group, the proportion of schools at each year group providing drug education and the average time spent on drug education by those schools who provide drug education (Scottish Executive 2006f; 2006g; 2006h). Data on the average size of secondary school classes is patchy and the most recent data is from a 2003 study estimating Maths and English class size for years S1 and S2 at 25.5 pupils (Scottish Executive

<sup>237</sup> A cross-sectional survey of all individuals with diagnosed HIV infection who attend for HIV-related care at an NHS site in England, Wales and Northern Ireland.

<sup>238</sup> Research was carried out in 27 HIV clinics across the United Kingdom between 1996 and 2002.

2004). Using the same cost per minute as in England, the total estimated expenditure for Scotland amounts to €3.7m (£2.5m)

In Northern Ireland in 2005/06 there were 313,737 primary and secondary school pupils with an average class size of 20.5 for primary school and 14.4 for secondary school<sup>239</sup>. There are, however, no studies estimating the time spent by teachers on drug education so it is not possible to produce a figure for expenditure. In Wales local police forces provide drug education in schools so estimates cannot be calculated.

Total estimated expenditure for the United Kingdom is €106.4m (£72.7m).

### *Social protection*

#### *Unemployment benefits*

It is possible to estimate spend on unemployment benefits by using problem drug use (PDU) estimates and findings from NTORS, which suggest that 81 per cent of those not in treatment and 79 per cent of those in treatment are unemployed (Gossop *et al.* 1998). The most recent PDU estimates for the United Kingdom are for 2004/05 and give a central estimate of 398,845<sup>240</sup>. National Drug Treatment Monitoring System (NDTMS) data suggest that 42 per cent of problem drug users were in treatment in England during 2005/06 (using 2004/05 PDU estimates). Extrapolation to the United Kingdom gives a figure of 231,330 not in treatment and 167,515 in treatment.

Unemployment benefits are paid at a lower rate to those under 25 with another band for 16 and 17 year olds. As there are no data on PDUs aged under 18, the rate for 18 to 24 year olds is used for all those under 25. The figures are adjusted to take into account differences in the proportion of PDUs who are under 25 in England (21%) and Scotland (30%). PDU estimates for Northern Ireland are not broken down by age so, as with Wales, they are extrapolated from England. The calculations are not adjusted to account for the impact of age on treatment status.

Included in the calculations is the cost per person of administering unemployment benefits calculated as 10.6 per cent of the total expenditure on unemployment benefits.<sup>241</sup> This gives an estimated figure of €27.8m (£19m) for 2005/06.

*Table 11.9: Cost of unemployment benefits for problem drug users in the United Kingdom, 2005/06*

	Under 25 years old	Over 25 years old
Number of PDUs unemployed	70,861	248,853
Annual rate of benefit <sup>242</sup>	€65.23 (£44.59)	€82.36 (£56.30)
Administration costs	10.6%	10.6%
Total cost	€5.1m (£3.5m)	€22.7m (£15.5m)

The relationship between drug use and unemployment is complex and assuming a causal link will tend to overstate the cost of drug use (Godfrey *et al.* 2002). However, this calculation only takes into account expenditure on unemployment benefits for PDUs and it may underestimate the impact of recreational drug use on benefit costs. Furthermore, there is insufficient data to estimate the cost of providing housing

<sup>239</sup> <http://www.inca.org.uk/2313.html#433> Class size

<sup>240</sup> Range 397,033 – 421,012, 95% CI

<sup>241</sup> <http://www.dwp.gov.uk/publications/dwp/2006/dr06/annexa/Table2.asp>

<sup>242</sup> Using 2007/08 rate and HM Treasury's GDP deflator. See: [http://www.hm-treasury.gov.uk/economic\\_data\\_and\\_tools/gdp\\_deflators/data\\_gdp\\_fig.cfm](http://www.hm-treasury.gov.uk/economic_data_and_tools/gdp_deflators/data_gdp_fig.cfm)



benefit to drug users as drug agencies do not routinely collect housing status data or do so in insufficient detail (Home Office 2004).

### *Social Services*

Expenditure on personal social services is provided for England (The Information Centre 2007b), Scotland (Scottish Executive 2007e) and Wales (LGDUW 2007). Northern Ireland has joint Health and Social Services Boards (HSSB) so separate costs are not available for substance misuse and HIV/AIDS clients as they are accounted for in labelled costs or in the health costs calculations in section 11.3.3 .

#### *Personal social services for substance misuse*

Personal social services in England provide services for people with substance misuse problems and are paid for through social services revenue support grants supplemented by various grants such as the carers grant, council tax and other rates. Monies are not ring-fenced and are allocated to different services according to local priorities. Some local authorities have pooled budgets with local PCTs but this is excluded from data on net expenditure. Funding is similar in other parts of the United Kingdom.

In England for 2005/06, expenditure on personal social services for adults with substance misuse problems (including alcohol) was €132.2m (£90.4m). In Scotland expenditure for 2005/06 was €37.9m (£25.9m) and in Wales €8.6m (£5.9m).

In a review of expenditure on tackling drug misuse in Scotland (Scottish Executive 2000), the authors estimated that two-thirds of substance misuse community care spending was on drug misuse. This may be an overestimate as alcohol has been given increased policy importance in recent years but no other estimate is available. Extrapolation to England and Wales gives an overall figure of €119.2m (£81.5m) for the United Kingdom.

#### *Personal social services for adults with HIV/AIDS*

In England expenditure on personal social services for those with HIV/AIDS was €22.8m (£15.6m), in Scotland €2.5m (£1.7m) and in Wales €0.12m (£0.08m). Using the proportion of HIV-infected individuals seen for care in 2005 who were infected through intravenous drug use (HPA 2006b), overall estimated expenditure is €0.9m (£0.6m).

#### *Personal social services for people with mental health problems*

There are many studies of the prevalence of co-morbidity but findings differ depending on which substances are included (alcohol, opiates, crack cocaine and other drugs) and which definition is used (dependency or harmful use). Furthermore, while substance use often exacerbates mental health problems there is insufficient evidence to assume a causal link. Data from Scotland (Scottish Executive, 2000) suggests that 10 per cent of mental health community care service expenditure for adults aged 18 to 64 is attributable to drug use. The same figure is used here for the whole of the United Kingdom including Northern Ireland (DHSSPSNI 2007b) although there is a need for more robust estimates. The total estimated expenditure for mental health personal social services attributable to drug misuse is therefore €172.6m (£118m).

#### *Child and Family social work*

Research on the relationship between substance misuse and child and family social work often does not distinguish between drug and alcohol use. There are also wide variations amongst studies depending on when and where the study was carried out and whether incidence or prevalence was used. The measure employed to assess the impact of drug use also has an impact on findings, for example including only

cases where drug use was a 'major factor' or played a 'central role' or cases where drug use was mentioned.

This raises questions about the causal link between drug use and child welfare concerns and highlights the complexity of the relationship between drug use and social impacts as well as the difficulty in attributing expenditure consequences. For example, one study found parental mental illness in a quarter of cases with substance misuse concerns (Forrester and Harwin 2006). However, the only statistically significant differences from non-substance misuse cases were the existence of parental convictions and having a parent experiencing violence.

One incidence study carried out in an inner London Borough<sup>243</sup> found that 34 per cent of families allocated for long-term social work intervention had substance misuse issues, 59 per cent of those involved concerns about drug use (Forrester and Harwin 2004; 2006). In another study in an anonymous English city<sup>244</sup>, substance misuse raised concerns for child welfare in 22 per cent of cases, over half of these involved drug or drug and alcohol use (Hayden 2004).

Hart and Powell's prevalence study<sup>245</sup> (2006) found that children of parents with drug problems accounted for an average of 19 per cent of the authorities' looked after population and 20 per cent of children on child protection registers.

In a review of expenditure on drugs in Scotland (Scottish Executive 2000), a figure of 30 per cent was used to estimate drug-related spend although it is unclear whether this includes alcohol. In Scotland, research from Glasgow City Council found that 40 per cent of Child Protection Orders made in 1998-1999 cited drug-related risk. In Dundee, 70 per cent of children subject to child protection case conferences had parents with substance misuse problems, a rise of 33 per cent from 1998/99 and, in October 2000, 53 per cent of children on the child protection register had parents with problems related to substance misuse (Scottish Executive 2001).

The higher proportions in the Glasgow and Dundee studies may reflect the existence of substance misuse concerns amongst more serious cases. Thus in the Forrester and Harwin study (2006), 40 per cent of cases involving children on the child protection register (CPR) and 62 per cent of children subject to care proceedings involved substance misuse concerns. This supports the findings of a literature review undertaken for the Department of Health which showed that at referral stage, 20 per cent of parents had a substance misuse problem, increasing to 25 per cent at first enquiry, 25 to 60 per cent at child protection conference and 70 per cent for those subject to care proceedings (Cleaver *et al.*, 1999).

Due to the higher costs involved in such cases, when using the proportion of overall caseloads and applying it to expenditure, estimates may be lower than they are in reality. However, social services expenditure is not broken down in sufficient detail to enable more complex calculations and, where it is, does not correspond exactly to the existing research on parental substance misuse.

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<sup>243</sup> All case-files going for long-term allocation in four London local authorities over the period of one year, 2000-2001 were allocated to the parental substance misuse (PSM) sample when concern about PSM was noted on the social work file by any professional.

<sup>244</sup> Research was carried out in a city social work department. Social workers completed a one-sided questionnaire on cases where they felt PSM raised concerns for a child's welfare.

<sup>245</sup> All new and existing cases where parents were identified as drug users were identified by children's social services between January and March 2004 in two local authorities; one a small, deprived northern unitary authority and the other a large southern, wealthy county.

For the purposes of this chapter, the most recent estimate by Forrester and Harwin (2006) that 20 per cent of cases in England involve drug use concerns will be used although further research centring on causality would be useful. This will also be extrapolated to Wales. Considering the higher proportion in studies carried out in Scotland and the higher rate of problem drug use in Scotland, 30 per cent will be used for Scotland. For Northern Ireland there is no research available on which to base assumptions and, given the much lower rate of problematic drug use, it would not be appropriate to extrapolate from England to estimate the proportion of the €208m (£142m) expenditure on child and family social work attributable to drug use. Overall the estimated expenditure on child and family work attributed to drug use is estimated at €1.76 billion (£1.2billion).

### 11.2.5 Overall costs attributable to drugs

Table 11.10 shows unlabelled and labelled government expenditure attributable to drugs. For 2005/06 drug-related government expenditure is estimated at around £5.9 billion, 83 per cent of which is unlabelled costs. Over half of the estimated expenditure is on public safety and order but the importance of social protection expenditure is also evident with almost a quarter (23.8%) of overall expenditure falling into this category, the majority on child and family social work (Table 11.10).

*Table 11.10: Overall estimated unlabelled government expenditure attributable to drugs in the United Kingdom 2005/06*

Category	€m	£m	% of overall spend
Police	3,321	2,270	45.8
Law courts	171	116.5	2.4
Prison – drug offenders	535.9	366.3	7.4
Prison – other offences	880.7	602	12.1
<b>03 Public Order &amp; Safety expenditure</b>	<b>4,908.3</b>	<b>3,355.2</b>	<b>67.7</b>
Methadone prescribing (Scotland)	17.8	12.2	0.2
Inpatient – drug misuse	54.4	37.2	0.8
Inpatient – maternity	13.6	9.3	0.2
Inpatient – poisoning	13	8.9	0.2
Inpatient – hepatitis C	48.4	33.1	0.7
HIV costs	32	21.9	0.4
<b>07 Health expenditure</b>	<b>179.2</b>	<b>122.6</b>	<b>2.5</b>
Drug education in schools	106.4	72.7	1.5
<b>09 Education expenditure</b>	<b>106.4</b>	<b>72.7</b>	<b>1.5</b>
Unemployment benefits	27.8	19.0	0.4
PSS – substance misuse	119.2	81.5	1.6
PSS – HIV/AIDS	0.9	0.6	<0.1
PSS – mental health	172.6	118.0	2.4
PSS – Child and family	1,760	1,200	24.2
<b>10 Social protection expenditure</b>	<b>2,080.5</b>	<b>1,419.1</b>	<b>28.6</b>
<b>Total unlabelled expenditure</b>	<b>7,274.4</b>	<b>4,954.8</b>	<b>100</b>

Total estimated labelled and unlabelled expenditure amounts to €8.7 billion (£6 billion), of which 16.8 per cent is labelled expenditure and 83.2 per cent is unlabelled. Using these estimates, expenditure per capita is €144.43 (£98.73)<sup>246</sup> and overall expenditure amounts to 0.48 per cent of United Kingdom GDP.<sup>247</sup>

<sup>246</sup> Based on ONS population figure of 60.2 million in the middle of 2005.

<sup>247</sup> Based on OECD GDP for United Kingdom, 2005.

### 11.3 National studies on drug-related public expenditures: methods and results, and networks of EU experts

National reports concerned with drug-related public expenditure form part of 'cost of drug misuse' studies, rather than public expenditure only.

Reuter (2004) refers to a report on *A Strategic Budget* published in 2001 in the United Kingdom providing a breakdown of expenditure for particular categories of drug control (Home Office Memorandum submitted to the House of Commons inquiry : *How Effective is our Drug Policy*), no longer available. He states that the focus was on three issues; integration of targeted and "related" expenditures, the distinction between agency and programme labels and devolution of budgets to lower level governments, with funds divided on the basis of goals, which facilitates performance measurement of strategic objectives.

In 2001 the Home Office commissioned a study to look at the economic and social costs of Class A drug use in England and Wales in 2000 (Godfrey *et al.*2002). The model used in this study involved an estimation of the prevalence of total drug users, identifying a typology of three types of drug users:

- young recreational users – defined as those taking Class A drugs aged under 25 but not in the problem user group;
- older regular users – defined as those regularly taking Class A drugs aged 25 or over but not in the problem user group; and
- problem users – users of any age whose drug use is no longer controlled or undertaken for recreational purposes and where drugs have become a more essential element of the individual's life.

Next estimates of the prevalence of different consequences attributed to the drug users of different types were identified. These prevalence estimates were combined with estimates of the unit costs of each type of consequence to yield the economic and social cost estimates.

For young recreational users, it was estimated that there were a total of €9.9 million<sup>248</sup> (£6 million) health service and criminal justice costs in the year, translating to a cost of €12.32 to €24.64 (£7.50 to £15) per user depending on whether a lower or higher estimate of the number of young recreational users is used. Total social costs for this group was estimated at €47.3 million (£28.8 million), a cost per user between €59 and €118 (£36 and £72). These social costs included an estimate of the full costs of premature deaths from ecstasy use. Older regular users were estimated to cost around €10.2 million (£6.2 million), a cost per user between €4.9 and €9.9 (£3 and £6). Estimates for young recreational and older regular users excluded any allowance for productivity effects and effects from driving and drug taking. For problem drug users, total economic costs range from €4.8bn to €8.7bn (£2.9bn to £5.3bn), based on low to high estimates of the number of problem drug users (the medium estimate was €5.7bn (£3.5bn)), €17,082 (£10,402) per user per annum. Total economic and social costs for this group increase the range of figures to between €16.6bn and €28.6bn (£10.1bn and £17.4bn), €58,224 (£35,455) per user per annum.

This research was updated in 2006 for 2003/04 using the same methodology (Gordon *et al.* 2006). However a number of data sources have improved since then, including improved estimates of the prevalence of problematic drug use, and costs relating to the criminal justice system. Based on the methodological and data

<sup>248</sup> Bank of England annual spot exchange rate for 2000 at 1.6422

updates, the economic and social costs of Class A drug use were estimated to be around €22.3 billion<sup>249</sup> (£15.4 billion) in 2003/04, equating to €63,940 (£44,231) per year per problematic drug user. The associated confidence range was between €22.1 billion and €23.3 billion (£15.3 billion and £16.1 billion). It was estimated that problematic Class A drug use accounts for most of the total costs (99%, or €22.1 billion (£15.3 billion)). Drug-related crime was the domain that accounted for the largest proportion of cost (90%, or €20.1 billion (£13.9 billion)).

A study of the economic and social costs of drug is to be undertaken in Scotland, and in Wales.

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<sup>249</sup> Bank of England annual spot exchange rate for financial year 2003/04 at 1.4456.

## 12. Vulnerable groups of young people

### 12.1 Profile of main vulnerable groups

United Kingdom drug strategies use the term 'young people' to refer to those up to and including the age of 24. Young people under 18 are classed as minors and wherever possible in this chapter separate data has been presented to reflect this.

#### 12.1.1 Children living in government care institutions

In the United Kingdom, looked after children are those who are legally 'looked after' by the local authority or health and social services departments. They may or may not be the subject of a care order. Typically, they may be in residential care, special schools or in foster care. Some may be in 'kinship' care (where they are looked after by a member of their family) (Home Office 2005).

#### *Demographic characteristics*

Around 81,000 children were looked after in the United Kingdom in 2005/06 (60,900 in England<sup>250</sup>; 2,436 in Northern Ireland<sup>251</sup>; 12,966 in Scotland<sup>252</sup> and 4,800 in Wales<sup>253</sup>). This equates to around 55 looked after children per 10,000 population aged under 18<sup>254</sup>. Scotland and Wales had a higher proportion of looked after children (116 children per 10,000 and 70 children per 10,000 respectively) than England and Northern Ireland (55 children per 10,000 and 56 children per 10,000 respectively).

In the United Kingdom there were more boys than girls in the looked after system (55% male, 45% female). The majority of these children in England, Northern Ireland and Wales were in foster care (70% in England; 63% in Northern Ireland; 74% in Wales), whereas in Scotland this figure was only 29 per cent. In Scotland over half (56%) were looked after at home with their parents or with family and friends, with a further 13 per cent in residential accommodation.

In 2005/06 in the United Kingdom, 64 per cent of looked after children were aged between five and 15 (4% were under one; 15% were between one and four; and 17% were over 16). In England and Wales,<sup>255</sup> most (43%) were in the age range of 10 to 15 years and just under a fifth (19%) were aged between five and nine. In Northern Ireland and Scotland, around a third (35%) of looked after children were aged between five and 11 and a third (34%) were between the ages of 12 and 15. Around 70 per cent of looked after children in the United Kingdom had been in the system for at least 12 months.

Black children and children of mixed ethnic origins are over-represented in the looked after system, whilst some other ethnic minority communities are underrepresented (e.g. Asian and Asian British) (Home Office 2005). In 2005/06 around 20 per cent of looked after children in the United Kingdom were from Black and Minority Ethnic

<sup>250</sup> See: <http://www.dfes.gov.uk/rsgateway/DB/SFR/s000691/SFR44-2006.pdf>

<sup>251</sup> See: [http://www.dhsspsni.gov.uk/statistics\\_and\\_research-cib\\_looked-after-children](http://www.dhsspsni.gov.uk/statistics_and_research-cib_looked-after-children)

<sup>252</sup> See: <http://www.scotland.gov.uk/Resource/Doc/159750/0043434.pdf>

<sup>253</sup> See: [http://www.dataunitwales.gov.uk/Documents/Data\\_Set/PSS/2005\\_06/lgd01006\\_01\\_children\\_2005\\_06\\_v1\\_eng.pdf](http://www.dataunitwales.gov.uk/Documents/Data_Set/PSS/2005_06/lgd01006_01_children_2005_06_v1_eng.pdf)

<sup>254</sup> Using mid-2006 population estimates the UK population of young people age 0 to 19 is 14,733,600 see: <http://www.statistics.gov.uk/statbase/Expodata/Spreadsheets/D9668.xls>

<sup>255</sup> There were reporting differences in some of the age categories: England and Wales reported on ages five to nine; and ten to 15, whereas, Northern Ireland reported ages five to 11 and 12 to 15.)



(BME) backgrounds, whereas the general BME youth population is estimated to be around 14 per cent.

#### *Other problems*

Looked after children are more likely to:

- have a lower educational attainment than children in the general population (DfES 2007a; Scottish Executive 2007i);
- be unemployed on leaving school (Home Office 2005);
- be cautioned or convicted of an offence (DfES 2007a); and
- be physically or mentally disabled (ONS 2003; ONS 2004a,b) (see 12.4).

#### **12.1.2 Early school leavers / academic failure**

In the United Kingdom, education is compulsory for children aged five to 16 (Education Act 1996). Each local education authority has a duty to provide suitable education (in or out-of-school) for children of compulsory school age who, by reason of illness, exclusion from school or otherwise, may not for any period receive suitable education unless such arrangements are made for them<sup>256</sup>.

#### *Demographic characteristics*

In the United Kingdom between 2004 and 2005 there were 759,100 pupils in their last year of compulsory education (51% male and 49% female) (DfES 2006d). Three per cent of these pupils (around 22,800) did not gain any graded qualifications<sup>257</sup>. Of these, 62 per cent were male and 38 per cent female. It is estimated that there are around 2 million young people of working age<sup>258</sup> in the United Kingdom with no qualifications (21% of those aged 16 to 19 and 8% of those aged 20 to 24).

#### **Excludees and Truants**

'Excludees' are those who have been expelled (permanently excluded) or suspended (temporarily excluded) from school. 'Truants' are those who miss school through unauthorised absence, including parentally condoned absence where no appropriate explanation has been supplied.

#### *Demographic characteristics*

In the United Kingdom in 2005/06 there were 9,939 permanent exclusions from schools (around 1 pupil per 1,000 of the school population)<sup>259</sup>. In the same period there were 400,654 fixed period exclusions/ suspensions (around 41 pupils per 1,000 of the school population). The majority of exclusions occur in secondary schools.

Boys are more likely to be permanently excluded, to receive a fixed exclusion and to receive it at an earlier age than girls; they represent around three quarters of the total number of permanent exclusions each year (80% in England, 74% in Northern Ireland, 78% in Scotland and 73% in Wales). (DfES 2007c; DENI 2007b; Scottish Executive 2007g; WAG 2007a).

<sup>256</sup> A Pupil Referral Unit (PRU) is a type of school maintained by an LEA for children who, because of exclusion or other reasons are not able to attend a mainstream or special school. There are currently over 421 PRUs in England. In 2002-03, 17,523 pupils attended Pupil Referral Units (PRUs) at some point during that year. They do not have to provide a full National Curriculum, but should offer a basic curriculum which includes English, mathematics, the sciences, PSHE and ICT. This flexibility is intended to ensure that more time is spent addressing the child's behavioural problems, for example through counselling, citizenship or PSHE programmes. [http://www.dfes.gov.uk/exclusions/alternative\\_provision\\_policies/pupil\\_referral\\_units.cfm](http://www.dfes.gov.uk/exclusions/alternative_provision_policies/pupil_referral_units.cfm)

<sup>257</sup> See: [http://www.dfes.gov.uk/rsgateway/DB/VOL/v000696/Chapter\\_3.xls](http://www.dfes.gov.uk/rsgateway/DB/VOL/v000696/Chapter_3.xls)

<sup>258</sup> Working age is defined as males aged 16-64 and females 16-59 including unpaid family workers, those on government employment and training programmes, or those who did not answer

<sup>259</sup> See: <http://new.wales.gov.uk/topics/statistics/headlines/schools2007/hdw200703211/?lang=en> for school population numbers

In England in 2004/05, pupils of Black or Mixed ethnic origin had a higher exclusion rate (8%) than White (6%) and Asian pupils (2%) (DfES 2006e). Pupils with Special Educational Needs (SEN) are over 3 times more likely to be permanently excluded from school than the general population. Each day, over 54,000 pupils miss school without permission and an estimated 7.5 million school days are missed each year through truancy<sup>260</sup>.

#### *Other problems*

Children who are not in school are more likely to be:

- unemployed after leaving school;
- drawn into crime and anti-social behaviour<sup>261</sup> (Edmonds *et al.* 2005); and
- at greater risk of gaining a criminal conviction in adulthood (McAra and McVie 2007).

### 12.1.3 Youth in families with drug and/or alcohol use

#### *Demographic characteristics*

It is estimated around two per cent of children under 16 in the United Kingdom<sup>262</sup> have one or both parents with serious drug problems (between 250,000 to 350,000 children) (ACMD 2007a). The available data are based on people in treatment so this may be an underestimation. In the United Kingdom it is estimated that up to 1.3 million (one in eleven) young people are living with parents who misuse alcohol (Cabinet Office 2004).

#### *Other problems*

Young people who live in families with substance or alcohol misuse may be affected by:

- poor parenting or parental absence;
- lack of basic necessities (food, heat, safe environment);
- poor educational attainment; and
- emotional, cognitive, behavioural and other psychological problems (ACMD 2003; Aberlour 2007).

### 12.1.4 Homeless youth

#### *Definition*

In the United Kingdom the term 'youth homelessness' generally refers to young single people aged between 16 and 25 years old who do not have accommodation in the UK or elsewhere; or if they do have accommodation, it is not reasonable for them to occupy. Under the law, even if someone has a roof over their head they can still be homeless, because they may not have any right to stay where they live or their home may be unsuitable to live in. Pleace and Fitzpatrick (2004) defined a young person as 'homeless' if they do not have, or are imminently going to lose, accommodation that they could reasonably be expected to occupy. Homelessness can range from 'rooflessness' or sleeping rough, to living in bed and breakfast accommodation and hostels, or an inability to leave unsatisfactory housing conditions. The 'visible homeless' are those such as rough sleepers and hostel and night shelter residents. The 'hidden homeless' are those who, for example, may be staying temporarily with family and friends ('sofa surfing'). In most circumstances, local authorities in the United Kingdom have a statutory duty to provide

<sup>260</sup> See: <http://www.dfes.gov.uk/schoolattendance/truancysweeps/> accessed 17<sup>th</sup> July 2007

<sup>261</sup> See: <http://www.dfes.gov.uk/schoolattendance/truancysweeps/> accessed 17<sup>th</sup> July 2007

<sup>262</sup> UK mid-2006 population estimates that the number of people in the UK under 16 is 11,537,000 see: <http://www.statistics.gov.uk/pdfdir/popest0807.pdf> accessed 19<sup>th</sup> September

accommodation for homeless people under 18 (in addition to 18 to 20 year olds who were formerly in care) and older people if they are judged to be in priority need.

#### *Demographic characteristics*

According to official statistics, in 2005/06 there were nearly 51,000 homeless<sup>263</sup> people under the age of 25 in the United Kingdom (36,770 in England<sup>264</sup> ; 3,375 in Northern Ireland<sup>265</sup>; 9,943 in Scotland<sup>266</sup> and 851 in Wales<sup>267</sup>). In England and Wales in that period, nine per cent of all homeless acceptances by local authorities were from young people aged 16 and 17 or care leavers aged 18 to 20 years old. In England, more than a third (39%) of new cases of homelessness that year were young people aged under 25 (DCLG 2007) and in Northern Ireland this figure was 20 per cent<sup>268</sup>. In the first quarter of 2007, over half (53%) of homeless acceptances in Wales were for the under 25 age group (WAG 2007b).

However, it has been reported that this age group are less likely than other age groups to seek advice about their homelessness problems (Kenrick 2007)<sup>269</sup> and that statistics in England are only collected for people who have been accepted as homeless by local authorities, rather than for all applicants as in other parts of the United Kingdom<sup>270</sup>, so the actual numbers of homeless youths could be higher.

Black and minority ethnic (BME) households are over-represented among England's homeless population, 57 per cent of young people assisted by the homeless charity Centrepoin<sup>271</sup> are from BME backgrounds, while the BME youth population in England is around 14 per cent according to the 2001 Census. According to Centrepoin, around 40 per cent of young homeless people have no qualifications and around a fifth of them have been looked after by a local authority.

#### *Other problems*

Being homeless has been associated with increased risk of:

- offending and risk-taking behaviour;
- poorer education and employment prospects;
- experiencing difficulties accessing training and health care;
- being vulnerable to poor physical and mental health; (Shelter 2005; Wincup *et. al* 2003);
- being a victim of crime; and
- financial and/ or sexual exploitation (Scottish Executive 2002)

<sup>263</sup> In England this means that they were accepted as Homeless by their Local Authority and in the rest of the UK it means that they presented themselves as Homeless to their Local Authority (regardless of whether they were accepted as homeless).

<sup>264</sup> See: <http://www.communities.gov.uk/index.asp?id=1508508>

<sup>265</sup> <http://www.simoncommunity.org/FAQs/>

<sup>266</sup> See: <http://www.scotland.gov.uk/Publications/2006/09/25151544/0>

<sup>267</sup> See: <http://www.dataunitwales.gov.uk/eng/Project.asp?nc=B05C&id=3676>

<sup>268</sup> See: <http://www.simoncommunity.org/FAQs/>

<sup>269</sup> See: <http://www.youthaccess.org.uk/news/upload/locked%20out%20article.pdf>

<sup>270</sup> See: <http://www.centrepoin.org.uk/content/view/268/41/>

<sup>271</sup> See: <http://www.centrepoin.org.uk/content/view/37/21/>

### 12.1.5 Young offenders

#### *Definition*

In England, Wales and Northern Ireland,<sup>272</sup> young people aged 10 to 17 found guilty of, or cautioned for, an indictable offence are defined as young offenders (YOs). Young offenders are also defined as those aged between 18 and 20 within the prison population<sup>273</sup>. In Scotland, a young person is any child aged between eight and 15 years of age at the time of an offence referral or any person aged 16 and over who is already the subject of a supervision requirement.<sup>274</sup>

#### *Demographic characteristics*

In England and Wales in 2005/06, 85,467 young people came into contact with the youth justice system for the first time (around 1.4% of the 10 to 17 age group). Young males were four times more likely to have committed an offence than young females. In the same period, 301,860 offences resulting in a disposal<sup>275</sup> were committed in England and Wales, of these 80.6 per cent were by males and 19.4 per cent by females. Young people in the between the ages of 14 and 17 committed the vast majority of offences (84.5%) (YJB 2006a). In Great Britain<sup>276</sup> there are approximately 3,424 young offenders aged between 15 and 17 years of age in custody, 97 per cent of these are male (3,314 males, 110 females)<sup>277</sup> (Scottish Executive 2007k).

#### *Other problems*

Young offenders are likely to:

- have a wider range of needs than the non-offending population;
- have been in care, witnessed violence in the home or been the victim of crime;
- have insufficient access to healthcare, particularly for mental health (Healthcare Commission 2006);
- have housing problems (Shelter 2005);
- re-offend with 41 per cent of young offenders in 2004 committing a further offence within one year which led to a pre-court disposal or a conviction in court (Whiting *et al.* 2006); and
- be convicted as adults (McAra and McVie 2007).

### 12.1.6 Youth in deprived places/neighbourhoods and/or with high drug availability<sup>278</sup>

#### *Definition*

Dimensions of deprivation in an individual area include variables such as income, employment, education and health. They are usually identified and measured separately. These dimensions are then aggregated to provide an overall measure of multiple deprivation.<sup>279</sup>

<sup>272</sup> See: [http://www.cjsni.gov.uk/index.cfm/area/information/page/young\\_crimes](http://www.cjsni.gov.uk/index.cfm/area/information/page/young_crimes)

<sup>273</sup> See: [http://www.hmprisonservice.gov.uk/adviceandsupport/prison\\_life/youngoffenders/](http://www.hmprisonservice.gov.uk/adviceandsupport/prison_life/youngoffenders/)

<sup>274</sup> See: [http://www.childrens-hearings.co.uk/pdf/Scottish\\_per\\_cent20Youth\\_per\\_cent20Justice\\_per\\_cent20Baseline.pdf](http://www.childrens-hearings.co.uk/pdf/Scottish_per_cent20Youth_per_cent20Justice_per_cent20Baseline.pdf)

<sup>275</sup> Pre-court disposal (e.g. Reprimand or Final Warning or a court disposal) NB data refers to number of offences not numbers of offenders

<sup>276</sup> England, Scotland and Wales

<sup>277</sup> See: [http://www.hmprisonservice.gov.uk/adviceandsupport/prison\\_life/juvenileoffenders/](http://www.hmprisonservice.gov.uk/adviceandsupport/prison_life/juvenileoffenders/)

<sup>278</sup> ACORN is a geo-demographic classification used to identify and understand the United Kingdom population. It combines geography with demographics and lifestyle information to categorise United Kingdom postcodes into 5 categories, 17 groups and 56 types. Information showing this relationship can be found at <http://www.cci.co.uk/acorn/acornmap.asp>

<sup>279</sup> Indices of deprivation identify areas of multiple deprivation at the small area level. Based on a methodology developed by the Social Disadvantage Research Centre at the University

### *Demographic characteristics*

It is difficult to quantify how much of the United Kingdom is deprived as there are English, Welsh and Northern Ireland and Scottish Indices of Deprivation which are not directly comparable; they contain some similar but some different indicators and domains, cover varying time periods and have differences in the way they are compiled<sup>280</sup> (Scottish Executive 2006j). In the United Kingdom in 2004, 16.4 per cent of children lived in workless households (WAG 2005). In England, nearly a quarter (22%) of local authority areas are classed as 'deprived'<sup>281</sup> (ODPM website 2007). In Wales, figures for 2002/03 indicate that 30 per cent of children lived in low-income households<sup>282</sup>. Across Scotland, 14 per cent of the population (over 700,000 people) are income deprived, just under a sixth (15%) of the most deprived areas<sup>283</sup> contain around a third of Scotland's income and employment deprived working age population (36% and 33% respectively) (Scottish Executive 2007i).

### *Other problems*

Youths living in deprived areas may be affected by:

- unemployment;
- low incomes;
- poor health;
- higher than average crime rates;
- inadequate housing (ONS 2007);
- lower educational attainment (DfES 2007d); and
- higher mortality rates (Baker *et al.* 2006);

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of Oxford, separate indices have been constructed for England, Northern Ireland, Scotland and Wales. Though not directly comparable, each index is based on the concept that distinct dimensions of deprivation such as income, employment, education and health can be identified and measured separately. These dimensions, sometimes referred to as 'domains' are then aggregated to provide an overall measure of multiple deprivation and each individual area is allocated a deprivation rank and score. The indices are used to help target policies and funding, and reinforce a common goal to improve the quality of life in disadvantaged communities. However, the indices may not be used together to create a single UK index.

<sup>280</sup>

See:

[http://www.neighbourhood.statistics.gov.uk/dissemination/Info.do;jsessionid=ac1f930cce678c81da7dcfc48d1bb63d93378684660.e38Qa3mPbh4Kai0NaNiKc3iTb3n0n6jAmljGr5XDqQLvpAe?page=Indices\\_of\\_deprivation.htm&bhcp=1](http://www.neighbourhood.statistics.gov.uk/dissemination/Info.do;jsessionid=ac1f930cce678c81da7dcfc48d1bb63d93378684660.e38Qa3mPbh4Kai0NaNiKc3iTb3n0n6jAmljGr5XDqQLvpAe?page=Indices_of_deprivation.htm&bhcp=1)

<sup>281</sup> These areas are classed as deprived in that they are eligible to receive Neighbourhood Renewal Fund (NRF). The Neighbourhood Renewal Fund (NRF) aims to enable England's most deprived local authorities, in collaboration with their Local Strategic Partnership (LSP), to improve services, narrowing the gap between deprived areas and the rest of the country. The allocation for 2006-08 is based upon the Indices of Deprivation 2004. 86 local authority areas (out of a total of 388) are now eligible to receive Neighbourhood Renewal Fund (NRF).

<sup>282</sup> Households with incomes below 60 per cent of median income

<sup>283</sup> The Scottish Index of Multiple Deprivation (SIMD) is the Scottish Executive's official measure for identifying small area concentrations of multiple deprivation across all of Scotland. The SIMD is relevant to policies and funding wholly or partly aimed at tackling or taking account of the causes and effects of concentrations of multiple deprivation. The Index is based on the small area statistical geography of data zones which contain on around 750 people. The domain ranks are combined using the ratios 12:12:6:6:4:1:2 in the following order: Current Income, Employment, Health, Education, Skills and Training, Geographic Access, Housing and Crime <http://www.scotland.gov.uk/Topics/Statistics/Browse/Social-Welfare/TrendSIMD> (SIMD 2006)



### 12.1.7 Ethnic minorities

#### *Definition*

The term 'ethnic minority' is mainly used to denote people who are in the minority within a defined population on the grounds of 'race', colour, culture, language or nationality.

#### *Demographic characteristics*

According to the 2001 Census:

- 14 per cent of under 16 year olds (1,629,141 people) in the United Kingdom are from minority ethnic groups;<sup>284</sup>
- 24 per cent of the BME population were under 16 whilst this figure was 20 per cent for White British; and
- non-White groups are more likely to live in England than other United Kingdom countries (they made up 9 per cent of the total population of England and only 2 per cent in both Scotland and Wales)<sup>285</sup>.

#### *Other problems*

- Unemployment rates for people from some non-White ethnic groups<sup>286</sup> are generally higher than those from White ethnic groups (ONS 2004c);
- a large proportion of minority groups live in urban areas, and these are more likely to contain deprived local areas (Jacobs and Tinsley 2006); and
- some ethnic groups show lower educational attainment than the national average e.g. Black minority ethnic groups, Bangladeshi, Pakistani and pupils of Mixed White and Black Caribbean heritage (DfES 2007e).

### 12.1.8 Party goers

#### *Demographic characteristics*

A recent Mintel survey<sup>287</sup> found that total nightclub admissions were estimated to be around 179 million in 2006, with a fairly even gender split:

- those in the 18 to 24 and 24 to 35 year old age ranges are the main audience for nightclubs (clubbing was found to dwindle significantly after the age of 25);
- 79 per cent of 15 to 19 year olds, and 92 per cent of 20 to 24 year olds have ever been to a nightclub (in 2006 there were estimated to be 5.6 million 18 to 24 year olds in the United Kingdom);
- 4.6 million adults visited nightclubs once a month or more, and 78 per cent of those were 15 to 24 year olds (42% 15 to 19 year olds and 36% 20 to 24 year olds);
- 73 per cent of 15 to 19 year olds and 72 per cent of 20 to 24 year olds go to a nightclub either on special occasions or more regularly; and
- in 2006, 240 music festivals took place in the United Kingdom, the ten most popular had an estimated capacity of 745,000 people.

<sup>284</sup> Minority ethnic group in this case has been taken to mean anyone in the 2001 Census who defined themselves in any category other than 'White British' see [http://www.statistics.gov.uk/downloads/theme\\_compendia/foe2004/FocusonEthnicity.zip](http://www.statistics.gov.uk/downloads/theme_compendia/foe2004/FocusonEthnicity.zip)

<sup>285</sup> See: <http://www.statistics.gov.uk/statbase/product.asp?vlnk=10991>

<sup>286</sup> In 2003/04 unemployment rates for: Bangladeshi (18%), Mixed ethnic origin (17%), Black African (15%), Pakistani (14%) and Black Caribbean (13%) men were around 3 times higher than for White British men (5%). Unemployment rates were around 3 times the rate of White British women (4%) for the following groups: Pakistani (17%), Black African (12%), Mixed ethnic origin (12%), and Black Caribbean (12%).

<sup>287</sup> Mintel Nightclubs United Kingdom report December 2006 a sample of 2010 internet users were asked about their clubbing habits



### *Other problems*

There is no evidence that party goers as a group experience particular problems, however there are some risks that this group can be exposed to such as fighting or violent crime, hearing damage from loud music, risk of injury in crowded venues (Anderson *et al.* 2007; Kilfoyle and Bellis 1997; RNID 2007).

## **12.2 Drug use and problematic drug use among vulnerable groups (from special studies)**

Results from the 2003 Offending, Crime and Justice Survey (OCJS) showed that, while those in vulnerable groups represented less than a third (28%) of young people in the sample, they accounted for 61 per cent of recent Class A drug users (Becker and Roe 2005). Analysis of vulnerable young people<sup>288</sup> from the 2004 OCJS suggested that they were more likely to take any drug, Class A drugs and be frequent users than young people who were not classed as vulnerable (Budd *et al.* 2005). Young people who were in more than one vulnerable group were also more likely to be frequent users and report higher levels of any and Class A drug use than those in only one category of vulnerability.

### **12.2.1 Children living in government care**

#### *Prevalence*

Research has shown that looked after children report higher levels of all illicit drug use than the general population and use drugs more frequently. In one study, 75 per cent of the sample had ever used drugs and 73 per cent had tried cannabis (52% monthly and 34% daily cannabis users) (Ward *et al.* 2003<sup>289</sup>). However, it has been reported that up to 30 per cent of the looked after population may be described as existing problematic users, or potentially problematic users (Edmonds *et al.* 2005).

#### *Primary drug (by age and gender)*

As in the general population, cannabis was the most commonly reported drug used by children looked after by local authorities in England, Scotland and Wales (ONS 2003, ONS 2004<sup>290</sup>; Ward *et al.* 2003).

#### *Patterns of drug use*

Ward *et al.* (2003) reported in their study that cannabis and solvents were first used at 14 years of age, little gender differences were reported.

<sup>288</sup> Identified as vulnerable to heightened levels of drug use in a report based on the 2003 sweep of the OCJS e.g. ever in care; ever homeless; truants; those excluded from school and serious or frequent offenders (Becker and Roe 2005).

<sup>289</sup> A 12-month study funded by the Home Office Drugs and Alcohol Research Unit was carried out between July 2001 to June 2002. It examined young care leavers' patterns of drug use as they moved from care to live independently. A survey was conducted with 200 young people in the process of leaving care, or having recently left care. A sub-sample of 30 were selected to participate in an in-depth interview on their experiences of care and leaving care, with a focus on recent changes in their progress towards independent living and associated changes in patterns of drug use. These interviews were carried out six months after the first interview contact. The sample consisted of young people aged 13-24 years, average age 18 years.

<sup>290</sup> A series of reports presenting data from national surveys of the mental health of young people looked after by local authorities in England, Scotland and in Wales. The survey was carried out in England by the ONS for the Department of Health between October 2001 and June 2002. A total sample of 2,500 child identifiers (approximately 1 in 18 of all looked after children) excluding those in short term placements, was drawn from the anonymised database of looked after children held by the Department of Health, proportional to the number of children looked after in each authority. Equivalent surveys took place in Scotland and in Wales in 2002/03.

*Social and geographical profiles*

In an ONS study, looked after children in Scotland were nearly twice as likely as their English counterparts, and one and a half times more likely than their Welsh peers to smoke, drink alcohol and take drugs (15%, 8% and 10% respectively) (ONS 2004).

*Trends in the last 10 years*

NO INFORMATION AVAILABLE

**12.2.2 Early school leavers/ academic failure***School Excludees and Truants*

Edmonds *et al.* (2005) state that there is a great deal of evidence from the United Kingdom to suggest a strong association between truancy, exclusion and drug use, though there is no evidence of causality. There is also evidence to suggest an association between lack of involvement with the education system and elevated levels of illicit drug use (MORI 2004; Powis *et al.* 1998). Reasons put forward for this include: greater exposure to drugs, greater opportunity to use as a result of not being under parental/ teacher supervision during the day and/or mixing with older people who are not in education. In addition, there is strong evidence to suggest that school attendance is a protective factor against drug misuse and individual students are more likely to initiate drug use in schools where truancy is high. Furthermore, regular attendance at school will increase the level of exposure to school-based universal drug prevention initiatives.

*Prevalence*

Latest data from the English school survey<sup>291</sup> show that in 2006, nearly a fifth (19%) of pupils reported past truancy, 12 per cent reported having been excluded and a quarter of pupils reported one or both of these. As in previous years, pupils who had truanted or been excluded from school were more likely to say they took drugs at least once a month (11%) and to have used a Class A drug (14%) than those who had not truanted or been excluded (1% in both cases). Pupils who had ever been excluded from school were nearly twice as likely as those who had not to have taken drugs in the last month (odds ratio = 1.80). Pupils who had ever truanted were 2.4 times more likely to have taken drugs in the last month (Fuller *et al.* 2007).

Analysis of latest SALSUS<sup>292</sup> data showed that, in Scotland, 70 per cent of 13 year olds who had never truanted had never used drugs compared to only two percent of 13 year olds who had truanted more than 10 times. Similarly, 60 per cent of 15 year old pupils who had never truanted had never used drugs compared to only four per cent of 15 year old pupils who have truanted more than 10 times (ISD Scotland 2007).

Latest data for England and Wales is taken from the British Crime Survey 2005/06 (BCS) showing that:

<sup>291</sup> A national survey of secondary school pupils aged 11 to 15 carried out by the National Centre for Social Research (NatCen) and the National Foundation for Educational Research (NFER) on behalf of the Information Centre for health and social care and the Home Office. 8,200 pupils in 290 schools in England completed the surveys in the autumn term of 2006.

<sup>292</sup> Scottish Schools Adolescent Lifestyle and Substance Use Survey is carried out among 13 and 15 year old school pupils in Scotland. In Autumn 2006 23,180 pupils took part in the survey.

- lifetime and last year use of any drug is approximately twice as high amongst former truants<sup>293</sup> within the 16 to 24 year old age group than among non-truants (66% compared to 34% and 40% compared to 18% respectively), while last month use is almost three times greater (26% compared to 9.1%);
- lifetime and last year use of any illicit drug amongst former excludees in the 16 to 24 year old age group is more than one and a half times greater than use amongst those in the same age group who had never been excluded (66% compared to 41% and 39% compared to 22% respectively); and
- almost two-thirds of excludees also reported that they had ever truanted, this group reported the highest levels of lifetime and last year drug use (75.8% and 47.1%) (Roe and Man 2006).

*Primary drug (by age and gender)*

Cannabis (34%) is the most common drug used recently by former truants and excludees, followed by cocaine and ecstasy (Roe and Man 2006).

*Patterns of drug use*

NO INFORMATION AVAILABLE

*Social and geographical profiles*

NO INFORMATION AVAILABLE

**12.2.3 Youth in families with drug and/or alcohol use**

In the NCCDP annual review of drug prevention, Sumnall *et al.* (2006a) reported that drug use in the family can influence future individual drug using behaviours, but exactly how is unclear and it does not necessarily directly lead to increased drug use. Analysis of 2006 SALSUS data found that, of those who had reported ever using drugs, six per cent of 13 and five per cent of 15 year olds obtained drugs from a brother or sister and six per cent of 13 year olds and one per cent of 15 year olds reported obtaining drugs from a parent (Maxwell *et al.* 2007). In a report based on the Edinburgh Study of Youth Transitions and Crime (ESYTC) and looking at family functioning, McVie and Holmes (2005) found that at age 15 young people whose parent(s) had used drugs during the previous year were more than twice as likely to have used a drug themselves in the same period than those whose parent(s) had not used a drug (Table 12.1).

*Table 12.1: Percentage of 15 year olds who have used drugs in the last year by parental drinking and drug use, Scotland*

	'Any' drug use at age 15	
Parents drink excessively in an average week	Yes	38
	No	26
	Significance	=p<.001
Parents used drugs in the last year	Yes	55
	No	26
	Significance	=p<.001

Source: McVie and Holmes 2005

*Primary drug (by age and gender)*

NO INFORMATION AVAILABLE

*Patterns of drug use*

NO INFORMATION AVAILABLE

<sup>293</sup> In 2005/06 the British Crime Survey (BCS) included questions for respondents aged 16 to 24 that allowed identification of those who had ever truanted e.g. skipped school without permission for a whole day and those who had ever been excluded from school.

*Social and geographical profiles*

NO INFORMATION AVAILABLE

*Trends in the last 10 years*

NO INFORMATION AVAILABLE

**12.2.4 Homeless youth***Prevalence*

Evidence suggest prevalence and frequency of drug use amongst homeless youth tends to be greater than in the general population (Wincup *et al.* 2003; Edmonds *et al.* 2005). Wincup *et al.* (2003<sup>294</sup>) reported high lifetime, last year and last month prevalence rates for drug use amongst young homeless people (95% of the sample had used drugs). Seventeen per cent of the sample were identified as problem drug users and a further 14 per cent had been problem drug users in the past.

*Primary drug (by age and gender)*

In research by Wincup *et al.* (2003) cannabis was the primary drug used (94% of the sample had ever used, 80% in last year, 68% in last month and 53% in last week). Fourteen was the typical age that they began using drugs.

*Patterns of drug use*

Again, based on the research by Wincup *et al.*:

- At least half of interviewees had used cannabis, amphetamine, ecstasy, LSD, magic mushrooms, cocaine and poppers;
- two in five of the homeless young people had used heroin; and
- prevalence of use in the last year, last month and last week indicate that for many use of drugs is ongoing rather than experimental, particularly for cannabis, heroin, crack cocaine and ecstasy (Wincup *et al.* 2003).

*Social and geographical profiles*

NO INFORMATION AVAILABLE

*Trends in the last 10 years*

NO INFORMATION AVAILABLE

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<sup>294</sup> Over an 18 month period from January 2001, data were gathered in four case study areas in England and Wales. The main methods used were interviews with young homeless people and professionals who work with them. The research team conducted interviews with 160 young people aged 25 and under who were in contact with homelessness services. These divided almost equally across the four case studies. Purposive sampling techniques were employed in order to gain access to different experiences of homelessness, for example rough sleeping, living in hostels and staying with friends on a temporary basis, and to explore the different experiences of young people of different ages, sex and ethnic origins. In each area young people were contacted through key organisations, both in the voluntary and statutory sector that provided services for young homeless people. The interviews investigated a wide range of issues and responses were recorded on a questionnaire<sup>4</sup> that included both closed and open-ended questions. The interview was divided into seven sections covering personal characteristics; experiences of homelessness; health issues (physical and mental health, health care); substance use; risky behaviours (for example, injecting drugs); experiences of crime and victimisation, and finally a self-assessment of their current needs. The interviews took place in a variety of settings, mainly hostels and day centres, and lasted between one hour and two and a-half-hours.

### 12.2.5 Young offenders

There have been a large number of studies that show a strong association between delinquency, offending and drug use. Most studies, however, suggest that rather than directly causing offending, these may simply be other expressions of a general tendency to delinquency (Goulden and Sondhi 2001; Lloyd *et al.* 1998; Borrill *et al.* 2003; Budd *et al.* 2005). Results from the 2005 OCJS reported that young people who had taken drugs in the previous year were significantly more likely to have committed a frequent or serious offence than those who had not taken drugs (46% of those who had taken drugs had committed an offence compared to 19% who had not taken drugs) (Wilson *et al.* 2006).

The ESYTC considered drug use and offending amongst young people.<sup>295</sup> The findings suggests that there is an incremental increase in both variety and frequency of offending from the non-user group to the multiple user group, with the scale of difference being least between the double and triple user groups. This is true for each age group (McVie and Bradshaw 2005). A separate report on the ESYTC looked at patterns of referral to Children's Hearings in Scotland (McAra and McVie 2005).<sup>296</sup> Ten per cent of the cohort were referred to a reporter for drug and alcohol misuse and a further three per cent for offences under the *Misuse of Drugs Act (1971)*. In another 11 per cent of cases drug and/or alcohol was raised as an issue. The report does not provide an analysis by age.

A Home Office report on the evaluation of the Drug Interventions Programme (DIP) pilot for young people reported that between November 2003 and September 2005 2,327 young people aged 10 to 17 had contact with arrest referral. The most common substance used was cannabis (30%) and use of cocaine (4%), crack (1%) and heroin (1%) was low. Most had been arrested for acquisitive crimes such as theft and burglary, drug offences were low (Home Office 2007e).

#### *Primary drug (by age and gender)*

The evaluation of the Drug Interventions Programme (DIP) for children and young people (Home Office 2007e) reported that the most common substance used by the 2,237 young people involved in the pilot was cannabis (30%). The use of cocaine (4%), crack (1%) and heroin (1%) was low.

#### *Patterns of drug use*

The results of the DIP pilots found that a range of substances were used. The frequency of cannabis use was high, over half of those that used cannabis did so on a daily or weekly basis (Home Office 2007f).

<sup>295</sup> In this study two measures of delinquent behaviour were used: variety of offending (a count of the number of different offending behaviours the respondent had engaged in) and volume of offending (the cumulative frequency of offending across all the offending behaviours asked about). Fifteen items of anti-social or delinquent behaviour were used to create both of these measures. These were: fare dodging; shoplifting; noisy or cheeky in public; joyriding; theft from school; carrying a weapon; graffiti; vandalism; housebreaking; robbery; theft from home; fire-raising; assault; theft from vehicle; and truanting from school. The four substance use sub-groups (non-regular users, single substance users, two substance users and three substance users) were compared in terms of their mean variety and volume of self-reported delinquency at ages 13 to 15.

<sup>296</sup> The Scottish children's hearings system is based on a coherent vision of criminal and social justice known as the "Kilbrandon" philosophy. According to this philosophy juvenile offending and other troublesome behaviours (including drug or alcohol misuse) should be regarded as manifestations of deeper social and psychological malaise and/or failures in the normal upbringing process. The aim is to address the needs of the child. The system deals with young people aged between 8 and 16 years referred on offence grounds and from birth to age 16 referred on a range of care and protection grounds.



*Social and geographical profiles*

NO INFORMATION AVAILABLE

*Trends in the last 10 years*

NO INFORMATION AVAILABLE

**12.2.6 Youth in deprived places/ neighbourhoods and/or with high drug availability**

In a further ESYTC report, McVie and Norris (2006) reported that characteristics of the neighbourhoods in which young people live do play a role in influencing aspects of their (delinquent and) drug using behaviour, although their impact is relatively weak in comparison to the effect of individual characteristics, such as gender and personality. Whereas delinquency and hard drug use are partially explained by negative neighbourhood characteristics (such as greater deprivation in the case of delinquency and higher crime rates for hard drug use), more frequent cannabis use is greater within prosperous neighbourhoods but also within areas in which there is greater social disorganisation .

Analysis of SALSUS (ISD Scotland 2006) found no significant difference in drug use by pupils in the most deprived areas. Similarly, analysis of the 2006 English School Survey (Fuller *et. al* 2007) found no relationship between recent drug use and income and socio-economic status (Fuller 2007).

*Primary drug (by age and gender)*

At age 16, 32 per cent of young people living in deprived areas of Edinburgh reported recent cannabis or Class A drug use (McVie and Norris 2006).

*Patterns of drug use*

NO INFORMATION AVAILABLE

*Social and geographical profiles*

Less than one percent of drug users reported 'hard drug' use (i.e. heroin, crack). Whereas delinquency was correlated with cannabis use, analysing geographic areas, aggregation of indicators of drug use and deprivation revealed that the highest areas of drug use were not always the areas with the highest levels of deprivation. Frequent cannabis users were more likely to live in areas of affluence.

*Trends in the last 10 years*

NO INFORMATION AVAILABLE

**12.2.7 Ethnic minorities**

Edmonds *et al.* (2005) report that, although young people from BME communities have generally lower levels of drug use than the general population, there are significant variations in use between ethnic groups. Young people of mixed ethnicity tended to have higher levels of drug use. Latest data from the 2006 school survey for England showed that pupils of mixed ethnicity and Black pupils were more likely to report current drug use than White pupils (odds ratio = 2.26 and 1.90 respectively). Among other minority ethnic groups, the odds of recent drug use were not significantly different from white pupils (Fuller 2007).

*Primary drug (by age and gender)*

As with the wider population, cannabis was the most widely reported drug used among all ethnic groups (Fountain *et al.* 2003).

*Patterns of drug use*

In England according to the 2005 school survey, pupils of mixed ethnicity were more likely than any other group to have taken drugs in the last year (25%), with similar



prevalence across genders. The proportions of White and Black pupils who had used drugs in the last year were similar (19% and 17% respectively). There were few gender differences amongst White pupils, whereas among Black pupils 14 per cent of boys and 20 per cent of girls reported that they had taken drugs in the last year. Thirteen per cent of 'other' ethnicity and 12 per cent of Asian pupils reported last year drug use. Fourteen per cent of Asian boys and 16 per cent of boys of 'Other' ethnicity reported recent drug use compared to nine per cent of Asian girls and 10 per cent of 'Other' girls. A similar pattern exists for current drug use. Pupils of mixed ethnicity were more likely to report current drug use (16%) with the prevalence of current drug use among other groups ranging from eight per cent of Asian pupils to 11 per cent of White pupils (NatCen/NFER 2006).

#### *Social and geographical profiles*

NO INFORMATION AVAILABLE

#### *Trends in the last 10 years*

NO INFORMATION AVAILABLE

### 12.2.8 Party Goers

#### *Prevalence*

Research has shown that young people who go to nightclubs are more likely to use drugs more frequently and in larger quantities (O'Hagan 1999; Measham *et al.* 2001). Higher drug use has also been associated with the frequency of going to pubs and/or bars (Riley *et al.* 2001). Recent analysis of the BCS has shown an association between frequency of visits to nightclubs and/or pubs and wine bars with cocaine powder use. Sixteen to 29 year olds who made frequent visits to nightclubs reported almost three times the level of current cocaine use as those who had not been to a club in the past month (4.2% compared to 1.6%). Those who had been to pubs or bars were over four times more likely to report current cocaine use than those who visited pubs or bars less frequently (7.3% compared to 1.7%) (Roe and Man 2005). Latest data from the 2006 school survey for England reported a relationship between recent drug use and whether pupils had been to a pub, bar or club in the last month. Those who had been in any of those places were 1.4 times more likely to have taken drugs in the last month (NatCen/NFER 2007).

An annual survey was carried out with readers of Mixmag (a specialist dance music magazine) until 2005 (McCambridge *et al.* 2005). However, as the mean age in each survey was approximately 24 or older, it has not been reported on here.

#### *Primary drug (by age and gender)*

NO INFORMATION AVAILABLE

#### *Patterns of drug use*

NO INFORMATION AVAILABLE

#### *Social and geographical profiles*

NO INFORMATION AVAILABLE

### 12.2.9 ESPAD

#### *Drug use by siblings*

According to latest ESPAD<sup>297</sup> data:

<sup>297</sup> The UK participates in the European School Survey Project on Alcohol and other Drugs (ESPAD), which is undertaken amongst 15 and 16 year olds in about forty European countries. Data are collected every fourth year. The next data collection will be carried out

- A quarter of all United Kingdom students had older siblings who smoked cannabis, 2.5 times the European average and 3 per cent took ecstasy (in line with the European average)
- for male students 22 per cent had older siblings that smoked cannabis and six per cent took ecstasy (European average 10% cannabis, 3% ecstasy)
- for female students 28 per cent had older siblings that smoked cannabis and nine per cent took ecstasy (European average 10% cannabis, 3% ecstasy)

Results for all ESPAD countries showed that, among European students, having an older sibling who uses a particular substance was associated with more use by the younger sibling.

#### Single parents

Significantly higher cannabis use was found among those living with a single parent in the United Kingdom, as was the case with over 70 per cent of ESPAD countries (21 of the 29).

#### Truancy (ESPAD data)

According to ESPAD data, truancy is associated with increased use of cannabis among United Kingdom students as is the case for all ESPAD countries.

#### Parental supervision (ESPAD data)

Significantly higher cannabis use was found among students whose parents did not know what they were doing on a Saturday night in the United Kingdom and in 97 per cent of ESPAD countries (30 of the 31) (ESPAD 2003).

## 12.3 Vulnerable groups among the treated population

### 12.3.1 Description of treated population by vulnerable groups

Government figures show that five per cent of looked after children were identified as having a substance misuse problem in 2006, with nearly two thirds of them (63%) receiving an intervention (DfES 2007a).

Data from the NDTMS<sup>298</sup> National Young People report for England show that between April 2006 and March 2007, 21,765 young people (aged between 9 and 17) received treatment for drugs and/or alcohol. Between April and August 2007, 16,355 young people (aged between 9 and 17) received treatment with 6,060 new presentations. In 2003/04<sup>299</sup> 6,536 11 to 17 year olds received treatment for drugs only in England, this equated to five per cent of the treatment population. In the 18 to 24 age category 29,616 people received treatment, equating to 23.6 per cent of the treatment population. It is worth noting that in 2003/04 it wasn't mandatory for Young People's services to report to NDTMS so numbers appear low in comparison to 2006/07 data. NDTMS treatment referral figures for the North West region of England in 2005/06 (Khundakar *et al.* 2007) reported that in the general population

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during the spring of 2007 and the results are to be published the following year. So far three ESPAD surveys have been conducted, with 1995 as the starting year.

<sup>298</sup> See: <http://www.ndtms.net/NatEnglandPerformanceReport.aspx?AllAgesOrYP=YP> . The National Drug Treatment Monitoring System (NDTMS) relates to the process of collecting, collating and analysing information from and for those involved in the drug treatment sector. All drug treatment agencies must provide a basic level of information to the NDTMS on their activities each month known as the Core Data Set

<sup>299</sup> See: [http://www.nta.nhs.uk/areas/facts\\_and\\_figures/0304/default.aspx](http://www.nta.nhs.uk/areas/facts_and_figures/0304/default.aspx)  
[http://www.nta.nhs.uk/areas/facts\\_and\\_figures/0304/docs/NDTMS\\_200304\\_bulletin\\_Jul\\_05.doc](http://www.nta.nhs.uk/areas/facts_and_figures/0304/docs/NDTMS_200304_bulletin_Jul_05.doc)

the main source of referral into drug treatment was via self-referral. However, this is dependent on age. Whilst 40 per cent of episodes in the 25 to 29 year age range self-referred into treatment services, only eight per cent of treatment episodes in under 18s came from self referral and a third came from the Criminal Justice System (CJS), which includes Youth Offending Teams (YOTs).

Treatment Demand Indicator (TDI) data for 2005/06 show that there were 16,021 presentations by individuals under the age of 19 in the United Kingdom, representing 12 per cent of the total TDI population. Of these, 2,787 (17%) were under the age of 15 of which 68 per cent (1,895) were first presentations. Amongst the 15 to 19 age group there were 13,234 treatment presentations and 61 per cent of these were first presentations. The gender split was approximately 70 per cent male and 30 percent female.

Beckett *et al.* (2004) reported on 103 young people attending drug services in Stoke-on-Trent and Newcastle<sup>300</sup>. Sixty per cent of respondents lived in areas of moderate or high material deprivation but there was no direct relationship between material deprivation in the areas in which respondents lived and their level of problematic drug use.

## 12.4 Correlates and consequences of substance use among vulnerable groups

### 12.4.1 Psycho-social and health problems related to substance use

Vulnerable young people often experience a number of psycho-social and health problems, some of which may be related to the consequences of substance use. However, the relationship is complex and attribution is difficult to ascertain.

#### *Children living in government care institutions*

In 2006, rates of cautions or convictions for offences were almost three times higher amongst looked after children aged 10 or over (9.6%) than for all children (DfES 2007a). Nearly a fifth of care leavers experience homelessness within two years of leaving care and it is estimated that between a quarter and a third of all people sleeping on the streets have spent time as children being looked after by local authorities (Shelter 2005). Looked after children are also more likely to have no qualifications than those in the general population, in 2005/06 around half of care leavers had no qualifications<sup>301</sup> when they left (57% in England, 50% in Scotland, 48% in Wales).

#### *Early school leavers / academic failure*

Children who are not in school are more likely to be unemployed after reaching school leaving age<sup>302</sup> and some studies have found an association between lack of involvement with the education system and elevated levels of criminality (Edmonds *et al.* 2005). The recent evaluation of the Drug Interventions Programme pilot for young people reported that a fifth of 14 and 15 year olds who had contact with arrest referral

<sup>300</sup> Interviewed using a structured questionnaire. 46 parents were also interviewed between June 2001 and June 2002. Respondents' average age at interview was 16.3 (range: 11 to 20) and they had been using drugs for an average of 3.6 years. The primary aim of the study was to define the hierarchy of risk and protective factors among the adolescents attending designated drug services and to understand the direct and indirect links between these factors.

<sup>301</sup> See: <http://www.dfes.gov.uk/rsgateway/DB/SFR/s000691/SFR44-2006.pdf>; <http://www.scotland.gov.uk/Resource/Doc/159750/0043434.pdf>; and [http://www.dataunitwales.gov.uk/Documents/Data\\_Set/PSS/2005\\_06/lgd01006\\_01\\_children\\_2005\\_06\\_v1\\_eng.pdf](http://www.dataunitwales.gov.uk/Documents/Data_Set/PSS/2005_06/lgd01006_01_children_2005_06_v1_eng.pdf).

<sup>302</sup> See: <http://www.dfes.gov.uk/schoolattendance/truancysweeps/> accessed 17<sup>th</sup> July 2007

had been excluded or had truanted from school (Home Office 2007e). Children (particularly boys) who are excluded from school, or leave as soon as they reach 16, are at greater risk of gaining a criminal conviction in adulthood (McAra and McVie 2007).

#### *Youth in families with drug and/or alcohol use*

Problems faced by children living in families with drug and alcohol use include poor parenting or parental absence, lack of basic necessities (food, heat, safe environment), poor educational attainment and emotional, cognitive, behavioural and other psychological problems (ACMD 2003; Aberlour 2007).

#### *Homeless Youth*

Homelessness can be associated with offending and risk-taking behaviour such as self-neglect, self-harm, suicide, and substance use. Young homeless people are vulnerable to poor physical and mental health and are more likely to experience a variety of medical problems, such as infectious diseases and nutritional disorders and they can have difficulties in accessing health care services. Homelessness can have long-term implications for education, employment prospects and difficulties accessing and completing training courses (Shelter 2005). Mental health problems are disproportionately high amongst young homeless people (Wincup *et al.* 2003) (see also Taylor *et al.* 2006). Lack of stable accommodation can put young homeless people at risk of being a victim of crime and of financial and/ or sexual exploitation (Scottish Executive 2002).

#### *Young Offenders*

Involvement with the criminal justice system can lead to housing problems for young people (Shelter 2005). Young offenders are more likely to have truanted or been excluded from school; be under-achieving at school; associate with criminal peers; not live with both parents; have a learning disability; have been in care; been subjected to poor parenting; witnessed violence in the home or been the victim of crime. (YJB 2003; Healthcare Commission 2006). They often have more health needs than the non-offending population and have insufficient access to healthcare, particularly mental health. In a recent review<sup>303</sup> of community healthcare for young offenders it was found that in 2004/05, 18 per cent of the young people that took part in the review had physical health issues, 42 per cent had substance misuse issues and 44 per cent had emotional or mental health needs (Healthcare Commission 2006). Re-offending rates are high, in 2004, 41 per cent of young offenders committed a further offence within one year which led to a pre-court disposal or a conviction in court (Whiting *et al.* 2006). Research conducted in Scotland has found that young people who have been involved with the juvenile justice system are three times more likely to be convicted as adults than those who have not (McAra and McVie 2007).

#### *Youth in deprived places/neighbourhoods and/or with high drug availability*

Living in deprived areas is associated with unemployment, poor health and crime (ONS website 2007). It can also be associated with lower educational attainment. In England in 2005/06, 53 per cent of pupils in Neighbourhood Renewal Fund (NRF) areas achieved five or more A\* to C grades at GCSE or equivalent compared to 60.3 per cent of pupils in non-NRF areas. In 2006, a third of teenagers from disadvantaged backgrounds achieved five A\* to Cs at age 16 compared to 57 per cent of all pupils (DfES 2007d). In Scotland, pupils registered for free school meals

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<sup>303</sup> The review is based on the findings of 50 inspections of youth offending teams (45 in England and 5 in Wales) that were published between 2003 and 2006. During the inspections the views of young offenders were gained through face to face interviews, a postal questionnaire and an electronic questionnaire.

scored less well in exams on average than those who were not. Similarly, pupils who lived in the top 15 per cent of the most deprived areas had lower than average exam tariff scores than those in the other 85 per cent of areas (Scottish Executive 2007i). Studies have shown that those living in more deprived areas have higher mortality rates than those living in less deprived areas (Baker *et al.* 2006). Some studies have also found a relationship between deprivation and mental disorder. In 2004, 10 per cent of those aged five to 16 in the general population had a clinically diagnosable mental disorder, 18 per cent of boys and 13 per cent of girls living in households with a gross weekly income of under £100 had a mental disorder (Green *et al.* 2005).

#### *Ethnic minorities*

Unemployment rates for people from some non-White ethnic groups are generally higher than those from White ethnic groups (ONS 2004c). In general, a far greater proportion of minority groups live in urban areas, which are more likely to contain deprived local areas (Tinsley and Jacobs 2006). Social exclusion and deprivation are high in many of these areas and these are risk factors that can be associated with problematic drug use (Fountain *et al.* 2003). In England in 2005/06, some ethnic groups showed lower educational attainment than the national average e.g. Black minority ethnic groups, Bangladeshi, Pakistani and pupils of Mixed White and Black Caribbean heritage are below the national average at GCSE and equivalent. Chinese, pupils of Mixed White and Asian heritage, Irish and Indian pupils consistently achieve above the national average across Key Stages 2, 3 and 4 (DfES 2007e).

#### *Party Goers*

The night-time economy is a setting in which violent crime commonly occurs (Finney 2004). In a recent study,<sup>304</sup> 11 per cent stated they had been involved in a fight in a pub, bar or nightclub, in the street, or both whilst on a night out during the past twelve months (13% of males and 8% of females) (Anderson *et al.* 2007). There is a potential for sustaining minor injuries in dark, noisy, unventilated and crowded venues (Bellis and Kilfoyle 1997) and loud music in venues such as nightclubs, bars and concerts can lead to hearing damage. A recent report showed that 70 per cent of clubbers, 68 per cent of gig-goers and 44 per cent of people who go to bars experience the symptoms of hearing damage after their night out, such as dullness of hearing or tinnitus (ringing in the ears) (RNID 2007<sup>305</sup>).

#### 12.4.2 Criminal behaviours

See above. Latest data from the Offending Crime and Justice Survey<sup>306</sup> (Wilson *et al.* 2006) reported that young people who had taken drugs in the past 12 months were significantly more likely to have committed a serious offence<sup>307</sup> and/ or to have

<sup>304</sup> The study targeted young people aged 18 to 35 years old who visit pubs, bars and nightclubs. The survey was conducted opportunistically between the hours of 5pm and 11pm on different nights of the week in 18 pubs, bars and nightclubs across Liverpool. Interviewers completed the questionnaires by interviewing participants on a one to one basis. A total of 424 questionnaires were completed during the course of the study.

<sup>305</sup> In 2005, 1381 face-to-face surveys were conducted with 16-30 year olds from England, Scotland and Wales. They asked questions about exposure to loud music, experiences of ringing in ears and use of hearing protection products.

<sup>306</sup> The Offending, Crime and Justice Survey (OCJS) is the longitudinal, self-report household survey for England and Wales. It was first conducted in 2003 and will be repeated annually until 2006. The main aim is to examine the extent of offending, anti-social behaviour and drug use among the household population, particularly among young people aged 10 to 25.

<sup>307</sup> Serious offences include the following: theft of a vehicle; burglary; robbery; theft from a person; assault resulting in injury; selling class A drugs



been a frequent offender<sup>308</sup> than those who had not taken drugs. Nearly half (46%) of those who had taken drugs in the past 12 months had committed an offence compared to 19 per cent who had not taken any drug.

Sixty-two per cent of drug users aged between 10 and 17 had committed an offence in the last 12 months, compared with a quarter (23%) of those who had not taken drugs. The equivalent figures for 18 to 25 year olds were 40 per cent and 15 per cent respectively (Table 12.2). (Wilson *et al.* 2006).

In 2005 over 50 per cent of young offenders in custody reported Class A drug use in the past year, among the highest for any at risk group (DfES, HO and DH 2005).

*Table 12.2 Proportion of 10 to 25 year olds who committed an offence in the last 12 months by drug status, England and 2005*

	No drugs	Any drugs	Non-class A drugs	Class A drugs	Not frequent user	Frequent user
	%	%	%	%	%	%
<b>All</b>						
Non-offender	81	*54	58	*48	78	*40
Offender	19	*46	42	*52	22	*60
Serious offender	9	*24	20	*31	11	*30
Frequent offender	4	*18	15	22	5	*28
<b>10 to 17 year olds</b>						
Non-offender	77	*38	42	*26	74	*31
Offender	23	*62	58	*74	26	*69
Serious offender	11	*33	31	40	12	*37
Frequent offender	4	*25	23	35	6	*33
<b>18 to 25 year olds</b>						
Non-offender	85	*60	66	*52	82	*44
Offender	15	*40	34	*48	18	*56
Serious offender	7	*21	14	*30	9	*27
Frequent offender	3	*15	12	*20	4	*25
<i>Unweighted bases</i>						
<b>All</b>	3,680	896	611	285	4,232	345
<b>10 to 17</b>	2,309	347	284	63	2,522	135
<b>18 to 25</b>	1,371	549	327	222	1,710	210

\* indicates a significant difference between no drugs and any drugs, Class A and non-Class A drugs, frequent and non-frequent users, within age groups.

Source: Wilson *et al.* 2006

Data from the Arrestee survey<sup>309</sup> (Boreham *et al.* 2006) reported on prevalence of drug use in young people in the 17 to 24 year old age bracket. Two thirds of

<sup>308</sup> Frequent offenders are those young people who committed six or more offences, including the less serious, in the last 12 months

<sup>309</sup> In the period covered by this report (1st October 2003 to 30th September 2004) the first Arrestee Survey was carried out in a national sample of 60 custody suites, including both DIP intensive and other areas in England and Wales. Within each custody suite, interviewers worked six-hour shifts and attempted to interview as many eligible arrestees as possible. Arrestees were eligible if they were 17 years or over and arrested on suspicion of committing any offence (not just the trigger offences targeted by DIP interventions). In total interviewers worked 5043 shifts and interviewed 7535 arrestees. The interview consisted of a 20-minute computerised interview with a substantial self-completion section, which contained the most sensitive questions about offending behaviour, drug and alcohol use and treatment for drugs.



arrestees (65%) had used drugs in the past month (66% male, 58% female, 28% heroin, crack and/or cocaine (HCC) for both sexes):

- 57 per cent had used cannabis in the last month (59 % male, 47% female)
- 14 per cent had used powder cocaine (14 % male, 8% female),
- 15 per cent had used heroin (14 % male, 21% female),
- 12 per cent had used crack (12% male, 17% female).

## Responses to drug problems among vulnerable groups

### 12.5 Policy and legal development

#### 12.5.1 National and legal development

Reducing the use of drugs, particularly by young people, is a central aim of United Kingdom drug strategies. The first United Kingdom drug strategy does not specifically refer to vulnerable young people but does give consideration to the needs of young people at risk of transition from regular to problematic use (United Kingdom ADCU 1998). The Updated National Drug Strategy (Home Office 2002) includes a target to reduce the use of Class A drugs and the frequent use of any illicit drug among all young people under the age of 25 by 2008 (especially by the most vulnerable), noting that vulnerable young people are more at risk of developing drug problems than other young people. The recent consultation document outlining proposals for a new national drug strategy to begin in 2008 suggests that there is a need to reach out more effectively to the most vulnerable and the most at risk young people (HM Government 2007a).

In Scotland and Wales, the needs of vulnerable young people were referred to in earlier drug strategies. In Scotland, the 1999 Drugs Strategy refers to "*support for children and young people in vulnerable situations*" (Scottish Office 1999). The Welsh substance misuse strategy specifically mentions that action to tackle substance misuse and work with vulnerable young people is required (National Assembly for Wales 2000).

#### 12.5.2 Strategies and policies for social exclusion that refer to vulnerable groups

The Hidden Harm report by the Advisory Council on the Misuse of Drugs (ACMD 2003) on children of drug using parents can be regarded as a catalyst for policies designed to respond to the needs of this vulnerable group. Its publication coincided with proposals by the United Kingdom government for significant reform of children's services; in particular the recognition of the need to have more integrated working between services to better address the often multiple needs of some children and young people. In England and Wales, the *Children's Act 2004* provided the context for this. The *Every Child Matters: Change for Children* programme in England focuses on the well-being of children and young people up to the age of 19 (DfES 2004a).<sup>310</sup> This programme embraces five key outcomes for every child, namely: 'be healthy'; 'stay safe'; 'enjoy and achieve'; 'make a positive contribution'; 'achieve economic well-being', requiring a range of departments and organisations to work together for the benefit of children. Choosing not to take illegal drugs is identified as a key aim within the 'be healthy' outcome of the programme. *Every Child Matters: Change for Children: Young People and Drugs* (DfES, HO and DH 2005) is a joint strategy published by the previous Department for Education Skills (DfES<sup>311</sup>), the

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In addition, arrestees were asked to provide an oral fluid sample for analysis of recent drug use.

<sup>310</sup> For more information see: <http://www.everychildmatters.gov.uk/>

<sup>311</sup> The work of the Department for Education Skills in the area of children and young people is now the responsibility of the Department of Children, Schools and Families.

Home Office and the Department of Health (DH). It links *Every Child Matters* and the national drug strategy and sets out how children's services and Drug Action Teams should work together to target vulnerable young people.

The *Children's Act* and guidance under the *Every Child Matters* programme includes the following elements designed to maximise integrated working:

- the development of integrated Children's Services Trusts led by local authorities;
- the production of annual *Children's Services Plans*;
- a *Common Assessment Framework* (CAF) to promote earlier recognition and assessment of children with additional needs;
- a new joint inspection process, the *Joint Area Review*, based on a detailed *Outcomes Framework* based on the five key outcomes;
- a set of common core skills and knowledge for all workers with children and young people, linked to a comprehensive workforce development programme; and
- the establishment of a *Local Safeguarding Children Boards (LSCB)* by every Local Authority.

In addition, linked to *Every Child Matters*, the *National Service Framework for Children, Young People and Maternity Services* (DH 2004a) sets out a ten-year programme of improvement in children's health and well-being, including that of the unborn child, setting standards for the care of children, young people, and for maternity services. Delivery of this is the responsibility of the National Health Service (NHS) in partnership with Children's Service Trusts. This framework also states that staff from all agencies should identify children and young people at risk of misusing drugs or alcohol and should provide them with access to prevention and treatment services.

One key element of integrated working is that staff from any one service should not presume to have the skills to address all problems in isolation, but instead should work with other services whose staff have the skills to do so, and that this should be done in an integrated manner, presuming a sharing of information, knowledge and skills.

*Every Child Matters: Change for Children – Young People and Drugs* sets out how those responsible for the delivery of children and young people's services and the drugs strategy can co-operate and plan comprehensive responses for children and young people who are using or otherwise affected by drug misuse; developing a *Young People and Drugs Delivery Plan*. Responsibility for performance management of this lies with the cross-departmental Young People and Drugs Programme Board. To support this the Home Office and the former DfES (now the DCSF) established Joint Regional Teams within each regional government office from February 2005, consisting of regional DfES, National Treatment Agency (NTA), public health, youth justice and drugs and crime staff.

*Drugs: guidance for schools* (DfES 2004b) proposed that schools should provide supportive relationships, encourage school attendance and identify and respond to the drug-related needs of vulnerable pupils.

The Welsh Assembly Government's strategic policy with respect to children and young people is set out in *Children and Young People: Rights to Action* (WAG 2004c). In some respects it is similar to the policy in England, including a requirement on all authorities to produce three year strategic *Children and Young People's Plans*, a *Common Assessment Framework* (CAF), and *Local Safeguarding Children Boards (LSCB)*, but there are no *Children's Trusts*, nor are there integrated

structures under a single director. Instead, the approach in Wales is based on the statutory duty to co-operate between local authorities and their statutory partners, as set out in the *Children's Act*.

In Scotland, *Children: Better Integrated Children's Services* (Scottish Executive 2001) highlighted the need for integrated services. *Getting Our Priorities Right* (Scottish Executive 2003b) set out a comprehensive approach to unifying and integrating services focusing on the children of substance misusing parents. A *Children's Charter* (Scottish Executive 2004) outlined the needs and expectations of children and young people in relation to their protection from harm, as did *Getting it right for every child*.<sup>312</sup> An *Integrated Children's Services Planning*<sup>313</sup> framework requires the development of a single plan agreed with all relevant agencies (e.g. local authorities, NHS Boards, police, child protection and the voluntary sector), to deliver integrated services for all children and young people, including those who are vulnerable and at risk. An *Integrated Assessment Framework*, together with an electronic record based on a child's needs is required of all services in contact with children and young people. The planning framework is backed by a *Quality Improvement Framework for Integrated Children's Services*<sup>314</sup> and by multi-agency joint inspections of children's services.<sup>315</sup> In 2007, an *Action Framework* for children and young people's health in Scotland (Scottish Executive 2007j) sets out action to be taken to enhance integration.

In Northern Ireland, the *Children (Leaving Care) Act 2002* and the *Protection of Children and Vulnerable Adults Order 2003* seek to protect children.

### 12.5.3 Definitions and concepts of vulnerability in the national context

There are slight variations in the designation of vulnerability in policy documents, reflecting both the different drug strategies and differences in need. In Scotland, young people who are vulnerable, excluded or in the most impoverished groups include looked after children, homeless young people, travellers and young offenders, as well as those living in more deprived communities (Scottish Office 1999). In the Welsh substance misuse strategy, vulnerable young people include; pupils excluded from schools, truants, looked after children, young offenders, young homeless and children of substance-misusing parents and young people not in education, work or training (National Assembly for Wales 2000). In the consultation document on the new national drugs strategy, vulnerable groups include: young offenders; looked-after children; young homeless people; children who truant or are excluded from school; young people who have been sexually exploited or who work in the sex industry; and children whose parents misuse drugs or alcohol (HM Government 2007a). In its 2007 guidance, the National Institute for Health and Clinical Excellence (NICE) suggests that vulnerable and disadvantaged children and young people aged under 25 who are most at risk of misusing substances include: those whose family members misuse substances; those with behavioural, mental health or social problems; those excluded from school and truants; young offenders; looked after children; those who are homeless; those involved in commercial sex work; and those from some Black and minority ethnic groups.

<sup>312</sup> For more information see:

<http://www.scotland.gov.uk/Publications/2005/07/25112327/23294>

<sup>313</sup> For more information see:

<http://www.scotland.gov.uk/Topics/Government/DataStandardsAndeCare/ChildrenandFamilie s/IAF>

<sup>314</sup> For more information see <http://www.scotland.gov.uk/Publications/2006/04/27135008/0>

<sup>315</sup> For more information see: <http://www.hmie.gov.uk/services/default.asp>

## 12.6 Prevention and Treatment

Having set in place a framework, within wider generic responses to meeting the needs of young people (in particular the vulnerable), strategies encompass two distinct areas for action; preventing vulnerable young people from becoming problem drug users; and for those who are already experiencing problems, providing appropriate treatment. Current strategies are, in effect, based on prevention, early intervention and treatment. There are a number of policy documents and guidance on prevention, both in general and in the particular context of the vulnerable. In the latter case, premised on their higher risk of becoming drug users.

The National Institute for Health and Clinical Excellence (NICE)<sup>316</sup> has produced guidance on community-based interventions<sup>317</sup> to reduce substance misuse among vulnerable and disadvantaged children and young people (NICE 2007a). This provides advice on helping young people access the right support and services and outlines effective individual, family and group-based support, which can improve motivation, family interaction and parenting skills. These reflect the series of recommendations for prevention produced by, for example, the NTA and reviews from the National Collaborating Centre on Drug Prevention (NCCDP). The latter include that by Burrell *et al.* (2005) which describes an approach to service provision based on the four-tiered model of service which is premised on the idea that such an approach enhances the ability of a range of agencies to work closely together to provide a seamless service. Also, from the NCCDP are research reports on drug prevention amongst vulnerable groups (Edmonds *et al.* 2005), a report on drug prevention effectiveness within the grey literature (McGrath *et al.* 2006) and a more recent report on the evidence base for prevention initiatives (Sumnall *et al.* 2006b) (see below).

NICE makes recommendations with respect to different groups of children and young people:

- all those under the age of 25 who are vulnerable and disadvantaged;
- those who are vulnerable and disadvantaged, aged 11 and 16 years, and assessed to be at high risk of substance misuse, and their parents or carers;
- children aged 10 to 12 who are persistently aggressive or disruptive and assessed to be at high risk of substance misuse and their parents or carers; and
- those who are vulnerable and disadvantaged under 25 who are problematic substance misusers (including those in schools or further education).

For any child or young person under the age of 25 who is vulnerable and disadvantaged, local strategic partnerships are expected to develop and implement a strategy to reduce substance misuse amongst this group as part of a local area agreement. In addition, practitioners and others who work with this group (NHS, local authorities and the education<sup>318</sup>, voluntary, community, social care, youth and criminal justice sectors) are expected to screen for drug misuse or risk of misuse. It is also recommended that they work with parents or carers, education welfare services, children's trusts, child and adolescent mental health services, school drug advisers or other specialists to either provide support or referral to appropriate service providers.

For those aged 11 to 16 assessed to be at high risk of substance misuse it is recommended that parents or carers should be offered a family-based programme of

<sup>316</sup> See: <http://guidance.nice.org.uk/PH14/guidance/pdf/English/download.dsp>

<sup>317</sup> Community-based interventions are defined as interventions or small-scale programmes delivered in community settings, such as schools and youth services.

<sup>318</sup> In schools this includes teachers, support staff, school nurses and governors.

structured support over two or more years. More intensive support (for example, family therapy) is recommended for families who need it.

For children aged 10 to 12 who are persistently aggressive or disruptive and assessed to be at high risk of substance misuse, it is recommended they be offered group-based behavioural therapy over one to two years before and during the transition to secondary school. It is recommended that sessions take place once or twice a month and last about an hour, each session focusing on coping mechanisms such as distraction and relaxation techniques: help develop the child's organisational, study and problem solving skills; and involve goal setting. In addition, it is suggested that parents or carers be offered group-based training in parental skills on a monthly basis, over the same time period (as the child). It is recommended that sessions focus on stress management, communication skills and how to help develop the child's social-cognitive and problem solving skills and advise on how to set targets for behaviour and how to establish age related rules and expectations for their children.

NICE also recommends that vulnerable and disadvantaged children and young people aged under 25 who are problematic substance misusers (including those attending secondary schools or further education colleges) should be offered one or more motivational interview(s) according to the young person's needs. Each session should last about an hour and the interviewer should encourage them to discuss their use of both legal and illegal substances, reflect on any physical, psychological, social, education and legal issues related to their substance misuse and set goals to reduce or stop misusing substances.

In Scotland guidance is provided on assessing young people at risk (EIU 2004).

#### *Drug use prevention among young people*

The National Collaborating Centre on Drug Prevention has looked at evidence of the effectiveness of practice (Sumnall *et al.* 2006b). This follows an earlier review of the evidence in McGrath *et al.* (2006). Key findings include:

- there is a limited amount of evidence to suggest that brief interventions may successfully help young people to moderate their drug use;
- moderately intensive family-based interventions can have a positive effect upon a wide range of outcomes, including drug use, problem behaviours, educational engagement, and offending;
- approaches in nightlife settings should promote healthy lifestyles in addition to consideration of drug use; and
- there is often little consideration of non drug-related outcomes in prevention projects (e.g. health).

#### 12.6.1 Treatment for young problematic drug misusers

In England, a target has been set to increase the number of young people under 18 with drug problems entering, receiving and completing treatment programmes by 50 per cent between 2004 and 2008, with NTA monitoring performance (HM Treasury 2004). In 2005 the NTA provided guidance on the essential elements of a young people's substance misuse treatment services (NTA 2005). In addition, a directory of substance misuse services for young people in England has been published by NTA<sup>319</sup> and a directory of residential services for young people under 18s.<sup>320</sup> A recent joint review by DfES and NTA found that there is still considerable regional

<sup>319</sup> For information see:

[http://www.nta.nhs.uk/about\\_treatment/treatment\\_directories/young\\_people/default.aspx](http://www.nta.nhs.uk/about_treatment/treatment_directories/young_people/default.aspx)

<sup>320</sup> For information see: [http://www.nta.nhs.uk/programme/national/Young\\_per\\_cent20people\\_per\\_cent20directory.pdf](http://www.nta.nhs.uk/programme/national/Young_per_cent20people_per_cent20directory.pdf)



variation in investment, access and quality of provision for under 18s, not necessarily reflecting local needs. From April 2008 the NTA is to take on a leadership role for young people's substance misuse treatment in England.<sup>321</sup>

### *Young Offenders*

As with young people in other vulnerable groups, in England and Wales, each stage of the youth justice system is seen as an opportunity to identify those at risk of becoming problematic users or who are in need of specialist treatment (YJB 2006b; WAG 2006b). All are expected to receive screening for substance misuse issues and those identified with a problem to receive an assessment within five working days, and within 10 working days of this, access to early intervention or treatment services.

At the end of the 2005/2006 period, performance statistics for England showed that 92.7 per cent of young offenders accessing youth offending teams received a substance misuse screening.

In addition, the Drug Interventions Programme<sup>322</sup> in England has piloted youth-centred models of arrest referral and drug testing for 14 to 17 year olds charged with those crimes that are most often linked to drugs.<sup>323</sup> An evaluation of these schemes found few young people involved in the arrest referral pilots to be problematic drug users and only five per cent using Class A drugs, therefore, there was insufficient evidence to demonstrate its effectiveness. Sumnall *et al.* (2006b) (see earlier) found some evidence that interventions for young offenders may reduce rates of offending, re-offending and imprisonment in the short term.

### *Persistent truants and school excludees*

NICE (2007) (see above) recommend drug misuse assessments be carried out in school or pupil referral units and that, those found to use drugs or be at risk of using them, should receive appropriate support with the aim of returning them to mainstream education. In their review of drug prevention, Sumnall *et al.* (2006b) (see earlier) found some evidence that community based truancy interventions have significant effects upon psychosocial factors that subsequently modulate drug use and that school-based social work schemes evaluated in the United Kingdom have some short term effect on drug use.

### *Looked after children*

In the Care Matters green paper, the former DfES set out the steps it will take, together with local delivery partners, to improve outcomes for children and young people in care, including addressing drug misuse (DfES 2006f).

### *Homeless Young People*

There is a lack of guidance on effective prevention and treatment for homeless young people. Existing documents mostly centre on policy, service delivery and engagement with adult drug users. NICE (2007) reported no United Kingdom guidance for this population.

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<sup>321</sup> For more information see: [www.nta.nhs.uk](http://www.nta.nhs.uk)

<sup>322</sup> For more information see: <http://www.drugs.gov.uk/drug-interventions-programme/>

<sup>323</sup> Arrest referral schemes for children and young people (10 to 17 year olds) were piloted in ten areas; all were operational from August 2004. On-charge drug testing of 14 to 17 year olds under Section 5 Criminal Justice Act (CJA 2003); piloted in five areas have been operational from August 2004. Statutory powers to test young people at the pre-sentence stage and while on licence also exist under the CJA 2003 but were not enacted during the evaluation period.



### *Children and young people with behavioural, mental health or social problems*

NICE (2007) provided guidance around monthly, group-based behavioural therapy sessions for children aged 10 to 12 who are persistently aggressive or disruptive and assessed to be at high risk of substance use. It also recommends that group-based training in parenting skills for the parents or carers of the children should take place at the same time.

### *Ethnic Minorities*

There is a lack of guidance on effective prevention and treatment for ethnic minorities. Existing documents mostly concerns policy, service delivery and engagement with adult drug users. NICE (2007) reported no guidance for this population.

### 12.6.2 Institutional responses

Custodial establishments are required to develop a youth resettlement plan with the young person and their Youth Offending Team (YOT) worker prior to their release, which should include substance misuse where relevant. Secure establishments and specialist substance misuse services are expected to work together to improve continuity of care between custody and the community. It is expected that information from specialist assessments, care plans and resettlement plans be shared, with consent, to reduce the need for repeat assessments and improve the young person's journey through the system. In some cases the YOT will act as a main conduit for this information; in other complex cases, the specialist substance misuse services will assume this role (NTA 2007h).

### 12.6.3 Responses in the area of social exclusion

There are two major drug prevention related initiatives in this area, social inclusion programmes such as Positive Futures and an initiative focused in deprived areas, the High Focus Area (HFA) initiative. In addition, there are more generic initiatives, and it should be noted that policy throughout the United Kingdom is now looking towards such initiatives, seeing drug misuse as just one of many issues for young people that require addressing and developing early intervention programmes, that aim to improve the ability of children to reach their potential. These include programmes such as Sure Start<sup>324</sup>, targeting the very young.

### *Positive Futures*

Positive Futures was launched in 2000, and is a national sports and activity based social inclusion programme using sport and leisure activities to engage with disadvantaged and socially marginalised young people aged between 10 and 19. It is funded by the Home Office Crime and Drug Strategy Directorate and managed by Crime Concern. Currently, it operates through over 120 local projects across England and Wales. The Home Office suggests that Positive Futures is not a 'diversionary' or a sports development programme as traditionally understood and practiced. Rather, it is a 'relationship strategy' which seeks to engage with young people through an ability to teach or help them learn something they think is worthwhile, using sport and other activities as a basis for establishing relationships with young people who have otherwise become alienated and distanced from mainstream social policy agencies and 'authority' figures. Its aim is to 'have a

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<sup>324</sup> Sure Start is a government programme in England which aims to achieve better outcomes for children, parents and communities by increasing the availability of childcare for all children, improving health and emotional development for young children, and supporting parents as parents and in their aspirations towards employment. For more information see: <http://www.surestart.gov.uk/>

positive influence on participants' drug use, physical activity and offending behaviour by widening horizons and access to lifestyle, educational and employment opportunities within a supportive and culturally familiar environment' (Home Office 2003). A final report outlines the key findings from the programmes (Crabbe *et al.* 2006) and focuses on processes rather than outcomes giving guidance on how to run future projects.

The Scottish Executive has published an Evaluation and Description of Drugs Projects Working with Young People and Families funded by Lloyds TSB Foundation Partnership Drugs Initiative (PDI) (McIntosh *et al.* 2006). This report provides case study process and outcome evaluation of four projects in Scotland. Positive changes were reported by young people in both use of substances and risk factors for use. PDI is a funding initiative providing grants to voluntary sector organisations working with children and young people affected by drugs and alcohol misuse. Current projects funded by this initiative are targeted on such groups as pre-teen drug users, children growing up in families affected by parental drug use, and those who are developing problem behaviours, including drug and alcohol misuse, in their mid teens. The Scottish Executive provided €5.1 (£3.5) million funding to the PDI between 2000 and 2005, with a further €1,010,000 (£750,000) agreed for financial year 2006/07.

#### *High Focus Areas*

In England, a High Focus Areas (HFA) initiative was launched in April 2005 in 30 local authority areas to support faster and sustained progress in implementation of universal, targeted and specialist services as set out in strategic guidance *Every Child Matters: Young People and Drugs*, and to learn from their experience. The areas were selected on the basis of local need and levels of current service provision, including deprived/high crime areas where drug misuse problems are prevalent. Objectives are to develop and test a best practice model for wider dissemination; and to make an early and sustained impact on delivery of drug services for children and young people.

#### 12.6.4 Responses to public nuisance

There is no specific response for young people at risk of drug use *per se* with respect to public nuisance, although powers provided to the police and Local Authorities through the *Anti-Social Behaviour Act 2003*, which is designed to tackle nuisance associated with properties used for the sale and use of crack and other drugs can be used. Also, *Anti-Social Behaviour Orders* (ASBOs) were introduced following the *Crime and Disorder Act 1998*.<sup>325</sup> The Respect agenda is a cross-Government strategy aimed at tackling bad behaviour and nurturing good behaviour<sup>326</sup>.

#### 12.6.5 Trends and changes in recent year

The most important trend in recent years has been the move towards seeing drug prevention amongst the vulnerable, and, more particularly prevention and treatment of problematic drug use amongst this group, as being part of a more generic response to tackling a wider range of health and social problems, rather than just seeking to address drug use in isolation from other problems.

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<sup>325</sup> For more information see:

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

<sup>326</sup> For more information see: <http://www.respect.gov.uk>

### 12.6.6 Early intervention strategies

Early intervention strategies in the United Kingdom tend to be defined in terms of strategies both aimed at reducing substance misuse and related risk-taking behaviour among vulnerable groups, such as the programme in the London Boroughs of Lambeth, Southwark and Lewisham Health Authority, targeting young offenders, children of drug using parents, socially excluded young people, and young people excluded from school (Ghate *et al.* 2003) or, more recently projects such as those targeting very young people where there are problems in their families, such as substance misuse (see section on children of drug using parents for projects in Wales).

The National Institute for Health and Clinical Excellence (NICE) has issued national standards calling for anyone who works with young people to identify those who are vulnerable to drug problems, and intervene at the earliest opportunity - before they start using drugs at all or before they get into worse problems if they are already misusing drugs. It gives advice on stepping in and helping young people access the right support and services, and outlines effective individual, family and group-based support which can improve motivation, family interaction and parenting skills. It also recommends that local strategic partnerships develop and implement substance misuse reduction strategies for vulnerable young people based on local area profiles that should be developed on the basis of age, factors that make them vulnerable and other locally agreed characteristics.

### 12.6.7 Selective prevention for families at risk

#### *Children of drug using parents*

As noted previously, the ACMD report on the children of drug using parents, *Hidden Harm*, may be seen as a catalyst in terms of a government response to the needs of vulnerable young people as a whole, coinciding as it did with policy designed to enable young people to reach their potential (ACMD 2003). ACMD made a number of recommendations with respect to these young people. A further report was recently published describing the extent to which the recommendations have been implemented and points to areas where work is still required (ACMD 2007a). It is suggested that despite sustained policy developments regarding children, there is evidence of differing levels of priority accorded to the actual and potential harm experienced by them across the four countries, and therefore the depth and breadth of implementation has been markedly different.

In Wales there are two specific initiatives to support the children of substance misusing parents:

- Option 2 is a family intervention service that responds to a crisis that could result in children having to be taken into care. The aim of the service is to develop and encourage new behaviours within the family so that they can move beyond the crises.
- An Early Parental Intervention Service Programme is being developed and piloted. The focus of the service is on families where an adult's substance misuse has been identified as having an impact on their parenting capacity. The aim is to deliver early preventative services in order to prevent a crisis that could result in children being taken into care (Internal communication Welsh Assembly Government).

Sumnall *et al.* (2006b) found that high intensity, family-based intervention programmes with children of drug using parents have shown to have an effect on drug-related behaviours.

The Bottling It Up report (Turning Point 2006) found that there are currently gaps in service provision for children who are affected by parental alcohol misuse. The research was based on interviews with children and parents affected by alcohol misuse and highlighted the far-reaching consequences of parental alcohol problems on everyone in the family. It found that families generally received little support to help address the practical and emotional issues that arise. If an adult problematic drinker accesses services, they largely find their role as a parent is not addressed. Many parents told Turning Point that they were struggling to meet their children's basic care needs or provide adequate emotional support, and children had to rely on either their own coping strategies or resilience, or the support of others to get by. It was also reported that staff in adult alcohol services often feel ill-equipped to meet the needs of children of misusing parents, and therefore concentrate on adults. In children's services, many staff feel that they lack the knowledge, skills and confidence to address parents' substance related problems even where they affect children. Very few professionals are confident about addressing the needs of both client groups. As a result, significant gaps exist in specialist provision and where services do exist, the focus is primarily on parental drug misuse, rather than alcohol. The report calls for direct services for children of alcohol-misusing parents to meet their specific needs, as well as providing support directly to their parents so that they can improve their parenting. It goes on to say that services that work with alcohol-misusing adults should have protocols in place to protect children, and to provide prompt access to a wider range of specialist services when required.

#### *Engaging vulnerable families*

The Bouncing Back! prevention programme aims to pilot and develop good practice, knowledge and expertise to engage vulnerable family members, carers and parents in drug education initiatives. The programme recognises the links between positive parenting education and drug awareness (ADFAM 2007). The project work includes workshops for parents, filmmaking and drama with young people, group work with fathers and drug education for foster carers. The projects produced resources for working with families, including resources for practitioners, DVDs, magazines and toolkits. All the projects illustrated that with good partnership working, innovation, significant resources and planning, vulnerable and diverse families can become involved in drug and alcohol prevention programmes. The Department of Health is funding the production of a training/ resource pack as a follow-up to this programme.

## 13. Drug-related research in Europe

### 13.1 Research structures

#### 13.1.1 Drug-related research in national policy

A United Kingdom Drug Strategy, *Tackling Drugs to Build a Better Britain*, was launched in 1998 (UKADCU 1998). One of the underlying principles of the strategy was that it should be evidence based and the strategy identified the research and information needs for each of its four aims: preventing drug use amongst young people; safeguarding communities; providing treatment; and reducing availability. In 2002, the updated Strategy (DSD 2002) set out progress in developing the evidence base including the development of a performance management framework. A three month consultation on the development of the new Drug Strategy ran from July to October 2007.

The devolved administrations have their own drug strategies. In Scotland, *Tackling Drugs in Scotland: Action in Partnership* (Scottish Office 1999) explicitly laid out the role of information and research in implementing the Drug Strategy. This was complemented by the *Scottish Drug Misuse Information Strategy* to “support the implementation of current Government policies, and provide a basis for monitoring their application and continuing appropriateness” (Scottish Office 1998).

Similarly, a key component of the Welsh Strategy, *Tackling Substance Misuse in Wales: A Partnership Approach* (National Assembly for Wales 2000) is to address the substance misuse information and research gap and improve the evidence base for evaluating progress. The Strategy expires in 2008 and consultation on a new strategy has identified seven key themes, one of which is to further develop the evidence base.

Northern Ireland launched a new combined drugs and alcohol strategy in 2006 (DHSSPSNI 2006) with monitoring, research and evaluation identified as one of five supporting pillars. Main areas of research will be identified through various new groups although as yet no definite priorities have emerged.

#### 13.1.2 Relationship between research and policy

The need for policy to be evidence based is a central tenet of the government's policy making agenda (Cabinet Office 1999) and the different drug strategies throughout the United Kingdom all place a strong emphasis on research.

##### *Research evidence for policy making*

There are concrete examples of research informing drug policy by providing an evidence base on which to make policy decisions. In the 1990s, the Task Force responsible for the Effectiveness Review<sup>327</sup> commissioned nine research projects including the National Treatment Outcomes Research Study (NTORS) concluding that ‘treatment works’, now an established principle of drug strategies across the United Kingdom (MacGregor 2006).

Research is often undertaken to address a specific knowledge gap. In Scotland, a review of drug misuse research was undertaken in 2000 to identify a programme of research in support of the Scottish Drug Misuse Strategy. The report by McIntosh

<sup>327</sup> The Taskforce was established in April 2004 to look at the effectiveness of treatment for people who misuse drugs. It ran for 2 years and had a budget of £1 million.

and McKeganey (2000) assessed the contribution of research to the Strategy and suggested improvements to the evidence base, including the need for a clear research strategy.

In Wales, ten research projects were recently commissioned by the National Public Health Service for Wales (NPHS Wales), with the support of Welsh Assembly Government (WAG) to provide evidence for the upcoming Blood Borne Viral Hepatitis Action Plan for Wales. The programme includes research estimating the prevalence of problem drug use and incidence of Hepatitis C amongst IDUs in full and feeds in to the strategy.

Similarly, research estimating prevalence of problem opiate and problem cocaine use was commissioned in Northern Ireland in recognition of its importance in formulating policy (Hay *et al.* 2006b).

#### *Linking research with policy development: Blueprint*

Blueprint is the largest research programme ever run in England. The five year programme commenced in 2003 and will run at an overall cost of around £6.5 million with the aim of designing, delivering and evaluating an evidence-based drug prevention programme. At all stages of the programme's development existing evidence on drug prevention programmes has been reviewed and supplemented with culturally-specific research on teaching and learning practice in addition to market research with pupils, teachers and parents.

The research strategy employed by Blueprint places evidence at the heart of drug education from needs assessment and curriculum development to policy development and evaluation. The final evaluation, due to be published in 2008 will assess the relationship between education and outcomes across all elements of programme. The research combines process, impact and outcome evaluation, uses quantitative, qualitative and economic methods and comprises 12 inter-related evaluation components. It is hoped that the evaluation will be 'formative' in that it may guide changes to programme design and delivery (Baker 2006).

### 13.1.3 Main national structures for drug-related research

#### *Government coordination bodies for drug-related research*

The UK Drug Strategy is a cross-government initiative with the Home Office taking overall responsibility for delivery. The Department of Health has responsibility for treatment targets and a programme of research to support this. The devolved administrations also commission and fund research to support the development of their drug strategies.

#### *Drug-related research in England*

Crime and Drugs Analysis and Research is an embedded Home Office Research, Development and Statistics team that undertakes drugs research and analysis<sup>328</sup>. The team is responsible for developing and maintaining the evidence base that supports the Government's Drug Strategy. In addition to on-going work to monitor performance and measure progress against the Home Office's Public Service Agreements, the team undertakes analysis of the nature and scale of problematic drug use and the impact of interventions to tackle it. Major pieces of research undertaken include PDU estimates, cost studies, sizing the drug market and the Arrestee Survey.

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<sup>328</sup> See <http://www.homeoffice.gov.uk/rds/drugs1.html>



The Drug Misuse Research Initiative (DMRI)<sup>329</sup> was a £2.4 million programme of research between 2000 and 2005. Based within the Department of Health Policy Research Programme it comprised 14 studies on drug misuse. Phase two ROUTES<sup>330</sup> (research on understanding treatment experiences and services) comprises of 10 projects related to drug treatment and will run between 2005 and 2008 at a cost of around £1.4 million.

The National Treatment Agency (NTA) also has a remit to undertake research to develop the evidence base related to treatment, for example, an ongoing programme of epidemiological research from the National Drug Evidence Centre at the University of Manchester.<sup>331</sup> Other government departments, such as the Department for Transport occasionally carry out drug-related research projects. A recent example is Drug Futures<sup>332</sup>, a programme run by the Office for Science and Technology (OST) based at the former Department for Trade and Industry (DTI). The programme explored the impact that scientific and technological advances may have on our knowledge and understanding of addiction and drug use.

The Alcohol and Drugs Policy Branch (ADPB) within the Department for Health, Social Services and Public Safety Northern Ireland (DHSSPSNI) has lead policy responsibility for delivery of the New Strategic Direction (NSD)<sup>333</sup>. The Drug and Alcohol Information and Research Unit within DHSSPSNI is the main coordination branch for drug-related research linked to the NSD. Both are based in the same government department and work closely together in linking research and policy, and through widespread dissemination of research findings this feeds into practice. Other organisations such as the Health Promotion Agency also conduct drug-related research on occasion specifically linked to the delivery and evaluation of public information campaigns. Other locally based research is also commissioned through the four Drug and Alcohol Coordination Teams based in each of the Health Boards. Major pieces of research include the Drug Prevalence Survey carried out with Ireland.

#### *Drug Analytical Programme in Scotland*

The Drugs Analytical Team co-ordinates analytical activity relating to drugs within the Scottish Executive. It sits within a broader Justice Analytical Programme and combines research, statistical, and economic analysis in order to develop and promote use of the evidence base on key drugs policy issues. The Team works closely with analytical colleagues in other areas, and in particular with health on alcohol-related issues and the Information Services Directorate (ISD Scotland) which collates and disseminates information from a wide range of sources including the Scottish Drug Misuse Database and a national study of Prevalence of Problem Drug Use in Scotland. The current analytical programme includes research on homelessness and substance misuse, drug deaths, police and prison staff occupationally exposed to blood and/or body fluids, and a project to assess the scale and impact of illicit drug markets in Scotland. Statistical work around drug treatment data management and drug seizures is also an ongoing part of the team's work.

<sup>329</sup> See <http://www.mdx.ac.uk/www/drugsmisuse/>

<sup>330</sup> See <http://www.lshtm.ac.uk/research/dmri/>

<sup>331</sup> See <http://www.medicine.manchester.ac.uk/ndec/>

<sup>332</sup> See

[http://www.foresight.gov.uk/Previous\\_Projects/Brain\\_Science\\_Addiction\\_and\\_Drugs/index.html](http://www.foresight.gov.uk/Previous_Projects/Brain_Science_Addiction_and_Drugs/index.html)

<sup>333</sup> See

[http://www.dhsspsni.gov.uk/index/stats\\_research/public\\_health/statistics\\_and\\_research-drugs\\_alcohol-2.htm](http://www.dhsspsni.gov.uk/index/stats_research/public_health/statistics_and_research-drugs_alcohol-2.htm)

*Drug-related research in Wales*

Based within the Community Safety Division of the Welsh Assembly Government's Department for Social Justice and Local Government, substance misuse research forms part of the department's overall research and evaluation plan.

*Research institutions and organisations*

Many universities carry out drug-related research within relevant research institutes, centres and groups. Some of those most actively involved in drug-related research are listed in Table 13.1.

*Table 13.1: University research groups and institutes currently undertaking drug-related research*

<b>Research institution</b>	<b>University</b>
Addictions Research Group	Keele University
Birmingham Alcohol, Drugs, Gambling & Addiction Group	University of Birmingham
Centre for Addiction Research & Education Scotland	University of Dundee
Centre for Drug Misuse Research	University of Glasgow
Centre for Public Health	Liverpool John Moores University
Centre for Drugs & Health Behaviour	London School of Hygiene & Tropical Medicine
Department for Health Science	University of York
International Centre for Drugs Policy and Department of Addictive Behaviour	St. George's, University of London
Mental Health Research and Development Unit	University of Bath
National Addiction Centre	Kings College London
National Drug Evidence Centre	University of Manchester
Oxford Substance Misuse Research Group	Oxford Brookes University
Scottish Addiction Studies	University of Stirling
Drug & Alcohol Research Group	Middlesex University

In addition, a number of non-academic organisations undertake drug-related research when commissioned to do so. This includes survey organisations, general research institutes and charities.

*Main funding frameworks*

A review of drugs research in 2000 claimed that research funded by government departments dominated the total national research effort (MacGregor 2000). This remains the case with the government directly funding the majority of drug-related research in the United Kingdom. Government research is occasionally carried out in-house but is often commissioned from outside providers using competitive tendering for contracts. In addition to research programmes such as ROUTES, money is available for individual research studies. In Northern Ireland, £0.2 million has been allocated for policy development/research in 2007/08.

Research Councils also provide funding for academic research, including drug-related research. The Economic and Social Research Council (ESRC) is a publicly funded, independent organisation that funds research and training in social and economic issues. In 2006/07 £99.8 million was spent on research, 25 per cent of which was on research programmes, 17 per cent on research centres and 27 per cent on research grants. Drug-related research projects can be funded through direct research grants such as the current £0.23 million *Governing drug-related crime*

*in the risk society* project grant and can also form part of a larger linked research programme such as the recently published *Risk, protection and substance misuse amongst young offenders* project which was one of five projects funded from the £1.41 million priority network programme, *Pathways Into and Out of Crime: Risk, Resilience and Diversity*.

Similarly, the Medical Research Council provides funding for medical research and is currently funding a number of projects on addiction. They range from small grants of £60,000 for a two year project, *Pathfinder - An investigation of trait impulsivity and vulnerability to drug addiction* to the five year £2 million project on *Neural and psychological basis of compulsive drug seeking and relapse prevention in drug addiction*.

Another major source of funding for drug-related research is the Joseph Rowntree Foundation, a social research charity spending around £10 million per year on research and development. A Drug and Alcohol Research Programme ran from 2001 to 2005 at a cost of £1.5 million; funding a large number of drug-related research projects and a small number of alcohol projects. However, in 2007 a new programme of research began with a sole focus on alcohol.

In Scotland, the Robertson Trust sponsors drug-related research as a major topic in one of its four priority areas. Other research funding organisations may provide ad-hoc funds for drug-related research but it is not, or has not recently been an identified priority area for research.

## 13.2 Main recent studies and publications

### 13.2.1 Main recent studies since 2000

There is a wealth of high-quality research studies across the United Kingdom, which makes it difficult to isolate individual projects for attention. Some important large projects such as Blueprint have been mentioned previously so will not be included in this section.

#### *Drug Treatment Outcomes Research Study*

In England, DTORS (Drug Treatment Outcomes Research Study)<sup>334</sup> is currently running and will provide a valuable update to research on treatment outcomes. The research is being carried out by the National Drug Evidence Centre (NDEC) at the University of Manchester and the National Centre for Social Research (NatCen). Funded by the Home Office, the cost of the project is estimated to be around £2 million.

**Background:** The National Treatment Outcome Research Study (NTORS)<sup>335</sup> was a study carried out in England and Wales between the years 1995 and 2000 and was able to make a clear case for the effectiveness and cost-effectiveness of treatment. Since NTORS the UK has seen some major changes in treatment provision that make it necessary to reinvestigate the impact of different drug treatment pathways on treatment outcomes

**Objectives:** The aims of the research are to: evaluate the impact of drug treatment on a range of outcome measures; establish which types of treatment pathways produce the best outcomes for particular sub-groups of drug users; provide a cost-benefit analysis of drug treatment based on the outcome measures; and explore

<sup>334</sup> See: <http://www.dtors.org.uk/DTORSHome.aspx>

<sup>335</sup> See: <http://www.dtors.org.uk/NTORS.aspx>

reasons for the non take-up of drug treatment of problematic drug users who refuse or drop out of treatment.

**Methods:** DTORS is divided into three separate study components. A quantitative study will follow a baseline sample of drug users from 100 randomly selected DATs and will adopt a longitudinal cohort design comprising of survey interviews with clients at the outset of treatment and at three and 12 months. The qualitative component consists of in-depth interviews with both service providers and service users selected using purposive sampling. Finally the cost-benefit analysis will use cost consequences analysis to descriptively compare the costs and outcomes of drug treatment. Cost benefit analysis will be used to estimate the net benefit (cost) of drug treatment

**Results/conclusions:** Early indicative findings are due late 2007 with further reports to be published during 2008.

#### *Estimating the National and Local prevalence of problem drug use in Scotland*

**Background:** There is a recognition that the prevalence of problem drug misuse should be an essential part of the evidence base used to formulate policy (Hay *et al.* 2006b). However, until 2001 there had been no robust national estimates of problem drug use due to a lack of reliable data sources and methodological difficulties. The increased use of monitoring systems across the public sector improved reliability while the capture-recapture method has become an accepted method for estimating problem drug use. The estimates published in Scotland were the first robust national estimates utilising the capture-recapture method and will be described here.

**Objectives:** To provide national and local estimates of the prevalence of problematic drug misuse within Scotland in 2000 (Hay *et al.* 2001).

**Methods:** The study utilised the capture-recapture methodology. The method involved collating information on drug misusers in contact with a wide range of agencies to provide a minimum enumeration of the known drug misusing population. Statistical methods were then applied to these collated data to obtain an estimate of the size of the hidden population, which combined with the known data provided an estimate of the total prevalence of drug misuse.

**Results/conclusions:** The study provided the first ever national and local estimates of problematic drug use and showed that there were problematic users in rural as well as urban areas. The report also showed that it is possible to provide reliable estimates and paved the way for future estimates. The study has been repeated to provide estimates for 2003 and will be repeated again to provide 2006 estimates.

Since 2001 England (Hay *et al.* 2006a), Northern Ireland (Hay *et al.* 2006b) and Scotland (Hay *et al.* 2004) have all published national estimates while Welsh estimates are currently being produced. In England a three year programme to provide consecutive annual estimates is underway.

#### *Substitute prescribing for opiate dependence in Northern Ireland*

**Background:** In Northern Ireland the number of people dependent on heroin was traditionally small and far below the levels in other parts of the United Kingdom. Consequently there was no formal substitute prescribing system in Northern Ireland although individual doctors could prescribe heroin substitutes.

In 2002, however, estimates of problem heroin use were published putting the number between 695 and 1250 (McElrath 2002). To complement these findings,

DHSSPSNI commissioned a review of research on substitute prescribing for opiate dependence in Northern Ireland (McElrath 2003).

**Objectives:** To review the research evidence for substitute prescribing for opiate dependence.

**Methods:** An international literature review of both clinical and observational studies.

**Results/conclusions:** The final report set out 19 recommendations, the principal recommendation being the introduction of a methadone maintenance programme in Northern Ireland. DHSSPSNI accepted this recommendation leading to the publication of national guidelines on substitute treatment for opiate dependence (DHSSPSNI 2004).

### 13.2.2 Peer-reviewed scientific journals

Table 13.2 lists drug-related research articles published in scientific journals during 2006.

*Table 13.2: Drug-related articles published in scientific journals by UK based researchers in 2006*

Reference
Aceijas, C., Friedman, S., Cooper, H., Lucas Wiessing, Stimson, G., Hickman, M. (in press) Estimates of injecting drug users at the national and local level and gender and age distribution. <u>Sexually Transmitted Infections</u> .
Afuwape, S., Johnson, S., Craig, T., Miles, H., Leese, M., Mohan, R. and Thornicroft, G. (2006). Ethnic differences among a community cohort of individuals with dual diagnosis in South London. <u>Journal of Mental Health</u> 15 (5): 551-567.
Baker, P.J. (2006). Developing a Blueprint for evidence-based drug prevention in England. <u>Drugs: education, prevention and policy</u> .13: 17–32.
Bakker, A. and Fazey, C. (2006). Methadone tolerance testing in drug misusers. <u>British Medical Journal</u> 333: 1056-1059.
Bargagli, A M., Hickman, M., Davoli, M., Perucci, C A., Schifano, P., Buster, M., Brugal, T. and Vicente, J. (2006). Drug related mortality and its impact on adult mortality in eight European Countries. <u>European Journal of Public Health</u> 16: 198-202.
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Barrowclough, C., Haddock, G., Fitzsimmons, M. and Johnson, R. (2006). Treatment development for psychosis and co-occurring substance misuse: A descriptive review. <u>Journal of Mental Health</u> 15 (6): 619-632.
Bennett, J. and Whale, R. (2006). Galactorrhoea may be associated with methadone use. <u>British Medical Journal</u> 332: 1071.
Bennett, T. and Holloway, K. (2006). Variations in drug users' accounts of the connection between drug misuse and crime. <u>Journal of Psychoactive Drugs</u> 38(3): 243-254.
Beynon, C.M., Sumnall, H.R., McVeigh, J., Cole, J.C. and Bellis, M.A. The Ability of Two Commercially Available Quick Test Kits to Detect Drug-Facilitated Sexual Assault Drugs in Beverages. <u>Addiction</u> . (in press)
Beynon, C.M. and McVeigh, J, (in press). The role of Substance use in non-drug related deaths: a cross sectional study of drug treatment clients in the North West of England. <u>Journal of Substance Use</u> .
Beynon, C.M. and Bellis, M.A. and McVeigh. J. (2006). Trends in drop out, drug free discharge and rates of re-presentation: a retrospective cohort study of drug



treatment clients in the North West of England. <u>Public Health</u> 6: 205.
Bloor, M., Neale, J., and McKeganey, N. (2006). Persisting local variations in prevalence of hepatitis C virus among Scottish problem drug users: Results from an anonymous screening study. <u>Drugs: education, prevention and policy</u> 13 (2): 189–91
Bolding, G., Hart, G., Sherr, L. and Elford, J. (2006) Use of crystal methamphetamine among gay men in London. <u>Addiction</u> 101: 1622-1630
Boylan, J., Braye, S., Worley, C. (2006). Life's a gas? The training needs of practitioners and carers working with young people misusing volatile substances. <u>Social Work Education</u> 25 (6): 591-607.
Cameron, I., Matheson, C., Bond, C., van Teijlingen, E., Wardell, F., Cronkshaw, G. and Lawrie, T. (2006) A national survey of nurses working in the management of illicit drug misuse in Scotland. <u>International Journal of Drug Policy</u> 17: 442-446
<u>The Criminal Justice and Immigration Bill 2006-07</u> . The Stationary Office, London
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Coggans, N. (2006) Drug education and prevention: Has progress been made? <u>Drugs: education, prevention and policy</u> 13 (5): 417-422
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Forrester, D. and Harwin, J. (2006). Parental substance misuse and child care social work: Findings from the first stage of a study of 100 families. <u>Child and Family Social Work</u> 11: 325-335.
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Godfrey, C. Evidence-based illicit drug policy: the potential contribution of economic evaluation techniques. <u>De Economist</u> 154(4): 563-580
Gordon, R., McDermott, L., Stead, M. and Angus, K. (2006) The effectiveness of social marketing interventions for health improvement: What's the evidence? <u>Public Health</u> 120: 1133-1139
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### 13.3 Collection and dissemination of research results

#### 13.3.1 Information flows

##### *Focal Point structure*

The United Kingdom Focal Point is based at the Department of Health and the North West Public Health Observatory, Liverpool John Moores University. Members of the Focal Point team collate data and information from a number of partners including relevant government departments, the devolved administrations and leading experts in the United Kingdom.

##### *Information collection and dissemination*

There is an expert for each of the epidemiological indicators who provide valuable data and information about their relevant fields. Workshops are held to discuss and agree what data is available for each indicator in the United Kingdom and each year the experts compile a report on the status of implementation of the relevant indicator.

Standard tables and structured questionnaires are completed in collaboration with the relevant partners taking into account data available in each of the four administrations. The Annual Report is completed by Focal Point staff with contributions from experts and consultation with partners.

In addition to workshops on the key indicators, the Focal Point is an active member of the Research and Information Working Group (RIWG). RIWG provides a network for the exchange of information between those involved in government drugs research and promotes good practice when developing drug-related research.

The Focal Point maintains a listing of current research and recent publications including journal articles. This is circulated amongst RIWG members and sent to those involved with the Pompidou Group.

The listing is also available on the Focal Point website which also contains information about the work of the Focal Point and provides access to recent standard tables and the UK Focal Point's Annual Report. It is envisaged that the UK Focal Point website will continue to develop and provide a valuable resource for the dissemination of detailed country specific drugs data, information and research in the UK.

### 13.3.2 National scientific journals

Six of the major national journals dedicated to drug or addiction research are described below. All abstracts are published in English. By definition some of these are not national journals but international.

#### *Drug research journals*

**Addiction** is an international monthly journal published by the Society for the Study of Addiction. It contains peer-reviewed research reports on alcohol, illicit drugs, tobacco and gambling.

**Addiction Research & Theory** is published six times a year by Informa Healthcare. It is an international cross-disciplinary peer-reviewed journal and focuses on the context of substance use and misuse

**Drugs, Education, Prevention and Policy** is published by Informa Healthcare six times a year. It is a refereed journal and publishes research on policy, prevention and harm reduction issues regarding the use of alcohol, tobacco and other drugs. Although it does contain international contributions, the majority are national.

The **International Journal of Drug Policy** is published six times a year by the International Harm Reduction Association. It aims to publish material on the social, political, legal, and health contexts of illicit and licit psychoactive substance use. The journal is international in focus.

The **Journal of Substance Use** is published six times a year by Informa Healthcare. Articles are peer-reviewed and cover a wide range of topics related to illegal and legal drug use including prevention, treatment and policy. Although it publishes international research, the focus is predominately national.

Taylor & Francis have commissioned a new journal, **Mental Health and Substance Use: Dual Diagnosis** which will commence publication in February 2008. There will be three editions a year focusing on current trends and perspectives related to coexisting mental health and substance use. The journal will be peer-reviewed and international in focus.

#### *Other national disciplinary scientific journals*

There is a plethora of journals in the United Kingdom that occasionally publish relevant drug-related research. It is therefore impractical to provide details of each. Table 13.3 lists a selection of national journals that have published drug-related research articles in the past two years.

Table 13.3: National disciplinary scientific journals publishing drug-related research since Autumn 2005

Journal title
Advances in Psychiatric Treatment
British Journal of Criminology
British Journal of Psychiatry
British Journal of Social Work
British Medical Journal
Child & Family Social Work
Critical Social Policy
Emergency Medicine Journal
Epidemiology & Infection
Health and Social Care in the Community
Health Education
International Journal of Epidemiology
Journal of Clinical Pharmacy and Therapeutics
Journal of Mental Health
Journal of Psychiatric & Mental Health Nursing
Journal of Psychopharmacology – this is just drugs
QJM: An International Journal of Medicine
Sexually Transmitted Infections
Social Science & Medicine
Social Work Education
The Lancet
The Probation Journal

### 13.3.3 Other means of dissemination

#### *Websites dedicated to research*

Drug Misuse Information Scotland<sup>336</sup> provides information, statistics and research on drug misuse in Scotland as well as links to other UK research. Drugscope's<sup>337</sup> website includes a comprehensive library of drug literature from the UK and beyond.

The National Collaborating Centre for Drug Prevention (NCCDP)<sup>338</sup> hosts a Drug Prevention Evidence website, which provides details of research carried out both by the NCCDP itself and other organisations.

#### *National drug conferences*

Conferences listed in Table 13.4 are annual national conferences, which include an element of research dissemination. There are also many practical conferences and one-off conferences.

<sup>336</sup> See: <http://www.drugmisuse.isdscotland.org/>

<sup>337</sup> See: <http://www.drugscope.org.uk/>

<sup>338</sup> See: <http://www.drugpreventionevidence.info/>

*Table 13.4: National drug conferences with an element of research dissemination*

<b>Conference</b>	<b>Organiser</b>
Annual Reducing Drug-Related Deaths Conference	North West Ambulance Service NHS Trust
National Conference on Injecting Drug use	Exchange Supplies
National Drug Treatment Conference	Exchange Supplies
DrugScope National Conference	DrugScope
Managing Drug Users in General Practice	Royal College of General Practitioners
Annual Drug & Alcohol Professionals Conference	Federation of Drug & Alcohol Professionals
ANSA (Association of Nurses in Substance Abuse) National Conference	ANSA
National Drugs Conference	ACPO
Centre for Addiction Research & Education Scotland	University of Dundee





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**List of abbreviations used in the text**

A&E	Accident and Emergency
ABC	Activity Based Costing
ACMD	Advisory Council on the Misuse of Drugs
ACORN	A Classification of Residential Neighbourhood
ACPO	Association of Chief Police Officers
ACPOS	Association of Chief Police Officers Scotland
ADATs	Alcohol and Drug Action Teams
AD(H)D	Attention Deficit (Hyperactivity) Disorder
ADPB	Alcohol and Drugs Policy Branch
AIDS	Acquired Immunodeficiency Syndrome
Anti-HBC	Antibodies to hepatitis B virus
Anti-HCV	Antibodies to hepatitis C virus
BCS	British Crime Survey
BHIVA	British HIV Association
BME	Black and Minority Ethnic
BNF	British National Formulary
BYDS	Belfast Youth Development Study
BZP	Benzylpiperazine
CAF	Common Assessment Framework
CAPi	Computer Assisted Personal Interviewing
CARATS	Counselling, Assessment, Referral, Advice and Through-care Services
CCTV	Closed Circuit Television
CDR Weekly	Communicable Disease Report Weekly
CDRPs	Crime and Disorder Reduction Partnerships
CDSC (NI)	Communicable Disease Surveillance Centre Northern Ireland
CDT	Community Drugs Team
CDTD	The Central Drugs Trafficking Database
CI	Confidence Interval
CJA	Criminal Justice Act
COFOG	Classification of the Functions of Government
CSPs	Community Safety Partnerships
D(A)ATs	Drug (and Alcohol) Action Teams
DACTs	Drug and Alcohol Coordination Teams
DAIRU	Drug and Alcohol Information and Research Unit
DASA	Drug Assisted Sexual Assault
DATs	Drug Action Teams
DCSF	Department for Children, Schools and Families
DCLG	Department for Communities and Local Government
DfES	Department for Education and Skills
DFSA	Drug Facilitated Sexual Assault
DH	Department of Health
DHSSPSNI	Department of Health, Social Services and Public Safety Northern Ireland
DIP	Drug Interventions Programme
DIR	Drug Interventions Record
DMRI	Drug Misuse Research Initiative
DORIS	Drug Outcome Research in Scotland
DRD	Drug Related Deaths
DRR	Drug Rehabilitation Requirement
DSD	Drug Strategy Directorate
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4th. Edition
DTORS	Drug Treatment Outcomes Research Study
DTTO	Drug Treatment and Testing Order
DVLA	Driver and Vehicle Licensing Agency
EDDRA	Exchange on Drug Demand Reduction Action
EIU	Effective Interventions Unit
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction

ESPAD	European School Survey Project on Alcohol and Other Drugs
ESRC	Economic and Social Research Council
EU	European Union
EYTC	Edinburgh Youth Transitions Survey
FSS	Forensic Science Service
GAE	Grant Aided Expenditure
GCSE	General Certificate of Education
GDP	Gross Domestic Product
GHB	Gamma hydroxybutyrate
GLADA	Greater London Alcohol and Drug Alliance
GMR	General Mortality Register
GP	General Practitioner
GRO	General Register Offices for England and Wales
GRONI	General Register Office for Northern Ireland
GROS	General Register Office for Scotland
HAS	Health Advisory Service
HBSC	Health Behaviour in School Aged Children
HBV	Hepatitis B Virus
HCC	Heroin, Crack and Cocaine
HCV	Hepatitis C Virus
HES	Hospital Episode Statistics
HFA	High Focus Area
HIV	Human Immunodeficiency Virus
HMPS	Her Majesty's Prison Service for England and Wales
HMRC	HM Revenue and Customs
HMSO	Her Majesty's Stationery Office
HPA	Health Protection Agency
HPS	Health Protection Scotland
HSSB	Health and Social Service Boards
HSSD	The Housing Strategy and Support Directorate
ICD-10	International Statistical Classification of Diseases and Related Health Problems – tenth edition
IDMU	Independent Drug Monitoring Unit
IDTS	Integrated Drug Treatment System
IDUs	Injecting Drug Users
ISD	Information Services Division
ITMDF	Integrated Team Monitoring Data Form
KPI	Key Performance Indicator
LDPF	London Drug Policy Forum
LGDUW	Local Government Data Unit Wales
LHB	Local Health Board
LSCB	Local Safeguarding Children Boards
LSD	Lysergic Diethylamide acid
MDA	Methylenedioxymethamphetamine
MDMA	3,4-Methylenedioxy-n-methylamphetamine
MDT	Mandatory Drug Tests
MHRA	Medicines and Health Care Products Regulation Agency
MMT	Methadone Maintenance Therapy
MoJ	Ministry of Justice
MRSA	Methicillin resistant Staphylococcus aureus
NACD	National Advisory Committee on Drugs
NatCen	National Centre for Social Research
NCB	National Children's Bureau
NCCDP	National Collaborating Centre for Drug Prevention
NCH	National Children's Home
NCIS	National Criminal Intelligence Service
NDEC	National Drug Evidence Centre
NDTMS	National Drug Treatment Monitoring System
NET	Neuro-Electric Therapy
NFER	National Foundation for Educational Research

NHS	National Health Service
NICE	National Institute for Clinical and Health Excellence
NIO	Northern Ireland Office
NOMS	National Offender Management Service
NPHSW	National Public Health Service for Wales p 88
np-SAD	National Programme on Substance Abuse Deaths
NSD	New Strategic Direction
NSPCC	National Society for the Prevention of Cruelty to Children
NTA	National Treatment Agency
NTORS	National Treatment Outcome Research Study
OASys	Offender Assessment System p120
OCJS	Offending Crime and Justice Survey
ODPM	Office of the Deputy Prime Minister
Ofsted	Office for Standards in Education
ONS	Office for National Statistics
OST	Office for Science and Technology
p2w	Progress2Work
PCC	Primary Care Clinic
PCTs	Primary Care Trusts
PDI	Partnership Drugs Initiative
PDU	Problem Drug Users
PF	Positive Futures
PPO	Prolific and other Priority Offender
PSA	Public Service Agreement
PSHE	Personal, Social, Health and Economic Education
PSM	Propensity Score Matching
PSNI	Prison Service Northern Ireland
RCGP	Royal College of General Practitioners
RCT	Randomised Controlled Trial
RDS	Research Development and Statistics
RIOTT	Randomised Injectable Opiates Treatment Trial
RIWG	Research Information Working Group
RoB	Restriction on Bail
ROUTES	Research On Understanding Treatment Experiences and Services
RSA	Royal Society for the encouragement of Arts, manufactures and commerce
SACDM	Scottish Advisory Committee on Drugs Misuse
SALSUS	Scottish Schools Adolescent Lifestyle and Substance Use Survey
SARCS	Sexual Assault Referral Centres
SCDEA	Scottish Crime and Drug Enforcement Agency
SCIEH	Scottish Centre for Infection and Environmental Health
SCVS	Scottish Crime and Victimisation Survey
SD	Standard Deviation
SDS	Severity of Dependence Scale
SLO	Schools Liaison Officer
SMATs	Substance Misuse Action Teams
SMMGP	Substance Misuse Management in General Practice
SMR	Special Mortality Register
SMRT	Substance Misuse Research Team
SOCA	Serious Organised Crime Agency
SOCRATES	Stages Of Change Readiness And Treatment Eagerness Scale
SOPHID	Survey of Prevalent HIV Infections Diagnosed
SPD	Substitute Prescribing Database
SPS	Scottish Prison Service
STI	Sexually Transmitted Infection
TDI	Treatment Demand Indicator
TOP	Treatment Outcomes Profile
UAPMP	Unlinked Anonymous Prevalence Monitoring Programme
UK	United Kingdom
UKADCU	United Kingdom Anti Drugs Co ordination Unit
UKDPC	United Kingdom Drug Policy Commission



VDT	Voluntary Drug Testing
VSA	Volatile Substance Abuse
WAG	Welsh Assembly Government
YOT	Youth Offending Team
YPSMG	Young People's Substance Misuse Partnership Grant

**List of websites used in the text**

10 Downing Street <a href="http://www.number-10.gov.uk/output/Page1.asp">http://www.number-10.gov.uk/output/Page1.asp</a>	Criminal Justice System Northern Ireland <a href="http://www.cjsni.gov.uk/">www.cjsni.gov.uk/</a>
Aberlour <a href="http://www.abelour.com">www.abelour.com</a>	Dan <a href="http://www.askdan.org.uk/">http://www.askdan.org.uk/</a>
Association of Chief Police Officers <a href="http://www.acpo.police.uk">www.acpo.police.uk</a>	Department for Education and Skills <a href="http://www.dfes.gov.uk">www.dfes.gov.uk</a>
Bank of England <a href="http://www.bankofengland.co.uk">www.bankofengland.co.uk</a>	Department for Transport <a href="http://www.dft.gov.uk">www.dft.gov.uk</a>
Barnardos <a href="http://www.barnardos.org.uk">www.barnardos.org.uk</a>	Department for Transport, Local Government and the Regions <a href="http://www.dltr.gov.uk">www.dltr.gov.uk</a>
British Broadcasting Corporation <a href="http://www.bbc.co.uk">www.bbc.co.uk</a>	Department for Environment, Food and Rural Affairs <a href="http://www.defra.gov.uk">http://www.defra.gov.uk</a>
Cabinet Office <a href="http://www.cabinetoffice.gov.uk/">http://www.cabinetoffice.gov.uk/</a>	Department for Work and Pensions <a href="http://www.dwp.gov.uk">www.dwp.gov.uk</a>
CACI <a href="http://www.caci.co.uk/">http://www.caci.co.uk/</a>	Department of Health <a href="http://www.dh.gov.uk">www.dh.gov.uk</a>
Centre for Drug Misuse Research, University of Glasgow <a href="http://www.gla.ac.uk/centres/drugmisuse">www.gla.ac.uk/centres/drugmisuse</a>	Department of Health, Social Services and Public Safety, Northern Ireland <a href="http://www.dhsspsni.gov.uk">www.dhsspsni.gov.uk</a>
Centrepoint <a href="http://www.centrepoint.org.uk">www.centrepoint.org.uk</a>	Drug Misuse Research Initiative <a href="http://www.mdx.ac.uk/www/drugsmisuse/">http://www.mdx.ac.uk/www/drugsmisuse/</a>
Children and Young People's Unit Northern Ireland <a href="http://www.allchildrenni.gov.uk/">http://www.allchildrenni.gov.uk/</a>	Drug Misuse Research Initiative: Routes <a href="http://www.lshtm.ac.uk/research/dmri/">http://www.lshtm.ac.uk/research/dmri/</a>
Children in Scotland's Policy Information Network <a href="http://childpolicyinfo.childreninscotland.org.uk/">http://childpolicyinfo.childreninscotland.org.uk/</a>	Drugs Misuse Information Scotland <a href="http://www.drugmisuse.isd.scotland.org">www.drugmisuse.isd.scotland.org</a>
Children's hearings <a href="http://www.childrens-hearings.co.uk">www.childrens-hearings.co.uk</a>	Drugs Strategy Directorate, Home Office <a href="http://www.drugs.gov.uk">www.drugs.gov.uk</a>
Communicable Disease Surveillance Centre, Northern Ireland <a href="http://www.cdscni.org.uk">www.cdscni.org.uk</a>	DrugScope <a href="http://www.drugscope.org.uk">www.drugscope.org.uk</a>
Communities and Local Government <a href="http://www.communities.gov.uk/corporate/">http://www.communities.gov.uk/corporate/</a>	Drug Treatment Outcomes Research Study <a href="http://www.dtors.org.uk">http://www.dtors.org.uk</a>
Community Care <a href="http://www.communitycare.co.uk/">www.communitycare.co.uk/</a>	Every Child Matters <a href="http://www.everychildmatters.gov.uk">www.everychildmatters.gov.uk</a>
Crime Reduction <a href="http://www.crimereduction.gov.uk">www.crimereduction.gov.uk</a>	Foresight

<http://www.foresight.gov.uk/>

FRANK

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

General Register Office

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

General Register Office for Scotland

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

General Register Office Northern Ireland

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

Health Promotion Agency

<http://www.healthpromotionagency.org.uk/>

Health Protection Agency

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

Her Majesty's Inspectorate of Education

<http://www.hmie.gov.uk/>

Her Majesty's Prison Service for England and Wales

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

Her Majesty's Treasury

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

Home Office

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

Hospital Episode Statistics Online

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

International Review of Curriculum and Assessment Frameworks Internet Archive

<http://www.inca.org.uk/index.html>

Know the Score

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

Medicines and Healthcare products Regulatory Agency

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

Mind (National Association for Mental Health)

<http://www.mind.org.uk/>

Ministry of Justice

<http://www.justice.gov.uk/>

National Children's Bureau

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

National Children's Homes

<http://www.nch.org.uk/>

National Collaborating Centre for Drug Prevention

<http://www.drugpreventionevidence.info/>

National Drug Treatment Monitoring System

[www.ndtms.net](http://www.ndtms.net)

National Institute for Health and Clinical Excellence

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

National Society for the Prevention of Cruelty to Children

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

National Statistics

<http://www.statistics.gov.uk/>

National Treatment Agency for Substance Misuse

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

Northern Ireland Prison Service

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

Office of Public Sector Information

<http://www.uk-legislation.hmso.gov.uk/>

Politics.co.uk

<http://www.politics.co.uk/>

Re-solv

[www.re-solv.org](http://www.re-solv.org)

Respect

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

Scottish Drug Forum

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

Serious Organised Crime Agency

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

Substance Misuse Management in General Practice

[www.smmgp.demon.co.uk](http://www.smmgp.demon.co.uk)

Sure Start

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

The Children's Society

<http://www.childrenssociety.org.uk/>

The Herald

<http://www.theherald.co.uk/>

The Mentor Foundation

<http://www.mentorfoundation.org/>

The National Electronic Library for Medicines

<http://www.nelm.nhs.uk>

The National Youth Agency's Youth Information website

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

The Royal College of Psychiatrists

<http://www.rcpsych.ac.uk/>

The Shipman Inquiry

<http://www.the-shipman-inquiry.org.uk/home.asp>

The Stationary Office

[www.official-documents](http://www.official-documents)

The United Kingdom Parliament

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

UK Drug Policy Commission

<http://www.ukdpc.org.uk/index.shtml>

Welsh Assembly Government

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

Welsh Local Government Data Unit

[www.lgdu-wales.gov.uk](http://www.lgdu-wales.gov.uk)

World Health Organisation

[www.who.int](http://www.who.int)