



European Monitoring Centre
for Drugs and Drug Addiction



**UK Focal Point
On Drugs**

**2006 NATIONAL REPORT (2005 data)
TO THE EMCDDA
by the Reitox National Focal Point**

**UNITED KINGDOM
New Development, 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) 2006**

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Report submitted to the EMCDDA: 31st October 2006

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. Along with equivalent organisations in other European Union (EU) Member States, the Focal Point provides detailed information to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) on the drug situation in England, Northern Ireland, Scotland and Wales.

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 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.

The UK Focal Point website can be found at www.ukfocalpoint.org.uk and is currently under development.

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

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The structure and content of this report

The structure and content of this annual report are pre-determined by the EMCDDA to facilitate comparison with similar reports produced by the other European Focal Points. Ten chapters cover the same subjects each year, and 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 UK. 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 already been reported in previous reports. Generally, this includes developments that have occurred in the second half of 2005 or the first half of 2006. 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 2007.

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Thanks are also extended to, Sarah Burrow, Jan Annan, Stuart Priestley, Wade Freeman, Nick Lawrence, Crispin Acton and David Marteau at the Department of Health; the large number of staff who contributed to this report at the Home Office in addition to those mentioned above including Jessica Harris, Rachel Pennant and Paul Worthington; Duncan Smith at the National Offender Management Service, Drug Strategy Unit; staff who contributed from the Scottish Executive, in particular Korin Lebov; staff at the Welsh Assembly Government and Health Solutions Wales; staff from the Department of Health, Social Services and Public Safety, Northern Ireland; Rhian Stone from the Department for Education and Skills; Donal Cairns and Andrew Jones from the National Drugs Evidence Centre; Scott Parrott of the Forensic Science Service Ltd; Simon Cheng and Charlotte Davies, UK Focal Point on Drugs at the Department of Health; and Zara Anderson, Angela Connelly, Martin Chandler, Karen Hughes, Sara Hughes and David Seddon at the Centre for Public Health and the National Collaborating Centre for Drug Prevention at, Liverpool John Moores University.

The United Kingdom and its constituent countries



The United Kingdom (UK) population was estimated to be 60.2 million in the middle of 2005 (ONS *et al.* 2006): 83.8 per cent (50.4 million) live in England, 8.5 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.

CONTENTS

SUMMARY 10

 Main findings..... 10

 Most relevant developments and trends 13

 Consistency between indicators 14

PART A: NEW DEVELOPMENTS AND TRENDS 16

 1. National policies and trends 16

 1.1 Overview 16

 1.2 Legal Framework 17

 1.3 Institutional framework, strategies and policies 20

 1.4 Budget and public expenditure 24

 1.5 Social and cultural context 25

 2. Drug use in the population..... 27

 2.1 Overview 27

 2.2 Drug use in the general population..... 28

 2.3 Drug use amongst young adults..... 30

 2.4 Drug use in the school and youth population 35

 2.5 Drug use among specific groups 39

 3. Prevention..... 42

 3.1 Overview 42

 3.2 Universal prevention 43

 3.3 Selective/indicated prevention 47

 4. Problem drug use 50

 4.1 Overview 50

 4.2 Prevalence and incidence estimates 50

 4.3 Profile of clients in treatment 52

 4.4 Main characteristics and patterns of use from non-treatment sources 54

 5. Drug-Related Treatment..... 55

 5.1 Overview 55

 5.2 Treatment system 56

 5.3 Drug-free treatment 70

 5.4 Medically assisted treatment 71

 6. Health correlates and consequences 72

 6.1 Overview 72

 6.2 Drug-related deaths and mortality of drug users 74

 6.3 Drug-related infectious diseases 78

 6.4 Psychiatric co-morbidity (dual diagnosis) 82

 6.5 Other drug-related health correlates and consequences 82

 7. Responses to health correlates and consequences..... 85

 7.1 Overview 85

 7.2 Prevention of drug-related deaths 86

 7.3 Prevention and treatment of drug-related infectious diseases 88

 7.4 Interventions related to psychiatric morbidity 92

 7.5 Interventions related to other health correlates and consequences..... 94

 8. Social correlates and consequences..... 98

 8.1 Overview 98

 8.2 Social exclusion 99

 8.3 Drug-related crime 100

 8.4 Drug use in prison..... 104

 8.5 Social costs..... 106

 8.6 Drug use in the workplace 107

9. Responses to social correlates and consequences	108
9.1 Overview	108
9.2 Social reintegration	109
9.3 Prevention of drug related crime	111
9.4 Responses to other social correlates and consequences	123
10. Drug markets	124
10.1 Overview	124
10.2 Availability and supply	124
10.3 Seizures	125
10.4 Price/purity	125
10.5 Interventions to disrupt drug markets	127
10.6 New research on UK drug markets	127
PART B: SELECTED ISSUES.....	131
SUMMARY	131
11. Drug use amongst very young people.....	133
11.1 Drug use and problematic drug use amongst very young people.....	133
11.2 Treatment demand indicator data.....	145
11.3 Profile of the main groups of young people at risk of drug use and of problematic drug use	145
11.4 Correlates and consequences of substance use among very young people.....	150
11.5 Responses to drug problems among minors.....	152
12. Cocaine and crack.....	161
12.1 Prevalence, patterns and trends of cocaine and crack use.....	161
12.2 Cocaine use among school students.....	172
12.3 Prevalence and patterns of use among specific populations	175
12.4 Problems related to cocaine and crack use	178
12.5 Responses and interventions related to cocaine and crack use	181
12.6 Cocaine and crack-related crime	185
12.7 Cocaine and crack markets	185
13. Drugs and driving.....	186
13.1 Policy	186
13.2 Prevalence and epidemiological methodology	189
13.3 Detection, measurement and law enforcement.....	190
13.4 Prevention.....	192
Bibliography; list of tables, figures, abbreviations and websites used in text.....	194
Bibliography	195
List of figures and tables used in the text	219
List of abbreviations used in the text	224
List of websites used in the text.....	228

SUMMARY

Main findings

1. National policies and trends

Classification of the following drugs has been considered and the following decision reached:

- methylamphetamine to be reclassified from Class B to Class A;
- ketamine was classified as a Class C drug;
- cannabis remains Class C; and
- khat is not to be classified.

A new Northern Ireland Drug and Alcohol Strategy was published in 2006.

There has been a strengthening of the law to tackle drugs and crime.

- Drug testing is being introduced in Scotland.
- In England and Wales further implementation of provisions of the Drugs Act 2005 has led to:
 - drug testing on arrest;
 - Required Assessment for suspected drug users arrested by police;
 - Restriction on Bail for drug misusers,
 - a new probation order, the Drug Rehabilitation Requirement, for those sentenced to a community sentence; and
 - a new presumption of intent to supply.

Importantly, assessment and treatment become a mandatory requirement for those identified as using Class A drugs. Failure to comply may result in a custodial sentence.

2. Drug use in the population

Latest survey data for England and Wales are for 2005/06. These show that the fall in recent and current prevalence of drug use amongst adults aged 16 to 59, first seen in 2004/05, has continued. Cannabis use has continued to decline, whereas the previous fall in cocaine use has been reversed. Similar trends can be seen for young adults.

Data for Scotland are for 2004 and show the same downward trend in drug use identified in England and Wales in 2004/05.

Amongst school children in England drug use has remained broadly level since 2001 with a suggestion of a recent dip.

3. Prevention

The ACMD suggests that there should be a reassessment of the role of schools in drug prevention, informing of hazards associated with drug use.

The Inspectorate of Schools in England has criticised schools for not placing enough emphasis on the negative social consequences of substance use.

Drug testing is being piloted in several schools in Kent, but the idea has been rejected by the Scottish Executive.

There is continued emphasis on vulnerable young people. In England, the Home Office and the Department for Education and Skills are working towards ensuring that any professional group working with young people, are able to identify drug misuse and a Common Assessment Framework was introduced in 2006.

4. Problem drug use

Problem prevalence estimates have been produced for Northern Ireland suggesting prevalence of 1,395 (1.28 of per thousand population problem drug users (95% CI = 1.21 to 1.75). A wider estimate for problem opiate and / or problem cocaine use was also obtained, with 3,303 problem opiate or problem cocaine users, a rate of 3.03 per thousand population (95% CI = 2.84 to 3.95).

5. Treatment

Recent initiatives to improve the evidence base include:

- surveys of inpatient services in England;
- a review of the evidence on treatment effectiveness; and
- a further round of research funded by Government under the Drug Misuse Research Initiative.

There have been several initiatives to strengthen the treatment system, including:

- an Updated Models of Care;
- new guidance on needs assessment;
- the National Institute for Health and Clinical Excellence to produce clinical guidance for:
 - psychosocial management;
 - methadone and buprenorphine treatment;
 - opiate detoxification;
- consultation on residential rehabilitation;
- Clinical Guidelines on drug misuse to be updated;
- Healthcare Commission improvement reviews into substance misuse services;
- the Healthcare Commission are to undertake a technology appraisal of naltrexone as a treatment for relapse prevention in drug misusers; and
- encouraging the management of drug users in primary care.

There have been several initiatives to improve capacity and skills, including: workforce planning; nurses prescribing; and increasing the role of pharmacists.

Two major reports have suggested that while treatment works it is not a simple process; these refer to:

- Treatment Journeys; and
- Addiction Careers.

Scotland has undertaken work to look at how to provide effective treatment in rural areas; this has suggested better use be made of the internet.

Improving treatment for young people prioritised.

6. Health correlates and consequences.

There was an increase in the number of drug related deaths in 2004 though this followed a large fall in 2003. Opiates/opioids, alone or in combination with other drugs, continued to account for the majority of fatalities; there were increases in the number of cases involving amphetamines, cannabis and cocaine; and GHB was found in 3 cases.

The prevalence of HIV among IDUs has continued to increase. The rise in prevalence probably reflects increased levels of transmission. The prevalence of HIV in those who began injecting in the last three years is a measure of recent transmission.

Data indicate that overall more than four in ten IDUs have been exposed to hepatitis C infection in the UK. There is also evidence that suggests that the prevalence has increased, for example, among current IDUs.

The prevalence of hepatitis B remains stable.

The outbreaks of hepatitis A seen among IDUs and the homeless in parts of the UK appear to have waned.

7. Responses to health correlates and consequences.

In Scotland there is a new strategy and action plan to reduce drug related deaths. A pilot has begun for heroin users to be issued with naloxone.

In England, D(A)ATs are to have their performance measured in meeting hepatitis B prevention targets. There is to be a review of hepatitis testing and vaccination against hepatitis B of all clients in drug treatment.

Results from a syringe exchange audit in Scotland and England found that:

- pharmacists were limited in providing interventions necessary to reduce drug-related harm and blood-borne viruses, suggesting that pharmacy schemes should be complementary to agency based services rather than seen as an alternative facility;
- not all agency based services provide comprehensive harm reduction and hepatitis prevention measures;
- many did not address hepatitis B vaccination and testing;
- did not offer immunisation on site: and
- did not address hygiene and safer injecting techniques.

There have been changes to the way mental disorder is defined to make it clear that people who are dependent on alcohol and drugs are not excluded from the scope of the *Mental Health Act* if they also suffer from another mental disorder.

Considerable work has been undertaken in Scotland to address the needs of children of drug using parents, with a strategy published.

8. Social correlates and consequences

There was an increase of the number of persons found guilty, given a fiscal fine or dealt with by compounding for drug offences in the UK in 2004, with a rise in offences concerning amphetamines, cocaine, crack, ecstasy and heroin, but a fall in those concerning cannabis and LSD. The fall in offences concerning cannabis is probably associated with changes in the classification of the latter in 2003.

Positive results for mandatory drug testing of the prison population fell in 2005/06 in England and Wales, but increased in Scotland.

A survey of prisoners in Scotland found that:

- half of prisoners reported using drugs at some point in the past; and
- 34 per cent reported drug use in the month immediately prior to survey completion.

9. Responses to social correlates and consequences

A consultation has been undertaken concerning the Supporting People initiative which seeks to find appropriate accommodation for former, or recovering, drug users; results of this have not yet been published. In England and Wales, a Comprehensive Rent Deposit Model, funded by the Drug Interventions Programme, aims to help drug misusing offenders leaving prison find accommodation.

In England, education, training and employment is to be integrated into treatment plans. A report has been published on best practice in helping drug users to find employment.

In England and Wales an Integrated Drug Treatment System will enhance the treatment of prisoners. In Scotland a new Throughcare Addiction Service, which aims to help prisoners who have been drug users, to access services appropriate to their needs on release from custody, replaces the Transitional Care Initiative.

In England and Wales, the requirement for drug users to engage in treatment has been strengthened through the 'Tough Choices' programme, which, in addition to changes to better identify drug users through the criminal justice system, and require assessment and treatment, referred to in section 1 of this summary, also includes the introduction of Conditional Cautioning nationally; and stronger links the programme targeting Prolific and Other Priority Offenders.

Scotland is to introduce testing on arrest.

Drug courts are being piloted in England. In Scotland, previously piloted drug courts will run for a further 3 years in Glasgow and Fife, based on evidence of reduced offending.

Northern Ireland is to introduce Drug Treatment and Testing Orders.

Scotland is to introduce arrest referral following evaluation of pilots schemes.

There are two new criminal justice interventions for young people being piloted in England and Wales; drug testing for 14 to 17 year olds and two community sentences for 10 to 17 year olds who have, or are at risk of developing, substance misuse problems.

10. Drug Markets

Seizures data for all of the UK are not yet available but, in England and Wales, seizures fell by two per cent in 2004. Cannabis remains the most seized drug. Seizures of heroin and cocaine rose.

The price of heroin, ecstasy and cocaine has fallen since 2004, while the price of cannabis, crack cocaine and LSD has remained stable; the price of amphetamines increased by more than ten per cent in 2005, having fallen in recent years.

The average purity of most drugs decreased. Heroin seized by HM Revenue and Customs was purer than that seized by the police. The purity of heroin seized increased considerably between 2003 and 2004.

Most relevant developments and trends

In terms of epidemiological indicators the most relevant trends are:

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

England and Wales. A rise in cocaine use amongst school children in England, should be treated with caution.

Also relevant is the increase in drug related deaths, though again the trend is downward. There has been a small increase in HIV and in hepatitis C.

It is difficult to pick out the most relevant issues in terms of response, given the large number of initiatives in the UK. However, perhaps most important are those that relate to treatment, both treatment *per se* with initiatives to improve the evidence base; to strengthen the treatment system with measures to improve capacity and staff skills; as well as initiatives to provide for vulnerable young people. Of major significance has been a strengthening of initiatives to identify drug users in the criminal justice system. In Scotland, and in England and Wales, arrestees can be tested for drugs on arrest, rather than only once charged. Also, the new sentencing order, the Drug Rehabilitation Requirement; the latter, with Required Assessment and Restriction on Bail make assessment and treatment a mandatory requirement for those identified as using Class A drugs; failure to comply may result in a custodial sentence. There is also a new presumption of intent to supply, targeting dealers. In Scotland and Northern Ireland arrest referral and Drug Treatment and Testing Orders will enhance referral into treatment from the criminal justice system.

Consistency between indicators

Opiates continue to be the main drug for most treatment presentations in the UK. Seizures of heroin rose slightly in 2004, and the number of persons found guilty or cautioned for drug offences involving heroin rose. In the UK there has also been an increase in the number of deaths where heroin or morphine was mentioned.

The latest survey data in the UK show an increase in cocaine use within the general population. Treatment demand in the UK for cocaine has increased since 2003/04 and there has been an increase in the number of deaths where cocaine was mentioned. The number of persons found guilty or cautioned for drug offences involving cocaine and crack rose in 2004. Further, there has been concern over an apparent increase in risk behaviour with respect to infectious disease transmission by injecting of crack cocaine.

Use of amphetamines, having fallen considerably in previous years continued to fall in 2005/06. The number of persons found guilty or cautioned for drug offences involving amphetamines had risen in 2004.

The number of persons found guilty or cautioned for ecstasy offences in the UK in 2004 rose slightly and there was an increase in the number deaths associated with ecstasy.

Cannabis use has continued to fall in the adult population and the decline in use amongst school children appears to be continuing. Treatment demand for cannabis rose. The number of persons found guilty or cautioned for cannabis offences in the UK fell in 2004; this is probably associated with the change in the classification of cannabis from Class B to Class C in 2003.

Lifetime use of magic mushrooms showed a rise amongst adults in 2005/06, but current use declined significantly. This is probably associated with changes in the law on magic mushrooms which mean that they are classified, regardless of whether or not they have been processed.

PART A

NEW DEVELOPMENTS AND TRENDS

PART A: NEW DEVELOPMENTS AND TRENDS

1. National policies and trends

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 June 2006 Government announced its decision to reclassify methylamphetamine from Class B to Class A. There has been a consultation on the threshold for possession for personal use of controlled drugs. In addition, a review of the drug classification system is currently in progress. 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 the Public Service Agreements, placing responsibility on a number of Government departments to meet the targets set. Each of the devolved administrations¹ (Northern Ireland, Scotland and Wales) has its own strategy, reflecting the aims of the United Kingdom Strategy, but tailored to their individual circumstances (NIO 1999; Scottish Office 1999; National Assembly for Wales 2000). Northern Ireland launched a new combined drugs and alcohol strategy in 2006 (DHSSPSNI 2006a) and in Wales consultation is beginning to renew the Welsh strategy.

Delivering the Drug Strategy is a cross-government initiative. Since 2002, this has been led by the Drug Strategy Directorate (DSD) in the Home Office; in 2006 this was merged with the Crime Reduction Directorate in the Home Office to create the wider Crime and Drug Strategy Directorate (CDSD). In all four administrations, delivery is through local multi-agency partnerships.²

A *Drug Harm Index* measures the impact of the Drug Strategy on reducing the harms associated with illegal drugs. Latest evidence shows that the index has fallen by 27.9 points (24%) between 2002 and 2004, a reduction from the baseline value 115.8 points, at the introduction of the Updated Drug Strategy in 2002, to 87.9 points in 2004.

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

² In England known as Drug Action Teams, or if they also take responsibility for alcohol, Drug and Alcohol Action Teams (referred to collectively here as D(A)ATs), in Northern Ireland, Alcohol and Drugs Coordination Teams (ADCTs), In Scotland Alcohol and Drug Action Teams (ADATs) and in Wales, Substance Misuse Action Teams (SMATs).

1.2 Legal Framework

1.2.1 Laws, regulations, directives or guidelines

Review of the drug classification systems

In January 2006, the then Home Secretary announced a review of the drug classification systems (Home Office 2006a). However in October 2006 the Government announced in its response to a House of Commons Science and Technology Committee report on reclassification that it would not be proceeding with a review (see 1.5.3).

Thresholds for the possession of controlled drugs

The Home Office has undertaken a consultation, seeking the views of the police, courts and drugs agencies on the setting of particular thresholds for the possession of controlled drugs (Home Office 2005b). The Home Secretary has subsequently announced that he does not intend to proceed with the provision establishing these thresholds (Home Office 2006b).

During the reporting period, consideration has been given to the classification of a number of drugs under the *Misuse of Drugs Act 1971*.

Ketamine

Ketamine was brought under the control of the of the *Misuse of Drugs Act 1971* as a Class C drug on January 1st 2006 having been previously unclassified.

Cannabis

Following a report by the Advisory Council on the Misuse of Drugs (ACMD)³, (2005a) cannabis remains a Class C drug (Home Office 2006c). ACMD's latest report stated that:

“After a detailed scrutiny of the evidence, the Council does not advise the reclassification of cannabis products to Class B; it recommends they remain within Class C. While cannabis can, unquestionably, produce harms, these are not of the same order as those of substances within Class B. Nevertheless, the Council wishes to emphasise that cannabis is harmful. We therefore recommend that: a) further efforts are made to discourage consumption through the development and delivery of a sustained education and information strategy; b) the availability of appropriate treatment services, for those individuals who are experiencing difficulties arising from the use of cannabis, is reviewed by the Health Departments; and c) research into the relationship between cannabis use and mental health problems continues to be supported by public and private funds.” (ACMD 2005a: Foreword).

The report did however suggest that,

“the weight of evidencesuggests an association between cannabis use and the development of psychotic symptoms which is consistent between studies and which remains after adjustment for confounding factors. While bias and residual confounding factors cannot be entirely excluded, these are unlikely fully to explain the findings”, also that, “the current evidence suggests, at worst, that using cannabis increases the lifetime risk of developing schizophrenia by 1%.” (p.11).

It also noted that the extent to which the potency of cannabis products, as used by consumers, has increased over the past few years is unclear. However based on

³ The ACMD is an independent body comprising experts from a range of backgrounds in the drugs field.

current evidence they suggest that the potency of most cannabis products appears to be unchanged, though the potency of sinsemilla⁴ may have doubled over the past 10 years.

Khat

Three reports on khat use were published in 2005. Two were research reports (Turning Point 2005b and Patel *et al.* 2005⁵) looking at use amongst Somali, Ethiopian and Yemeni communities in the United Kingdom and suggesting there were problems with use. ACMD was also asked by government to carry out a review of the scientific evidence about the impact of khat use, risks and current treatment options (ACMD 2005b). On the basis of the evidence, the Council recommends that, “Khat is not controlled under the *Misuse of Drugs Act 1971*. Use of the substance is very limited to specific communities within the United Kingdom, and has not, nor does it appear likely to, spread to the wider community. However, that is not to say that use of khat is without detrimental effects and its use should be discouraged.” (p.1).

In keeping with this the ACMD made a number of other recommendations relating to educating and informing users and potential users of the harms associated with Khat use, ensuring effective advice and treatment is available and restricting supply to children. In particular, it felt that this education should be, at least partly focused through local communities, including peer education models, and through primary care services and not exclusively through addiction services. It also recommended that education activity had to ensure that it reached females. The ACMD suggested that users, when seeking advice and help, should not automatically be encouraged to attend addiction services.

On the basis of the report the Government has not classified khat under the Misuse of Drugs Act 1971 (Home Office 2006a).

Methylamphetamine

In 2004 the Government asked the ACMD to review the scientific evidence of the harmful effects of methylamphetamine and the nature of the threat posed to the UK. The ACMD’s report concluded that MA had the potential to be very harmful to both individuals and society (ACMD 2005c). However, at that time it recommended that methylamphetamine should not be re-classified to Class A as there was little evidence that there was significant use of methylamphetamine in the UK and that re-classification might draw unwanted attention to methylamphetamine’s properties. When making this recommendation, the ACMD also made a series of recommendations relating to an “early warning system”. Furthermore, they undertook to review their position within 12 months.

The ACMD re-considered its position in 2006 as it had undertaken to do. Having received evidence that indicated that methylamphetamine use was starting to become more widespread and that the police had become aware of the existence of a small number of domestic illicit laboratories making methylamphetamine in the UK, it revised its advice and recommended reclassification of methylamphetamine to a

⁴ Sinsemilla, a higher potency preparation, which is both imported and home-grown, comprises the flowering tops from unfertilised, female cannabis sativa plants and is most commonly produced by intensive indoor cultivation methods. Skunk is a form of sinsemilla.

⁵ ACMD notes that neither of these studies used random sampling techniques. Khat chewers were more likely to be sampled and thus the extent that these findings can be generalized to the communities studied is limited. It is apparent that khat use is widespread in the communities mentioned but almost unknown outside of these ethnic groups.

Class A drug. Following this, it was announced in June 2006 that methylamphetamine was to become a Class A drug (Home Office 2006d). The parliamentary process required to effect the law change is underway and it is likely that methylamphetamine will be reclassified in the early part of 2007.

Date rape drugs: GHB and Rohypnol

In January 2006 the ACMD was asked to consider the classification of so-called date rape drugs, including GHB and flunitrazepam (marketed in the United Kingdom as "Rohypnol") (Home Office 2006a)⁶. Findings have not yet been published.

The management of controlled drugs

The Home Office published a consultation paper setting out its proposals to amend the *Misuse of Drugs Regulations (2001)*, in order to implement elements of an action programme published in *Safer Management of Controlled Drugs* (December 2004), the Government's Response to the Fourth Report of The Shipman Inquiry. The purpose of the proposed changes is to strengthen the system for managing controlled drugs in order to minimise the risk to patient safety of their inappropriate use. The changes will be introduced over a period of time, but the first two sets of changes being implemented in July 2006 (Home Office 2006a). The *Health Act 2006* also strengthened the governance arrangements around controlled drugs in the health and social care setting. Regulations under the Act will become available in the near future.

Guidelines have been issued about the safe management of controlled drugs in the primary care setting (DH 2006a).

Drug testing on arrest in Scotland

The *Police, Public Order and Criminal Justice (Scotland) Act (2006)* provides for drug testing and referral on arrest, bringing Scotland in line with the rest of the United Kingdom. Provisions will commence from Spring 2007 and will be piloted in the first instance.

Research

Following on from previous research on the policing of cannabis (May *et al.* 2002) the Joseph Rowntree Foundation has commissioned further research following reclassification of cannabis from Class B to Class C⁷. The research is due to be completed in the early part of 2007.

1.2.2 Laws implementation

Implementation of provisions of the Drugs Act 2005

As part of action to reduce drug related crime, from 1st December 2005 the police have been allowed to test for drugs on arrest. This implements the provisions of the *Drugs Act 2005* (see Chapter 9.3.2) (Home Office 2005b).

Under the provisions of the *Drugs Act 2005* courts must treat as an aggravating factor when considering the seriousness of an offence, dealing on, or in the vicinity of, school premises, or use of children as couriers in drug transactions and will face stiffer jail terms. This provision commenced on 1st January 2006 (see Chapter 9.3.2) (Home Office 2005c).

⁶ For more information see:

<http://press.homeoffice.gov.uk/press-releases/home-sec-resp-to-ACMDs?version=1>

⁷ For more information see: <http://www.jrf.org.uk>

From the same date, police have also been given powers to require x-rays from suspects they believe may have swallowed cocaine or heroin, or intimate searches of those believed to have secreted drugs in a bodily orifice to avoid detection. A court may draw such inferences as it considers appropriate from an unreasonable refusal to consent to such procedures. In addition, suspected drug "mules" can be remanded by a magistrate into police custody for up to 192 hours, to allow extra time for drugs to pass through their systems (Home Office 2005c).

Provisions in the *Criminal Justice Act 2003* were brought into force on 4 April 2005 introducing the new *Community Order* that replaces the Drug Testing and Treatment Order (DTTO), and other community orders, for adults. The new order, with individual requirements selected by the court, is expected to allow provision to be tailored to the seriousness of the offence and offence-related needs of the individual as it will consist of a "menu" of requirements including the *Drug Rehabilitation Requirement* for different types and levels of drug treatment (see Chapter 9.3.2).

Implementation of the law on cannabis

In order to reinforce the law on cannabis and the harms associated with its use a widespread education campaign on the harms of cannabis (and all illegal drugs) is underway. In partnership with DfES, the Home Office has produced 'Understanding Drugs', a comprehensive teacher and pupil information pack which is now available to every secondary school in England. The FRANK campaign has updated its cannabis information resources with new TV and radio adverts and information leaflets coming on stream. In addition, the Department of Health will be issuing a toolkit for Mental Health practitioners on the links between cannabis and mental health.

The police are to focus on strong action to reduce the supply of cannabis. The Association of Chief Police Officers of England, Wales and Northern Ireland (ACPO) has conducted a consolidated campaign of action to address the production of cannabis. At the same time, it will revise and strengthen its guidelines for dealing with policing cannabis (Home Office 2006c).

1.3 Institutional framework, strategies and policies

1.3.1 Coordination arrangements

See section below for Northern Ireland.

1.3.2 National plan and/or strategies

Strengthening of policy to treat drug users who commit crime

The Drug Interventions Programme (DIP) has been strengthened by the introduction of measures contained in the *Drugs Act 2005* mentioned in the previous section; Testing on Arrest, rather than at charge; and Required Initial Assessments for those testing positive. These provisions were implemented across three selected police force areas from 1st December 2005 and were then expanded to all other DIP intensive areas from the end of March 2006. By March 2006 Restriction on Bail provisions were extended to all Local Justice Areas across England (See 1.2.1 with respect to drug testing on arrest in Scotland). The Home Office review of the Criminal Justice System *Rebalancing the Criminal Justice System in favour of the Law-Abiding Majority*, announced that the required follow-up assessment would be introduced (Home Office 2006e). The new *Drug Rehabilitation Requirement*, a community based sentence, also further strengthens drug policy to treat drug users involved in crime.

New Drug strategy for Northern Ireland

A new Drug Strategy for Northern Ireland was published in May 2006, *New Strategic Direction for Alcohol and Drugs 2006-2011* (DHSSPSNI 2006a), combining both drugs and alcohol in one strategic framework. The overall aim is to reduce the level of alcohol and drug related harm in Northern Ireland. Long term aims are to:

- provide accessible and effective treatment and support for people who are consuming alcohol and/or using drugs in a potentially hazardous, harmful or dependent way;
- reduce the level, breadth and depth of alcohol and drug-related harm to users, their families and/or their carers and the wider community;
- increase awareness on all aspects of alcohol and drug-related harm in all settings and for all age groups;
- integrate those policies which contribute to the reduction of alcohol and drug-related harm into all Government Department strategies;
- develop a competent, skilled workforce across all sectors that can respond to the complexities of alcohol and drug use and misuse;
- promote opportunities for those under the age of 18 years to develop appropriate skills, attitudes and behaviours to enable them to resist societal pressures to drink alcohol and/or use illicit drugs, with particular emphasis on those identified as potentially vulnerable; and
- reduce the availability of illicit drugs in Northern Ireland.

Five supporting pillars have been identified which are to provide the conceptual and practice base. These are: prevention and early intervention; treatment and support; law and criminal justice; harm reduction; monitoring, evaluation and research. A number of key performance indicators have been set to measure achievement; these will form the basis of an annual report.

In common with all strategic and local practice throughout the United Kingdom, integration and coordination between policy development and providers is seen as key to effective provision for substance misusers.

Local Drugs and Alcohol Co-ordination Teams will continue, although they will be redesignated as local Alcohol and Drugs Coordination Teams (ADCTs).

In order to ensure effective and co-ordinated implementation the following structure, a new Strategic Direction for Alcohol and Drugs Steering Group (NSDSG) will maintain an overview of the NSD. Reporting to the NSDSG will be four advisory groups who will address the following areas:

- Children, Young People and Families.
- Treatment and Support.
- Law and Criminal Justice.
- 'Binge Drinking'.

1.3.3 Implementation of policies and strategies

Northern Ireland drug strategy

See above (1.3.2) for new implementation arrangements in Northern Ireland

Local Area Agreements

In England, Local Area Agreements (LAAs) are a new contract between central and local government to deliver the priorities of local people⁸. The key aim is to improve the effectiveness and efficiency of the way Government works with local authorities, and their delivery partners, to improve public services, allowing greater flexibility for local solutions to meet local circumstances. LAAs simplify central funding and reporting requirements. A LAA is a three year agreement, based on local Sustainable Community Strategies⁹, that sets out the priorities for a local area. The agreement is made between Central Government, represented by the Government Office and a local area, represented by the lead local authority and other key partners through Local Strategic Partnerships (LSPs)¹⁰. One of the mandatory outcome is to reduce the harm caused by drug misuse; as a minimum requirement this is to be measured by public perceptions of local drug dealing and drug use. LAAs were signed with 20 first wave areas in March 2005 and since then a first and second wave of local authority areas have signed them in 2006. The intention is that all 150 lead local authorities in England will be party to an LAA from April 2007 (ODPM 2006).

Local Delivery Plans (LDPs) provide the main mechanism for the Department of Health (DH) to ensure national priorities are met. At the local level Primary Care Trusts (PCTs) agree LDPs with all key stakeholders both within the National Health Service (NHS), across local government and with other agencies. These LDPs are agreed by higher level Strategic Health Authorities (SHAs). At this level it is expected that plans submitted to, and ultimately signed off by the Department of Health must, as a minimum, meet national target levels. The key measures for drug misuse within this are defined as:

- an increase in the participation of problem drug users in drug treatment programmes by 100 per cent by 2008 (from a 1998 baseline); and
- increase year on year of the proportion of users successfully sustaining or completing treatment programmes.

New targets have since been set regarding performance indicators for assessment in 2005/2006 and include: an increase in the percentage of users sustained in treatment for 12 weeks in community services (Healthcare Commission 2006).

Local D(A)ATs and Primary Care Trusts, have been encouraged to set local "stretch targets" for those in treatment that reflect both current performance against their LDPs and improvements on these (DH internal communication 2006).

The Drug Interventions Programme: Tough Choices Project

In England and Wales, the *Tough Choices Project*, initiated in December 2005, as part of Drug Interventions Programme, expanded the programme to include three new elements; Testing on Arrest, Required Assessment and Restriction on Bail in order to increase the number of drug misusing offenders being directed into treatment via the criminal justice system (DSD 2005a). Importantly, assessment and treatment became a mandatory requirement for those identified as using Class A drugs. Failure to comply may result in a custodial sentence (see Chapter 9.3.2).

⁸ For more information see: <http://www.communities.gov.uk/index.asp?id=1161632>

⁹ For more information see: <http://www.communities.gov.uk/index.asp?id=1139881>

¹⁰ For more information see: <http://www.communities.gov.uk/index.asp?id=1133894>

Changes in Drug the Strategy Directorate

In April 2006 the Drug Strategy Directorate merged with the Crime Reduction Directorate in the Home Office to create the wider Crime and Drug Strategy Directorate at the Home Office (CDSD).

1.3.4 Impact of policies and strategies

Drug Harm Index

In England, the impact of the Drug Strategy is measured predominantly by performance against Public Service Agreements (PSAs). An overarching PSA target, which encompasses measures on reducing the availability of drugs, drug-related crime and other harms caused by drug misuse, is measured by the Drug Harm Index (DHI). The index captures the harms generated by the problematic use of any illegal drug by combining national indicators into a single figure which can be tracked as an index over time. The harms include domestic and commercial drug related crimes, community perceptions of drug problems, drug nuisance and health impacts such as blood-borne viruses, overdoses and drug-related deaths. Current performance against the PSAs is shown in Table 1.1.

Table 1.1: Performance against PSAs

Public Service Agreement	Government Department Responsible	Performance
To reduce the harm caused by illegal drugs, including substantially increasing the number of drug-misusing offenders entering treatment through the Criminal Justice System	Home Office	The Drug Harm Index shows a reduction of 27.9 points or 24% from the baseline value of 115.8 points, at the introduction of the Updated Drug Strategy in 2002, to a current value of 87.9 points (Macdonald <i>et al.</i> 2006). The number of drug-misusing offenders entering treatment through the Criminal Justice System currently exceeds 2,800 each month, from a baseline of 384 in March 2004 (Home Office 2006 – internal communication)
To increase the participation of problem drug users in drug treatment programmes by 100% by 2008 and increase year-on-year the proportion of users successfully sustaining or completing treatment programmes	Department of Health (England)	In 2005/06, 113% more people entered drug treatment than in 1998 (181,390 drug users were in structured treatment in 2005/06 compared to 85,000 in 1998). Of those people, 78% either successfully completed treatment in 2005/06 or were retained in treatment on 31 March 2006, compared to 75% in 2004/05
To reduce the use of Class A drugs and the frequent use of any illicit drug among all young people under the age of 25, especially by the most vulnerable young people.	Department for Education and Skills (England)	In 2005/06, the use of Class A drugs in the last year amongst young people aged 16-24 was stable, compared to both 1998 and 2003/04 (British Crime Survey 2005/06). The frequent use of any illicit drug in the last year amongst 16-24 year olds decreased by 23% in 2005/06, compared to 2003/04. Class A drug amongst truants and excludes aged aged 11-15 was stable in 2005, compared to 2003 (Department of Health Schools Survey). Frequent drug use in the last year amongst truants and excludes aged 11-15 decreased by 16% between 2003 and 2005 (Department of Health Schools Survey). (NatCen/NFER 2006) (see Chapter 2).

1.4.2 Funding arrangements

Local Area Agreements

See section 1.3.3.

In Scotland, funding is paid through NHS Boards to Alcohol and Drug Action Teams (ADATs) to tackle drug misuse. ADATs allocate funding according to local needs and priorities, with a focus on achieving real sustainable outcomes for drug misusers, their families and the wider community. This is monitored on an annual basis through Corporate Action Plans (CAPs) which are submitted by ADATs to the Scottish Executive.

The Scottish Executive is currently undertaking a stock-taking exercise which will measure the effectiveness and efficiency of ADATs against the principles of best value, including the consideration of how best to improve current accountability and funding arrangements.

1.5 Social and cultural context

1.5.1 Public opinions of drug issues

In Scotland respondents to the Scottish Crime and Victimization Survey (SCVS) 2004 identified drug abuse as the biggest social problem in Scotland; 76 per cent rated it as a 'big problem', whereas 60 per cent rated alcohol as a 'big problem' and 59 per cent, crime. Other social issues such as unemployment, housing conditions, standards of education and public transport are rated as less of a problem (Hope 2006).

In England and Wales, 27 per cent of respondents to the British Crime Survey for 2005/06 reported that people using and dealing drugs was a problem in their local area¹³ (Walker *et al.* 2006).

1.5.2 Attitudes to drugs and drug users

The majority of respondents to the SCVS thought that "a lot of young people take drugs nowadays" and that "young people start taking drugs to keep up with their friends". There was considerable agreement with a statement that "a lot of crimes are committed by people on drugs" but also agreement that "people who have drug problems need help not punishment". There was overwhelming agreement that "injecting drugs is very dangerous", although around one in seven thought that "taking an illegal drug once won't do you any harm" (Murray and Harkins 2006).

1.5.3 Initiatives in Parliament and civil society

The drug classification system

A report from the House of Commons Science and Technology Committee addresses the relationship between scientific advice and evidence and the classification of illegal drugs (House of Commons Science and Technology Committee 2006). It made 50 wide ranging findings, including a number of strong criticisms of the drug classification system and the ACMD. In particular, it suggests that the current classification system should be replaced with a more scientifically

¹³ The British Crime Survey is a victimisation survey in which adults living in private households are asked about their experience of crime. 47,670 individuals were surveyed by face to face interview in England and Wales between April 2005 and March 2006. The overall response rate was 75 per cent.

based scale of harm, decoupled from criminal penalties; that there are anomalies in the classification of individual drugs; that there is a lack of consistency in the rationale used to make classification decisions. It also sets out a number of concerns about the make-up, transparency and operation of the ACMD.

In its response to the Committee's Report, the Government has restated that the existing system continues to discharge its function fully and effectively; that the current 3-tier system allows for clear and meaningful evidence based distinctions to be made between drugs; and that the classification system is by its design a ranking of harms and that these harms will continue to be linked to the penalties attached to possession and trafficking offences. Furthermore, the Government confirmed that it has faith in the advice provided by the ACMD, although acknowledged some issues of transparency could be addressed. In addition, the Government reiterates that whilst legal control contributes to identifying the most harmful drugs, it is the Government's Drugs Strategy that incorporates prevention, treatment, education and enforcement, that is having the real impact and that the Government will not be distracted from these very real priorities. In conclusion, the Government confirms that after careful consideration, it will not be proceeding with a review of the classification system at this time (Home Office 2006b).

Public consultations

A number of consultation exercises have been established, enabling the public and non-government organisations to comment on proposed changes to the law and to interventions. These have included consultations in respect to thresholds for the amount of certain illegal drugs a person can possess without being charged with supply (DSD 2005b) and on the changes in the law on ketamine (Home Office 2006a). Responses to consultations are available from the Home Office website.¹⁴

1.5.4 Media representations

The Government believes that since 1998, the result of combined efforts is that drug-related crime is falling and record numbers of drug-misusing offenders are accessing treatment. Although it is acknowledged that there is much more to be done, nevertheless the strategy is well ahead of target and it is felt that media coverage of the issue does not always reflect the work being done. In October 2005 the Drug Strategy Directorate launched the 'Tackling Drugs Changing Lives campaign' which provided local agencies with the tools to communicate the action being taken to tackle drugs in their areas. The campaign ran for 8 months and achieved a significant amount of positive media coverage highlighting the achievements of local agencies and the positive impact of this action on local communities (CDSD – internal communication).

¹⁴ See: <http://www.homeoffice.gov.uk/about-us/haveyoursay/responses/>

2. Drug use in the population

2.1 Overview

A survey of drug use in the general population in England and Wales has been carried out since 1994¹⁵, every two years until 2001 after which the survey has been continuous. Less frequent surveys have also been carried out in Scotland¹⁶ and Northern Ireland¹⁷; however both surveys are to become continuous in the near future. Combining these survey data, in 2005, it was estimated that in the United Kingdom just over a third of the adult population aged between 16 and 64, report having used an illicit drug at some time in their lifetime. Prevalence has been highest in England and Wales, but latest data show a decrease in use since the previous year.

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 again. In England and Wales amongst these young adults, figures for 2004/05 showed a significant decline in lifetime prevalence for the first time, further declining in 2005/06.

Amongst school children drug use increased markedly between 1998 and 2002, to around 20 per cent (based on lifetime prevalence), but appears to have stabilised over recent years.¹⁸

Males are more likely to report drug use than females but the difference varies according to age group, tending to be more pronounced with age.

Cannabis continues to be the most commonly used drug across all age groups, close to prevalence rates for use of any drug; though prevalence has declined in recent

¹⁵ The British Crime Survey 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.

¹⁶ The Scottish Crime and Victimisation Survey (previously the Scottish Crime Survey) is a household 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. Surveys were carried out, as part of the British Crime Survey (BCS) in 1982 and 1988, and as the independent Scottish Crime Survey in 1993, 1996, 2000, 2003 and the face-to-face SCVS in 2004.

¹⁷ The Northern Ireland Crime Survey is also a household 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. Surveys have been carried out in 1998, 2001, and annually since 2003. A Drug Prevalence Survey, based on the EMCDDA model questionnaire, was carried out in 2002/03, a second such survey will be carried out in 2007.

¹⁸ Amongst the school age population, surveys of drug use prevalence are 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*, which 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 annually. The *Health Behaviour in School Age Children Survey* (HBSC) provides Welsh data and is undertaken every four years with a two-year interim survey. The most recent survey, the sixth in the series, was conducted in 2001/02.

years. Prevalence of all other drugs is considerably lower, no more than three per cent for recent use. In England and Wales, which provided the most recent data, use of cocaine powder (cocaine), having remained stable since 2000, has risen. The use of magic mushrooms, having risen sharply in 2004/05 fell in 2005/06. Amongst school children in England, again providing the latest information, the prevalence of recent cocaine use increased in 2005 from 1.4 to 1.9 per cent, but it is not clear if this is just an artefact of sampling; and cannabis use remained lower than in 2003.

2.2 Drug use in the general population

Since submission of the 2005 United Kingdom Focal Point report, results from both the 2004/05¹⁹ and the 2005/06²⁰ British Crime Survey (BCS) covering England and Wales have been published. Data from the 2004 Scottish Crime and Victimization Survey has also been published.²¹

2.2.1 Drug use in the general population.

England and Wales: the British Crime Survey.

Prevalence and trends in drug use: England and Wales

Following publication of the 2004/05 BCS in November 2005 (Roe 2005), a standard table based on it was provided to EMCDDA. However, analysis of the data was not included in the 2005 United Kingdom Focal Point report.

Prevalence estimates are shown in Table 2.1.

Table 2.1: The proportion of 16-59 year olds reporting having used drugs in their lifetime, in last year and in last month, in England and Wales, 1996 to 2005/06

	Lifetime			Last year			Last month		
	2003/4	2004/5	2005/6	2003/4	2004/5	2005/6	2003/4	2004/5	2005/6
Any drug	35.6	34.5	34.9	12.3	11.3	10.5*	7.5	6.7	6.3*
Amphetamines	12.2	11.2	11.5	1.5	1.4	1.3	0.6	0.5	0.6
Cannabis	30.8	29.7	29.8	10.8	9.7	8.7*	6.5	5.6	5.2*
Cocaine	6.7	6.0	7.2*	2.4	2	2.4*	1.1	0.9	1.2*
Crack	0.9	0.8	0.9	0.2	0.1	0.2	0.1	0.1	0.1
Ecstasy	6.9	6.7	7.2*	2	1.8	1.6	0.9	0.7	0.7
LSD	6.1	5.1	5.5	0.2	0.2	0.3	0.1	0	0.1
Magic Mushrooms	7.1	6.5	7.3*	0.8	1.1	1	0.3	0.4	0.2*
<i>Base</i>	<i>24,295</i>	<i>28,330</i>	<i>29,748</i>	<i>24,197</i>	<i>28,206</i>	<i>29,631</i>	<i>24,162</i>	<i>28,186</i>	<i>29,604</i>

*Significant change from 2004/05 to 2005/06

Source: Roe and Man 2006

¹⁹ 28,509 respondents completed the drugs module of the 2004/05 BCS and an extra 2,653 16 to 24 year olds were also interviewed as part of the 2004/05 BCS youth boost. The response rate for the core BCS sample was 75 per cent and 74 per cent for the 16 to 24.

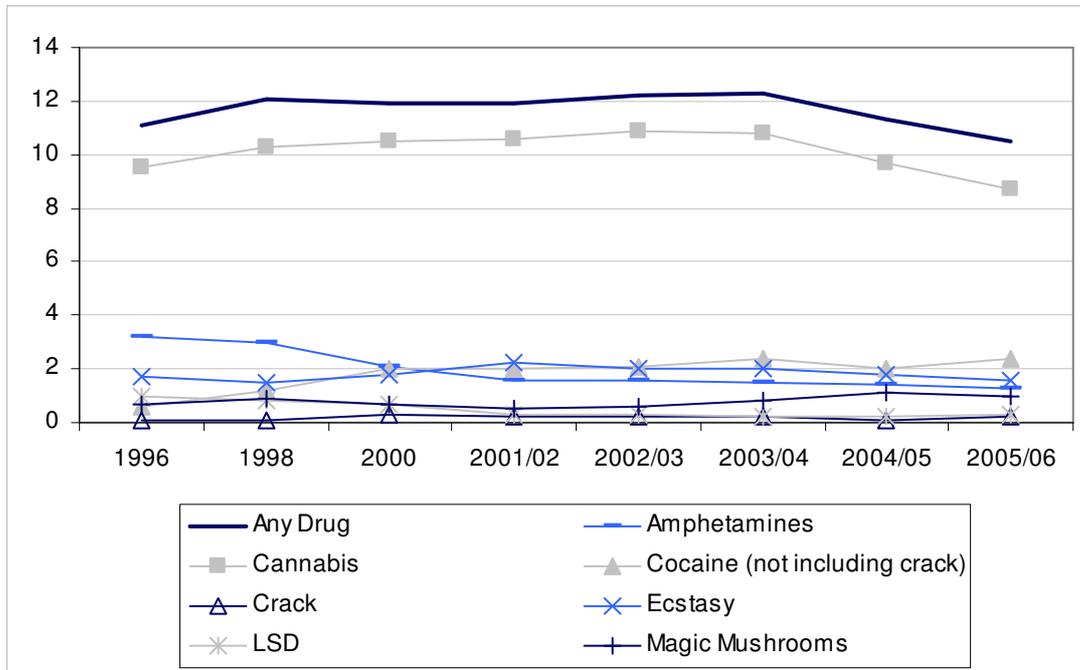
²⁰ 29,932 respondents completed the drugs module of the 2005/06 BCS and an extra 2,259 16 to 24 year olds were also interviewed as part of the 2005/06 BCS youth boost

²¹ The 2004 face-to-face SCVS interviewed 3,034 adults aged 16+. A further 1,973 adults completed an abbreviated version of the main survey. This consisted of a short face-to-face questionnaire with questions on fear of crime and demographics, and these respondents were also asked to undertake the self-completion questionnaire. The overall response rate for the 2004 survey was 67 per cent. Of the 5,007 adults who completed either the 2004 main survey or the 2004 shortened version, 4,424 undertook the self-completion questionnaire. The response rate for the self-completion element of the 2004 survey was therefore 59 per cent (based on all of the eligible sample).

There was a significant fall in the lifetime use of amphetamines, cannabis, cocaine and LSD in 2004/05, and also in recent use of cannabis and cocaine, though there was a significant rise in the use of magic mushrooms.

Analysis from the 2005/06 BCS (Roe and Man 2006) shows there had been a small rise in lifetime use of amphetamines, cannabis and LSD from the previous year while lifetime use of cocaine, ecstasy and magic mushrooms has risen significantly. There had also been a significant rise in the recent and current use of cocaine, however this followed falls in the previous year. Recent cannabis use has fallen significantly and for the first time current and recent cannabis use is significantly lower than in 1998. Despite the rise in lifetime use of magic mushrooms, current use has fallen significantly. Recent and current use of ecstasy has remained stable (Table 2.1). Figure 2.1 shows the changes over time since 1998 for recent use, indicating a fall in overall drug use and it also shows the rise in cocaine use.

Figure 2.1: The proportion of 16 to 59 year olds reporting having used drugs in the last year in England and Wales, 1996 to 2005/06



Note that the first three time intervals in this graph are greater than a year
Source: Roe and Man 2006

The Scottish Crime and Victimization Survey

Prevalence and trends in drug use: Scotland

Prevalence estimates from the 2004 Scottish Crime and Victimization Survey are shown in Table 2.2.

Table 2.2: The proportion of 16 to 59 year olds reporting having used drugs in their lifetime, last year between 2000 and 2004

Drug	Lifetime			Last year		
	2000	2003	2004	2000	2003	2004
Any drug	19.2	25.3	23.7	6.6	9.2	7.7
Amphetamines	6.3	9.6	8.4	0.5	1.4	1.0
Cannabis	17.4	22.8	21.9	5.5	8	6.3
Cocaine	2.5	4.8	4.6	0.7	1.4	1.5
Crack	1.0	1.2	1.2	0.0	0.2	0.2
Ecstasy	3.7	6.0	5.4	1.0	1.7	1.2
Base	2,886	4,665	2,955	2,886	4,665	2,955

Source: Murray and Harkins 2006

This shows that, as in England and Wales, there had been a reduction in lifetime and recent use of any drug, and a reduction in use of cannabis and amphetamines.

Gender

Men continue to be more likely than women to have used any illicit drug (Table 2.3).

Table 2.3: Use of any drug by gender in England and Wales, 2004/05 and 2005/06 and Scotland, 2004 as a percentage

	Ever used		Last year		Last month	
	Male	Female	Male	Female	Male	Female
England and Wales 2004/05 (aged 16 to 59)	40.3	29.0	14.3	8.3	8.8	4.5
England and Wales 2005/06 (aged 16 to 59)	40.6	29.4	13.7	7.4	8.6	4.0
Scotland 2004 (aged 16 to 64)	25.7	18.9	8.1	6.2	4.9	2.6

Source: Standard Table prepared for UK Focal Point based on crime surveys

Frequency of use

Analysis of the SCVS found that of the 4 per cent (n=129) who indicated they had currently taken any drugs, a substantial minority reported taking drugs very frequently; 34 per cent had taken drugs 'every day or almost every day' and a further 47 per cent at least once a week. A fifth (19%) had only taken drugs 'once or twice' in the previous month. Cannabis was the drug used most often (Murray and Harkins 2006).

2.3 Drug use amongst young adults

2.3.1 Young People 16 to 34

Prevalence and trends in drugs use in England and Wales

Prevalence estimates from the 2004/05 and 2005/06 British Crime Survey, for young people aged 16 to 34 are shown in Table 2.4.

Table 2.4: The proportion of 16 to 34 year olds reporting having used drugs in their lifetime, last year and last month in England and Wales, 2003/04 to 2005/06

	Lifetime			Last year			Last month		
	2003/4	2004/5	2005/6	2003/4	2004/5	2005/6	2003/4	2004/5	2005/6
Any drug	48.2	46.9	46.6	22.1	20.6	19.4	13.6	12.7	11.7
Amphetamines	18.4	16.5	16.8	3	2.7	2.6	1.1	1.0	1.1
Cannabis	43.4	41.4	41.5	19.5	17.9	16.3	12	10.6	9.6
Cocaine (including crack)*	11.6	10.5	12.1	4.9	4.1	4.9	2.4	1.8	2.3
Ecstasy	13.6	12.7	13.3	4.1	3.7	3.4	1.9	1.4	1.4
LSD	9.2	7.3	7.6	0.5	0.5	0.6	0.2	0.1	0.2
Magic mushroom	9.7	8.7	10	1.8	2.2	2.1	0.5	0.7	0.5

* As data for 16 to 34 years olds is taken from Standard Tables, figures for cocaine include crack and may therefore be higher than if they were for cocaine only as in tables for 16 to 59 year olds and tables for 16 to 24 year olds.

Source: Standard Table prepared for UK Focal Point based on crime surveys

A fall in lifetime use of all drugs between 2003/04 and 2004/05 can be seen (Table 2.4). Similarly for recent use, a fall is seen in all but magic mushrooms; the same for current use. Between 2004/05 and 2005/06 lifetime use of most drugs continued to fall but use of cocaine and magic mushrooms increased. Recent and current use of all drugs apart from cocaine remained stable or decreased.

Prevalence and trends in drugs use in Scotland

Estimates of prevalence for 2004 from the Scottish Crime and Victimisation Survey, for adults aged 16 to 34 are shown in Table 2.5. There has been a fall in lifetime prevalence of all drugs except LSD since the previous survey.

Table 2.5: The proportion of 16 to 34 year olds reporting having used drugs in their lifetime, last year and last month in Scotland, 2003 and 2004

	Lifetime		Last year		Last month	
	2003	2004	2003	2004	2003	2004
Any Drug	38.5	36.2	18	15	10.4	7.8
Amphetamines	16.5	14.4	2.3	2.1	0.6	0.8
Cannabis	35.9	34.4	16.5	12.8	9.5	6.6
Cocaine (including crack)*	8.7	8.1	3.2	2.9	0.9	0.7
Ecstasy	12.5	11.4	3.8	2.6	1.6	0.8
LSD	7.8	7.9	0.2	0.5	0.1	0.2
Magic Mushrooms	7.0	6.2	0.4	0.3	0.0	0.0

* As data for 16 to 34 years olds is for Standard Tables, figures for cocaine include crack and may therefore be higher than if they were for cocaine only as in tables for 16 to 59 year olds and tables for 16 to 24 year olds.

Source: Standard Table prepared for UK Focal Point based on crime surveys

2.3.2 16 to 24 year olds

Prevalence and trends in drug use in England and Wales

Following a recent review of the data processing procedures for the BCS youth boost dataset, it was discovered that there were inconsistencies in the calculation of calibration weights for the youth boost compared with the main BCS dataset (Roe and Man 2006). Revised estimates of young people's drug use are included in this report.

Prevalence estimates from the 2004/05 and 2005/06 British Crime Survey, for young people aged 16 to 24 are shown in Table 2.6.

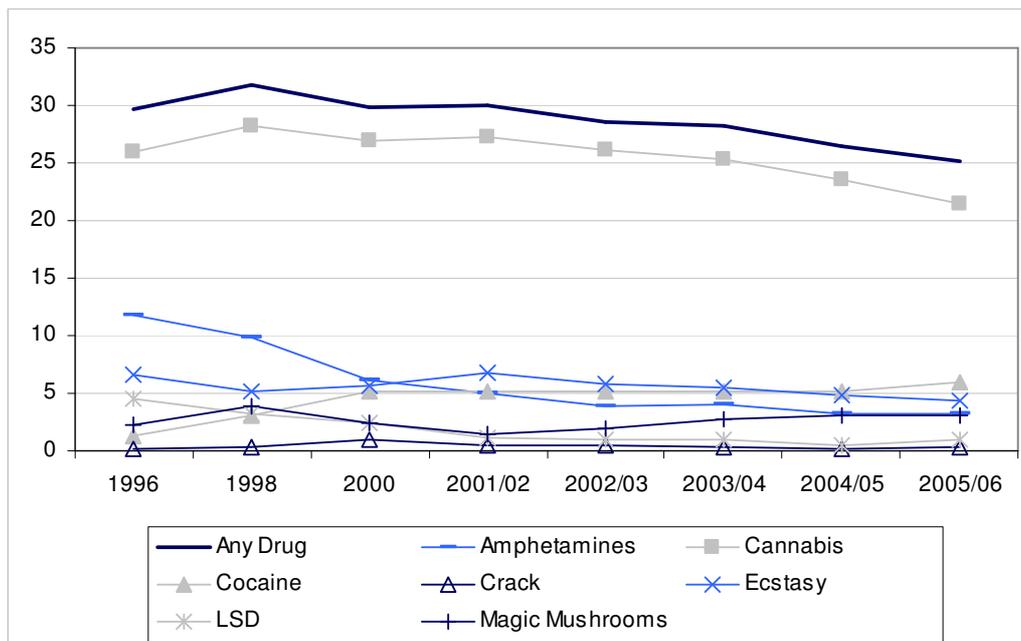
Table 2.6: The proportion of 16 to 24 year olds reporting having used drugs in their lifetime, last year and last month in England and Wales, 1996 to 2004/05

	Lifetime			Last year			Last month		
	2003/04	2004/05	2005/06	2003/04	2004/05	2005/06	2003/04	2004/05	2005/06
Any Drug	47.5	46	45.1	28.3	26.5	25.2	17.5	16.4	15.1
Amphetamines	13.1	11.6	11.3	4.0	3.2	3.3	1.6	1.3	1.6
Cannabis	42.2	41.1	40.1	25.3	23.6	21.4	15.8	14.1	13
Cocaine (not including crack)	9.7	9.1	10.6	5.2	5.1	5.9	2.7	2.1	3.0
Crack	1.6	1.1	1.3	0.4	0.1	0.4	0.2	0.1	0.2
Ecstasy	11.3	10.8	10.4	5.5	4.9	4.3	2.6	1.9	2.0
LSD	4.8	3.5	3.7	0.9	0.5	0.9	0.4	0.2	0.2
Magic Mushrooms	7.0	7.0	8.3	2.7	3.0	3.0	0.8	0.9	0.7
Base	5,387	6,240	5,929	5,351	6,196	5,892	5,327	6,182	5,876

Source: Roe and Man 2006

The decrease in lifetime use of any drug among 16 to 24 year olds in England and Wales since 1998, when the Drug Strategy commenced, continued in 2004/05 and 2005/06 with significant falls in the use of cannabis, amphetamines, LSD and magic mushrooms (Figure 2.2). Following a period of increasing use prior to 2000, cocaine use had broadly stabilised. However, 2005/06 saw increases in cocaine use amongst 16 to 24 year olds for all recall periods which were statistically significant for lifetime and current use but not recent use. The lifetime prevalence of ecstasy use has remained essentially stable since 1996.

Figure 2.2: The proportion of 16 to 24 year olds reporting having used drugs in the last year and percentage change in England and Wales, 1996 to 2005/06



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

Source: Roe and Man 2006

A similar pattern to that seen for lifetime prevalence was found when recent use was considered. There has been a consistent decline in the use of any drug since 1998, which is mirrored by most individual types of drugs, in particular cannabis and amphetamines. Recent use of ecstasy has remained generally stable in recent years but between 2005/05 and 2005/06 use of crack and LSD rose significantly.

The trends in current use are similar to those for other recall periods, with the exception of a significant decrease in current use of cocaine and ecstasy in 2004/05 compared with the previous year. Cocaine use again rose significantly in 2005/06 above 2003/04 figures, but ecstasy use remained stable.

Prevalence and trends in drugs use in Scotland

Prevalence estimates from the 2004 Scottish Crime and Victimization Survey, for young people aged 16 to 24 shown in Table 2.7.

Table 2.7: The proportion of 16 to 24 year olds reporting having used drugs in their lifetime, last year and last month in Scotland, 2003 and 2004

	Lifetime		Last year		Last month	
	2003	2004	2003	2004	2003	2004
Any Drug	39.8	35.2	25.9	19.0	15.6	9.2
Amphetamines	13.0	10.3	3.0	2.6	0.7	1.0
Cannabis	37.7	33.9	23.1	16.4	14.3	7.8
Cocaine	10.8	5.6	5.1	3.0	1.3	0.5
Ecstasy	14.3	7.0	5.2	2.4	2.5	1.4
LSD	6.1	3.8	0.3	0.7	0.0	0.3
Magic Mushrooms	5.6	4.0	0.3	0.3	0.0	0.0
<i>Base</i>	<i>619</i>	<i>330</i>	<i>619</i>	<i>330</i>	<i>619</i>	<i>330</i>

Source: Standard Table prepared for UK Focal Point based on crime surveys

Trends in drugs used 16 to 24 year olds: Scotland

In Scotland there has been a decrease in lifetime use of all drugs and current use of most drugs has declined (Tables 2.7).

Frequent use

Questions on frequency of use (used more than once a month) in the last year were first asked to 16 to 24 year olds in the BCS in 2002/03. Frequent use of any drug in the last year among all 16 to 24 year olds, has decreased significantly since 2002/03, with further decreases seen in the following two years (Table 2.8). Looking at frequent use of individual drugs, the drug that young users are most likely to use frequently is cannabis (41.2%), followed by amphetamines (26.1%). Frequent cocaine use rose sharply in 2005/06 to 22.3 per cent, ecstasy has remained stable at 16.1 per cent and frequent use of magic mushrooms has fallen to 1.8 per cent (Table 2.9).

Table 2.8: Frequency of use in the last year: proportion of 16 to 24 year olds (all respondents) who use more than once a month in England and Wales, 2002/03 to 2005/06

Drug	Year			
	2002/03	2003/04	2004/05	2005/06
Any Drug	11.3	12.4	10.3	9.5*
Base	4,292	5,234	6,070	5,768

*Statistically significant change 1998 to 2005/06

Source: Roe and Man 2006

Table 2.9: Frequency of use in the last year: proportion of 16 to 24 year olds who use more than once a month

Drug	% More than once a month					
	2003/04	Base	2004/05	Base	2005/06	Base
Any Drug	53.6	1,381	41.6	1,470	40.3	1,333
Amphetamines	18.8	191	25.4	198	26.1	164
Cannabis	46.9	1,267	41.1	1,348	41.2	1,164
Cocaine	17.2	253	14.2	275	22.3	321
Crack	..	18	..	9	..	17
Ecstasy	21.4	264	16.9	274	16.1	227
LSD	..	31	..	31	..	33
Magic Mushrooms	4.5	120	6.0	163	1.8	135

.. Sample size too small to analyse

Source: Roe 2006; Roe and Man 2006

Gender

For the most part men continue to be more likely than women to have used any illicit drug recently. However, in Scotland in 2004, results from the SCVS suggest that amongst young people, females are more likely to report recent use than are males (Table 2.10).

Table 2.10: Use of any drug by gender and age group (16 to 24 and 16 to 34) in England and Wales, 2004/05 and 2005/06 and Scotland, 2004

	Lifetime		Last year		Last month	
	Male	Female	Male	Female	Male	Female
England and Wales 2004/05						
16 to 34	53.1	40.9	26.1	15.3	16.6	8.9
16 to 24	51.2	40.8	32.3	20.6	20.5	12.2
England and Wales 2005/06						
16 to 34	52.0	41.3	24.9	14.1	15.6	7.9
16 to 24	49.2	40.9	29.9	20.6	19.2	11.1
Scotland 2004						
16 to 34	39.0	33.5	15.9	14.1	9.8	5.8
16 to 24	35.6	34.7	17.7	20.3	11.1	7.3

Source: Standard Table prepared for UK Focal Point based on crime surveys

In Scotland, amongst 16 to 24 year olds 35.6 per cent of males reported having ever used compared to 34.7 per cent females. For recent and current use, 17.7 per cent of males compared to 20.3 per cent of females, and 11.1 per cent of males compared to 7.3 per cent of females reported use of any drug.

Figures from 2005/06 BCS, however, show that lifetime and recent use remained stable for women aged 16 to 24 but decreased amongst men of the same age.

2.4 Drug use in the school and youth population

The latest published survey of school children in Northern Ireland (DHSSPSNI 2004) is for 2003 and has been referred to in previous United Kingdom Focal Point reports. A research report based on a secondary analysis of the 2003 Young Persons Behaviour and Attitudes Survey²² and findings from the 2000 survey showed that there had been a significant decrease in the lifetime prevalence of illegal drugs by young people although there was a significant increase in the use of cannabis (SMR 2005). This survey is referred to more extensively in chapters 11 and 12 of this report. The next survey to be carried out in Northern Ireland will be in 2007.

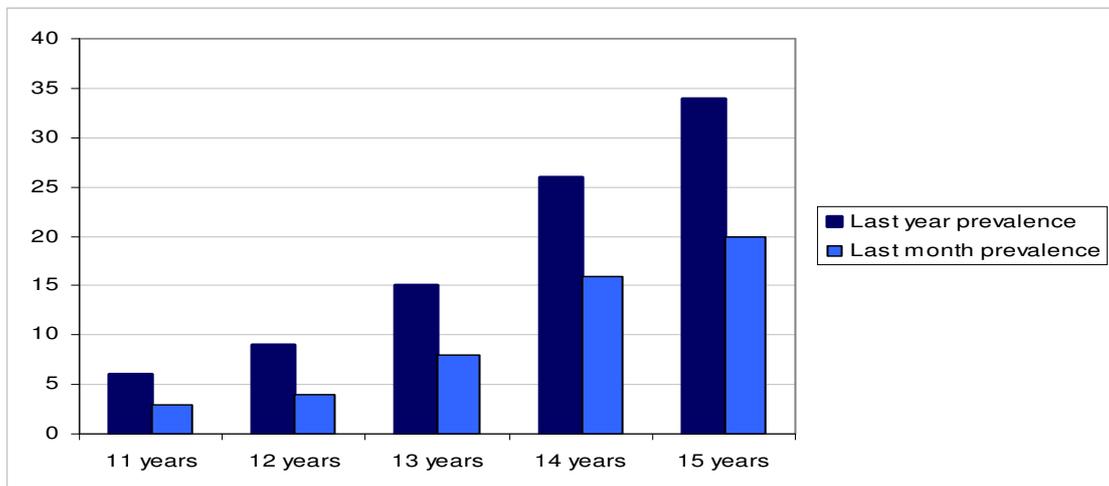
In Scotland the latest published survey is for 2004 (Corbett *et al.* 2005) and again was referred to in the previous United Kingdom Focal Point Report; the next survey will be carried out in 2006. In Wales, the Health Behaviour in School Children (HBSC) survey is supplemented by questions relevant to 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 May 2006. Results of the 2004 survey will be published in the autumn of 2006.

Results from a new school survey in England, conducted in 2005, are available (NatCen/NFER 2006)²³. These showed that amongst school children aged 11 to 15:

- 27.5 per cent reported using one or more drug in their lifetime;
- 19.1 per cent reported using one or more drug in the last year; and
- 10.9 per cent reported using one or more drug in the last month.

There are large differences between age groups, with major increases in use being seen from one age to the next (Figure 2.3).

Figure 2.3: Last year and last month prevalence by age in England, 2005



Source: NatCen/NFER 2006

²² The Young Persons Behaviour and Attitudes Survey (YPBAS) assesses the behaviour and attitudes of school children in years 8-12 towards a range of different topics including school, general health and the environment. The survey was first conducted in 2000 and repeated in 2003. This survey was conducted with a sample of 7223 students aged 11-16 in Autumn 2005.

²³ Over 9,000 pupils in 305 schools in England completed questionnaires in the 2005 autumn term.

Frequency

Six per cent of pupils reported that they usually took drugs once a month, five per cent once or twice a month, two per cent at least once a week and one per cent on most days.

Availability of drugs: offered drugs

A larger proportion of pupils reported being offered drugs than reported having used them, (39%). The proportion offered drugs increases sharply with age (18% of 11 year olds and 63% of 15 year olds).

Drug used

As with adults, cannabis remains the most used drug; most other drugs having a much lower prevalence (Table 2.11). However there are differences in drugs used by age, with volatile substances being by far the most prevalent substances used recently and currently by 11 and 12 year olds, but cannabis being used recently by near equal numbers of 13 years olds. Current use by 13 year olds shows cannabis is more frequently used than volatile substances. At 14, recent use of cannabis increases significantly, though volatile substances are still used, in addition to a much wider range of substances. At 15, prevalence of all types of drug increases, except for recent and current use of volatile substances (Table 2.11).

Table 2.11: Whether had taken individual drugs in the last year and last month, by age in England, 2005 as a percentage

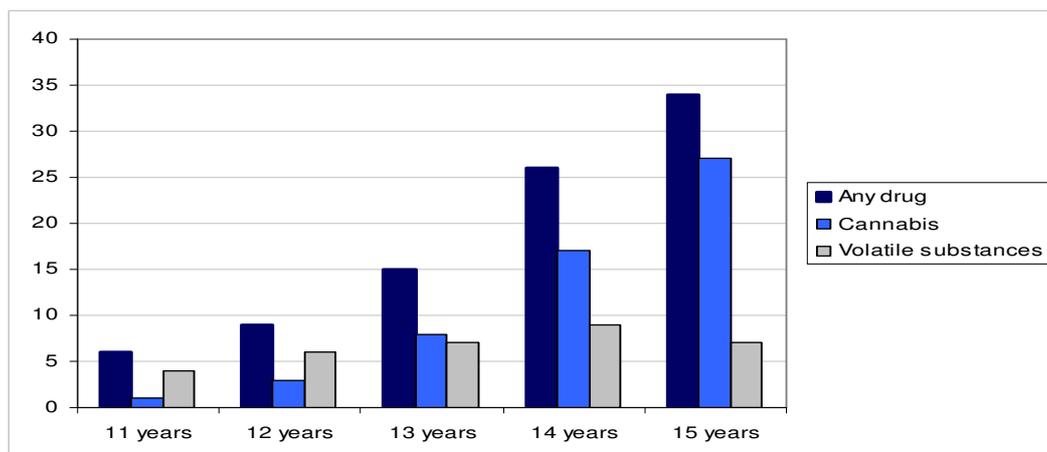
Drug	Age					Total
	11	12	13	14	15	
Last year						
Cannabis	0.7	2.6	7.6	17.2	27.1	11.7
Cocaine	0.4	0.4	1.0	2.8	4.3	1.9
Crack	0.3	0.4	0.9	1.6	1.5	1.0
Ecstasy	0.3	0.1	0.8	2.2	3.6	1.5
Amphetamines	0.1	0.2	0.7	2.0	2.5	1.2
LSD	0.2	0.3	0.4	0.9	1.3	0.6
Magic mushrooms	0.3	0.4	1.2	3.0	3.8	1.8
Heroin	0.3	0.5	0.8	1.3	1.0	0.8
Volatile substances*	4.5	5.9	7.1	8.7	6.8	6.7
Any drug	6.2	9.4	14.8	26.3	33.9	19.1
Last Month						
Cannabis	0.6	0.7	4.3	10.9	15.6	6.8
Cocaine	0.3	0.2	0.6	1.8	2.1	1.1
Crack	0.2	0.2	0.4	0.6	0.8	0.5
Ecstasy	0.3	0.1	0.3	0.8	1.2	0.5
Amphetamines	0.1	0.0	0.3	0.9	0.9	0.5
LSD	0.1	0.1	0.2	0.4	0.5	0.3
Magic mushrooms	0.3	0.1	0.5	1.3	1.3	0.7
Heroin	0.3	0.2	0.5	0.7	0.4	0.4
Volatile substances*	2.1	2.9	2.9	3.9	3.0	3.0
Any drug	3.3	4.2	7.8	16.1	20.3	10.9
Base	1,341	1,685	1769	1,794	1,887	8,476

*includes glues, gas, aerosols and solvents

Source: Standard Table prepared for UK Focal Point

Figure 2.4 shows the extent to which volatile substance abuse contributes to levels of drug use amongst young people.

Figure 2.4: Whether had taken any drug, volatile substance and cannabis in the last year, by age in England, 2005 as a percentage



Source: NatCen/NFER 2006

Gender

There are differences in use by gender; boys tending to use more than girls (Table 2.12).

Table 2.12: Whether had used individual drugs in the last month, in the last year and ever, by gender in England, 2005

	Male			Female			Total		
	In last month	In last year	Ever	In last month	In last year	Ever	In last month	In last year	Ever
Cannabis	8	12	15	6	11	14	7	12	14
Cocaine	1	2	3	1	2	2	1	2	2
Crack	0	1	1	0	1	1	0	1	1
Ecstasy	1	1	2	0	2	2	1	1	2
Amphetamines	0	1	1	1	1	2	0	1	1
Amyl nitrate/ Poppers	1	3	6	2	4	6	1	4	6
LSD	0	1	1	0	1	1	0	1	1
Magic mushrooms	1	2	3	1	2	2	1	2	3
Ketamine	0	1	1	0	0	0	0	0	1
Heroin	0	1	1	0	1	1	0	1	1
Methadone	0	0	0	0	0	0	0	0	0
Volatile substances*	3	6	3	3	7	15	3	7	14
Any drug	11	19	28	10	19	27	11	19	28
Any drug (excluding volatile substances)	9	15	19	8	15	18	9	15	18
Base	4,667	4,667	4,667	4,507	4,507	4,507	9,174	9,174	9,174

*includes glues, gas, aerosols and solvents

Source: NatCen/NFER 2006

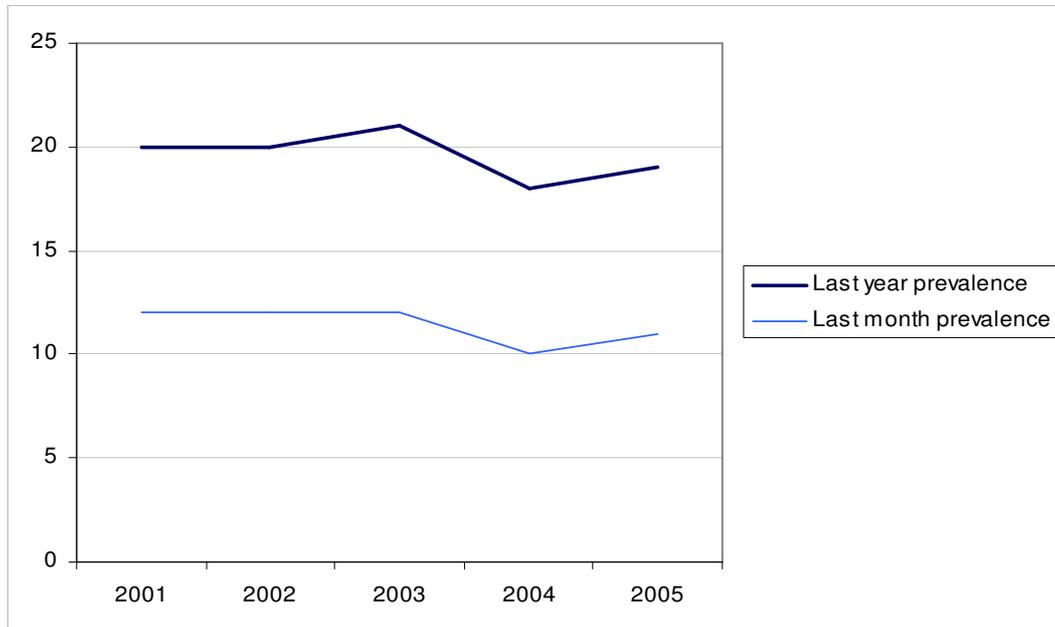
For a more in depth analysis of drug use amongst minors based on this data, as well as surveys for Scotland and Northern Ireland carried out in previous years, see Chapter 11: Drug use amongst minors.

Trends in drug use amongst school children in England and Wales

Drug use steadily increased until 2001 (NatCen/NFER 2006), but seems to have stabilised since then with perhaps signs of a recent fall (See Figure 2.5). However, in 2005, there was an increase in current use of cocaine from 1.4 per cent to 1.9 per

cent but it is too soon to judge if this is the start of a trend since estimates of such low prevalence are subject to considerable variation.

Figure 2.5: Drug use amongst school children in England and Wales, 2001 to 2005



Source: NatCen/NFER 2006

Table 2.13: Prevalence of drug use in the last month amongst school children in England, 2001 to 2005

Drug	2001	2002	2003	2004	2005
Cannabis	13	13	13	11	12
Cocaine	1	1	1	1	2
Crack	1	1	1	1	1
Ecstasy	2	1	1	1	1
Amphetamines	1	1	1	1	1
Poppers	3	4	4	3	4
LSD	1	1	1	1	1
Magic Mushrooms	2	1	2	2	2
Ketamine**	-	-	-	-	0***
Opiates	1	1	1	1	1
Volatile substances*	7	6	8	6	7
Base	8,799	9,146	9,658	9,086	8,408

* Includes glues, gas, aerosols or solvents

**Ketamine was measured separately for the first time in 2005

*** = less than 0.5% but not zero

Source: NatCen/NFER 2006

A survey of drug use in primary schools

A survey of drug and alcohol use among primary school children had been carried out in schools in Northern Ireland; results are expected to be made available in the autumn of 2006.

The Offending Crime and Justice Survey 2004

Drug use identified in the Offending Crime and Justice Survey (OCJS)²⁴ for 2004 mirrors findings from the British Crime Survey. Nearly a quarter (22%) of young people aged 10 to 25 said they had taken a drug in the preceding 12 months. The most commonly used drug was cannabis. Males were more likely to report having taken a drug recently compared with females. A quarter of males had taken a drug compared with less than a fifth of females. Young people aged 18 to 25 had significantly higher drug use compared with young people aged 10 to 17. Prevalence of drug use remained stable between 2003 and 2004 (Budd *et al.* 2005).

2.5 Drug use among specific groups

2.5.1 Conscripts

NO NEW INFORMATION AVAILABLE

2.5.2 Minorities

NO NEW INFORMATION AVAILABLE

2.5.3 Sex workers

NO NEW INFORMATION AVAILABLE

2.5.4 Ethnic groups

Sharp and Budd (2005) looked at ethnicity and drug use in their analysis of the 2003 OCJS. It was found that overall, for 10 to 65 year-olds, white respondents and those of mixed ethnic origin have the highest levels of drug taking recently (Table 2.14).

²⁴ The Offending, Crime and Justice Survey (OCJS) is the national longitudinal, self-report offending survey for England and Wales. The survey, covering people living in private households, 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 from 10 to 25. It covers offences against households, individuals and businesses. In addition to 'mainstream' offences such as burglary, shoplifting and assault, it also covers fraud and technology offences. The survey will also collect longitudinal data (that is information from the same individuals over time) to allow researchers to examine the pathways into and out of delinquency and the impact various risk and protective factors have on these pathways. It gathers evidence to support the effective targeting of resources for reducing levels of crime and illegal drug use, providing:

- measures of self-reported offending;
- indicators of repeat offending;
- trends in the prevalence of offending;
- trends in the prevalence and frequency of drug and alcohol use;
- evidence on the links between offending and drug / alcohol use;
- evidence on the risk factors related to offending and drug use; and
- information on the nature of offences committed, such as the role of co-offenders and the relationship between perpetrators and victims.

Table 2.14: Percentage who have taken drugs in the last year by ethnicity in England and Wales, 2003

Drug	White	Mixed	Asian or Asian British	Black or Black British	Other
Amphetamines	2	2	<0.5*	<0.5*	<0.5*
Cannabis	12	16	4*	10	6*
Cocaine	3	3	<0.5*	1*	<0.5*
Crack	<0.5	<0.5	<0.5	<0.5	-
Ecstasy	3	3	<0.5*	1*	1*
Heroin	<0.5	-	-	<0.5	-
LSD/magic mushrooms	1	1	<0.5*	<0.5	2
Amyl nitrite	2	1	<0.5	<0.5*	1
Glue	<0.5	-	<0.5	<0.5	<0.5
Any drug	13	17	4*	11	9*
Base	9,160	415	1,091	723	334

- indicates that there was no response in that category

* significantly different from the white group at 5% level

Source: Sharp and Budd 2005

Recent use of any drug was highest among respondents of mixed ethnic origin, followed by white respondents, and lowest among Asian respondents (17% mixed; 13% white; 11% black; 9% other and 4% Asian). Use of Class A drugs was highest among white respondents and those of mixed ethnic origin (4% for both). Levels were significantly lower among black and Asian respondents (1.6% and 0.5% respectively) (Sharp and Budd 2005).

2.5.5 Vulnerable young people

In the previous United Kingdom Focal Point report analysis of drug use by vulnerable young people identified in the OCJS 2003 was reported²⁵, suggesting that drug use was more prevalent among vulnerable young people, especially those who were in more than one vulnerable group (Becker and Roe 2005). Drug use amongst these groups was again considered in analysis of the 2004 OCJS. It was again found that they reported higher levels of drug use (44%), Class A use (18%) and frequent drug use (26%) compared with those who were not vulnerable (13%, 3% and 5% respectively). Those having more than one vulnerable characteristic reported higher levels of drug use (46%), Class A use (26%) and frequent use (30%) than those who were only in one vulnerable group (33%, 12% and 14% respectively). Further, they reported higher levels of use for all of the individual drugs listed in the survey (Table 2.15).

²⁵ Identified as those who had ever in care, ever been homeless, truants, those excluded from school and serious or frequent offenders

Table 2.15: Vulnerability and use of drugs in England and Wales, 2004 as a percentage

Drug	Vulnerability status			
	Not Vulnerable	Vulnerable	1 vulnerable group only	More than 1 vulnerable group
Cocaine	1.8	12.6*	7.0	13.6
Crack	-	0.8*	0.3	2.9
Ecstasy	1.6	12.7*	7.3	18.3*
Hallucinogens	0.6	7.3*	3.3	12.5*
Heroin	-	0.3	0.3	1.9
Amphetamines	0.9	8.0*	2.7	13.6*
Cannabis	11.5	41.0*	30.5	42.3
Amyl nitrite	2.1	7.5*	4.7	13.5*
Solvents	0.6	2.3*	1.3	3.8
Any drug	13.0	43.7*	33.4	45.6
Frequent user	4.8	26.2*	14.4	30.1*
<i>Base: Frequent user</i>	<i>1,128</i>	<i>1,055</i>	<i>300</i>	<i>115</i>

* indicates a significant difference between vulnerable and not vulnerable and between member of one vulnerable group and member of more than one vulnerable group.

Source: Budd *et al.* 2005

Other Research

The Joseph Rowntree Foundation has funded research with young people into what constitutes 'heavy' cannabis use. The research will examine how such use impinges on friendship networks, relationships and educational/career choices at a key stage of youth transitions. A longitudinal approach will be adopted using a combination of focus groups, questionnaires and repeat in-depth interviews. The research had not been published at the time of writing.

3. Prevention

3.1 Overview

Prevention of young people's drug use is one of the four elements of the United Kingdom Drugs Strategy. In particular, the 2004 Spending Review Public Service Agreement (PSA) stated that by 2008 there should be a reduction of use of all Class A drugs and the frequency of use of any illicit drugs among all young people under the age of 25, especially by the most vulnerable.

The *Every Child Matters: Change for Children* programme (2004)²⁶ aims to reform children's services to enable children to reach their full potential. The programme is measured across a range of outcomes for children and young people, namely: being healthy, staying safe, enjoying and achieving, making a positive contribution and economic wellbeing. One of the aims under the be healthy outcome seeks to ensure that young people 'choose not to take illegal drugs'.

Drug prevention initiatives in the United Kingdom have grown markedly since 1998. One of the most high profile of these is the FRANK communications initiative²⁷, an intervention that offers substance related information to users, contemplators, and their friends and family. In Scotland, Know the Score²⁸, and in Northern Ireland, Drugs Website Northern Ireland²⁹, provide similar information. In 2006 it was announced that FRANK communications would have an extra focus on vulnerable young people.

In England, drug education is a statutory part of the national curriculum; the majority of primary (80%) and secondary schools (95%) have adopted drug education policies (DfES 2004b). Drug education in schools is now widely available and is a part of the Personal, Social and Health Education (PSHE) curriculum, and the National Healthy Schools programme³⁰, which includes drug education as one of its core themes. In 2006 Ofsted reported on the scope and quality of drugs prevention in schools (Ofsted, 2006). In Northern Ireland drug education is also a statutory part of the national curriculum and in Scotland almost all schools provide drug education as an integral part of health education.

The Connexions Service, which, as part of its wider activities, identifies young people with drug problems and provides appropriate referral or support, covers most of England (80%). Key priorities, established in 2002, are intended to be achieved by 2006. These include increasing the proportion of 16 year olds who transfer into further learning, and the proportion of 16 to 18 year olds who are either in learning or work. According to Connexions estimates, in November 2005 7.7 per cent of 16 to 18 year olds in England were not in education, employment or training. In line with the priorities of *Every Child Matters and Youth Matters* it has been announced that, by April, 2008 funding that currently goes to the 47 Connexions partnerships will go

²⁶ See: <http://www.everychildmatters.gov.uk/aims/> for more information

²⁷ See: <http://www.talktofrank.com>

²⁸ See: <http://www.knowthescore.info/>

²⁹ See: <http://www.nics.gov.uk/drugs/index.htm>

³⁰ The National Healthy School Standard (see: <http://www.wiredforhealth.gov.uk>) has three strategic aims; to reduce health inequalities; to promote social inclusion; and to raise educational standards. Themes include PSHE; Citizenship; Drug education (including alcohol and tobacco); emotional health and wellbeing; healthy eating; physical activity; safety; sex and relationship education.

directly to each of the 150 local authority areas. Despite a change in funding status, Connexions is expected to contribute to young people's services.

Positive Futures³¹ continues to offer inclusionary sports and art activities to young 'vulnerable' people. Management and delivery of Positive Futures was taken over by Crime Concern in 2006. Although Positive Futures (see section 3.3.2 below) primarily targets people in deprived communities, there is no assumption of the existing level of drug use. Moreover participants are allowed to self refer, hence drug education incorporates universal prevention approaches.

There is no specific national universal prevention campaign aimed at families. However, D(A)ATs (and their Welsh and Northern Irish equivalents) support family based drug prevention through Tier 1³² activities. The FRANK and Know the Score campaigns offer free drugs information resources for parents and carers for use in (informal) prevention activities.

In 2005/06 the National Collaborating Centre for Drug Prevention (NCCDP)³³ was commissioned by the Evidence Based Steering Group of the National Young People and Drugs Board to produce briefings on recent Government work on drug prevention. This series of studies reported on drug prevention in universal and vulnerable populations and is summarised in the relevant sections below.³⁴

3.2 Universal prevention

Universal prevention targets the general population regardless of individual levels of risk, for example through the classroom.

In the context of Every Child Matters (DfES *et al.* 2005), any professional group in contact with young people, given sufficient experience and skill, is expected to deliver universal drug prevention services.

3.2.1 Evidence reviews

The National Institute for Health and Clinical Excellence (NICE) published reviews by the NCCDP in 2006. *Drug use prevention among young people: a review of reviews* (McGrath *et al.* 2006) provided an update to the Health Development Agency's review or reviews published in 2004 (Canning *et al.* 2004). This was accompanied by *Drug use prevention among young people: Evidence into Practice Briefing* (Sumnall *et al.* 2005) which provided guidance to different professional groups on how to access and implement evidence based drug prevention practice. *Review of grey literature on drug prevention among young people* (McGrath *et al.* 2006), reviewed drug prevention materials not traditionally included in academic reviews. These publications are available on the NICE website.³⁵

The NCCDP has reported the findings of a review of Government sponsored universal drug prevention (Jones *et al.* 2006). This work was considered in the context of the wider drugs literature. The report concluded that Government funded

³¹ See: <http://www.drugs.gov.uk/young-people/positive-futures/?version=1>

³² Tier 1 consists of services offered by a wide range of professionals (e.g. primary care medical services, generic social workers, teachers, community pharmacists, probation officers, housing officers, homeless persons units). Tier 1 services work with a wide range of clients including drug users, but their sole purpose is not simply substance misuse.

³³ See: <http://www.drugpreventionevidence.info>

³⁴ Available from: http://www.drugpreventionevidence.info/web/NCCDP_Reports164.asp

³⁵ See: <http://www.nice.org.uk>

community-based prevention initiatives have tended to target deprived communities and universal prevention programmes delivered in this setting have not been widely assessed. School-based interventions were the most popular and widely researched method of delivering universal drug prevention programmes. Review evidence suggested that Life Skills Training (LST), or approaches based upon it, was one of the few programmes that has demonstrated a small but positive effect on reducing indicators of drug use. However, only those schools particularly dedicated to drugs education and eager to have pupils take part in this type of education see benefits. Multi-component programmes and those based on the social influence model showed the most consistently positive outcomes, but even these programmes were limited in their effects on reducing drug use. In addition, research is lacking regarding which components contribute to the overall effectiveness of multi-component programmes.

The report also identified a need for evaluation and long-term follow-up of drug education programmes targeted at primary school aged children. Review of the limited literature available suggested that primary school interventions should focus upon family intervention and parent education, school organisation and behavioural management. In addition, families play an important role in young people's choices around drug use. Research from the US has shown that family components may enhance the effectiveness of universal programmes. Currently, United Kingdom-based evidence is lacking about which interventions work most effectively with parents and how best to engage parents in drug prevention activities. Although international research has shown early evidence that provision of generic health and educational services may have a positive effect on drug use behaviours, a lack of United Kingdom-based research in this area was identified.

The Advisory Council on the Misuse of Drugs (ACMD) published its report, *Pathways to Problems; Hazardous use of tobacco, alcohol and other drugs by young people in the UK and its implications for policy* (ACMD 2006b). The report makes a number of recommendations including that there should be a careful reassessment of the role of schools in drug misuse prevention. It places an emphasis on providing all pupils with accurate, credible and consistent information about the hazards of tobacco, alcohol and other drugs, including volatile substances (ACMD 2006b, p.6). The Government's response to this report's recommendations is forthcoming.

3.2.2 School

In England, Ofsted currently monitors the provision and quality of drugs education in schools, and last reported in 2005 (see United Kingdom Focal Point report 2005). In a supplementary examination of a purposive sample of 18 schools, Ofsted criticised schools for not placing enough emphasis on the negative social consequences of substance use (Ofsted 2006). It was reported that schools which Ofsted believed delivered good drugs education made extensive use of external contributors. However, in an earlier review commissioned by the DfES, White *et al.* (2004) argued that although it was important to combine the contributions of external contributors with class teachers in order to increase pupil engagement, there was little guidance available on how to do this effectively. Furthermore, although external contributors were well received there was little evidence available to suggest that external contributors had any impact upon drug using behaviours.

At the time of writing, the evaluations of drug education in Scotland (Evaluation of the impact of drugs education in Scottish schools) and Wales (Evaluation of the All Wales School Programme) were not available.

In England, the National Healthy Schools Standard (NHSS), which encourages a whole school approach towards drugs and drug prevention education³⁶ has been reported in previous UK Focal Point report. Although achieving NHSS is not a statutory requirement, from September 2005, Ofsted has expected that all schools demonstrate how they contribute towards the five national outcomes for children outlined in Every Child Matters. Achieving Healthy School status will allow schools to show good evidence of this. Healthy School status is also a Beacon Council theme for 2006/2007³⁷. The Beacon Scheme was introduced in 1999 by the Office of the Deputy Prime Minister³⁸ to identify centres of excellence in local government. In January 2006 the NHSS Programme Board agreed a new marketing strategy that recommended rebranding of the Healthy Schools programme. Consultation is currently underway with young people and key stakeholders.

A practice development resource pack for school nurses offers a framework to support the development of a modern school nurse role (DfES and DH 2006). It identifies key national policies that are currently shaping developments in children's services and sets out a child centred public health approach for school nursing teams.

The Blueprint research programme is continuing to examine the effectiveness of a multicomponent approach to drugs education and prevention in schools (Baker 2006). Data collection has ended and a full evaluation is due to be published in 2007. In 2005/06 the following research themes were addressed:

- observation of Year 8 (pupils aged 12 to 13) lessons in Blueprint Schools;
- qualitative interviews with teachers;
- 2nd impact survey of Year 8 in all Blueprint schools;
- parent survey in all Blueprint schools;
- qualitative interviews with pupils and parents in all pilot schools; and
- 2nd and 3rd lifestyle surveys.

Also see the ACMD report mentioned in the previous section.

Drug testing in schools

While there is no policy to encourage drug testing in schools, DfES guidance for schools states that the decision is for each school. However in 2006 it was announced that the DfES would evaluate the results of a pilot random drugs testing scheme in Kent (England) schools, although no further details are as yet forthcoming.³⁹ Schools are expected to report back on the scheme during 2007.

The Scottish Executive has announced that it has no plans to introduce random drug testing into schools.⁴⁰

³⁶ The National Healthy School Standard has three strategic aims: to reduce health inequalities; to promote social inclusion and to raise educational standards. The Department of Health and the Department for Education and Skills have agreed new national targets for the NHSS: all schools with 20% + Free School Meal Eligibility (approximately 7000) to achieve NHSS level three status by 2006 and all schools in England to continue to be provided with the opportunity to access the services of a nationally accredited local healthy schools programme 2003 to 2006. See: www.wiredforhealth.gov.uk

³⁷ See: http://www.communities.gov.uk/pub/443/Round8ApplicationBrochure_id1164443.pdf

³⁸ Now the Department for Communities and Local Government

³⁹ See:

<http://www.teachernet.gov.uk/teachers/issue45/secondary/news/Randomdrugtestsforpupils/>

⁴⁰ See:

Campaigns

An evaluation of the Know the Score cocaine campaign in Scotland, aimed at 16 to 26 year olds, who socialise once a week or more, has been published (Binnie *et al.* 2006). In 466 interviews conducted in December 2005, there was high reported awareness of the different campaign strands (TV, radio, print) and, although the majority could not report specific campaign themes (51%), after prompting 91 per cent were aware of at least one strand of the campaign. Thirty per cent said that they were less likely to take cocaine after seeing the advertisements. Fifty six per cent reported that the campaign did not alter intentions to use cocaine and 11 per cent that they were more likely to use. Impact was greatest amongst existing cocaine users, those respondents believed to be most likely to be exposed to cocaine and females. A greater percentage of the latter group reported that they were less likely to use cocaine after seeing the adverts. The results of the evaluation should be placed in the context of recent figures published by the Scottish Executive from the Scottish Crime and Victimisation Survey indicating that in 2004 cocaine was the second most popular drug amongst 20 to 24 year olds (7.1% reported lifetime use, 3.5% recent use) (Murray and Harkins 2006).

Also see the FRANK campaign below (3.2.3).

3.2.3 Family

In 2006, FRANK launched a new communications initiative aimed at families and parents, *All about drugs: does your child know more than you?*⁴¹. Know the Score provides similar information targeted at parents.

3.2.4 Community

In England, New Deal for Communities partnerships aimed to integrate drug prevention into community regeneration strategies. Evaluation was completed at the end of 2005⁴², but at the time of writing only one publication examining the impact upon drug prevention has been published (Peters *et al.* 2003). However, this study did not describe specific interventions or outcomes.

In April 2006, the functions of *Scotland Against Drugs* (SAD), an organisation that provided support to community based services, were transferred to the Scottish Centre for Healthy Working Lives (SCHWL). SCHWL will be responsible for taking forward the employability and employment of drug misusers as part of their overall business plan. The existing *Scottish Drugs Challenge Fund* has been integrated into the activities of SCHWL, but its purpose will be subject to a forthcoming review. In Scotland in 2005/06, 31 projects shared €863,000 (£590,000) from the *Scottish Drugs Challenge Fund*. This scheme aims to promote partnership working between the public, private, and voluntary sector to support community based drug prevention. Funded projects have included inclusionary/diversionary activities and skills training. Only those other activities of SAD pertaining to employability have been transferred; drugs education and prevention activities have been transferred to NHS Scotland.

Youth Matters: Next Steps (DfES 2006) builds upon the green paper *Youth Matters* (2005). It builds upon the results of consultation with around 19,000 young people. Drug prevention falls under proposals supporting the objective of improving physical and emotional health. *The Youth Capital Fund* is intended to improve and develop

http://www.ltscotland.org.uk/sharednews/2006/educational/september/news_tcm4375198.asp

⁴¹ See: http://www.homeoffice.gov.uk/materials/Parents_Leaflet.pdf

⁴² See: <http://ndcevaluation.adc.shu.ac.uk/ndcevaluation/Home.asp>

facilities for young people, and the *Youth Opportunity Fund* will allow young people to prioritise spending for activities in their local area. The funding guidance notes⁴³ do not specifically refer to substance use, but allow for spending on diversionary and inclusionary activities.

The National Institute for Health and Clinical Excellence (NICE) has commissioned the NCCDP to conduct a systematic review into the effectiveness of community based drug prevention in vulnerable young people. This is due to be published, with associated guidance, in early 2007.⁴⁴

3.3 Selective/indicated prevention

Selective or indicative prevention initiatives target those groups identified as being high risk such as truants or young offenders.

3.3.1 Recreational settings

A poster campaign focusing on the risks of illegal drugs was launched in December 2005 by the Health Promotion Agency for Northern Ireland⁴⁵. The posters were aimed at 18 to 30 year olds and were displayed in pubs and nightclubs. The campaign also covered general risks such as purported drink spiking, contaminated preparations, poly substance use and interactions with other risky behaviours.

3.3.2 At-risk groups

The Advisory Council on the Misuse of Drugs (ACMD)⁴⁶ has written to all D(A)ATs⁴⁷ informing them of statutory guidance for Local Safeguarding Children's Boards (LSCB)⁴⁸ to be included in *Working Together to Safeguard Children* (HM Government 2006). D(A)ATs are expected to form close links with LSCBs over matters of child protection, especially where concerning children in drug using families (see ACMD Hidden Harm, 2003).

The Drug Interventions Programme's pilots for children and young people aim to address substance related issues such as accommodation, family, or mental health problems.⁴⁹ At various points of the youth justice system they identify children and young people who have, or are at risk of developing, substance misuse problems. Their needs are assessed in order to facilitate appropriate support and treatment services.

Positive Futures (PF)⁵⁰, the national sports-based social inclusion programme aimed at marginalised 10 to 19 year olds with projects in most deprived areas in the country, as identified by the Index of Multiple Deprivation.⁵¹ In April 2006 the charity Crime Concern took over responsibility for continuing the programme. In its third and

⁴³ See: guidance notes at:

<http://www.everychildmatters.gov.uk/files/6619BB0981484D39AC878329AB10B7F5.pdf>

⁴⁴ See: <http://www.nice.org.uk/page.aspx?o=SubstanceMisuseInt&c=publichealth> for details

⁴⁵ See: <http://www.drugsalcohol.info/Home.aspx>

⁴⁶ The Advisory Council on the Misuse of Drugs, is an independent expert body that advises Government on drug related issues in the UK

⁴⁷ See: <http://www.drugs.gov.uk/publication-search/young-people/acmd-letter-lscb?view=Standard&pubID=321609>

⁴⁸ LSCBs are new organisations taking on the responsibilities of the old Area Child Protection committees

⁴⁹ See: <http://www.drugs.gov.uk/drug-interventions-programme/strategy/children-yp/>

⁵⁰ See: <http://www.drugs.gov.uk/young-people/positive-futures/>

⁵¹ See: <http://www.communities.gov.uk/index.asp?id=1128444>

final impact report (DSD, 2006) it was reported that 109,456 young people had been involved in regular PF activities since its inception in 2002, 26,586 since the beginning of 2005. No formal outcome assessment has yet been made of the programme, although surveys suggest that project facilitators believe that participation was beneficial for young people. New participatory monitoring and evaluation systems are currently being piloted and are due to be introduced nationally in summer 2006.

The Common Assessment Framework (CAF) was introduced in 2005/06 and is due to be implemented across all areas in England before 2008. CAF is a shared assessment tool used across agencies coming into contact with young people in England. It has been designed to help practitioners assess needs at an earlier stage.⁵² It is envisaged that information sharing through the CAF will allow better identification and service response to children with additional needs, including substance use. A common assessment will be performed whenever a child is thought unlikely to achieve the five Every Child Matters outcomes without additional services.

In a review of recent Government sponsored research into drug prevention in vulnerable young people, Edmonds *et al.* (2005) concluded that school engagement was an important factor against harmful drug use and as an important medium for prevention delivery. These authors also argued that training in drug use issues, particularly screening and appropriate use of external educators, was needed for all non-specialist groups who may come into contact with vulnerable young people. Many research gaps were identified, particularly the lack of outcome evaluations of interventions targeted at this population, and the interaction between different vulnerabilities and drug use.

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. 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.

3.3.3 At-risk families

Sure Start is a United Kingdom government programme supporting children and their families from birth up to age 14 (up to age 16 for children with special needs or disabilities). The programme aims to increase the supply of good quality early learning, childcare and health, and family support, as well as encouraging the development of integrated and joined up services. Early evaluation of the programme in England and Wales has indicated that Sure Start Local Programmes (SSLP) were more than twice as likely to show evidence of better than expected functioning across multiple outcomes related to child development and parenting (National Evaluation of Sure Start, 2004). Although substance use has not been reported in the national evaluation, Sure Start supports local drugs prevention work, and local evaluations have included this outcome. Sure Start also runs in Scotland

⁵² See:

<http://www.everychildmatters.gov.uk/files/EE0F4CD8CFC720A63D04988B32F4FC44.pdf>

and Northern Ireland, although recent evaluations are not yet forthcoming.⁵³ The evaluation phase ends in 2007.

The DfES has commissioned research from the University of Stirling to explore the responses of child protection practices and procedures to children exposed to domestic violence, and parental substance use within families.

⁵³ Refer to: <http://www.scotland.gov.uk/Publications/2005/12/21153916/39170> for a Sure Start Scotland mapping exercise undertaken in 2004

4. Problem drug use

4.1 Overview

Population-based surveys⁵⁴, because of the often hidden nature of problem drug use, are considered to be of limited use in estimating the full extent of problem drug use in the United Kingdom. More reliable estimates have been derived from alternative methods, such as the capture-recapture method and the multiple indicator method (also known as the multivariate indicator method).⁵⁵ An estimate based on studies in the public domain as of September 2006 suggests that in the United Kingdom there were 357,160 problem drug users aged 15 to 64, 9.26 per thousand population. Estimates of injecting drug users for the United Kingdom suggested prevalence of injecting drug use of 117,722, 3.05 per thousand population. There are wide variations in the prevalence of problem drug use, and injecting drugs between the four constituent parts of the United Kingdom (see UK Focal Point Report for 2005). There are also wide local variations ranging from, for example, 1.6 per thousand in Orkney and to 33.1 in Glasgow.

There are variations between countries regarding the characteristics of clients presenting to treatment and this reflects the definitions of problem drug use between countries. While on the whole heroin is the main drug used throughout the United Kingdom, benzodiazepines are the second most used drug in Scotland. In Northern Ireland, just over a quarter reported the use of opiates as their primary drug but cocaine is seen as a problem, and nearly half report cannabis. Cannabis as the primary drug used by those presenting to services is reported less often elsewhere in the UK, though it is the second most reported main drug; at around ten per cent in England. Crack use is identified as more problematic in England. The proportion entering treatment who report injecting as main route of administration also varies between countries; with just over a quarter of clients reporting having ever injected in Northern Ireland and Scotland, but a much higher level in England and Wales, nearly two thirds.

For all new presentations (presentations where the individual has not previously been in treatment during the reporting period), approximately a third are under 24 years of age and a quarter of clients are aged between 25 and 29 years old; nearly three quarters are male.

4.2 Prevalence and incidence estimates

The only new problem prevalence estimates to be published are those for Northern Ireland, where estimates of problem opiate use and of problem opiate use and/or problem cocaine use were obtained. A large-scale study to estimate the prevalence of problem drug use (defined as opiate and/or crack cocaine use) is currently being carried out, to obtain prevalence estimates for England, along with 149 local estimates at the Drug and Alcohol Action Team (D(A)AT) area level for three successive years; 2004/05, 2005/06 and 2006/07. That study will also provide estimates of opiate use, crack cocaine use and drug injecting for each local area. An updated estimate of the prevalence of crack cocaine use in London has also been recently published, where a slightly different approach to prevalence estimation provided a higher estimate than originally published in the 2001 study. In addition, the findings from previous studies have appeared in scientific journals.

⁵⁴ Such as the British Crime Survey, Northern Ireland Crime Survey or Scottish Crime Survey.

⁵⁵ For information on this see Frischer *et al.* 2004.

4.2.1 England

Research into problem prevalence estimates for England using the multiple indicator method, first published through the Home Office in 2004 (Frischer *et al.* 2004), have been reported in a scientific journal (Frischer *et al.* 2006). The capture-recapture estimates from three cities that were used to inform the multiple indicator estimates for England in 2001 were also published in a scientific journal (Hickman *et al.* 2006); these capture-recapture estimates were compared with estimates derived using multiplier methods.

Estimates of crack cocaine in London

Estimates of prevalence of crack cocaine in 12 London boroughs, for 2000/01 were also published in 2006 (Hope *et al.* 2006)⁵⁶. Results suggest that prevalence was approximately 15.4 per thousand population (20,972) in 12 boroughs and approximately 13 per thousand (47,000) in London as a whole. The authors used a slightly different approach to obtain those estimates than the approach used in the original publication, where the corresponding prevalence for the 12 boroughs was 8.1 per thousand.

4.2.2 Northern Ireland.

Research has been completed to provide estimates of the number of problem drug users in Northern Ireland using the capture – recapture method, (Hay *et al.* 2006).⁵⁷ Estimates are for opiate users and opiate and/or problem cocaine use for 2004. National estimates and estimates for the four Health and Social Service Boards (HSSB) were provided. The research suggested prevalence of 1,395, 1.28 per thousand population for opiate users (95% CI = 1.21 to 1.75). A wider estimate for problem opiate and/or problem cocaine use suggested there were 3,303 problem opiate or problem cocaine users, a rate of 3.03 per thousand population (95% CI = 2.84 to 3.95). Results are shown in Table 4.1.

Table 4.1: Estimated number of opiate users and opiate and/or problem cocaine users aged 15 to 64 years old by HSSB area in Northern Ireland, 2004

HSSB Area	Opiate users			Opiate and/or problem cocaine users				
	Estimate	Rate	95% CI	Estimate	Rate	95% CI		
Eastern	725	1.68	1.07	3.04	1,612	3.74	2.75	5.40
Northern	360	1.29	1.04	1.70	663	2.38	1.85	3.09
Southern	130	0.65	0.27	2.41	4666	2.34	0.76	3.31
Western	180	0.99	0.48	3.60	562	3.08	1.75	7.00
Northern Ireland	1,395	1.28	1.21	1.75	3,303	3.03	2.84	3.95

Source: Hay *et al.* 2006b

The revised estimates for Northern Ireland (1,395, 95% CI = 1,316 to 1,910) suggest a higher estimate than previously reported for 2001/02 (828, 95% CI = 695 to 1,018). However, care must, however be taken in comparing prevalence estimates within Northern Ireland, particularly due to the relatively small numbers of individuals using drugs such as heroin.

⁵⁶ The capture-recapture method was used. Applied to three data sets: specialist drug treatment, arrest referral and an accident and emergency and community survey.

⁵⁷ The capture-recapture method was used.

4.2.3 Scotland

No new estimates are reported.

4.2.4 Estimates for problem drug use in Wales

In Wales, work is being undertaken to provide cyclical problem prevalence data. Results of the first study are expected late 2006. Prevalence estimates will be made for heroin, cocaine, crack and amphetamine users.

4.2.5 By substance used

Each prevalence study in the United Kingdom uses a slightly different case definition for problem drug use than those suggested by the EMCDDA. The new study in England will provide estimates for opiate and/or crack cocaine use and separate estimates for opiate use and crack cocaine use. The previous Scotland estimate looked at opiate and/or benzodiazepine use, however the large majority of problem drug users in that case definition were opiate users. The newer estimates for Northern Ireland included two definitions, problem opiate use and problem opiate and / or problem cocaine use.

4.2.6 By injecting drug use (ever and current)

The only prevalence estimates for drug injecting in the United Kingdom focus on current injecting. Published estimates of the prevalence of injecting drug use in England are for 2000/01, however a current study will provide estimates of injecting drug use for 2004/05, 2005/06 and 2006/07. There were too few data to provide a meaningful estimate in the 2004 prevalence study in Northern Ireland.

4.3 Profile of clients in treatment

4.3.1 By substance used

Based on Treatment Demand Indicator (TDI) data for 2004/05, in the UK there has been a large increase (25%) in the proportion reported to be using cocaine as a main drug of use and cannabis as a main drug of use (50%), with correspondingly relatively modest increases in the proportion using opiates as a main drug of use (6%). Table 4.2 shows the number and percentage of drug treatment presentations in 2003/04 m by primary drug of use in the UK and in each country.

Table 4.2: Number and percentage of drug treatment presentations in 2003/04 in the United Kingdom by primary drug of use and by country

	England		Northern Ireland		Scotland		Wales		United Kingdom	
	n	%	n	%	n	%	n	%	n	%
Amphetamines	3,045	3	19	1	269	2	398	13	3,731	3
Benzodiazepines	1,395	1	182	10	791	6	135	4	2,503	2
Cannabis	12,021	12	810	46	1,593	11	377	12	14,801	13
Cocaine	4,637	5	126	7	278	2	52	2	5,093	4
Crack	5,715	6	3	0	48	0	76	2	5,842	5
Opiates	60,030	61	360	21	8,162	57	1,627	53	70,179	60
Other/ NK	11,841	12	246	14	3,143	22	402	13	15,632	13
Total	98,684		1,746		14,284		3,067		117,781	

Source: Standard Tables prepared for UK Focal Point based on treatment monitoring systems

4.3.2 By centre types

In 2004/05 there were 111,436 reported new treatment demands for outpatient treatment, 2,945 for inpatient treatment and 3,402 for treatment in general practice.

4.3.3 By gender

In 2004/05 72 per cent (84,527) of demands were by males and 28 per cent (33,254) by females.

4.3.4 By age

There was an increase in the proportion of young people reported, with a 37 per cent increase in 15 to 19 year olds and a 8 per cent increase in 20 to 24 year olds.

4.3.5 By injecting

Overall numbers of those said to be injecting have increased, but the proportions said to be currently injecting have fallen from 34 per cent to 28 per cent.

The proportion said to be injecting opiates has reduced for all treatments from 51 per cent to 43 per cent; and for first treatment demands from 44 per cent to 38 per cent. There have also been modest reductions in those reporting injecting of cocaine. Additional information is available for Northern Ireland where a treatment census was undertaken in 2005 and an Addicts Index is still operated.

Treatment Census Northern Ireland

The first census of Drug and Alcohol Treatment Services in Northern Ireland was on the 1st March 2005 (DAIRU 2005). This showed that there were 5,064 individuals in treatment for drug and/or alcohol misuse. Approximately 6 in 10 (61%) of all those in treatment on 1 March 2005 were attending for alcohol-only related problems. Two in 10 people (20%) were in treatment for drug-only related problems and just under one fifth (19%) were in treatment for both drug and alcohol related problems.

Northern Ireland Drug Addicts Index

Northern Ireland also retains an Addicts Index.⁵⁸ People are registered on this database if they are known to be, or if a medical practitioner considers them to be, addicted to one or more of 14 controlled drugs. Published statistics for 2005 relate to people registered on the Northern Ireland Drug Addicts Index on the 31st December 2005 (DAIRU 2006). Statistics show that:

- there were 239 persons registered, a decrease of 20 from 259 persons registered at 31st December 2004;
- there were 178 re-notifications in 2005, compared to 157 in 2004;
- 78 cases were removed from the Addicts Index 2005;
- the gender profile has remained relatively unchanged since 2004, with seven out of every 10 addicts being males (71% males and 29% females);
- the age profile has remained relatively unchanged, with 38 per cent of registered addicts aged 29 years and under in 2005, compared to 39 per cent in 2004;
- heroin was the most frequently reported notifiable drug, used by 70% of all addicts registered at 31st December 2005, methadone (28%) and cocaine (11%) remained the next most commonly reported drugs;
- in 2005, more than a third (38%) of those registered addicts whose injecting behaviour was known reported currently injecting. The corresponding figure for 2004 was 49 per cent;
- of the 239 addicts on the Index, 61 were registered within the last year; and
- 120 addicts have been registered for between one and five years.

⁵⁸ The Addicts Index in the rest of the UK closed in April 1997.

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

4.4.1 By substance used

NO NEW INFORMATION AVAILABLE

4.4.2 Injecting drug users

NO NEW INFORMATION AVAILABLE

4.4.3 Other specific sub-populations

For information on minors in treatment see Chapter 11: Selected Issues, *Drug use and related problems among very young people*

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. Increasing the participation of problem drug users in treatment programmes is one of eight Public Service Agreement targets for the Department of Health (HM Treasury 2004) which is also translated into a corresponding target for the National Health Service. areas for the NHS (DH 2002a; DH 2004a).

Drug misuse and dependence: guidelines on clinical management and England's *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 (DH and Home Office 2006). Treatment providers are expected to offer advice and information, needle exchange, 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, and testing and counselling for hepatitis B and C, and HIV (DH 2002b). Oral methadone maintenance is the most common method used in treating heroin addiction; but buprenorphine and 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 providers of housing, employment, education and training has also become important, leading to the concept of *Wrap Around Services*.⁵⁹ This integrated approach is best seen through the introduction of the Drug Interventions Programme 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 whilst in prison (see Chapter 9).

Improving treatment for young people was also prioritised in 2005.

With access to effective treatment being a priority of United Kingdom drug strategy treatment capacity has increased substantially. This has been accompanied by significant financial investment. However, there remain issues around 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 GPs in the treatment and care of drug misusers.

⁵⁹ See:

http://www.drugmisuse.isdscotland.org/eiu/pdfs/eiu_litreviewsum.pdf#search=%22Wrap%20Around%20Services%20drug%20misuse%20%22, and
http://www.nta.nhs.uk/frameset.asp?u=http://www.nta.nhs.uk/publications/mocpart2/chapter2_5.htm

5.2 Treatment system

Based on the Treatment Demand Indicator a total of 117,783 individuals were reported as presenting for treatment during the period 2004/05, 36 per cent of whom were making their first treatment demand.

There were 111,436 outpatient reports. This represents an overall increase in reports of 22 per cent over the previous period, largely accounted for by an increase of 46 per cent in first treatment demands.

There has been a 27 per cent increase in the number of self-referrals and a 71 per cent increase in those referred from the criminal justice system.

During 2005/06 there were 181,390 drug users in structured treatment in England⁶⁰, this is an increase of 13 per cent from 2004/05 (160,450)⁶¹.

Also, in England, 141,511 individuals (78% of those treated in the year) either successfully completed treatment in 2005/06 or were retained in treatment on 31 March 2006. 2004/05 figures reported 120,700 (75%).

5.2.1 Access to treatment in the criminal justice system

Required assessment and treatment for drug using offenders

With many drug misusing offenders required to access treatment (see 1.3.2 and 9.3.2) the following additional performance indicators will apply in intensive Drug Interventions Programme (DIP) areas:

- assessment by criminal justice intervention team (CJIT) within 24 hours;
- care plan agreed with client within five working days; and
- substitute medication (if required) available within five working days (Home Office – internal communication).

Drug treatment in prison

Comprehensive drug treatment services are to be available in prisons in England and Wales (NTA, DH and Home Office 2006) and Scotland (SPS 2006) (See Chapter 9).

5.2.2 Strengthening the treatment system

There have been a number of initiatives in the United Kingdom to strengthen the treatment system.

Revision of Models of Care

Models of care for treatment of adult drug misusers: update 2006 (NTA, DH and Home Office 2006) revises the 2002 document in the light of a number of initiatives, changes in the drug treatment system, the introduction of an Effectiveness Strategy and the Drug Interventions Programme (see United Kingdom Focal Point report for 2005). The update explains more clearly the concept of the tiered approach, pointing out that there has been confusion amongst commissioners as to its nature. It also brings together new concepts such as *treatment journeys* (see below), and re-emphasises the need for care planning, harm reduction services and aftercare.

It is stated that 'tiers' provide a conceptual framework, not a rigid blueprint for provision, referring to interventions provided, not provider organisations. It is also

⁶⁰ See: <http://www.nta.nhs.uk>

⁶¹ An interim figure of 163,985 was suggested in previous UK Focal Point report.

noted that some harm reduction activities have been marginalised into being provided only by what have been called “Tier 2 services” (such as needle exchanges), at a time when there is evidence that rates of infection of blood borne viruses are rising. It is also suggested that care planning is frequently not undertaken (this is now a key tenet of the Effectiveness Strategy); all individuals in treatment should have an identifiable written care plan, which tracks their progress, and is regularly reviewed with them, by 2008.

Care Planning Practice Guide (NTA 2006a) and the report on the current evidence base for effective treatment by Gossop (2006) reported below, accompanies revised *Models of care for treatment of adult drug misusers: update 2006*.

Updated guidance on needs assessment

New guidance on the development of a needs assessment process for D(A)AT partnerships has been published (NTA 2006b).

Updated guidance for reporting waiting times for treatment services

Revised guidance on reporting waiting times in 2006/07 clarifies definitions and processes by which drug treatment service providers and D(A)ATs record waiting times and report them to the NTA through the National Drug Treatment Monitoring System (NDTMS) (NTA 2006c).

Clinical guidance and technological appraisal

The National Institute for Health and Clinical Excellence (NICE) report that they are to produce clinical guidance for:

- Drug Misuse: Psychosocial management of drug misusers in the community and prison setting (September 2007).⁶²
- Methadone and buprenorphine for the treatment of opiate misuse (March 2007).
- Opiate detoxification of drug misusers in the community and prison setting (September 2007).

They are also to undertake a technology appraisal of naltrexone as a treatment for relapse prevention in drug misusers (March 2007).

Drug misuse and dependence: guidelines on clinical management is to be updated over the coming year. This will incorporate reference to the conclusions of the NICE technology appraisals on methadone, buprenorphine and naltrexone, and the NICE guidelines on opiate detoxification and psychosocial interventions.

The management of drug users in primary care

The Royal College of General Practitioners' (RCGP) Sex, Drugs & HIV Group issued a consensus statement from its national conference *Management of Drug Users in Primary Care*, suggesting that, “Effective care for drug users is being delivered in general practice, because we have inherent ability and flexibility to see the person rather than the drug.”⁶³ The conference highlighted the developing role of shared care.

The role of pharmacists in the treatment and care of drug misusers

Guidance on commissioning pharmaceutical services for drug users has been published (NTA 2006c).

⁶² See: <http://www.nice.org.uk/>

⁶³ See: <http://www.rcgp.org.uk/>

New Legislation on Nurse Prescribing

From 1 May 2006, the Nurse Prescribers' Extended Formulary was discontinued and qualified Nurse Independent Prescribers (formerly known as Extended Formulary Nurse Prescribers) are now able to prescribe any licensed medicine for any medical condition within their competence, including some Controlled Drugs⁶⁴. This extends the range of practitioners able to prescribe for problem drug users. The Department of Health had provided the funding to pilot this (DH 2006b).

Improvement reviews into substance misuse services

The Healthcare Commission is undertaking improvement reviews into substance misuse services. The 2005/06 reviews are looking at community prescribing services and care planning and coordination (see below). In addition, the Healthcare Commission, in collaboration with the NTA, is also undertaking a review of systems management (across the key elements of risk management, patient choice, diversity and effective partnerships) and harm reduction provision. A review is also planned, looking at Tier 4 treatment and diversity in 2006/07. This is expected to be published during 2007/08.⁶⁵

The first of a series of these reviews into treatment in England has been made available on line.⁶⁶ This focused on two key aspects of drug treatment for 2005/2006, whether drug treatment services are prescribing drugs safely and appropriately and whether there is good treatment planning and coordination of services. Performance has been assessed against national standards. The review covered all 149 D(A)ATs; all 56 mental health trusts and 303 primary care trusts within those D(A)ATs have also been given a score.

Seventy-one per cent of D(A)ATs were rated as fair, 23 per cent as good, 5 per cent as excellent and one per cent as weak. At trust level: one mental health trust and 13 Primary Care Trusts (PCTs) (4% of the total) received a score of excellent: twenty-one mental health trusts (38% of the total) and 73 PCTs (24% of the total) received a score of good: thirty-four mental health trusts (61% of the total) and 211 PCTs (70% of the total) received a score of fair; and six PCTs (2% of the total) received a rating of weak.

Conclusions are that drug treatment services need to:

- keep service users in treatment longer; at least 12 weeks;
- improve methadone prescribing; while the majority (95%) of services have good policies on methadone prescribing, some services are still prescribing insufficient doses to maintain users and prevent the use of street drugs. It also suggests that there is a need to move away from standard policies, which prescribe the same amount for each service user and for prescribing to be linked more closely to individual need. In addition it states that more patients need to be supervised during methadone consumption in the early stages of treatment;
- involve service users more;

⁶⁴ See: <http://www.york.ac.uk/inst/che/research/argprojnew.htm>
<http://www.dh.gov.uk/PolicyAndGuidance/MedicinesPharmacyAndIndustry/Prescriptions/NonMedicalPrescribing/NursePrescribing/fs/en> (England); <http://www.scotland.gov.uk> (Scotland); <http://www.wales.gov.uk> (Wales); <http://www.dhsspsni.gov.uk> (Northern Ireland)

⁶⁵ More detailed information on the review process can be found on the NTA website at: www.nta.nhs.uk and www.healthcarecommission.org.uk

⁶⁶ See: <http://www.healthcarecommission.org.uk/serviceproviderinformation/reviewsandinspections/improvementreviews/substancemisuse.cfm>

- use individual care plans more consistently; the review found not enough service users have these, 48 per cent of D(A)ATs being weak in this area, and 32 per cent rated only as fair. The level of risk assessment was weak with 70 per cent weak when assessing and managing risks for service users; and
- improve commissioning; 63 per cent of D(A)ATs were rated as weak or fair when it came to assessing the detail of their specifications for community prescribing interventions.

The Healthcare Commission will use the review in its annual rating of mental health and primary care trusts. The Healthcare Commission and the NTA will also publish a national report detailing the overall findings later in the year.

The Unit costs of substance misuse

In July 2006 the NTA reported that it is working with the Department of Health, the Home Office, and HM Treasury to provide a better understanding of the costs of treatment.⁶⁷

Implementing treatment strategy locally: treatment plans

In England D(A)ATs are required to submit draft treatment plans for 2006/07 to the NTA. Following a period of assessment and negotiation, plans are to be published in October 2006.⁶⁸

Audit of prescribing in England

An audit of prescribing has been undertaken to inform to the Healthcare Commission and NTA improvement reviews (see above) of care planning and prescribing services (Best and Campbell 2006).⁶⁹ The aim of the audit was to produce a systematic analysis of prescribing for the management of drug use in a treatment context and to examine the implementation of *Drug Misuse and Dependence: Guidelines on Clinical Management* (DH, Scottish Office DH, Welsh Office, DHSSNI 1999).

A survey of services found 74.5 per cent of clients were prescribed a substitute opiate; 81 per cent received a prescription for methadone and 17 per cent of clients, buprenorphine. Amongst those prescribed methadone:

- three quarters received methadone maintenance, a quarter, methadone reduction;
- a majority (97%) of clients received oral methadone, 1.6 per cent ampoules and 1.7 per cent in tablet form:
- mean daily dose was 56.7mg, but ranged from 6.6mg to 127mg, 15 per cent received doses of less than 30 mg, 48 per cent, 31 to 60 mg, 28 per cent, 61 to 90, mg, seven per cent, 91 to 120mg, and two per cent doses greater than 120mg; and
- 64 per cent had doses dispensed daily or near daily, 12 per cent 3 to 4 days a week, 22 per cent once or twice weekly and 2 per cent less than once a week;

⁶⁷ See:

http://www.nta.nhs.uk/frameset.asp?u=http://www.nta.nhs.uk/programme/national/performance_information.htm

⁶⁸ See:

<http://www.nta.nhs.uk/frameset.asp?u=http://www.nta.nhs.uk/programme/main.htm>

⁶⁹ Three methods were used; data from the National Drug Treatment Monitoring System, data from Prescription Pricing Authority which provides information on the quantities of methadone and buprenorphine distributed in England, and a questionnaire survey of specialist services. Questionnaires were sent to 373 services, 242 responded (66%). Information was received on 51,482 clients, of whom 38,335 were prescribed opioid substitutes.

Nearly all services reported having some clients on supervised consumption; 73 per cent for the first week; a quarter of services continued to have all or nearly all clients supervised daily throughout their time on a prescription. A majority of clients (60%) on methadone had been on a prescription for more than six months.

Amongst those prescribed buprenorphine:

- 60 per cent were on a maintenance basis and 40 per cent on a reduction prescription;
- mean daily dose was 8.9 mg, with a range of 1.4mg to 24mg;
- less than 20 per cent were supervised; and
- 40 per cent had been on buprenorphine for over six months.

Thirty-one per cent of services prescribed drugs other than methadone and buprenorphine as opioid substitutes including dihydrocodeine, diamorphine, morphine, lofexidine and codeine and morphine.

The authors conclude that typical daily maintenance doses of methadone approach clinical guidelines but that mean daily maintenance doses of buprenorphine were suboptimal. Further, the widespread use of daily supervised methadone consumption in some services for all clients after the first 12 weeks may be unnecessary.

Shortfall in Availability of Diamorphine Injection

There continues to be a shortfall in the availability of injectable diamorphine in the United Kingdom, with a further alert posted on the 9th July 2006 by the NHS Purchasing and Supply Agency.⁷⁰ Based on manufacturing capacity, this shortfall is expected to continue throughout 2006, though it is hoped that the overall supply position might improve during 2007 (NHSPASA 2006).

The Department of Health has funded research into an incremental cost-effectiveness analysis of methadone maintenance as a baseline treatment, compared to adding a cognitive behaviour therapy (CBT) module to the therapy (DH – internal communication).

A study of supervised methadone consumption has been commissioned by the NTA to demonstrate whether supervised consumption and good dispensing practice reduces the prevalence of drug-related deaths (owing to accidental overdose and leakage to the illicit market), and to make recommendations for clinical practice. This has not been published at the time of writing.

Survey of inpatient services in England

A survey of inpatient services in England, conducted for the NTA, aimed to establish the current level of provision and to provide a snapshot of clinical practice, in terms of the number of services, location, availability of beds, types of cases managed, available resources, types of services and ranges of outcomes for inpatient services for stabilisation or detoxification of patients who have substance misuse disorders (Day *et al.* 2005).⁷¹

⁷⁰ For more information see: <http://www.smmgp.org.uk/html/news.php#090706>

⁷¹ A database of inpatient services based on commissioning records, treatment services directories and specialists in the field, was constructed. Units identified were then asked to complete a written survey.

It was estimated that there were 10,771 admissions for detoxification in 2003/04. Access to inpatient services varied across England, as did the range of services provided. A third of services do not require patients to have an aftercare plan in place prior to admission. Only one-third are discharged to residential or day care rehabilitation services. A large number of recommendations were made to improve services.

Research into Tier 4 services in England

In addition to the survey of inpatient services in England described above, the NTA also published a needs assessment of Tier 4 services in England that will feed into the forthcoming review by the Healthcare Commission referred to earlier. This survey found that there were huge variations in levels of provision across regions (Best *et al.* 2005)⁷² (see proposed Healthcare Commission review noted previously). It was found that a third of units provided detoxification service. Most residential rehabilitation services provide support groups for specific groups; e.g. gender-specific support groups, parenting groups and parenting support, while some also offer family therapy and counseling for children of clients, although the provision of such services is inconsistent. Availability for specific groups, such as the disabled, young people, pregnant women, parents with children and stimulant users, was on the whole, regarded as inadequate. Only one service offered a facility for mothers with children under the age of six months and one for mothers with children over the age of six months. However, a majority (83%) offered culturally sensitive menu options and 44 (68%) offered support for religious needs or cultural beliefs.

It was found that just over a third (35%) who entered residential rehabilitation completed the treatment, compared to 43 per cent of those entering inpatient detoxification units. The report suggest that this may, in part, be because only 69 per cent of those referred for residential rehabilitation received an assessment, compared to 92 per cent of those referred to inpatient detoxification units. The average residential rehabilitation waiting time was 3.7 weeks. The average annual number of residential rehabilitation places was estimated at 33 per D(A)AT (20 males and 13 females).

Only 34 per cent of the commissioners had carried out local needs assessments for inpatient detoxification units and 31 per cent for residential rehabilitation.

It was estimated that 51 additional places were needed annually for inpatient detoxification in each D(A)AT, and 33 additional places for residential rehabilitation per D(A)AT. They estimate that 12,485 inpatient detoxification and 10,007 residential rehabilitation places are required annually in England.

Consultation on residential rehabilitation

A consultation draft, *Models of residential rehabilitation* (NTA 2006d) states that residential rehabilitation may not be suitable for those who:

- have needs that require supervision in a controlled medical environment

⁷² The primary data collection method was a survey of 105 services providing residential rehabilitation treatment, identified through the NTA residential directory. Six of the listed services, which only provided supported accommodation, were excluded. The questionnaire was partly based on the schedule used in the inpatient detoxification survey conducted by the University of Birmingham, amended to cover residential rehabilitation services. The survey was posted out to each of the residential rehabilitation units identified, targeting the service manager, and was followed up by telephone contact to encourage completion. In total, 65 of the 105 identified residential rehabilitation units (61 per cent) returned the questionnaire.

- want to continue to use some drugs or drink during treatment; and/or
- cannot or will not comply with restrictions on liberty.

The range of services which should be available are:

- *Rehabilitative* programmes that provide accommodation and a structured, care planned programme of therapeutic and other activities, suitable for clients with medium or high dependence on drugs and medium to high care needs. Such programmes sub-divide into:
 - *Long stay* programmes run for 12 weeks or more, for clients whose drug use is long-term and entrenched, and who are socially-excluded, unemployed, in severe housing need, and persistent, prolific offenders.
 - *Short stay* programmes lasting less than 12 weeks, either:
 - *Intensive* programmes providing intensive medical and therapeutic interventions for clients likely to be in housing need, with complex medical needs and likely to need to go on to long stay residential treatment.
 - *Standalone* programmes providing lower intensity interventions for clients with shorter drug histories and who are more likely to be able to return to employment/housing with community/family support.
- *Supportive* programmes that provide accommodation, often following treatment in a rehabilitative programme, with specialist drug and non-drug related support, or from which clients attend therapeutic drug and non-drug related interventions. These are suitable for clients with low dependence on drugs or who are abstinent and have low care needs.

It is suggested that assisted withdrawal/detoxification provided in residential rehabilitation is important both as a standalone option for some clients returning to treatment in the community and for those entering a full residential rehabilitation programme.

Guidance for commissioning in-patient and residential rehabilitation

Guidance has been published on commissioning of in-patient treatment and residential rehabilitation interventions (HO, NTA and DH 2006).

Audit of aftercare

The NTA is undertaking an audit into aftercare. This is part of the NTA's Treatment Effectiveness agenda and aims to provide a better understanding of aftercare support. This has not been published at the time of writing.

Workforce development

There is recognition that the required expansion and improvement of the quality of treatment, as indicated in the PSA on treatment, needs to be supported by expansion of the workforce and development of its skills. Each D(A)AT is required to develop a workforce strategy, which will in fact be part of their treatment plan.

Workforce development plan

A joint Home Office and National Treatment Agency workforce development plan for the substance misuse field was published in 2006. The purpose is to provide a conceptual framework for the workforce required to implement national drug strategy, particularly given that a shortage of a skilled workforce has been identified as a risk to its achievement. It is suggested that in England 4,000,000 generic workers have, albeit occasional, responsibility for substance misusers, a further 200,000 generic workers have a substance misuse function as part of their portfolio and there are 36,000 specialist substance misuse workers and that the adult treatment workforce is 9,000. A target is set to expand to 11,000 workers in the drug treatment sector by 2008 (HO and NTA 2006).

Occupational Map of the drug and alcohol sector

Skills for Justice is currently updating an Occupational Map of drug (and alcohol) services, developed in 2001. This will provide an overview of drug (and alcohol) services, describing:

- the range of employers and key stakeholders, and their roles and responsibilities;
- opportunities for career progression, typical career routes and qualifications;
- the key trends and drivers for change within the sector ;
- key characteristics of employment within the sector; and
- numbers employed within the sector.

The Occupational Map will also provide an analysis of drug and alcohol services by Standard Industrial Classification and Standard Occupational Classification codes.

Diversity

Diversity assessment package

The NTA has developed a Diversity Assessment Package (DAP), available on CD.⁷³

Changes to the drug treatment monitoring system

New core items have been added to the National Drug Treatment Monitoring System (NDTMS). These are; Employment Status, Accommodation Status and Parental Status; the latter two being mandatory fields.⁷⁴

A new NDTMS application, File Upload Portal (FUP)⁷⁵ became operational in April 2006. This provides a secure mechanism to transfer data from treatment providers to NDTMS regions and instant validation feedback. Wandsworth D(A)AT is acting as a pilot. The system will become operational across much of England over the coming months.

User satisfaction survey

The first NTA user satisfaction survey (Best *et al.* 2006)⁷⁶ found that for over 90 per cent of respondents illicit drug use and involvement in crime had reduced since starting drug treatment. Responses also suggested that the vast majority were satisfied with the treatment they received in the areas measured:

- feeling respected;
- believing that treatment had made a positive impact on their lives; and
- being satisfied with the staffing and delivery of treatment.

Nevertheless, there were some differences between respondents:

- higher levels of satisfaction were reported by women and by black and white clients, compared to Asian clients or those of mixed race;
- greater satisfaction scores were reported by clients attending residential services compared to community services; and
- more satisfaction was expressed by clients who had shorter waiting times for treatment and had up-to-date care plans.

⁷³ For more information see: www.nta.nhs.uk/programme/national/diversity.htm

⁷⁴ See: <http://www.dtmu.org.uk/Core%20Data%20Set.htm>

⁷⁵ For more information see: <http://www.nta.nhs.uk/frameset.asp?u=http://www.nta.nhs.uk/programme/national/monitoring.htm>

⁷⁶ Questionnaires were sent to 900 drug treatment services identified across England and 6,770 service users completed and returned their questionnaires.

The minority who were not satisfied reported problems in the following:

- not receiving an optimal service;
- feeling that their families are excluded; and
- support services were not available.

There was no relationship between the dose of methadone or buprenorphine a client received and the satisfaction reported.

A second annual service user satisfaction survey is being carried out in August and September 2006 (NTA 2006e).

Review of Voluntary and Community Sector

A review of the Voluntary and Community Sector was announced in 2006 by the Home Office and the Department of Health to look at the part this sector plays in the delivery of the National Drug Strategy. The aims are to:

- to identify and map relevant organisations involved;
- consult key stakeholders on current and future needs in relation to the functions of the sector, e.g. representation, policy, support;
- review best practice across the voluntary sector and highlight key learning points for the drugs sector; and
- draw conclusions and put forward recommendations in relation to: (a) their roles and responsibilities; (b) their relationship with Government; (c) desired outcomes from and priorities for such organisation and appropriate accountability (Home Office 2006f).

Evaluation of community addiction teams in Glasgow

The Scottish Executive, through SMRT has commissioned a process evaluation of integrated Community Addiction Teams (CATs) in Glasgow. This was not available at the time of writing.

Quality Standard for Substance Misuse Services

A consultation on draft national quality standards for substance misuse services was begun by the Scottish Executive in 2006 (Scottish Executive 2006a). The Scottish Executive suggests that the principles which should underpin the development of quality standards and a framework in which these standards are set are that:

- there should be a set of common standards across Scotland, published by Scottish Ministers but with local ownership;
- there should be no added burden on services (in the form of another layer of inspections) without being of clear benefit;
- any evaluation of the use of quality standards should be supportive and address those aspects of practice not covered in existing inspections;
- the standards will cover both drug and alcohol services;
- the implementation of the standards will seek to improve services;
- development should build on existing good practice; and
- there should be substantial service user and community input to any evaluation of the implementation of the standards.

Treatment in rural areas

A major issue for Scotland is that of rurality⁷⁷ and therefore a review of treatment in rural areas has been undertaken (Scottish Executive 2005a).⁷⁸ This suggests there

⁷⁷ The Scottish Executive core definition of rurality: rural is a settlement of 3,000 or less people. The classification also distinguishes between 'accessible' and 'remote' rural areas,

are lower levels of drug use in rural areas; however, the gap is narrowing. Particular problems are:

- geography - the distances between centres where services are based;
- travel and transport - irregular and infrequent public transport;
- a smaller pool of staff with difficulties of recruitment and retention;
- a limited range of services, both specialist and generic;
- the high unit costs of providing services and perceived disadvantages in the funding formulae;
- the lack of suitable premises; and
- community attitudes.

To address these issues, the review reiterated the need for partnership, training and monitoring, but also suggested that consideration should be given to the use of the internet and other information technology to reach clients, and to provide continuing communication and support.

Waiting times for treatment in Scotland

Quarterly reports are now published on waiting times for treatment in Scotland, the latest report is for the period January to March 2006 (ISD 2006a). This is based on a National Waiting Times Information Framework for Scotland designed to enable ADATs to monitor service capacity within local areas and the key client/patient waits during their treatment. ADATs receive information from treatment agencies about every client in treatment at key points during the client/patient journey. Data collection is event driven with agencies reporting dates to ADATs when key milestones are passed. ADATs are therefore able to calculate key waiting times, for example, the time between referral and first assessment appointment offered, the end of the assessment process and beginning of the first treatment, the total time a client is in contact with an agency. ISD Scotland receive quarterly aggregate reports from ADATs and publish various summary statistics. The system was launched in April 2004.

Enhancement of the Scottish Drug Misuse Database (SDMD)

The SDMD currently collects information from clients/patients at the point when they enter treatment; with around 300 drug treatment agencies reporting on 14,000 new episodes of care in 2005. Demographic, drug misuse and health behaviour data are collected. The current enhancement of the database aims to provide new information in key areas:

- total number of clients/patients in treatment;
- types of interventions received;
- total length of time in treatment; and
- changes in drug misuse and wider health behaviours.

The new initial report (SMR25a) was launched on paper in April 20, however, follow-up reporting will not begin until electronic data submission is available. Procurement of the IT system is currently underway and it is anticipated that follow-up recording will be launched in the spring of 2007.

based on drive time to a settlement of 10,000 or more people. According to the core definition above, 98 per cent of Scotland's landmass and 18.7 per cent of its population is classified as rural.

⁷⁸ This review draws upon evidence from a number of sources including primary research, a literature review and includes examples of current practice and consultations with key individuals.

Review of Scotland's methadone programme

Following the death of a two year old child after drinking his parents' methadone the Scottish Executive announced a review of methadone treatment in Scotland.⁷⁹

5.2.3 Young people

Universal and targeted services for young people

In England, to support the delivery of *Every Child Matters: Change for Children* and the *Updated National Drugs Strategy*, in 2005 the Department for Education and Skills, the Home Office, and the Department of Health have agreed a joint approach to the development of universal and targeted specialist services to prevent drug harm and to ensure that all children and young people reach their full potential. As part of this programme of delivery the NTA has agreed a clear role for its work with children and young people on ensuring that high quality, targeted treatment interventions, able to meet young people's needs are readily accessible throughout England and this will form the NTA's young people's work during 2006 to 2007.

All local authorities in England and their partners are expected to make progress towards meeting its objectives from April 2005 with more rapid and sustained progress in 30 high focus areas.

The national target is to increase the participation of young people aged under 18 entering, receiving and completing treatment programmes by 50 per cent between 2004 and 2008. The NTA and Youth Justice Board also states that:

- within five working days of coming into contact with a youth offending team, a young person with substance misuse treatment needs should receive appropriate specialist assessment;
- within ten working days of this assessment, the young person should have been given access to early intervention or treatment services; and
- waiting times targets for all services will be announced in 2006.⁸⁰

Audit of the skills of those working with young people and families

Skills for Justice is working with the Home Office Crime and Drug Strategy Directorate (CDS) and the National Treatment Agency (NTA) to support the implementation of the DSD and NTA joint workforce development plan in three key areas: improving competence, increasing capacity and mainstreaming. This work contributes to the attainment of specific NTA targets by 2008:

- 75 per cent of non professionally trained staff are undertaking or have achieved NVQ Level 3 or equivalent;
- 6 per cent of professionally trained staff are undertaking a programme of continuous professional development, including professional development awards; and
- 90 per cent of managers are undertaking or have completed an appropriate management training programme as defined by their employers (HO and NTA 2006).

Directory of residential services for young people

In 2006 the NTA published a directory of residential services for young people. This should support substance misuse and children's workers to find residential services

⁷⁹ See: <http://news.bbc.co.uk/1/hi/scotland/4776998.stm>

⁸⁰ See: <http://www.nta.nhs.uk/frameset.asp?u=http://www.nta.nhs.uk/programme/national/young.htm>

(Tier 4) for under-18s. It is still in development and is not a comprehensive list of services. All the services listed on the directory are residential services for young people, ranging from generic children's homes, crisis placements and specialist substance misuse services. Services have been asked to help in updating the list.⁸¹

Young people's treatment needs

In a recent paper, Crome (2006) suggests that young people with problematic drug use have different treatment needs, and require different interventions and services to those of adults, and therefore, results of adult studies cannot necessarily be directly extrapolated to young people. She further goes on to state that over the last five years evidence has been rapidly mounting that treatment may potentially work in young people, but as yet it is not as extensive as that for adults. Interventions that appear most fruitful are those based on learning theory, e.g. cognitive behavioural therapy and family therapy. However, the evidence base is almost entirely from the USA, and cannot be simply transferred or transported to United Kingdom healthcare settings. It is suggested that the restricted treatment service network for young people in the United Kingdom makes the potential for undertaking studies on treatment effectiveness extremely limited, but because there is evidence of a growing number of young people requiring treatment, such specialist drug services require evaluation.

5.2.4 Budget

In England, the Department of Health, supported by €32 million (£22 million) of funding from the Home Office, will provide D(A)ATs with €562.6 million (£384.6million), an increase of 28 per cent from 2005/06. This funding will be used to invest in personnel, day-to-day running of services, and building and refurbishment of premises. D(A)ATs will also be able to bid for a portion of a further €80.3 million (£54.9 million), for the development of inpatient and residential rehabilitation services in 2007/08 (DH 2006d).

5.2.5 Research

The following describes research not referred to in the previous sections.

The Drug Misuse Research Initiative

In December 2005 the Department of Health completed the commissioning of a number of pieces of research as part of the second phase of the Drug Misuse Research Initiative (DMRI). The research is in areas related to drug treatment, with the aim of providing evidence to support the development and delivery of effective services and interventions in the field of drug misuse. The focus of this phase is on understanding the experience of treatment and service provision. Most of the research will be completed within one to two years. The projects are:

1. Barriers to the effective treatment of injecting drug users.
2. Routes out: estimating and explaining early exit from drug treatment.
3. A national survey of care coordination in drug treatment services: a multi-method observational study of implementation, model development, treatment, process and service-based outcomes.
4. User involvement in efforts to improve the quality of drug misuse services: factors that promote and hinder successful working.
5. Cost and cost effectiveness of treatment in drug misuse services.
6. A randomised trial of an assessment led brief intervention with young people who use cocaine powder.

⁸¹ For information see:

<http://www.nta.nhs.uk/programme/national/Young%20people%20directory.pdf>

7. Exploring young people's views and experiences of drug treatment services: a qualitative study.
8. Interventions supporting and meeting the needs of children and young people who have drugs misusing carers.
9. Interventions for children and families where there is problematic drug use: the development and evaluation of an inter-agency model of good practice in Devon.
10. Good practice in working with family members: disseminating and evaluating a model and methods in area and culture-based communities in Birmingham.

Overview of the first phase of the DMRI

An overview of the first phase of the DMRI suggested that the initiative showed the value of research in building an understanding of the causes and consequences of drug misuse, and, also, the value of specific interventions, and that the DMRI programme has been an effective vehicle for strengthening the evidence basis for prevention and treatment (MacGregor 2005)

Brief motivational interviewing among cocaine and ecstasy users

Marsden *et al.* (2006) reported an investigation as to whether a stimulant and alcohol-focused brief motivational intervention induces positive behaviour change among young, regular users of MDMA ('ecstasy'), cocaine powder and crack cocaine.⁸² It was found that there were no significant differences in abstinence between the experimental and control groups and that therefore brief motivational intervention was no more effective at inducing behaviour change than the provision of information alone.

Neurotransmitters in opiate and alcohol addiction

The Medical Research Council has commissioned research looking at neurotransmitters in opiate and alcohol addiction. The research has a tenure of three years.⁸³

A number of pieces of research have looked at the evidence base for treatment, and also, factors which should be taken into account in helping drug users become drug free.

The evidence base of treatment

A report on the evidence for treatment effectiveness looks closely at the many factors which might determine treatment outcomes, including the social characteristics of the users, therapies available, the treatment process and services issues such as delivery and setting (Gossop 2006).

⁸² This was a randomised trial of the intervention versus a control group who received written health risk information materials only. Participants completed a self-assessment questionnaire before the trial. Outcome measures were for self-reported period prevalence abstinence from ecstasy, cocaine powder and crack cocaine and the frequency and amount of stimulant and alcohol use in the previous 90 days, recorded at 6-month follow-up via self-completion questionnaire and personal interview. A total of 342 adolescent and young adult stimulant users (aged 16–22 years) were recruited and 87% were followed-up. The intervention was delivered by a team of 12 agency youth drug workers and two researchers at five locations in Greater London and south-east England.

⁸³ For more information see: http://www.mrc.ac.uk/prn/index/current-research/current-research_portfolio_search/current-research_portfolio_results/current-research_portfolio_grant_details.htm?GFR=G0400575&SD=01/03/05

Treatment effectiveness: Treatment Journeys

The concept of a service user's treatment journey is described in a briefing that emphasises that treatment is not an event, but a process, usually involving engagement with different services, perhaps over many years (NTA 2005a). It is suggested that this progression through drug treatment be divided into four overlapping segments:

- treatment engagement;
- treatment delivery;
- treatment completion; and
- community integration.

Addiction careers

Best *et al.* (2006) in a review of the evidence supporting the theory that most drug misusers will "mature out" of their drug use, albeit after many years in some cases, while recognising that some will never end their "addiction careers", looked at the evidence from major outcome studies in the United Kingdom and US. It is suggested that drug dependence, particularly heroin dependence, is not irreversible and that the majority of drug users will overcome their dependence eventually and, even among those with problems severe enough to enter treatment services, around two-thirds are likely to achieve stable and enduring abstinence by around twenty years after initiation. For the vast majority of heroin users whose use does not lead them to seek treatment, their careers are likely to be markedly shorter.

The implication is that those who voluntarily enter services are also those who have the most severe and entrenched problems, not only in relation to their heroin use, but also an array of life problems. There is also variability within the treatment seeking group; while the average length of the opiate-using career may be around 20 years, for those with lower severity and higher motivation, much shorter drug using careers are likely. On the basis of this they argue that attempting abstinence can be risky in that, if timed incorrectly, it may precipitate dropout, relapse, and a return to a range of drug-using problems. On the other hand, if maintenance is never challenged there may be no acute risks to the client, but there may also be an unsatisfactory bind and compromise that users may feel prevents them from getting on with their lives.

Nevertheless, the researchers conclude that addiction careers are not irreversible, but are slow and unpredictable in their reversibility, and while the vast majority of those who become dependent will ultimately overcome that dependence, services should be configured in such a way that completing the treatment journey is the long-term objective.

Reasons for ceasing or continuing heroin use

Mullen and Hammersley (2006) looked at reasons for ceasing or continuing heroin use in mid-life, examining the contribution of drug treatment and social factors to this process.⁸⁴ It was found that successful cessation occurred after repeated attempts and repeated treatments, often in the context of major life changes. Relapse occurred because of quitting without adequate mental preparation; returning to old haunts and life circumstances, life difficulties, the tedium of a life without heroin, and inability to cope with normal emotions previously blocked by heroin use. Men's lives could be understood as a set of tensions between the deviant subculture of heroin injecting and the conventional neighbourhood. The balance of these tensions

⁸⁴ A semi-structured qualitative interview discussing drug-using history was conducted with Glasgow men who had previously received treatment for drug problems.

affected men's behaviour and generally there needed to be both a push away from the subculture and a pull towards the neighbourhood for long-term cessation to occur. They conclude that, "Treatment of heroin dependence may be better regarded as the management of a chronic problem, rather than as a single intervention with a quantifiable outcome. Treatment needs to consider both the benefits and problems of heroin use and the benefits and problems of conventional living."

Estimating and explaining early exit from drug treatment

Research is being undertaken by the Institute for Criminal Policy Research, Kings College London and the European Institute of Social Service, University of Kent, and aims to estimate and explain the problem of people dropping out.⁸⁵

The Joseph Rowntree Foundation has commissioned research into user involvement in treatment decisions; this is due to be completed in October 2006. The rationale for this is that there is evidence to suggest that client satisfaction with drug services is associated with retention in treatment, reduction in drug consumption, and stabilisation of drug use, safer drug use and abstinence.

Day *et al.* (2006) compared the motivation for, and process of attempting, self-detoxification from opioids between white and Asian groups attending a drug treatment service.⁸⁶ The results suggest that Asian clients used different strategies for self-detoxification than the white population. Both groups reported avoidance and distraction as helpful strategies, but Asian clients were more likely to move away from their home than white clients were. Asian clients reported concerns about physical and mental health and pleasing their family, with white clients expressing concerns about crime. White clients reported that they were likely to relapse because of use of other drugs more often than Asian clients were.

An evaluation of the NTA pilots on cocaine treatment referred to in the previous United Kingdom Focal Point has not been published at the time of writing.

An evaluation of a pilot psychostimulant service in Scotland has not been published at the time of writing.

5.3 Drug-free treatment

A breakdown by type of treatment for 2005/06 was not available at the time of writing.

5.3.1 Inpatient treatments

Based on the Treatment Demand Indicator, in 2004/05 2,945 drug users entered inpatient treatment in the UK.

5.3.2 Outpatient treatments

Based on the Treatment Demand Indicator, in 2004/05 111,436 presented for treatment as 'outpatients in the UK'.

⁸⁵ For more information see: <http://www.kcl.ac.uk/schools/law/research/icpr/research.html>

⁸⁶ Eighty-nine clients, 41 Asians and 48 Whites attending a community opioid detoxification took part in the study. A questionnaire was administered to all those attending the service who agreed to take part in the study. 98 of the 114 attendees who had made at least one attempt at self-detoxification took part.

5.4 Medically assisted treatment

5.4.1 Withdrawal treatment

NO NEW INFORMATION AVAILABLE

5.4.2 Substitution treatment

For England see Prescribing Audit above.

Numbers in substitution treatment in Scotland

In Scotland, it is estimated that 19,227 people were prescribed methadone mixture in 2004. The cost per patient per year in 2004 was €985 (£673); this includes the cost of the medication and dispensing, and any clinical costs. The cost of dispensing methadone mixture (dispensing fees and ingredients) was €3,726 (£2,547) per 1,000 population in 2004.

Methadone prescribing rates have risen by 53 per cent over the last five years, from 53 prescriptions per 1,000 population in 2000/01 to 81 prescriptions per 1,000 population in 2004/05 (it is noted that higher prescriptions rates do not necessarily mean more volume of methadone, actual doses prescribed could be smaller). Estimates for the number of people receiving prescriptions show an increase between 2002 and 2004 (from 16,401 to 19,227). Thirty-four per cent of the individuals prescribed methadone in 2004 received their prescriptions in Glasgow

6. Health correlates and consequences

6.1 Overview

6.1.1 Drug-related death

The UK 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)⁸⁷. 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 EMCDDA and includes legal drugs.⁸⁸ DRDs, according to the UK 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 UK. The UK drug strategy definition is a subset of the ONS definition, with the main differences lying in the fact that under the UK Drug Strategy only controlled drugs are identified.

DRDs in the UK rose steadily from 1996 until 2000, then fell until 2003, but rose again in 2004.⁸⁹ However, the most up to date data, from the Special Mortality Register is for 2005, and again show 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. The overall average age at death fell in 2001 and 2002 to 34.0, rising in 2003 and again in 2004 when it was 35.9 years. Males were approximately 4 years younger than females at death, in 2004 (34.9 years and 39.0 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 at an older age 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. In Scotland, diazepam is more likely to be involved than elsewhere in the UK; for example, in 2004, it was involved in 21 per cent of DRDs.

⁸⁷ These deaths are known as 'overdoses', 'poisonings' or 'drug-induced deaths'. This definition 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.

⁸⁸ 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.

⁸⁹ 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.

6.1.2 Infectious disease

HIV⁹⁰ prevalence among injecting drug users (IDUs) in the United Kingdom has been 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 reported,⁹¹ following reported increases in injecting risk behaviour.

6.1.3 Dual Diagnosis

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

There is also increasing information regarding the association of mental health and cannabis use, and with ecstasy use.

6.1.4 Other physical health problems

Evidence of the extent of other physical health problems associated with problem drug use⁹² are not readily available.

⁹⁰ 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.

⁹¹ 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).

⁹² This includes thrombosis, blood clots and gangrene (ACMD 2000) as well as health problems that are associated with problem drug users' lifestyles including poor diet.

6.1.5 Pregnancies and children born to drug users

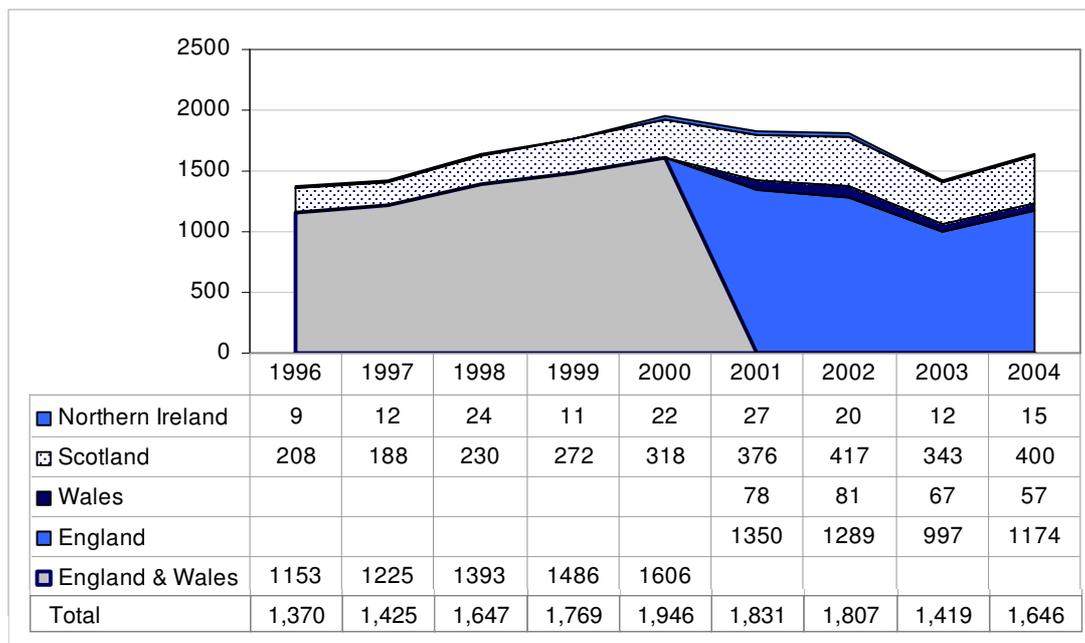
The impact of maternal drug use on unborn children is well known as is the fact that babies are affected by withdrawal from maternal drug use. In the United Kingdom, there is little evidence of HIV transmission to babies through maternal infection specifically associated with drugs, but there is a risk 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 standard definition of drug related death, the total number of deaths in the UK in 2004 was 1,646 (Figure 6.1), this was an increase of 16 per cent since 2003 (1,419). However the 2004 figures remain lower than any of the three years preceding 2003. The number of deaths per 100,000 population in the UK was 2.75. Differences exist between parts of the UK; in Scotland the rate was 7.88, in England 2.34, in Wales 1.93 and in Northern Ireland 0.88.

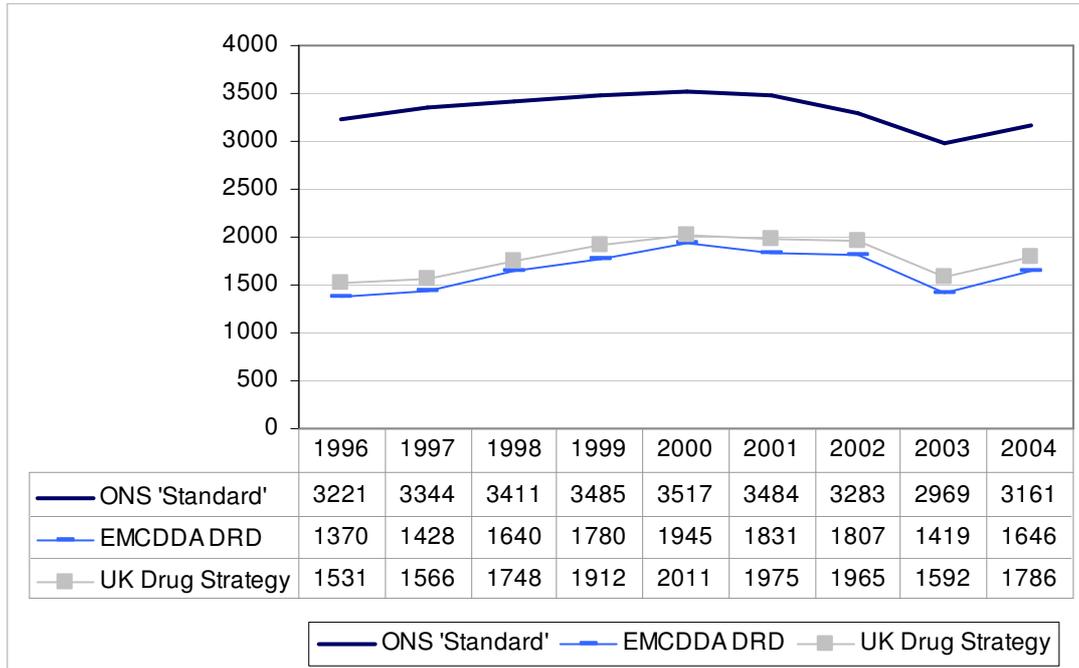
Figure 6.1: Number of deaths using EMCDDA DRD standard definition by country, UK, 1996-2004



Source: Compiled by J Corkery 2006

For the purposes of measuring the impact of the UK Drug Strategy, the slightly different definition shows the number of deaths in 2004 was 1,786, slightly higher than the EMCDDA standard definition. The total number of deaths in the UK using the ONS definition was 3,161, rising by 6.4 per cent from the previous year, having steadily fallen since 2001. Differences between the three definitions are shown in Figure 6.2.

Figure 6.2: Comparison of total number of deaths using three definitions, UK 1996 to 2004

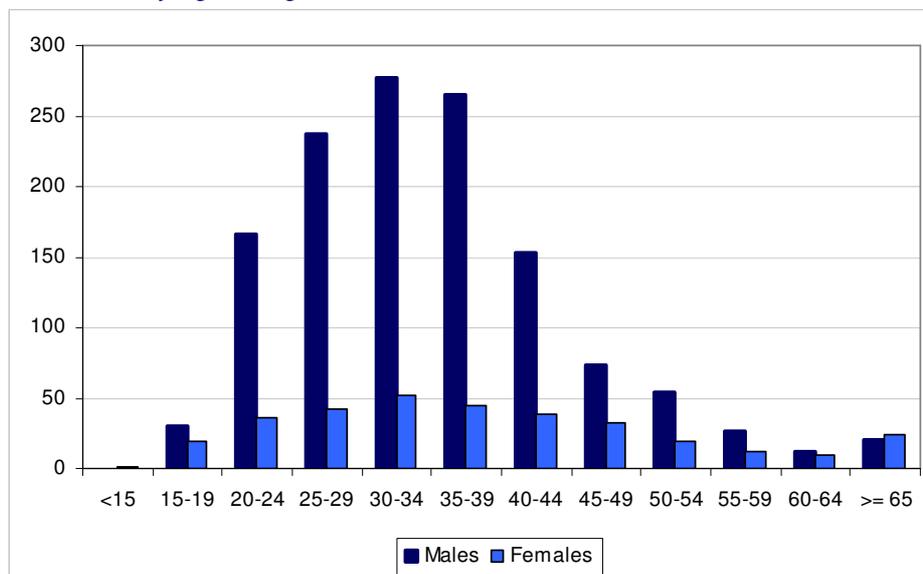


Source: Compiled by J Corkery 2006

Age and Gender

Based on the EMCDDA standard definition, 79.9 per cent (1,315) of deaths involved males and 20.1 per cent (331) females. This compares with 80.4 per cent males and 19.6 per cent females in 2004 (Figure 6.3). The highest proportion of males was 80.9 per cent in England and Wales and the lowest in Northern Ireland at 73.0 per cent (Figure 6.2). The average age of those dying in 2004 was 35.9 years (SD 11.8), with males (34.9 years, SD 10.6) tending to be about 4 years younger than females (39.0 years, SD 15.3); in 2003 the average age was 35.3 years. Age at death tended to be higher in Northern Ireland than in the rest of the UK. Overall, the highest number of deaths occurred in the 30-34 age group; this was true for both males and females. Figure 6.3 shows the number of deaths by age group and gender.

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



Source: Compiled by J Corkery 2006

Drugs mentioned on death certificates in the United Kingdom

Table 6.1 shows that mentions of heroin and morphine of death certificates increased since by 27 per cent in 2004, having declined between 2002 and 2003. Methadone deaths also increased (by 6 %), having shown a decline between 2002 and 2003, as did ecstasy deaths (by 32%) and cocaine (by 30%):

Table 6.1 UK drug mentions 2002 to 2004

Drug	Year		
	2002	2003	2004
Heroin/ Morphine	1,042	767	971
Methadone	314	263	280
Cocaine	171	142	185
Ecstasy	75	50	66

Source: Compiled by J. Corkery 2006

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 the ONS. The np-SAD Annual Report for 2006 (Ghodse *et al*, 2006) shows that in 2005:

- there were 1,644 drug-related deaths reported in 2005;
- there was a decrease of about 10 per cent over number of recorded in 2004 (1,820) ;
- the demographic profile of np-SAD cases remains consistent with previous reports. The majority of cases were males (74%) and under the age of 45 years (73%), and white (95%);
- throughout the period 1997 to 2005 about two-thirds of cases had a history of drug abuse or dependence, and on average death was 10 years or more earlier than for those without such a history;
- 67 per cent of cases died in a defined residential address, 24 per cent in hospital, and 9 per cent elsewhere (e.g. a public place);
- 50 per cent of those who died were unemployed;
- 46 per cent lived with others, compared to 37 per cent who lived alone, whilst 5 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 (70%) of fatalities;
- heroin/morphine alone or in combination with other drugs, accounted for the highest proportion (48%) of fatalities;
- deaths involving methadone were more likely to be the result of illicit use (60 % or more) rather than prescribed drugs;
- over the period 1997 to 2005 there were considerable increases in the number of cases in cannabis, amphetamines and to a lesser degree, cocaine; and
- GHB was found in 3 cases.

6.2.3 Death associated with Volatile Substance Abuse

The most recent report on deaths associated with volatile substance abuse (VSA) throughout the UK, shows that in 2004 there were 47 deaths in the UK associated with VSA (53 in 2003) (Field-Smith *et al*. 2006). This is the lowest figure since 1981 and compares with the all-time peak of 152 in 1990. Of this total, there were 41 VSA related deaths in England, four in Wales, one in Northern Ireland and one in Scotland. This is the lowest level of Scottish deaths since 1995, down five from the previous year.

6.2.4 AIDS

Deaths of IDUs (including men who have sex with men and who are also IDUs) with AIDS accounted for 7.7 per cent of the total number of AIDS deaths in England and Wales up to the end of the financial year in March 2006. In Northern Ireland, the figure was 5.1 per cent, but in Scotland it was 51.2 per cent. The UK figure of 59 for 2004 is about 28 per cent of the peak level in 1995 (212) (HPA personal communication to J. Corkery).

Research

A number of studies touching on drug related deaths in the UK underway.

Cohort mortality studies

Early indicative findings from a cohort study of clients in drug treatment programmes, commissioned by the Home Office are expected in autumn 2006 with a full report later in 2007⁹³.

As part of the DORIS⁹⁴, a request has been made to the General Register Office for Scotland (GROS) to check on deaths among non-respondents between the original survey (DORIS1) and the fourth sweep (DORIS4) at 33 months. To date they are aware of 33 deaths amongst the original cohort, but expect this to rise when the information from GROS is received (personal communication to John Corkery).

The extent and pattern of fatal injuries due to psychoactive drug intoxication

Oyefeso *et al.* (2006) sought to determine the nature, extent and pattern of fatal injuries under the Influence of Psychoactive Drugs (FIUI). Their observational study covered the period January 1999 to December 2001. A total of 3,803 drug-related deaths of persons aged 16 to 64 years were reported during the three-year period. There were 147 FIUI cases (119 males, 28 females), giving a proportionate mortality ratio of about 4 per cent. The majority of FIUI cases (84%) were aged 16-44 years (median 33). About half (56%) of FIUI occurred in urban areas of England. The leading mechanism for intentional FIUI was suffocation while the predominant mechanisms in unintentional FIUI were road traffic accidents and falls. There is a significant difference in the pattern of drug-specific risk between FIUI and fatal poisoning. Risks of intentional FIUI are elevated among Black and Minority Ethnic groups. The researchers suggest that the differences in the nature, extent and pattern of intentional and unintentional FIUI necessitate targeted prevention strategies.

Trends in cocaine/crack cocaine deaths for 1990-2004

Schifano and Corkery (2006) used a number of key indicators to examine UK trends in deaths involving cocaine and crack for 1990 to 2004. Cocaine/crack was the sole drug mentioned in 36 per cent of the 1,022 cocaine death mentions during this period. The number of cocaine/crack fatalities showed a year-on-year increase and correlated positively with the following cocaine figures: last year use; number of offenders; and number of seizures, but correlated negatively with price. Furthermore, number of cocaine/crack death mentions correlated positively with number of crack offenders and seizures, but correlated negatively with both crack purity and price over time. It is suggested that decreases in cocaine/crack cocaine prices may have facilitated an

⁹³ For more information see: <http://www.dtors.org.uk>

⁹⁴ For more information see: <http://www.gla.ac.uk/centres/drugmisuse/project%20details.html#doris> and <http://www.gla.ac.uk/drugmisuse/dorisreports.html>

increase in consumption levels and this, in turn, may have determined an increase in number of cocaine/crack cocaine-related fatalities.

Ecstasy deaths in the UK

Furthermore, Schifano *et al* (2006) used the same range of key indicators as the above in their study of ecstasy in the UK 1994-2003. Ecstasy was the sole drug mentioned in 42 per cent of 394 ecstasy death mentions identified. Overall, number of fatalities showed a year-per-year increase and positively correlated with: last year use; number of offenders; and number of seizures, but negatively correlated with price. Price negatively correlated with: last year use and number of seizures; but positively correlated with average MDMA dosage per tablet. Increasing production with a concomitant decrease in ecstasy price may have facilitated an increase in consumption levels and this, in turn, may have determined an increase in the number of ecstasy deaths mentions.

The relative toxicity of co-proxamol⁹⁵ in overdose

Afshari *et al* (2005) assessed the relative toxicity of co-proxamol in overdose in comparison to two other paracetamol-opioid combination products, co-codamol and co-dydramol. National Scottish data for July 2000-June 2002 were used to estimate the frequency of overdose and death for these paracetamol-opioid compound analgesics. When related to prescription volume, overdoses involving co-proxamol in Scotland were found to be ten times more likely to be fatal when compared with co-codamol or co-dydramol. In contrast there was no difference in the presentation rate or enquiry rates for these analgesics when corrected for prescriptions. The researchers conclude that the excess hazard from co-proxamol is due to inherent toxicity rather than increased use in overdose. They estimate from this study that withdrawal of co-proxamol would prevent 39 excess deaths per annum in Scotland alone.

6.3 Drug-related infectious diseases

Infectious diseases continue to cause considerable morbidity and mortality among injecting drug users in the UK. Results from the Unlinked Anonymous Prevalence Monitoring Programme (UAPMP) enhancement pilot study, which recruited IDUs in community settings at seven locations in England using fieldworkers and collected dried blood spot samples rather than oral fluids are now available. They are presented alongside those from the UAPMP agency survey and other data on infections among IDUs in the current Shooting Up report (HPA *et al.* 2006). A summary of key trends and new data is given here.

6.3.1 HIV

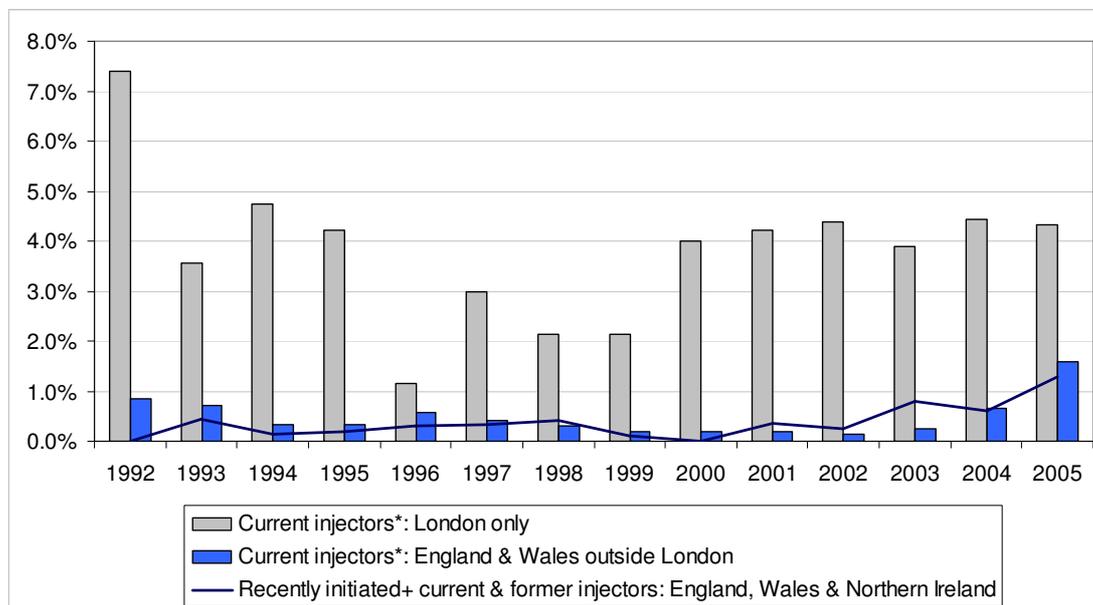
The prevalence of HIV among IDUs has continued to increase. The prevalence amongst current IDUs (those who reported injecting in the four weeks prior to taking part in the survey) in the UAPMP agency survey in England and Wales in 2005 was 2.1 per cent (HPA *et al.* 2006). This is the highest level ever seen amongst current IDUs in this survey, and indicates that the recent increase in HIV prevalence among current IDUs found when examining data from the UAPMP agency survey and the series of community recruited surveys undertaken by Centre for Research on Drugs and Health Behaviour (CRDHB) (Hope *et al.* 2005), has continued. This study had found that HIV prevalence declined in the early 1990s from 5.6 per cent in 1990 to 0.6 per cent in 1996 before increasing to 1.4 per cent in 2005.

⁹⁵ Co-proxamol has been withdrawn for use in the UK

The HIV prevalence among IDUs in London is higher than elsewhere. The UAPMP agency survey⁹⁶ found the HIV prevalence among current IDUs in 2005 was 4.3 per cent in London, which was similar to that seen in recent years (Figure 6.4). Elsewhere in England and Wales the prevalence was 1.6 per cent which is more than twice the prevalence seen in 2004 (0.66%), and this was the highest HIV prevalence ever seen in the UAPMP agency survey amongst current IDUs in England and Wales outside of London (Figure 6.4), indicating that the recent increase in HIV prevalence is focused outside London.

The rise in prevalence probably reflects increased levels of transmission. The prevalence of HIV in those who began injecting in the last three years is a measure of recent transmission. In 2005 among the participants in the UAPMP agency survey who began injecting in the last three years the HIV prevalence was 1.3 per cent (HPA *et al.* 2006) (Figure 6.4). This was the highest prevalence ever seen among this group in this survey, and suggests a recent increase in transmission. Corroboration for this comes from the community recruited cohort study of recently initiated IDUs in London undertaken by the CRDHB in 2001/03. This estimated that HIV incidence was 3.4 per cent per annum (Judd *et al.* 2005) and also found that the incidence was similar to the prevalence, which is also suggestive of a recent increase in transmission. The cohort study also found evidence that the incidence of HIV was higher among those who reported injecting crack-cocaine (around 6%). Results from the UAPMP enhancement pilot found a prevalence of 0.76 per cent among IDUs in England outside London. This survey found that those who reported injecting crack-cocaine had a higher prevalence than those who did not (1.4% and 0.32% respectively).

Figure 6.4: Prevalence of HIV infection among injecting drug users in England, Wales and Northern Ireland: 1992 to 2005.



*Those who last injected drugs during the four weeks prior to participating in the survey.
 +Those who started injecting drugs during the three years prior to participating in the survey. Includes Northern Ireland from 2002.

Source: HPA *et al.* 2006

⁹⁶ Drug users in treatment with specialist drug services.

By the end of 2005 there had been a total of 4,434 HIV diagnoses reported in the UK where infection was thought to have been acquired through injecting drug use. These accounted for 5.6 per cent of all the HIV diagnoses reported (78,639) in the UK. By end of June 2006 147 HIV diagnoses, where infection was thought to have been acquired through injecting drug use, have been reported in the UK for 2005 (HPA *et al.* 2006). Where reported, 53 per cent (52) of infections diagnosed in 2005 were probably acquired within the UK and 47 per cent (46) outside of the UK, mostly in southern Europe. In comparison, in 2003 only 34 per cent (53/95) of infections were probably acquired in the UK, whilst in 2004 the figure was 47 per cent (37/81), where reported (HPA *et al.* 2006).

6.3.2 Viral hepatitis

Data indicate that overall more than four in ten IDUs have been exposed to hepatitis C infection in the UK (HPA *et al.* 2006). There is also evidence that suggests that the prevalence has increased, for example, among current IDUs (those who had injected in the four weeks prior to taking part in the survey). In the UAPMP agency survey in England the prevalence has increased from almost 40 per cent in 1998, the year hepatitis C testing was added to this survey (Hope *et al.* 2001), to 46 per cent in 2006. The regional variations in prevalence of hepatitis C previously seen remained (HPA 2006); in England, from 20 per cent in the North East to 55 per cent in London and 58 per cent in the North West (data from 2004 and 2005 combined). The prevalence in Wales and Northern Ireland was lower than most of the English regions: combining data from 2004 and 2005, hepatitis C prevalence in Wales was 18 per cent (45 of 253), and in Northern Ireland it was 28 per cent (69 of 248).

Results from the UAPMP enhancement pilot found that 53 per cent of the participating current IDUs at the seven sites in England were anti-HCV positive. This is comparable to the UAPMP agency survey after allowing for the differences in test sensitivity and recruitment areas. Those who reported injecting crack-cocaine had a much higher prevalence than those who did not (67% and 44% respectively).

In Scotland a high prevalence was found in Glasgow during 2005. A survey of 435 current IDUs recruited at syringe exchanges in Glasgow found the prevalence of hepatitis C was 68 per cent. This compares to a prevalence of 77 per cent among 531 current IDUs recruited during a community-wide survey in Glasgow in 2004 (Taylor 2006). Among 34 IDUs surveyed in 2005 who had commenced injecting in the previous two years, the prevalence of hepatitis C was 30 per cent; this prevalence was lower than that detected among equivalent IDUs surveyed in 2001/2002 (43%) and 2004 (50%) (HPA *et al.* 2006). A recent review of epidemiological studies has indicated that the incidence of hepatitis C among IDUs in many parts of Scotland remains high (in the range 12 to 29 per 100 person-years) (Roy *et al. in press*).

The prevalence of oral fluid antibodies to anti-HBc remains stable among IDUs participating in the UAPMP agency survey in England, Wales and Northern Ireland. The outbreaks of hepatitis A seen among IDUs and the homeless in parts of the UK appear to have waned. (HPA *et al.* 2006).

6.3.3 Sexually transmitted infections

NO NEW INFORMATION AVAILABLE

6.3.4 Tuberculosis

NO NEW INFORMATION AVAILABLE

6.3.5 Other infectious morbidity

There is a continuing problem with bacterial infections among IDUs, including on-going problems with group A streptococcal infections. Enhanced surveillance data gathered during the strep-EURO programme has identified injecting drug use as one of the most important risk factors for severe group A streptococcal infections in the UK, with just over one fifth of reports being in injecting drug users (Lamagni 2006).

There has also been a continuing occurrence of wound botulism and tetanus cases among IDUs. During 2005, 28 suspected cases of wound botulism among IDUs in the UK were reported (25 in England, two in Scotland, and one Northern Ireland), and in two cases the patient died. Four of six tetanus cases reported to the HPA in England were confirmed to have been IDUs, indicating that tetanus continues to affect IDUs, albeit at lower numbers than in 2003 and 2004 (25 cases reported between 2003 and 2004).

6.3.6 Research

Two studies, one in Glasgow (University of Paisley) and one in London (CRDHB), which video taped injecting events, have recently been undertaken and the results are now available (Taylor et al. 2004; Rhodes *et al.* 2006). These studies provide a useful insight into injecting practice and hygiene (for details of the research by Rhodes et al. see Chapter 7.3.4).

Female injecting drug users

Tompkins *et al.* (2006) looked at the consequences for women of receiving injections from other drug users.⁹⁷ Findings suggest that their reliance on others to administer injections meant they had less control over their drug use. Exchanging drugs as currency for being injected was common. Women appeared to be confused about the risks associated with being injected and the perceived risks were often complex and polarized.

There are number of new and ongoing research projects. These include:

- A cohort study of injectors in Wales to estimate the incidence of HCV (led by National Public Health Service Wales (NPHSW) with CRDHB and HPA); results will be available shortly.
- DORIS, Health Protection Scotland and the Centre for Drug Misuse Research, Glasgow) will look at prevalence and incidence of HCV among IDUs attending drug services in Scotland.
- CRDHB and HPA is looking at whether collecting dried blood samples rather than full blood will increase the uptake of HCV testing among IDUs; a report will be available shortly.
- The first series of community recruited UAPMP enhancement surveys of IDUs has been completed in England (CRDHB and HPA). Initial results are available and further findings will be published shortly.
- Community recruited unlinked anonymous surveys of IDUs has recently been completed at a single location in England using respondent driven sampling and Computer Assisted Interviewing (CRDHB and HPA); analysis is currently ongoing.
- A pilot companion unlinked anonymous survey has been developed and piloted in Scotland (HPS with University of Paisley and HPA) which will focus on those using needle exchanges. Initial results are given above.

⁹⁷ Methods: In-depth interviews with 45 women injecting drug users who have been injected by other people, recruited from a needle exchange programme.

- Pilot study of the impact of visual cues to enhance the accuracy of self reported injecting risk behaviour and increase knowledge amongst IDUs (Liverpool John Moores University and University of Paisley)

The Scottish Executive has recognised the importance of tackling the hepatitis C epidemic through the publication of its first *Hepatitis C Action Plan* (Scottish Executive 2005c). A number of initiatives have been funded as part of the Action Plan, including:

- A survey of hepatitis C prevalence among injecting drug users attending needle exchange services across Scotland (led by HPS and University of Paisley, in collaboration with HPA).
- A two-year modelling study to estimate the cost of the current and future burden of hepatitis C virus infection in Scotland (HPS).
- A two-year study to determine the cost-effectiveness of different screening approaches for hepatitis C (HPS).

6.4 Psychiatric co-morbidity (dual diagnosis)

6.4.1 Prevalence

NO NEW INFORMATION AVAILABLE

The relationship between cannabis use and mental health

The report by the Advisory Council on the Misuse of Drugs (ACMD) on the association between cannabis use and mental health issues (ACMD 2005a) has been referred to in Chapter 1. The Beckley Foundation published another report looking at the issue, coming to the same conclusions as the ACMD, that the evidence is mixed (Hunt et al. 2006). In another article in the *Lancet*, Macleod *et al.* (2006) also caution about the epidemiological evidence that cannabis use causes schizophrenia, suggesting that premature conclusions around causality are likely to be counterproductive and could hinder the overall endeavour to find ways to effectively improve population mental health.

6.4.2 Personality disorders

NO NEW INFORMATION AVAILABLE

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 and sepsis

Information from Scotland for acute hospital discharges where there has been a diagnosis (main or secondary) of drug misuse shows that:

- the rate was 106 per 100 000 population;

- in the majority of cases (96%, 4,993 discharges), the main reason for admission was not drug misuse, the most common primary diagnoses were phlebitis⁹⁸, cutaneous abscesses and cellulites;
- males were much more likely than females to have a diagnosis of drug misuse, with over two-thirds (3,538) of such discharges being men;
- discharges involving drug misuse increased steadily up to 34 year olds (1,102 amongst 30 to 34 year olds) and then declined; very few discharges (234) were seen in those aged 50 and over;
- approximately half of all cases (2,856) were admitted to general medicine, with a further 13 per cent (695) being admitted to general surgery and nine per cent (447) to orthopaedics;
- admissions most often occurred as an emergency rather than an elective intake;
- the vast majority (89%, 4,616) of admissions involved a stay of less than a week; and
- the drug type most often recorded was opioids, being explicitly mentioned in over half (3,007) of all acute hospital discharges involving drug misuse.

It is reported that between 2000/01 and 2004/05, there was a nine per cent increase (from 4,789 to 5,204) in the number of discharges involving drug misuse (ISD 2006a).

Endocarditis

NO NEW INFORMATION AVAILABLE

Dental health

NO NEW INFORMATION AVAILABLE

6.5.2 Non-fatal drug emergencies

NO NEW INFORMATION AVAILABLE

Research

In a study of drug use amongst typical patients attending an emergency department in Bristol, Binks *et al.* (2005)⁹⁹ found that:

- 36.2 per cent had used illegal drugs in their lifetime and 16.1 per cent in the previous month;
- 9.9 per cent had used drugs within the previous 24 hours;
- 5.7 per cent had injected drugs;
- 6.9 per cent (55) of all patient attendances were directly (3.0%) or indirectly (3.9%) related to drug use, and hospital admission was required in nearly half of these, 2.9 per cent (23) required admission;
- the commonest diagnoses directly related to illegal drug use were deliberate self harm/psychiatric problems (11 out of 24 patients) and acute medical conditions such as cellulitis, chest pain, and deep venous thrombosis (12 out of 24 patients).

⁹⁸ Phlebitis is an inflammation of a vein.

⁹⁹ A representative sample of patients attending an inner city Emergency department covering a 168 hour week were asked if they would be interviewed face to face. Of 1,070 those approached (patients were excluded if they had a life threatening illness, chronic mental impairment, were unable to understand/give verbal consent, or did not speak English). 801 responded. Additional information collected from the treating clinician indicated whether each presentation was directly or indirectly related to illegal drug use.

6.5.3 Other health consequences

NO NEW INFORMATION AVAILABLE

6.5.4 Driving and other accidents

See Chapter 13, selected issue on drugs and driving.

6.5.5 Pregnancies and children born to drug users

NO NEW INFORMATION AVAILABLE

7. Responses to health correlates and consequences

7.1 Overview

Drug-related deaths (DRDs), infectious diseases, comorbidity and other health consequences are key policy issues within the United Kingdom Drug Strategy (DSD 2002).

7.1.1 Drug related death

A Government target to reduce DRDs by 20 per cent by 2004 from an English baseline of 1,568 deaths was set in 1999. A strategy for England and Wales was published in 2001, focusing on promoting treatment, with service providers are 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 was accompanied by guidance for both generic and specialist services, and a range of materials and training for drug users.¹⁰⁰ In Scotland a strategy and action plan to reduce DRD was developed in 2005.

The Scottish Executive 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. The Scottish Executive part funds a Scottish Solvent Abuse Field Worker, based at Re-Solv¹⁰¹. The worker offers support to community groups by providing VSA awareness videos and literature, and runs formal and informal sessions at local venues on the dangers of VSA. Throughout the UK there is information about volatile substances available on drug information websites.

7.1.2 Infectious disease

In the 1980s, United Kingdom drug policy was led by a public health approach aimed at containing HIV transmission. The subsequent action, based on a harm reduction approach, is regarded as having been successful in containing HIV amongst injecting drug users (IDUs); providing free needles and syringes, and 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.

7.1.3 Dual diagnosis

Standards of care for problem drug users with mental health problems were agreed in 2001 (HAS 2001). Guidance on good practice (DH 2002c) and the provision of services (DH 2002b) were developed in England. The Department of Health (DH 2002a) highlighted the need for generic health services to work in partnership with

¹⁰⁰ See: <http://www.nta.nhs.uk/programme/drd3.htm>

¹⁰¹ See: www.re-solv.org

other agencies, such as drug services. Local Implementation Teams (LITs) implement the policy requirements described in the guidance, and work in partnership with Drug (and Alcohol) Action Teams (D(A)ATs).

7.1.4 Children born to drug users

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) highlighted concern in its report of *Hidden Harm* of parental drug use for their children. Since then a number of initiatives have been undertaken to address problems identified throughout the United Kingdom, including a Scottish Executive action plan.

7.2 Prevention of drug-related deaths

7.2.1 Overdose prevention

Specialist needle and syringe exchange schemes

An audit of needle and syringe exchange schemes in England found that the provision of interventions to prevent overdose was limited (Abdulrahim *et al.* 2006) (see 7.3).

Scotland: Action to reduce drug-related deaths

Following the publication of the National Investigation into Drug-related Deaths in Scotland 2003, in July 2005, the Scottish Advisory Committee on Drugs Misuse (SACDM) produced a report and recommendations focusing on reducing drug-related death in Scotland (SACDM 2005). In response to the SACDM report the Scottish Executive published an Action Plan (Scottish Executive 2005b) which looked at each of the recommendations in turn and promoted similar actions to those identified in England:

- providing awareness materials;
- increasing access to treatment so that substance misusers have access to a range of evidence based treatments; particularly the most vulnerable;
- training of GPs;
- training of generic staff; and
- overdose training for prison staff and prisoners.

In addition, the Action Plan includes the following action points:

- ensuring police action is consistent with resuscitation;
- the Scottish Crime and Drug Enforcement Agency (SCDEA) is to produce Special Alerts and Health Alerts when problems such as contaminated drugs are identified;
- funding appropriate research;
- the Scottish Executive is to produce a half-yearly newsletter to share with ADATs and others information on drug deaths obtained at a national level. This may include new research, new information materials and examples of good practice;
- the SCDEA is to produce a monthly spreadsheet showing year to date figures on the number and distribution of drug-related deaths in each police force and ADAT area, compared to the same period the previous year; and
- establishing a new National Forum to look at trends, causes and good practice in preventing drug-related deaths.

A further recommendation by SACDM was that,

"In order to enable a long term, meaningful interpretation of post-mortem toxicological data, Procurators Fiscal, who instruct autopsies on these deaths,

should insist that the pathologists carrying out the autopsies follow a nationally agreed protocol based on an agreed best practice model.” (SACDM 2005 p.29)

The Scottish Executive states that it will explore this further.

The first issue of the newsletter was published in July 2006 (Scottish Executive 2006b). It reported that the National Forum held its first meeting on 12 May 2006.

Issuing heroin users with naloxone

In Scotland, Lanarkshire ADAT is currently running a pilot project involving Naloxone the anti-overdose drug. This involves the training of ten front line addictions staff, ten clients and ten family/friends currently living with an injecting drug user. Each group is being trained by the Scottish Ambulance Service on Naloxone administration, basic life support and the unconscious patient. After successful completion of the course the participants are issued with a 400 mcg pre-filled Naloxone syringe, sharps bin and harm reduction/health promotion material. The pilot will be monitored after two months to assess both the effectiveness of the training and the impact of the Naloxone. A similar pilot project is also being run in Greater Glasgow (Scottish Executive - internal communication).

Wales

A review group to conduct confidential local reviews into drug related deaths has existed in North Wales for some time and is reported to be working well. Currently action is being taken to replicate the system throughout Wales. It is expected that reporting will help identify best practice and disseminate lessons learned to help reduce, and ultimately prevent many drug-related deaths across Wales (Welsh Assembly Government – internal communications).

Research

NTA has provided funding for a psychological autopsy study of acute fatal heroin-related overdose. The aim is to investigate the psychological and social antecedents (lifestyle, personality, psychological and social circumstances, events and behaviours) of fatal heroin overdose.¹⁰²

In Scotland, the Scottish Executive is providing funding for research into how to reduce death by drug related overdose.

Safer use training

See above with respect to the Scottish Action Plan on drug related death.

First aid training

See above with respect to the Scottish Action Plan on drug related death.

Consumption rooms

The debate over consumption rooms is currently topical, see research below.

Research

Research report on drug consumption rooms

A report from an Independent Working Group set up and funded by the Joseph Rowntree Foundation suggests drug consumption rooms should be piloted in the United Kingdom (Joseph Rowntree Foundation 2006). The report suggests that they

¹⁰² For more information see: <http://www.shef.ac.uk/scharr/sections/gp/research/innovations>

offer a "unique and promising way" to help lessen fatal overdoses as well as take drug use off the streets and reduce numbers of discarded needles in public places.

In response NTA suggest,

"Any new treatment provision must be evidence based and cost effective. Further evidence is needed that there would be enough demand for drug consumption rooms to justify the use of scarce resources, when funding could be better spent on other treatment services." (NTA 2006g).

The Home Office has rejected the recommendation.¹⁰³

Antagonists

NO NEW INFORMATION AVAILABLE

Volatile substance abuse

In a review of the evidence relating to volatile substance abuse (VSA) in Scotland commissioned by the Scottish Executive (Skellington Orr and Shewan 2006) it was suggested that volatile substance abuse has, in the last 20 years, become a secondary research agenda and is often poorly understood as a drug misuse problem among care professionals. Also there was a lack of obvious presence of VSA in drug education programmes, professional training packages and treatment services. In addition it is suggested that death risks associated with VSA appear to present unique challenges to the drug education agenda with the drug education literature suggesting that scare tactics do not work well with young people and that stories of first time death risks are often not believed. Fear of raising awareness of VSA methods is also cited in the literature as a reason that VSA has not, in recent years, been targeted specifically as part of drug education in the UK. Whilst some of those working in the field have argued for specific VSA education, including primary school children, traditional drug education debates regarding the suggestibility of younger children may continue to act as a barrier to VSA education.

7.3 Prevention and treatment of drug-related infectious diseases

7.3.1 Counselling and testing

HIV

There is evidence that suggests an increasing proportion of IDUs may be unaware of their HIV infection. Only 47 per cent of those participating in the UAPMP agency survey who had antibodies to HIV were aware of their infection in 2005. This is the lowest level of awareness seen in this survey since this was first asked about in 1995 (the average between 1995 and 2003 was 74%) (HPA *et al.* 2006).

Hepatitis C.

Increasing the proportion of injectors with hepatitis C who are aware of their infection is one of the aims of the *Hepatitis C Action Plan for England* (DH 2004b) and there are signs of progress. Whilst most IDUs who took part in the UAPMP agency survey in England reported having accepted the offer of a test, 29 per cent of IDUs reported never having had a voluntary confidential test for hepatitis C in 2005, this compares with 51 per cent in 2000 (HPA *et al.* 2006). Of those who were infected with hepatitis C, 48 per cent in 2005 were unaware of their infection, compared to 60 per cent in

¹⁰³ For more information see:

[http://www.politics.co.uk/issueoftheday/drugs-foundation-government%e2%80%99s-drug-policy-irresponsible-\\$440680\\$440605.htm](http://www.politics.co.uk/issueoftheday/drugs-foundation-government%e2%80%99s-drug-policy-irresponsible-$440680$440605.htm)

2000. Of participants from Wales, 45 per cent reported never having a voluntary confidential test for hepatitis C in 2004/05, with almost three quarters of those with hepatitis C being unaware of their infection (HPA *et al.* 2006). Thirteen percent of the participants from Northern Ireland in 2004/05 reported not having been tested for hepatitis C, and just over one quarter of the participating IDUs with hepatitis C in the province were unaware of their hepatitis C infection (HPA *et al.* 2006).

7.3.2 Prevention

Vaccination

In England, Drug (and Alcohol) Action Teams have their performance rated through the NTA on hepatitis B prevention targets. A benchmarking exercise is planned to enable improvements in lowest performing D(A)ATs to be identified.

The uptake of the vaccine against hepatitis B by IDUs continues to improve. The numbers of IDUs participating in the UAPMP agency survey self-reporting¹⁰⁴ that they had taken up the offer of the hepatitis B vaccination has more than doubled from 25 per cent in 1998 to 59 per cent in 2005 (HPA *et al.* 2006). Of those who reported vaccination, just over half self-reported receiving three or more doses of the vaccine (56%). However, in 2005, among those who had first injected in the previous three years 46 per cent reported uptake of the vaccine, which was lower than in 2004 (51%) (HPA *et al.* 2006).

In April 2005 NTA began a review of hepatitis testing and vaccination against hepatitis B of all clients in structured drug treatment.

Syringe provision programmes

Survey of needles and syringe exchanges

Two reports on the United Kingdom audit of the provision of needle and syringe exchange in the United Kingdom have been published.¹⁰⁵

England

The report for England found both pharmacy and agency based services provided syringe exchange in the overwhelming majority of (D(A)AT) areas though, overall, pharmacies constituted 80 per cent of facilities (Abdulrahim *et al.* 2006). On average, two agency based services and eight pharmacies provided facilities in each D(A)AT area.

- The median number of visits by injectors to all needle exchange facilities in a D(A)AT area (pharmacies and drug services), between April 2004 and March 2005, was 8,000;
- the median number of clients who used needle exchange facilities in each D(A)AT area was 700, though this number has not been adjusted for double counting; and .
- a median number of 150,000 syringes were distributed per D(A)AT area.

There was, however, wide variation in activity between both services and D(A)AT areas.

¹⁰⁴ Vaccination uptake data should be interpreted with caution as they are based on self-reports.

¹⁰⁵ The survey comprised three separate questionnaires sent to commissioners (74% responded), specialist needle and syringe exchange services (55% responded) and pharmacy based schemes (48% of pharmacy exchange scheme co-ordinators responded) (see previous UK Focal Point report).

It is suggested that the ability of pharmacists to provide a range of interventions and measures necessary to reduce drug-related harm and blood-borne viruses was limited, suggesting that pharmacy needle exchange schemes must be developed as complementary to specialist services rather than as alternative facilities.

Also, many specialist services do not provide comprehensive harm reduction and hepatitis B prevention measures. When assessing new clients, 40 per cent did not address vaccination and testing for hepatitis B. In half of the D(A)AT areas viral testing was not available on site in needle exchange services, and 40 per cent of areas did not offer immunisation on site. Approximately a third did not address hygiene and safer injecting techniques.

Finally, the report suggested that management of needle exchange activity was poor, few D(A)ATs were able to provide data on number of visits, number of clients and quantities of equipment distributed or returned.

Scotland

This report is much more detailed than the summary for England (Griesbach *et al.* 2006). Some form of needle exchange was available in every D(A)AT area. There were 188 exchanges; 136 pharmacy exchanges, 43 specialist exchanges, six police custody suite exchanges and three hospital A&E exchanges; nearly half of specialist service provision was through mobile/outreach facilities. The ratio of pharmacy to specialist exchanges was 3:1.

In non-pharmacy services the median number of transactions per service was 1,054 (mean: 2,289):

- the mean number of transactions per pharmacy was 1,458;
- the median number of clients per service was 221 (mean: 491); and
- the mean number of clients per pharmacy was 479.

A roughly equal number of syringes were distributed by pharmacy and non-pharmacy services overall, though there was wide geographical variation. It is estimated that at least 1,563,312 syringes were returned to needle exchange services across Scotland, 849,113 to non-pharmacy services and 714,199 to pharmacy services; pharmacy having fewer returns than non-pharmacy exchanges.

Only about half of non-pharmacy services offered on-site interventions related to hepatitis C; commonly pre- and post-test counselling. Less than half provided key working, structured counselling, care for minor infections or complementary therapies. Fewer provided overdose prevention training for clients, housing, social welfare or legal advice, nutritional advice, primary care sessions or well-woman clinics.

Compared to England, services in Scotland were less likely to distribute filters, sterile water, stericups and Vitamin C to their clients, though more likely to distribute wipes or swabs. Services were less likely to provide on-site hepatitis B immunisation than in England. English services were much less likely to limit the number of syringes they gave out during any single needle exchange transaction; this is probably because of guidance in Scotland which limits the number given out.¹⁰⁶ Scottish services were more likely than those in England to provide injecting equipment to

¹⁰⁶ This suggests a maximum of 20 needles/syringes on a client's first visit; a maximum of 60 needles/syringes on subsequent visits; and an exceptional upper limit of 120 for holiday periods when facilities are closed or are difficult to access.

young people aged 16 or 17. As in England, pharmacy schemes offered a smaller range of interventions.

As in England, monitoring was poor, particularly with respect to the number of transactions, number of clients, number of syringes distributed and number of syringes returned.

Northern Ireland

Northern Ireland is the only country within the UK with a national syringe exchange database. Syringe exchange schemes are based in nine pharmacies. In 2004/05:

- 86,056 exchanges were made; there were 7,400 contacts, compared to 7,508 in the previous year :
- the overall rate of transactions involving the return of used equipment fell in 2004/05 to 54 per cent compared to 59 per cent in the previous year;
- just over half (54%) of all visits were made by clients aged 31 and over;
- just under one in 20 visits (4%) were by clients reporting themselves to be new users of the needle and syringe exchange scheme;
- twelve (0.2%) visits were by clients reporting to have shared needles (DHSSPSNI 2006b).

The value of syringe exchange and other low threshold services (tier 2) is shown by the analysis of the Merseyside Inter Agency Drug Misuse Database (Chandler 2006). It is shown that monitoring is both feasible and useful to commissioners, and also enables monitoring of care pathways.

DrugScope has published guidance on providing needle exchange for young people (DrugScope 2005a).

Paraphernalia and condom provision

The Scottish Executive has commissioned a study looking into safety, risks and outcomes from the use of injecting paraphernalia among IDUs. This is due for publication in Spring 2007.

Information materials

NO NEW INFORMATION AVAILABLE

Educational approaches

NO NEW INFORMATION AVAILABLE

7.3.3 Counselling and testing

NO NEW INFORMATION AVAILABLE

7.3.4 Infectious disease treatment

In 2005, a total of 45,171 individuals were seen for HIV-related treatment or care in England, Wales and Northern Ireland, of these 1,005 HIV-infected IDUs, a 15 per cent increase since 2000 when 872 IDUs were seen for care (total number seen in 2000 was 21,717). Whilst 30 per cent of IDUs were not receiving antiretroviral therapy in 2005, 53 per cent were on a combination of three drugs and 15 per cent were receiving four or more drugs (only 23 individuals were receiving mono or dual drug combinations) (HPA *et al.* 2006).

7.3.5 Specialist drug service treatment

Models of care for treatment of adult drug misusers: Update 2006 states that a greater emphasis is required on improving service users' physical and mental health,

importantly for those with hepatitis C infection and for those misusing alcohol. (NTA, DH and Home Office 2006).

Research

A pilot visual assessment of injecting drug use used ethnographic methods to capture drug injecting in the context of polydrug use and in particular heroin and crack (Rhodes *et al.* 2006.)¹⁰⁷ It concluded that public injecting environments compromise the maintenance of injecting hygiene:

- there is a preference among many polydrug users of crack and heroin for groin injecting;
- the shared use of cookers is common;
- general injecting hygiene is poor and;
- there remains scope for accidental equipment sharing, a considerable amount of blood was observed in the environment, including spillage as well as blood transfer between partners.

Further, they noted a large amount of vein damage, as well as common and severe, often untreated, injecting related bacterial tissue infections amongst injectors. In addition, they suggest that crack use may compromise and complicate risk management and safety routines, especially given that many speedball injectors also smoke crack, some immediately prior to injecting.

The research suggests a further project designed to generate evidence on:

- how injecting environments mediate risk, and the scope for interventions in public injecting environments;
- how crack injection complicates health risk management in relation to blood-borne hepatitis C and HIV, bacterial and surface infections related to injecting, blood safety, and injecting hygiene;
- health risk management in relation to groin injection; and
- the scope and feasibility of interventions specifically targeting risk management among poly injectors of crack and heroin.

7.4 Interventions related to psychiatric morbidity

Changes to the way mental disorder is defined

Changes to the way a mental disorder is defined are proposed through a Mental Health Bill; this has implications for dual diagnosis. The Bill is intended to make the Mental Health Act 1983 easier to use and clearer to those to whom it applies. The Department of Health will reword references to alcohol and drugs, to make it clear that the Act is not to be used to force people who are suffering from no other mental disorder, to accept treatment for substance dependence. However, it will also make clear that people who are dependent on alcohol and drugs are not excluded from the scope of the act, if they also suffer from another mental disorder. The Act will not apply to substance misuse by itself, as this is not classed as a mental disorder (DH 2006e).

¹⁰⁷ The research team obtained access to multiple injecting scenes in a variety of injecting environments in London and Bristol, having established contact with drug injecting networks. Approximately half of injecting users contacted through fieldworkers agreed to participate in the study. Fourteen separate cases were recorded, of which ten were selected involving 20 participants. Injecting practices were recorded with consent of all participants and field notes recorded.

Provision in Scotland

A report on the provision of health and social care services for those with co-existing mental health and substance misuse problems commissioned by the Scottish Executive aimed to identify the broad range of health and social care needs of such problems; and their experiences of accessing and receiving services from health, social care, and voluntary organisations¹⁰⁸(Hodges et al 2006). The report suggests that,

“The picture that emerged from this study was one of a group of people who struggled daily with the realities of living with co-morbid mental health and substance misuse problems and for whom existing support services were often inappropriate, inadequate and which could further undermine their already fragile self esteem and coping strategies.” (p 48)

There were some examples of good practice. However there was a lack of awareness of available help, lack of clarity about pathways for help and a lack of ongoing support. The study also uncovered considerable training needs across all professional groups and agencies.

Work has already gone into identifying the needs of service users affected by both mental health and substance misuse problems, as well as assessing current service provision and identifying areas for action. Recommendations have been made for improving awareness, support and service provision for people who have both mental health problems and problems associated with alcohol and substance misuse – particularly through the *Mind the Gap* and *A Fuller Life* reports.

The Executive is now supporting additional work on the next steps required to take these recommendations forward to help inform, support and shape the future of services for those users affected by both mental health and substance misuse problems. An Advisory Group with a strong delivery focus, with membership drawn from across the mental health and substance misuse fields, has been established to draw these recommendations together and translate them into practical measures to support their implementation.

The response in Wales

Co-occurring Substance Misuse and Mental Health Problems is one of five key modules, launched in 2004, as part of the Substance Misuse Treatment Framework for Wales (Welsh Assembly Government 2004). To support the implementation of the module a series of workshops have taken place bringing together professionals from mental health and substance misuse services to consider the working practices between the services to ensure a seamless pathway of treatment for these very vulnerable clients. A review of the impact of these is to be undertaken and consideration given to providing further events to assist in the development of robust protocols (Welsh Assembly Government – internal communications).

Responses to the evidence base on the relationship between cannabis and mental health

A report from the Beckley Foundation looked at the responses to the evidence base on the relationship between cannabis and mental health problem (Hunt et al. 2006). It suggests possible adverse effects of chronic, heavy cannabis use remain to be confirmed, and suggests research in the following areas:

¹⁰⁸ The researchers interviewed commissioners, service providers and service users to obtain a range of perspectives on these issues.

- a decline in occupational performance marked by underachievement in adults in occupations requiring high level cognitive skills;
- impaired educational attainment in adolescents; and
- subtle forms of cognitive impairment, most particularly of attention and memory, which persist while the user remains chronically intoxicated, which may or may not be reversed by prolonged abstinence from cannabis.

Regarding effective policies, it is suggested that:

“no simple solutions exist. However, an evidence-based response to cannabis-related harms - including those to mental health - would seem to require a multi-faceted, developmental approach that resists populist solutions” (p.11).

Exploration of healthcare provision for people with a dual diagnosis (comorbidity)

United Kingdom researchers are collaborating on a research project funded by the European Union. This will explore the healthcare provided to those with dual diagnosis in urban settings Denmark, Germany, Italy and the U.K. A prospective cohort design is being used with three cohorts from each centre using a consecutive admission technique. All will have a diagnosis of acute psychosis, but one cohort will consist of those who test positive only for cannabinoids, a second of those with a positive test for drugs excluding cannabinoids, and a third of those who test negative for all drugs.

Services for prisoners with dual diagnosis on release

In a review of primary health care and social care services for people recently released from prison in the United Kingdom for the Sainsbury Centre for Mental Health, Williamson (2006) asks what development work is currently being undertaken or planned in the area, what are the national policy drivers covering wider health care which may relate to and affect prisoners, how are they enabled to access primary care services and what organisational issues affect this access? Also, what are the gaps which require research, training or service development?

Amongst a number of issues addressed, the report suggests that services to meet the needs of substance misusing prisoners will, because of the high prevalence of dual diagnosis, have to be effectively delivered in partnership with mental health providers.

7.5 Interventions related to other health correlates and consequences

7.5.1 Somatic co-morbidity

NO NEW INFORMATION AVAILABLE

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

See Chapter 13, selected issue in Drugs and Driving.

7.5.4 Other health consequences reduction activities

NO NEW INFORMATION AVAILABLE

7.5.5 Interventions concerning pregnancies and children born to drug users

In the United Kingdom, all governments have undertaken further work to address the problems associated with being the children of drug using parents. This work, undertaken as part of what is referred to as the *Hidden Harm agenda* includes

provision for improving maternity services for drug users who are pregnant and for their babies. Policy in this area and provision of services for drugs users and their children, from birth to adulthood, relates to social as well as health consequences.

In England, *Models of care for treatment of adult drug misusers: Update (2006)* states that the children, carers or significant others of service users should also be considered during care-planned treatment and that the needs of the children of drug-misusing parents also require greater attention (NTA, DH and Home Office 2006).

Addressing the problems of living with substance misusing parents: Scotland

In response to the Hidden Harm Report (ACMD 2003) on the impact on family members, and particularly children, living with substance misusing parents, the Scottish Executive commissioned a number of pieces of research and a scoping study by Templeton *et al.*, "Looking Beyond Risk" (2006).

The Scottish Executive published *Hidden Harm – Next Steps: Supporting Children – Working with Parents* (Scottish Executive 2006c). The strategy identifies the range of actions and initiatives underway to improve the way in which young people in substance misusing households are supported and protected. As well as outlining work already underway, "*Hidden Harm*" identifies key areas for further action:

- more effective identification of children at risk, including at the stage of pregnancy - enabling appropriate support at the earliest possible stage;
- ensuring that drug users with children undergo a multi-agency assessment, so that decisions can be taken on parental capability and care plans with timetables that can be agreed and implemented - with the possibility of 'contracts' between service providers and parents;
- more effective communication between agencies, particularly between those dealing with adults and children, and including the sharing of information - building on proposed legislation to introduce a duty to share information for child protection purposes;
- to consider how barriers, including a culture of confidentiality, act as an impediment to sharing information can be broken down;
- re-training of social workers and other frontline staff in child protection;
- examining governance, capacity and training to ensure that those working in this complex and challenging area have adequate support and advice, that they are clear about their own and others' responsibilities and that they have the skills to do their jobs well; and
- developing a new national fostering strategy, to build on work already going on to help support fostering even more effectively in the future.

The Scottish Cabinet's Delivery Group on Children and Young People is overseeing implementation of a number of actions as it covers a wide range of Scottish Executive Departments.

The Aberlour Childcare Trust, a charity working for children and young people and families who need additional support to promote their development and well being, led a Think Tank together with the Scottish Association of Alcohol and Drugs Action Teams looking at children affected by parental substance abuse. The Think Tank Report *Have We Got Our Priorities Right* (Russell 2006) contributed to the public debate on the impact on parental substance misuse. The Think Tank was drawn from the knowledge and expertise of people working in the drugs and alcohol field, including those working directly with parents and drugs.

Drug tests for parents

One area for future action, identified in *“Hidden Harm”*, is contracts through which parents would commit to changing chaotic lifestyles and improving care for their children in return for intensive support plans to help them and their children. Drug testing is being looked at as part of these contracts, as only one way of demonstrating commitment to what is agreed in a contract. Consideration of how contracts might be developed is at an early stage.

Addressing the problems of living with substance misusing parents: Wales

In Wales there are a number of actions related to addressing the issues for the children of drug using parents. Some initiatives are specific to substance misuse policy development; others are in collaboration with other Welsh Assembly policy initiatives. Two of the most significant developments at a national level are as follows:

- the establishment of the all Wales network and collaborative centre for the promotion of excellence for education, training and development in substance misuse; the *All Wales Network and Collaborative Centre for the Promotion of Education, Training and Development in Substance Misuse*.¹⁰⁹ The establishment of this centre will help ensure that the health and social care workforce is better equipped to understand and respond to the needs of substance misusers; and
- the inclusion in Guidance for Local Safeguarding Children’s Boards (LSCB) of specific reference to the children of substance misusing parents. This is to encourage close collaboration between LSCB, and local Community Safety Partnerships and their Substance Misuse Action Teams to ensure that the need to safeguard the children of problem substance misuse is taken fully into account.¹¹⁰

At a local level, the 22 Community Safety Partnerships (CSPs) across Wales have to ensure that a Local Substance Misuse Action Plan is developed and implemented. In deciding what to incorporate in their plans, CSPs are expected to have regard to any guidance issued by the National Assembly. The guidance stated that the plans should reflect any relevant expert advice and direction of the Wales Advisory Panel on Substance Misuse and other national bodies e.g. the Advisory Council on the Misuse of Drugs. All 22 CSPs have produced action plans and all contain actions relevant to Hidden Harm.¹¹¹

Resource book for professionals on substance misuse in pregnancy

A resource book for professionals on substance misuse in pregnancy has been developed by DrugScope (Drug Scope 2005b). Increasing guidance on working with pregnant drug users and their children is being made available at the local level, for example in Lambeth (Lambeth Drug and Alcohol Action Team 2005).

¹⁰⁹ See:

<http://www.information.wales.gov.uk/content/decisionreports/education/education/establishment%20of%20an%20all%20wales%20network%20and%20collaborative%20centre%20for%20the%20promotion%20of%20excellence%20for%20education%20training%20and%20development%20in%20substance%20misuse.rtf>

¹¹⁰ See:

<http://www.everychildmatters.gov.uk/files/99A633771D7DFE72CCEDC6B7B89C9B08.pdf>

¹¹¹ See, for example: <http://www.wlga.gov.uk/content.php?nID=42;IID=1>

Research

Treatment for pregnant opiate users

A retrospective review of pregnant opiate users registered with a pregnant drug-users service between January 2001 and October 2002, aimed to identify the obstetric and neonatal characteristics of these high-risk pregnancies, the level of contact with the service and the relationship between level of attendance and pregnancy outcome (Crome *et al.* 2005)¹¹². It was reported that there were no pregnancy losses during the studied period. The birth weights of 27 of 39 babies were below the 10th percentile for gestational age. Associations between different antenatal variables and pregnancy outcomes were tested. The positive association between attending 70 per cent of expected antenatal visits to the service and the birth weight centile was significant ($p = 0.012$).

Identifying babies with neonatal abstinence syndrome and visual impairment

The Scottish Executive is currently in discussions with NHS Health Scotland and other stakeholders about commissioning a piece of investigative work to establish the number of babies who are born to alcohol and drug misusing mothers, (rather than specifically the number of babies actually born with neonatal abstinence syndrome (NAS)). This piece of work came about in response to the Hidden Harm report which recommended that drug and alcohol use should be routinely recorded at antenatal clinic appointments and linked to stillbirths, congenital abnormalities and subsequent developmental abnormalities. The Scottish Executive suggests that at present, national statistics on drug and alcohol misuse in pregnancy are under-reported and that alcohol usage in particular is difficult to record. The aim of this the work is to:

- conduct an audit of the current level of recording this data;
- to explore staff attitudes to questioning patients about such an issue; and
- to identify what does and does not work in relation to gaps in staff training and support and gaps in information systems, and to recommend actions for improvement (Scottish Executive – internal communication).

¹¹² All the pregnant opiate users registered with the service between January 2001 and October 2002, 50 women.

8. Social correlates and consequences

8.1 Overview

8.1.1 Social exclusion

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 users, (evidence suggesting up to 80 percent), and lacking educational qualifications (studies suggest up to 40 per cent lack any GCSEs¹¹³). 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.

8.1.2 Drugs and crime

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, in England and Wales, acquisitive crime, to which drug related crime makes a substantial contribution, has continued to fall in recent years.

8.1.3 Social and economic costs

Latest cost estimates are based on the study by Godfrey *et al.* (2002) and are for 2000. They estimated that drugs cost United Kingdom society between €16.2 and €29.3 (£11.1 and £20) billion a year; these include health as well as social costs; the costs of crime however are estimated to be by far the highest.

There is evidence that drug use can give rise to dangers associated with safety in the workplace and productivity. However, in the United Kingdom the full nature and extent of the problem is unknown. Other issues include the public nuisance associated with dealing and drug related litter (discarded needles and syringes).

¹¹³ Secondary Education (GCSE) is the principal means of assessing pupil attainment at the end of compulsory secondary education.

8.2 Social exclusion

8.2.1 Homelessness

Research

In a study of homelessness among problem drug users based on the Drug Outcome Research in Scotland (DORIS) cohort¹¹⁴, Kemp *et al.* (2006)¹¹⁵ found that 36 per cent of problem drug users had been homeless at some time, seven times that of the general population. Recent drug injection was found to be a risk factor (OR = 1.40; 95% confidence interval (CI) = 1.01-1.96) associated with homelessness. The research also found that becoming homeless was associated with recently losing custody of children (OR = 2.28; 95% CI = 1.27-4.08), other recent family problems (OR = 1.88; 95% CI = 1.21-2.94) and worsening general health (OR = 2.17; 95% CI = 1.15-4.09). No longer being homeless was associated with not having recent family problems (OR = 0.43; 95% CI = 0.24-0.79).

8.2.2 Unemployment

NO NEW INFORMATION AVAILABLE

8.2.3 School drop out

England

For the first time, in the survey on, *Smoking, drinking and drug use among young people in England* for 2004 pupils were asked whether they had ever truanted or been excluded from school.¹¹⁶ This analysis adds to the substantial evidence from the United Kingdom (see previous Focal Point reports) that truants and those excluded from school are more likely to use drugs than the general school population (NatCen/NFER 2006).

Truancy

In 2005:

- thirteen per cent of pupils had truanted at least once in the last year; and
- pupils who had played truant in the last year were much more likely than those who had never truanted or those who had last truanted more than 12 months ago (past truants) to have taken drugs in the last month, 37 per cent compared with 23 per cent of past truants and 6 per cent of those who had never truanted; and
- these patterns existed for girls and boys.

Amongst pupils who had truanted in the last 12 months, the prevalence of drug use (and of smoking and drinking) increased with frequency of truanting. Twenty-nine per cent of those who had stayed away from school once or twice had taken drugs in the last month compared with 42 per cent of those who had truanted more than three times.

¹¹⁴ 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>

¹¹⁵ This report is based on 877 problem users recruited to DORIS.

¹¹⁶ For methodology used see chapter 2.

Exclusion from school

There was also a relationship between exclusions and drug use (and smoking and drinking):

- Ten per cent said they had been excluded from school at least once; and
- pupils who had been excluded in the last 12 months were more likely than other pupils to have taken drugs in the last month, 36 per cent compared with 26 per cent of those who were last excluded more than a year ago and eight per cent of those who had never been excluded.

Former truants and excludees

In 2005/06 the British Crime Survey included questions for 16 to 24 year olds on whether they had ever truanted or been excluded from school. 36.4 per cent of respondents reported they had truanted and 16.2 per cent of respondents reported that they had been excluded (Roe and Man 2006).

Analysis again showed a relationship between truancy and drug use:

- former truants were almost twice as likely to have used drugs in their lifetime than non-truants, 65.8 per cent and 34.0 per cent respectively; and
- former truants were also much more likely to have used drugs recently (39.8%) and be current users (26.1%) than non-truants (17.6% and 9.1%).

The relationship was similar between exclusion and drug use:

- excludees were over one and a half times more likely to have ever used drugs or used drugs recently than non-excludees; and
- they were also more than twice as likely to be current drug users.

Differences were even more striking looking at Class A drugs. Analysis showed that, although there was a considerable overlap between truants and those excluded, those who had truanted only were more likely to have used drugs across all recall periods than those who had been excluded only. Those who had both truanted and been excluded were the most likely to have used Class A drugs.

8.2.4 Financial problems

NO NEW INFORMATION AVAILABLE

8.2.5 Social network

NO NEW INFORMATION AVAILABLE

8.2.6 The effect of drug misuse on the family of users

NO NEW INFORMATION AVAILABLE

8.3 Drug-related crime**8.3.1 Drug offences**

Drug related offences can be identified through the police, courts and HM Revenue and Customs. In 2004/05 there were 186,783 incidents involving alleged drug offences recorded by the police in the United Kingdom, an increase of 0.5 per cent from the 185,924 offences reported in 2003/04

The latest data on persons dealt with (persons found guilty, given a fiscal fine or dealt with by compounding) for drug offences is available for 2004 (Table 8.1). The total number of person dealt with was 122,459. This is an increase of 4 per cent from the previous year (117,532). Eighty eight per cent of persons were dealt with for drug

possession offences. Trafficking and dealing offences (i.e. supplying or possession with intent to supply, and unlawful import or export), accounted for 12 per cent of all drug offences in 2004.

Sixty-eight per cent of offences (82,845) (not persons dealt with) related specifically to cannabis, eight per cent to cocaine and 10 per cent to heroin. The proportion of offences related to cannabis has decreased from the previous year.

Table 8.1: Persons found guilty, given a fiscal fine or dealt with by compounding for drug offences in the UK, 2000 to 2004

Drug	Year				
	2000	2001	2002	2003	2004
Amphetamines	6,637	4,950	5,820	6,163	6,249
Cannabis	75,989	72,691	83,152	85,768	82,845
Cocaine	5,451	3,090	6,990	7,905	9,382
Crack	1,216	1,460	1,830	2,270	2,450
Ecstasy	6,630	7,880	6,590	5,940	6,209
Heroin	12,297	12,380	11,860	11,277	12,412
LSD	260	150	90	150	90
Methadone	617	600	470	438	400
Total	105,039	103,080	113,465	117,532	122,459

Source: Standard Table prepared for Focal Point by John Corkery 2006

8.3.2 Other drug-related crime

Property and acquisitive crime

In England and Wales acquisitive crime, to which drug related crime makes a substantial contribution has continued to fall in recent years, falling by 12 per cent in the year to April 2005. The 2005/06 British Crime Survey shows that overall household acquisitive crime in England and Wales has fallen by 55 per cent between 1995 and 2004/05, falling by 4 per cent between 2004/05 and 2005/06 (Walker *et al.* 2006).

Also, the fall in the Drug Harm Index value between 2003 and 2004 from 104.8 to 87.9, a drop of 16.9 points or 16.1 per cent (see Chapter 1.3.4) is mostly due to substantial falls in the number of drug-related crime types (e.g. burglary, shoplifting, robbery and vehicle theft) (MacDonald *et al.* 2006).

A report from Her Majesty's Inspectorate of Probation (2006) suggested that between 40 and 60 per cent of cases inspected involved substance misuse (including alcohol). Problematic drug use was found in between 16 and 23 per cent of cases; though it is suggested that this is an underestimate.

Research

Budd *et al.* (2005) reported on results from the 2004 Offending, Crime and Justice Survey¹¹⁷. In this survey the majority who used drugs used recreationally and

¹¹⁷ The Offending, Crime and Justice Survey (OCJS) is the national longitudinal, self-report offending survey for England and Wales. The survey, covering people living in private households, was first conducted in 2003 and will be repeated annually until 2006. The sample size is 3,489 people; 3,363 were aged from 10 to 25 at the time of the 2004

amongst those who reported offending much was of quite a low level. Nevertheless, over half (52%) who had taken a drug in the last year reported having committed an offence; this compared with 19 per cent who had not taken a drug. However, frequent drug takers, that is those having taken a drug two or three times a month or more, were more likely to have committed an offence (62%).

Crime and treatment

The Home Office also published findings from a study linking data on self-reported offending gathered as part of the National Treatment Outcome Research Study (NTORS) with convictions data held on the Home Office Offenders Index. The study adds to the evidence that criminal convictions reduced after admission to treatment, with further progressive reductions in criminal convictions across the five-year follow-up period. There was a statistically significant association between the conviction measures recorded in the Offenders Index and the self-reported offending measures used in NTORS (Gossop *et. al.* 2006).

Concealment of drugs by those detained in police custody

Havis *et al.* (2005) looked at concealment of drugs by those detained in police custody. Much of the evidence was based upon deaths in custody¹¹⁸. In half of the cases, the deceased was known, or believed, to have concealed drugs orally at the point of initial contact with police. In four out of the 16 cases, the individuals first showed signs of medical distress in a public place, a further four collapsed on arrival at the police station; two more were subsequently found collapsed in their cell. Drug toxicity was the most common cause of death (in 10 out of the 16), but in five cases death was caused by airway obstruction by swallowed packages. Both cocaine (in 14 out of 16) and cannabis (in 8 out of 16) traces were found in post-mortem samples. The authors suggest that police officers be trained to reflect this risk and police forces develop a policy for life preservation in the case of swallowing, and for the management and detection of other forms of drug concealment. It is suggested that when there is a suspected swallowing immediate hospitalisation without attending custody is essential. When a detainee's health deteriorates between arrest and booking in, or whose health deteriorates suddenly or when a detainee has convulsions or collapses in a cell, drug concealment should be suspected.

interviews. 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 from 10 to 25. It covers offences against households, individuals and businesses. In addition to 'mainstream' offences such as burglary, shoplifting and assault, it also covers fraud and technology offences. The survey will also collect longitudinal data (that is information from the same individuals over time) to allow researchers to examine the pathways into and out of delinquency and the impact various risk and protective factors have on these pathways. It gathers evidence to support the effective targeting of resources for reducing levels of crime and illegal drug use, providing:

- measures of self-reported offending;
- indicators of repeat offending;
- trends in the prevalence of offending;
- trends in the prevalence and frequency of drug and alcohol use;
- evidence on the links between offending and drug / alcohol use;
- evidence on the risk factors related to offending and drug use; and
- information on the nature of offences committed, such as the role of co-offenders and the relationship between perpetrators and victims.

¹¹⁸ The study was based on 16 cases of internal drug concealment drawn from 43 drug-related deaths in custody in England and Wales between 1997 and 2002. These data were supplemented by three case studies from a county force involving non-fatal drug concealment to illustrate practical custody issues.

Illegal prostitution

Prostitution is not illegal in the UK; soliciting for such purposes is an offence.

Research

Gilchrist *et al.* (2005)¹¹⁹, interviewing 29 prostitutes, 23 of whom had used cocaine and 15 of whom had used crack, found no evidence to suggest that they were first introduced to cocaine use through prostitution; most believed that using cocaine did not affect how they worked. However, respondents suggested that other prostitutes were prepared to take more risks to support their cocaine habit and worked longer hours to finance cocaine than to finance heroin use.

The reinforcement between drug use and sex work

Cusick and Hickman (2005)¹²⁰ examined the reinforcement of sex work and drug use. Half of sex workers involved in the study had sold sex before the age of 18 and three-quarters of participants had used drugs. Half had been in care; half had been homeless and a fifth (21%) had run away or left home before the age of 16. Researchers suggest that none of the above experiences explain 'trapping', that is sex workers remaining trapped as a result of their drug use. However, they suggest that there were "strong associations between being trapped and convictions (81%); and being trapped and outdoor/drift sex work (92%). After adjustment for the other vulnerabilities in the logistic regression only outdoor/drift sex work remained significant with sex workers involved in outdoor/drift sex-work having an adjusted odds ratio of over 7 (95% CI 1.7 - 28.3) of being trapped." It is concluded that outdoor/drift sex markets may reinforce vulnerability, sex work and problematic drug use. They recommend that interventions should seek to reduce the sex industry's potential for exploitation and abuse by disentangling sex and drugs markets.

Violence under the influence

Evidence from the Offending Crime and Justice Survey suggests that in three per cent of violent offences committed, the offender had taken a drug (but not alcohol), and in four per cent of cases both drugs and alcohol; however they note that causality cannot be assumed (Table 8.2).

Table 8.2: Proportion of offenders who had taken alcohol or drugs at the time of an incident in England and Wales, 2004

	Assault without injury	Assault with injury	All violent offences	Vehicle related Thefts	Criminal damage	Other thefts	All property offences
Drugs only	1	4	3	4	3	2	2
Alcohol only	13	24	18	8	27	2	7
Drugs and alcohol	2	6	4	10	6	1	3
Neither	80	64	72	77	62	92	84
<i>Base</i>	<i>537</i>	<i>543</i>	<i>1,096</i>	<i>119</i>	<i>235</i>	<i>740</i>	<i>1,141</i>

Source: Budd *et al.* 2005

¹¹⁹ Participants interviewed attended three street services for women involved in prostitution. In depth semi-structured questionnaires were used.

¹²⁰ Several recruiting strategies were used simultaneously to interview 92 sex workers; these included, services providing for sex workers, advertising space on the web and contact magazines and snowballing. A structured questionnaire was used to gather quantitative data on: drug use; sex work; use of services and offending. These topics were explored further in semi-structured interviews.

Problem drug users and assault

In research based on the Drug Outcomes Research in Scotland longitudinal study, Neale *et al.* (2005) found that one in five (18%) had committed assault in the previous three months and a quarter had been assaulted in the previous six months.¹²¹ Factors associated with committing an assault were: being male; having used crack in the last 90 days; having slept rough or in a hostel in the previous six months; and having been physically abused. Of those factors associated with committing an assault, four out of five were associated with being assaulted. Researchers state that these findings suggest that treatment services have a role in addressing both violent tendencies amongst clients and high levels of victimisation experienced.

Perceptions of the association between crime and violent crime

According to the 2005/06 BCS, victims believed the offender to be under the influence of drugs in just under a quarter (23%) of incidents of violence, an increase from 18 per cent in 2004/05 (Walker *et al.* 2006).

Research in progress

The Economic and Social Research Council has commissioned research which aims to investigate the nature of current forms of street violence. In particular, it seeks to explore areas where there are notable gaps in knowledge, for example situational factors, such as the role of drug misuse, drug markets, and individual factors, such as gender and ethnicity, in explaining: (1) specific aspects of violence in relation to violent offences, and (2) general aspects of violence. The research method will involve conducting interviews with offenders currently serving sentences for violent offences in prisons and young offender institutions.

Driving offences

See selected issue Chapter 13 on Drugs and driving.

8.4 Drug use in prison**8.4.1 Drug use in the prison population****Mandatory drug testing**

In England and Wales, from April 2005 to March 2006 random Mandatory Drug Testing (rMDT) positives' levels was 10.3 per cent, indicating that the target of achieving 11.7 per cent (or less) by March 31st 2006 was achieved. Overall, positive rMDT levels have fallen by approximately 58 per cent since the programmes introduction in 1996/97, when 24.4 per cent of tests proved positive. Over this period positive tests for opiates have decreased by more than 40 per cent (NOMS Drug Strategy Unit 2006 – internal communication).

In Scotland, the rate of positive results for Mandatory Drug Testing in prison over the past five years has slightly increased from 15 per cent in 2000/01 to 18 per cent in 2004/05. In 2004/05 the drugs most frequently detected by random mandatory drug testing were cannabis (15%), opiates (14%), and methadone (14%). Since 2000/01 methadone has been detected in an increasing proportion of random drugs tests (from 1% in 2000/01 to 14% in 2004/05).

¹²¹ Interviews were conducted with 560 drug users entering treatment.

Drug use by prisoners assessed under Counselling, Assessment, Referral, Advice and Throughcare services in England and Wales

A report¹²² on prisoners accessing Counselling, Assessment, Referral, Advice and Throughcare services (CARATs)¹²³ in England and Wales while in custody looked at drugs used, injecting behaviour and treatment prior to custody as well as crime committed (May 2005). This report confirmed evidence that heroin was the most commonly used drug prior to custody (62% of prisoners assessed by CARATs in 2004/05 had used it in the 30 days before custody). Crack (49%) and cannabis (42%) were also reported. However, the recorded use of both heroin and crack by CARAT clients in the 30 days before custody fell significantly between 2003/04 and 2004/05: heroin use fell from 70 per cent to 62 per cent and crack use from 55 per cent to 49 per cent. This is consistent with a fall in positive rMDT tests for heroin, reported in the previous paragraph. Seventy-four per cent took two or more different drugs in the month before custody, with 39 per cent taking both heroin and crack in this period. Amongst this group, 43 per cent considered heroin to be their main problem drug pre-prison, though this proportion had fallen from 49 per cent in the previous year. Alcohol was the next most common main problem drug, mentioned by 14 per cent, then crack, mentioned by 10 per cent.

Excluding unknowns, 35 per cent said they had injected in the 30 days before custody.

Excluding unknowns, 57 per cent had previously received treatment for a drug problem. However, as the proportion of unknowns was high (nearly a quarter of all cases), the results must be viewed with caution.

The most common main offences in 2004/05 were theft/handling (24%) and burglary (17%), pointing to a link between drug use and, in particular, acquisitive crime. Eleven per cent were convicted of a drug offence. On average, before going into prison, those who recorded a weekly spend on drugs were spending nearly £878 (£600). The highest expenditure was by users of crack.

There was also an association between type of offence and injecting behaviour prior to custody. Of those with theft/handling as their main offence, 52 per cent had injected compared to much lower rates for those who committed drugs offences (26%), robbery (24%), or violence (18%). Of those who had injected in the 30 days before custody, 72% gave heroin as their main problem drug.

¹²² There were 27,962 cases in the data for the first year (2002/03), 35,454 for the second (2003/04), and 48,675 for the third (2004/05). These figures represent 54 per cent, 65 per cent and 82 per cent respectively of the number of CARAT cases reported for management purposes as a key performance indicator.

¹²³ The CARAT service was established in 1999 as a universal drug treatment service in every prison establishment across England and Wales. CARAT services are a major element of the National Offender Management Service (NOMS) Drug Strategy. The results are based on the third year of data, 2004/05, unless otherwise stated.

The Scottish Prison Survey 2005

The Scottish Prison Survey 2005¹²⁴ shows that of those who responded, half of prisoners (50%) reported that they had used drugs in prison at some point in the past (Scottish Prison Service 2006). The majority of these individuals (81%) reported that their drug use had changed during their current period in prison. Three quarters (76%) reported a decrease in drug use in prison while less than a fifth (17%) reported an increase and less than a tenth (7%) indicated a similar level of drug use but with different drugs. Two-thirds (66%) reported that they had not used any illegal drugs in the month prior to the survey, while a third had used. The most common drugs reported by users in the last month were: cannabis (77%) and heroin (67%). A third of prisoners (33%) reported using benzodiazepines (e.g. Valium, Ativan), and a quarter opiates other than heroin (23%). Smaller proportions reported using cocaine (14%), methadone (12%) (not on prescription), ecstasy (8%), temazepam (9%) and amphetamines (4%).

A minority of prisoners (3%; n=126) reported injecting drugs in prison in the last month. Of these, 78 prisoners stated that they had shared their injecting equipment. Over half of prisoners (55%) reported that their drug use was a problem for them on the outside and that they were under the influence of drugs at the time of their offence (56%). A third (33%) indicated that they committed their offence to get money for drugs. Regarding help for drug problems, two thirds (66%) reported that they would take help for their drug problem on the outside while a slightly higher proportion (70%) would take help in prison, if offered.

Drug use amongst the prison population in Northern Ireland

A survey was undertaken of drug use amongst prisoners in Northern Ireland in Hydebank Prison, a medium to low security young offender centre and prison, accommodating male remand prisoners and sentenced young offenders. Inmates were aged between 17 and 21.¹²⁵ In this survey it was reported that over three quarters (77%) had used drugs in the month prior to custody, including cannabis (73%), cocaine (45%), heroin (3%), ecstasy (52%) and LSD (17%). Forty per cent reported drug use while in custody; cannabis (38%), cocaine (4%), ecstasy (15%) and LSD 4%) (O'Mahony *et al.* 2005).

8.5 Social costs

Updated and improved estimates of the costs of Class A drug use have been undertaken but were not published at the time of writing.

¹²⁴ This survey, which is undertaken in each of the 15 Scottish prisons, involves all Scottish prisoners. The survey is designed to a number of objectives: to make use of prisoners' perceptions of service-delivery and service-quality in its business planning; to provide prisoners with an opportunity to comment on a range of issues that impact on their experience in prison; to allow staff to get a better understanding of how the halls or areas they manage compare to equivalent areas and halls and in so doing to provide a tangible way to help share items of 'best practice'; and to allow the Service, through annual repeats of the same questions, to track progress (or the lack of it) across the various dimensions that are included in the survey. The evening prior to the survey, each prisoner was given a leaflet informing them of the survey and its aims. On the day of the survey, each prisoner was issued with a survey form personally by a member of the survey team (after being given the chance to complete the questionnaire in the privacy of their cell). This is the 8th annual prison survey reporting on prisoner perceptions.

¹²⁵ The sample frame was the total population (190 inmates), 182 were available for interview, only two refused.

8.6 Drug use in the workplace

In a reference book on drug misuse in the workplace aimed at managers (Ghodse 2005) it is suggested that “more than 60 per cent of drugs users hold some form of employment, it is essential that the workplace plays its role in combating all forms of substance misuse”. The evidence for this statement, however, is based on a report from 1998 (Ghodse 1998).

9. Responses to social correlates and consequences

9.1 Overview

9.1.1 Social reintegration

Social reintegration is a key element of the National Drug Strategy. Responsibility for responding to the social correlates and consequences discussed in Chapter 8 rests with a number of Government departments and agencies. In England, the Department for Education and Skills (DfES) has particular responsibility for ensuring that children and young people achieve their potential. The Places and Communities Group, situated within the Department for Communities and Local Government (DCLG)¹²⁶ is responsible for the National Strategy for Neighbourhood Renewal. A comprehensive programme of neighbourhood renewal was launched in 2001 to address deprivation in the poorest 10 per cent of neighbourhoods so that within 10 to 20 years no one should be seriously disadvantaged by where they live. The strategy is reflected in two long-term goals:

- in all the poorest neighbourhoods, to have common goals of lower unemployment and crime, and better health, skills, housing and physical environment; and
- to narrow the gap on these measures between the most deprived neighbourhoods and the rest of the country.

The Housing Strategy and Support Directorate (HSSD), also part of DCLG, coordinates policy nationally. Homelessness issues are also addressed in the United Kingdom Drug Strategy and the Government's Homelessness Strategy published in March 2005. There has been joint working between HSSD and the National Treatment Agency to build treatment services which are responsive to the needs of homeless people. In Scotland, the Homelessness Task Force is aiming to improve interventions for drug users. The Supporting People Programme introduced in 2003 provides housing related support to vulnerable groups generally, including people with drug problems, and is delivered through local authorities working in partnership with other support organisations.

Various projects have been established to help drug users and ex-drug users reintegrate. Progress2work (p2w), initiated in 2002, supports those who are drug free or stabilised, but whose history of drug use can be an important factor in preventing them from getting or keeping a job; this is a United Kingdom wide initiative. 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). Drug (and Alcohol) Action Teams (D(A)AT)s in England, Alcohol and Drugs Coordination Teams (ADCTs) in Northern Ireland. Substance Misuse Action Teams (SMATs) in Wales and Alcohol and Drug Action Teams (ADATs) in Scotland coordinate responses at the local level.

9.1.2 Reducing drug related crime

The Drug Interventions Programme (DIP), established in England and Wales in 2003 to reduce drug-related crime, is a major programme designed not only 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. Drug using offenders are helped to do this through multi-

¹²⁶ Previously the Office of the Deputy Prime Minister.

disciplinary Criminal Justice Integrated Teams (CJITs) at the local level, including links through Counselling, Assessment, Referral, Advice and Throughcare services (CARATs) to the prison system. Until 2005, interventions within the criminal justice system were based on voluntary referral, with access to assessment for treatment and support not obligatory (such as through Arrest Referral schemes, which have now been subsumed within CJITs). However, with the *Drugs Act* there have been a number of important changes, with drug testing on arrest and mandatory assessment and referral to treatment.

9.1.3 Reducing drug use in the prison population

It is considered by prison services to be unrealistic to expect prisons to be entirely drug free, as this would entail overly draconian measures. Instead a balance is struck between deploying robust security measures and maintaining a humane environment that supports the rehabilitation of offenders. However drug use in custody has reduced considerably (see Chapter 8). This reduction is due to the co-ordinated supply reduction, treatment and throughcare measures that prisons have in place. 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 – closed visits, visit bans and police arrest; and in England and Wales, use by all prisons of the *Supply Reduction Good Practice Guide*.¹²⁷

9.1.4 Other social correlates and consequences

Current attention is also focused on the impact of the drug use of parents on their children. In addition, there is a growing number of responses to neighbourhood problems associated with problem drug use, including 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

9.2.1 Accommodation

In November 2005, DCLG, the Home Office and National Treatment Agency (NTA) jointly wrote to D(A)ATs, local authorities and other local stakeholders to encourage effective joint working around relevant support services. This concerned data from the Supporting People Single Client Record Form collected by DCLG about service use, and will allow work at the local level to look at the extent to which capacity of the existing services is being fully used.

Approximately €44 (£30) million of the national Supporting People budget is recorded as being used to deliver services for those with substance misuse problems. According to statistics this equates to some 741 services nationally with around 25,500 people making use of them each year.

Work to develop a strategy for the Supporting People programme is allowing further consideration of how best to take forward support for all vulnerable groups including drug misusers. The initial Supporting People Strategy consultation ended on 31 March 2006. A document entitled, *Supporting Independence: Next Steps in our*

¹²⁷ See:

<http://www.hmprisonservice.gov.uk/prisoninformation/prisonersmagazine/index.asp?id=4480,18,3,18,0,0>

Supporting People Strategy was published in July 2006 following the consultation and sets out some preliminary conclusions and areas where further work and discussions will be carried out (DCLG 2006).

Comprehensive Rent Deposit Model

The DIP team at the Home Office has worked in partnership with DCLG, NOMS, NTA and a range of other partners to promote practice and solutions which can contribute to preventing homelessness for drug misusers. Work with the private rented sector was identified as an opportunity to increase local capacity, however it was recognised that support for a rent deposit by itself was not enough. From April 2005 13 D(A)AT areas were funded by DIP for two years to build on existing practice relating to working with the private rented sector and develop a Comprehensive Rent Deposit Model targeting those drug misusing offenders on the CJIT caseload leaving prison or residential provision. Funding is available for two years (until March 2007). Local partnerships have been encouraged to plan and develop provision alongside their local Homelessness Strategy, Supporting People and D(A)AT Treatment Plans.

Practice seminars alongside summaries of progress updates have helped to promote practice and emerging learning from the areas¹²⁸. Findings so far suggest that this project has helped to provide a focus and catalyst for change in these selected areas including improved strategic and operational working between drug and housing providers, appropriate assessments of individual need and provision of related support through joint working between CJITs, specialist tenancy/housing support workers, housing benefit advisors and other providers of wraparound support. Critical elements have also included the work local partnerships have developed to improve working arrangements with the private rented sector and the development of approaches to practically support clients to prevent loss of their accommodation building on skills and experience they already have. This may include help through 'start up packages' (i.e. a kettle and a microwave), support to manage previous rent arrears and overall budgeting which may include support with both shopping and cooking (Home Office 2006g).

9.2.2 Education, Training and Employment

Education, Training and Employment (ETE) provision is seen by the Government as an important factor in supporting and sustaining the recovery and resettlement of former or stabilised drug misusers. It is now expected that planning and delivery of ETE provision should be integrated into treatment pathways, and that pathways from treatment into aftercare should include planning for ETE provision.¹²⁹

The DIP Aftercare Team has worked in partnership with Jobcentre Plus, the National Offender Management Service (NOMS), the London Drug Policy Forum (LDPF), the Centre for Economic and Social Inclusion (Inclusion) and the NTA to produce a practice paper which summarises and promotes existing practice that creates and sustains partnerships between education, training and employment provision and D(A)AT partnerships/CJITs for DIP clients (Home Office 2006h). The paper looks at nine projects, identifying and highlighting key elements which can progress integration and implementation of ETE provision for clients.

¹²⁸ This information is available on www.drugs.gov.uk.

¹²⁹ For more information see: <http://www.drugs.gov.uk/drug-interventions-programme/guidance/throughcare-aftercare/?version=2>

Research

A longitudinal study of families living in low income neighbourhoods will examine the dimensions of exclusion and inclusion, exploring the impact of area initiatives (e.g. Sure Start and New Deal for Communities), looking in more detail at education and health, race relations, social networks and social capital, the role of community and community involvement, crime, drugs, disorder, and coping strategies, income, work and benefits.¹³⁰

The Department for Work and Pensions has commissioned research aimed at improving understanding of the problems that drug and alcohol addiction poses to job search, and in gaining and retaining employment amongst working age benefit clients. The research will draw together existing evidence and aims to generate better insight into the types of support services needed by people with substance abuse problems.¹³¹

An evaluation is currently being undertaken of a scheme which aims to increase employment opportunities for offenders with issues around their drug and alcohol use and mental health.¹³²

9.2.3 Basic social assistance

NO NEW INFORMATION AVAILABLE

9.2.4 Community involvement

A report on involving the community in crime and disorder problem-solving looked at the evidence from problem-solving initiatives that have been subject to evaluation and from practitioner assessment of the effectiveness of community involvement in problem-solving initiatives that have not been formally evaluated (Forrest *et al.* 2005). The report is intended as a resource for front-line practitioners and their managers. Its aim being to give practitioners:

- a range of types of involvement in problem-solving that might be appropriate in a given community;
- advice on devising a strategy to facilitate community involvement; and
- specific ideas about how to involve the community in a range of practical problem-solving activities.

9.2.5 Interventions for families affected by drug misuse by parents

See the Scottish Executive report *Hidden Harm Next Steps Supporting Children – Working with Parents* (Scottish Executive 2006c) in Chapter 7.

9.3 Prevention of drug related crime

9.3.1 Assistance to drug users in prison

Prevention

For 2005/06 the Voluntary Drug Testing (VDT) programme target in England and Wales was to maintain 28,000 prisoners on VDT compacts. The target was exceeded with around 34,000 of compact prisoners participating (NOMS Drug Strategy Unit 2006 – internal communication).

¹³⁰ For further information see: <http://sticerd.lse.ac.uk/dps/case/cr/CASereport6.pdf>

¹³¹ For further information see: http://www.crsp.ac.uk/publications/2000_for_2005.htm

¹³² For further information see: <http://www.kcl.ac.uk/schools/law/research/icpr/research.html>

Also see the section in Chapter 8 on Mandatory Drug Testing in England and Wales and Scotland.

Supply Reduction

2005/06 saw additional measures introduced in England and Wales, including: use of mobile phone detectors; research conducted into methods and patterns of supply to help establishments further develop their supply reduction strategies; and work commenced on updating the *Supply Reduction Good Practice Guide* (NOMS Drug Strategy Unit 2006 – internal communication).

Harm reduction

It is reported that in England and Wales, 1,200 prisoners received hepatitis B vaccinations each month and 40 per cent of intravenous drug users in the wider community who report receiving one or more hepatitis B vaccinations received them in prison (HM Prison Service 2006).

Treatment

At the end of 2005/06, in England and Wales, 116 drug rehabilitation programmes (including Therapeutic Communities) were running in 103 out of 139 prisons; of these 40 were the innovative high-intensity Short Duration Programmes (SDP) aimed primarily at those spending only a short time in custody. In 2005/06 there were more than 10,700 entrants onto prison drug rehabilitation programmes, with more than 8,000 successfully completing the courses, a 75 per cent completion rate (the 2005/06 target was to achieve a 65% completion rate, based on 5,850 entrants) (NOMS Drug Strategy Unit 2006 – internal communication).

In 2005/06 the target for HM Prison Service was to deliver 5,250 programmes, representing a 41 per cent increase over the target for the previous year. This was more than met, 7,280 drug treatment programmes were completed in 2005/06, a 58 per cent improvement in performance compared to 2004/05 (NOMS Drug Strategy Unit 2006 – internal communication).

The target for CARATs was to ensure that 61,400 offenders received a substance misuse triage assessment (SMTA). This target was exceeded, with 74,588 assessments conducted (this includes juvenile substance misuse service assessment) (NOMS Drug Strategy Unit 2006 – internal communication).

Integrated Drug Treatment System

An Integrated Drug Treatment System (IDTS) programme for prisons in England and Wales is being developed involving clinical, CARAT and treatment programme resources. IDTS aims to increase the volume and quality of treatment available to prisoners, with particular emphasis on early custody (an offenders first 28 days in custody), and will start to address better integration between clinical and CARAT Services and reinforce continuity of care between prisons and on release into the community. Its key elements are:

- treatment based on *Models of Care* (NTA, DH and Home Office 2006) and the treatment effectiveness strategy (NTA 2005b);
- ensuring that following triage and comprehensive assessment, a range of fully co-ordinated and structured services is available;
- improved clinical management with greater use of maintenance prescriptions;
- an increase in the number of treatment/stabilisation programmes in 2007/08 in prisons identified as part of the first wave where the programme will be introduced;
- intensive CARATs support during the first 28 days of intense clinical management, for all patients;

- greater integration of drug treatment generally, but a particular emphasis on clinical and CARATs services, with the objective of creating multi-disciplinary teams;
- better targeting of interventions to match individual need;
- raising of standards more comprehensively to National Treatment Agency Models of Care levels; and
- strengthening links to community services including Primary Care Trusts, Criminal Justice Integrated Teams (CJITs) and drug treatment providers.

To support these developments two documents have been produced:

- Clinical Management of Drug Dependence in the Adult Prison Setting describes how clinical services for the management of substance misusers in prison should develop during the next two years as increasing resources permit. The aim is to address the current challenges facing the care and treatment of substance misusers in prisons. This guidance is an addendum to Prison Service Order 3550¹³³; and
- Integrated Drug Treatment System the first 28 Days: Psychosocial Support. First wave model. This describes how psychosocial (CARAT) services will be delivered during the first 28 days of custody under the Integrated Drug Treatment System, as funding permits.¹³⁴

In the first instance IDTS will only be introduced in full to 17 prisons; a further 28 prisons are being funded to provided enhanced clinical treatment (NOMS Drug Strategy Unit; HM Prison Service and DH 2006).

Social reintegration

Throughcare/community links

Throughcare initiatives¹³⁵ are a part of the Drug Interventions Programme (See 9.3.2), delivered through Criminal Justice Integrated Teams in the community and CARAT Teams in Prison. Guidance for CARAT Teams and Prison Staff has been developed between the Home Office and the Drug Strategy Unit of the National Offender Management Service (NOMS). This guidance provides an overview of the programme and the contribution prison and probation services make to its interventions (Home Office 2006i).

Prevention

See Mandatory Drug Testing in chapter 8.

Harm reduction

NO NEW INFORMATION AVAILABLE

¹³³ See:

http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/DearColleagueLetters/DearColleagueLettersArticle/fs/en?CONTENT_ID=4137552&chk=iT2JD5

¹³⁴ See:

<http://kc.nimhe.org.uk/upload/IDTS%2028-ay%20psychosocial%20FINAL%20April%202006.pdf>

¹³⁵ "Throughcare" is the term used to describe arrangements for managing the continuity of care provided to a drug misuse from the point of arrest through to sentence and beyond.

*Treatment**Social reintegration**Throughcare/community links*

The Throughcare Addiction Service (TAS) in Scottish prisons was implemented in August 2005, replacing the Transitional Care Initiative (see evaluation of this initiative below) (Scottish Executive 2006d). The new service aims to prevent reoffending through improving continuity of care for prisoners, and also to reduce drug related deaths among newly-released prisoners. Local authority Criminal Justice Social Work groupings will replace the Scottish Prison Service (SPS) as the lead agency in the delivery of the scheme, working with ADATs, SPS, community services and other partners including the voluntary sector. TAS works with the offender in the six week period prior to release from custody through the six week period post release.

It is reported by the Scottish Prison Service that in 2004/05:

- of the 23,206 prison receptions, 14,282 (62 %) were referred to Addictions Services.
- of these, 65 per cent were offered an assessment, with 6,869 (48%) of prisoners undertaking an assessment.
- of the 4,686 individuals referred to Transitional Care (the processor of Throughcare Addiction Services) at time of discharge, 1,098 (22%) attended a first Transitional Care appointment (ISD 2005).

An evaluation of the Transitional Care Initiative

An evaluation of the Scottish Prison Service Transitional Care Initiative was published in 2006 (Macrae *et al.* 2006).¹³⁶ This scheme, introduced in 2001, aimed to effectively manage the transition between prison and the community. Transitional Care was to support short-term prisoners (that is, those serving less than four years) and remand prisoners with an identified substance misuse problem. The main aim of Transitional Care was to facilitate access to pre-existing community services based on an individual's assessed needs. This was done through the provision of support during a 12-week period immediately following a prisoner's return to the community. The evaluation suggested that the scheme was reasonably effective at linking clients with services. However, the extent to which it linked them with services they would not in any case have accessed by some other means was unclear and there were no apparent differences in short-term outcomes among those who attended Transitional Care and those who did not. The initiative was replaced by the Throughcare Addiction Service in 2005 (see above).

9.3.2 The Drug Interventions Programme (DIP): England and Wales

In April 2006 approximately 2,800 offenders were engaged in treatment through DIP, this was the highest monthly total since DIP began (Home Office – internal communication).

¹³⁶ A combination of quantitative and qualitative research methods was employed in this study. This included the analysis of Transitional Care monitoring data; surveys of prisoners four and seven months following release; in-depth interviews with ex-prisoners in three areas of the country with different demographic characteristics and varying arrangements for the delivery of Transitional Care; and interviews with prison and community based staff associated with Transitional Care. Interviews with prisoners included both those who had attended Transitional Care on release from prison and those who had not.

Tough Choices Project: drug testing on arrest, Required Assessment and Restrictions on Bail

The *Tough Choices Project*, initiated in December 2005 as part of DIP, describes the expansion of the programme to include three new elements; Testing on Arrest, Required Assessment and Restriction on Bail (DSD 2005a). Operational guidance for intensive and non-intensive areas is available (Home Office 2005f). Training courses have been organised for police officers, drugs workers and other staff.

Drug testing

Drug testing of offenders charged with a range of specific “trigger” offences was introduced in three phases from April 2003 onwards. It is now operational in 108 police Basic Command Units with high levels of acquisitive crime.

Testing on Arrest, a provision of the Drugs Act 2005 that is an alternative to drug testing after charge, has this year been phased in across all DIP intensive areas in England.¹³⁷ This provides an opportunity to screen up to three times as many people at some stage of their detention.

From April 2005 to April 2006 104,000 tests were completed. In April 2006, 17, 420 tests were completed, an increase of 203 per cent on April 2005 (5,622).

A total of 175 police custody suites now conduct drug testing on arrest and on charge. Testing on charge will continue where it currently exists, in nine custody suites across seven police forces in England and Wales (Home Office internal communication).

Required assessment

Those testing positive for drugs will be required to attend an initial assessment of their needs (treatment and support); failure to comply without good cause is an offence in its own right. Required assessment has been implemented in all the DIP intensive areas in England since March 2006. The required follow-up assessment provisions of the *Drugs Act 2005* have not been introduced at this time, although follow-up appointments and activities, and agreement of care plans will continue with those clients wishing voluntarily to access treatment and support. The Home Office review of the criminal justice system *Rebalancing the Criminal Justice System in favour of the Law-Abiding Majority* announced that the required follow-up assessment would be introduced. Over 80 per cent of those testing positive for drugs are attending assessments (Home Office 2006 – internal communication).

Restriction on bail

The restriction on bail (RoB) provision restricts access to court bail for individuals who have tested positive for a specified Class A drug either on arrest or after charge. By March 2006 restriction on bail was introduced in all local justice areas across England. This means that any adult who appears before a court in England, after testing positive in police detention for a specified Class A drug in connection with the offence for which they are charged, could be eligible. By the end of April 2006, there have been almost 10,000 episodes of RoB since it was introduced (Home Office internal communication).

¹³⁷ ‘intensive’ areas are those with the highest levels of acquisitive crime. Approximately 70 Drug Action Team areas in England have been classified as intensive areas.

Operational guidance for intensive¹³⁸ and non-intensive areas is available. Training courses have been organised for police officers and staff and drugs workers. A guide to prosecutors was made available by the Crown Prosecution Service (CPS) in March 2006 (Crown Prosecution Service 2006).

Drug Treatment and Testing Orders (DTTOs) and Drug Rehabilitation Requirements (DRRs)

A new Drug Rehabilitation Requirement (DRR), a community order that replaces the Drug Treatment and Testing Order (DTTO), and other community orders, for adults, has been introduced. The new order, with individual requirements selected by the court, can be more closely tailored to the seriousness of the offence and offence-related needs of the individual as it will consist of a “menu” of requirements including the Drug Rehabilitation Requirement for different types and levels of drug treatment. The Community Order applies to offences committed on or after 4th April 2005. The DTTO will continue for 16 and 17 year olds (until April 2007) and for adults in respect of offences committed before 4th April 2005 (Home Office – internal communication).

From April 2005 to March 2006, 14,001 DTTOs and DRRs have commenced and 3,987 successfully completed. Between October 2000 and April 2006, 46,144 were commenced. In April 2006 there were 1,056 commencements, and 346 completions (Home Office – internal communication).

Probation report on treatment

A report from HM (Her Majesty's) Inspectorate of Probation (2006) found that the expansion of treatment availability had led to all areas of probation to be able to deliver treatment promptly; 14,000 beginning treatment as part of DTTOs/DRR in 2005/06. However, guidance on DRRs, particularly concerning the introduction of the *Criminal Justice Act 2003* and the offender management model, was complex and needed to be simplified. Also, in many probation areas a full range of treatment provision was lacking and was largely determined by pre-existing provision. It was noted that the provision of treatment for alcohol use remained problematic.

Conditional Cautioning

Conditional Cautioning, introduced in 2005 in selected early implementation areas, and described in the previous United Kingdom Focal Point report, is becoming available nationally. This is being managed by a central Home Office Project Team and will be delivered locally through the relevant Local Criminal Justice Boards (LCJBs). The current aim is that all police forces will have at least one police BCU operating Conditional Cautioning by mid-2007. This disposal¹³⁹, introduced by the *Criminal Justice Act 2003*, allows, for the first time, for a condition that is conducive to restoration or rehabilitation to be attached to a police caution. Where the condition is not met, the offender may be charged with the original offence. This type of cautioning, including its use in engaging drug-misusing offenders in treatment through a drug rehabilitative condition, has been operated in a small number of early implementation areas from early 2005 (Home Office 2006j).

However, it is reported that take up of the scheme has so far been low. DIP is working with the Home Office project team and other partners to increase the throughput and consequential benefits of the drug rehabilitative condition. Guidance on the Drug Rehabilitation condition has been updated and the condition made more

¹³⁸ See: <http://www.drugs.gov.uk/drug-interventions-programme/guidance/tough-choices>

¹³⁹ How a perpetrator of a crime is dealt with.

measurable. An Early Implementation Evaluation report is due to be published in late 2006.

Prolific and Priority Offenders

DIP has established strong links to the national Prolific and other Priority Offender (PPO) programme (launched in September 2004). Through Crime and Disorder Reduction Partnerships (CDRPs), the PPO programme has established schemes to cover each CDRP geographical area. Using a matrix tailored to suit local priorities, local PPO schemes identify, target, monitor and rehabilitate those offenders who cause most harm to themselves and the local community. Each scheme deals with a minimum of 15 offenders (Home Office 2006k).

In many high crime areas, initial scoping indicates that as many as 85 per cent of offenders targeted under PPO schemes have drug treatment needs. It is therefore seen as imperative that PPO schemes, CJITs (see section on these teams below), drug treatment providers and criminal justice agencies work together to manage and support these individuals. It is considered that effective information sharing between agencies is key to successful partnerships. The Home Office is working with the Department of Health to develop a common message on this issue, so that necessary data are appropriately exchanged between PPO schemes and health workers. Schemes are funded using existing core resources but DIP has funded 12 D(A)AT partnerships to act as pilot sites. The aim is to collate good practice learned in these partnerships.

DIP therefore works with the Home Office Prolific and Other Priority Offenders Programme to ensure the two initiatives operate to maximise the benefit of both. To facilitate collaborative working, guidance has been published to address issues around information sharing, case management and treatment provision. DIP is also funding pilots in 12 D(A)AT areas to identify good practice in building healthy partnership between CJITs and PPO schemes. Further guidance and learning from good practice will be published on an ongoing basis.¹⁴⁰

Evaluation of the Prolific and Other Priority Offenders programme

An evaluation of the PPO programme¹⁴¹ found that amongst the 7,801 offenders on the scheme during its first six months 61 per cent misused drugs; this compared with 26 per cent amongst non-prolific offenders identified through the Offender Assessment Scheme (Dawson 2005). In the first six months of the scheme there was a 10 per cent reduction in recorded convictions for the first PPO cohort compared to the six months prior to the start. However, this evaluation was unable to disentangle the effects of the PPO programme from other factors (such as changes in the overall levels of crime and offenders brought to justice). Follow-up work is currently being undertaken.

Drug Interventions Record (DIR)

A Drug Interventions Record (DIR), used to gather data about DIP processes, has replaced the Integrated Team Monitoring Data Form (ITMDF) in intensive areas and the Arrest Referral Monitoring Form in others. During the initial assessment of clients who come into contact with DIP, information about their needs is gathered using this form (DSD 2005c). The DIR is used by both community agencies and prisons to improve information sharing, avoid duplication and thereby improve continuity of care of drug-misusing offenders.

¹⁴⁰ See: <http://www.drugs.gov.uk/drug-interventions-programme/strategy/police-custody/>

¹⁴¹ It is estimated that 10 per cent of all active offenders are responsible for half of all crime.

This is considered to be a major improvement over the previous form as it includes additional fields, has removed redundant fields and has improved the wording; better supporting continuity of care and improving the consistency and quality of data collected for monitoring and research purposes. It gathers comprehensive and accurate information from all areas, particularly by formalising and standardising arrangements in non-intensive areas.

Comprehensive guidance supports the use of the form and training was delivered at the time of its introduction in 2005, and again in 2006. Over 1,500 workers and partners have been trained in its use between January and March 2006.

Criminal Justice Integrated Teams

Criminal Justice Integrated Teams are now operating in every area in England and Wales comprising both community and prison treatment providers. Overall the numbers receiving a full CJIT assessment has increased by over 200 per cent between March 2004 and March 2006.

To enhance support by CJITs, responsible for the implementation of DIP, 24-hour single point of contact phone numbers are now available for clients.¹⁴²

Throughcare and Aftercare¹⁴³

Aftercare is seen as an important part of DIP. The Home Office states that:

“There is not one simple discrete process and aftercare can involve several important factors, such as housing, support with benefits, managing finances, employment, education and training opportunities, access to mental health services, rebuilding family relationships and so on. CJIT workers will provide, or broker the provision of, appropriate wrap-around services in relation to each of these factors supported by the local Drug Action Team. This work will also be informed by, as well as influence, delivery of the Regional Reducing Re-offending Action Plan. At a regional level Regional Offender Managers are working with Regional NTA and Government Office Drug Teams” (Home Office 2006k).

Peer Led Support

There is limited information on how peer-led support is best delivered to meet the diverse needs of those who have left prison or completed treatment and need help with the transition back to the community. Local partnerships are expected to develop an appropriate continuum of care and levels of support for drug users throughout their treatment journey and beyond. To help support meeting their diverse needs, the Home Office commissioned a practice guide to provide a resource for local partnerships that draws on practical approaches of peer-led support in England from the substance misuse sector as well as other associated sectors such as mental health and HIV (Home Office 2006l).

Race Equality and Diversity in DIP

DIP is taking forward a number of pieces of work to ensure that race equality and diversity issues are addressed across all areas of activity. Specific activities include:

- working with the University of Central Lancashire, which ran 10 community engagement projects in high crime DAT areas with the aims of improving

¹⁴² See: <http://www.drugs.gov.uk/drug-interventions-programme/strategy/throughcare-aftercare/>

¹⁴³ ‘Aftercare’ is the term used to describe what happens after drug using offenders are released from custody, complete community sentences and/or leave treatment. It is accepted that drug treatment plays only one part in supporting rehabilitation and re-integration.

engagement with services, building a more representative workforce, raising awareness of partners' responsibilities and learning what works so the community engagement lessons may be shared nationally;

- providing guidance to D(A)ATs on operating standards and management of contracts so they include diversity issues and supporting this through the work of the DIP Performance Interventions Team;
- setting up a multi-agency scrutiny panel to drive and challenge DIP's approach to race and diversity and, especially, to define the way forward for the DIP Race Equality and Diversity Strategy; and
- aiding adoption and implementation of the DIP Race Equality and Diversity action plan and strategy. The action plan has been written to ensure DIP meets its statutory duty in regards to race equality and diversity and to help drive up overall performance on the ground, and to identify and assist areas that are performing less well.

Funding

Government has invested about £167m in the Drug Interventions Programme in the financial year 2005/06.¹⁴⁴ This is on top of the additional funding for treatment through the Pooled Treatment Budget and funding for additional measures, such as the increased target for commencing community orders linked to treatment. This funding is used to meet the costs of all aspects of the programme – with by far the majority spent on workforce.

Interventions for young people

The Drug Interventions Programme has piloted a range of interventions in ten areas to engage young people early in their substance misuse and offending and to facilitate appropriate support and treatment services. These interventions include:

- drug testing for specified Class A drugs in twenty-two custody suites of 14 to 17 year-olds who are charged with those crimes most often linked to drugs. The purpose is to identify those young people who may be at risk of developing a problem with drugs and offending, in order to intervene early; and
- working with the Youth Justice Board on Drug Treatment and Testing Sentence Requirements to target young people who have, or are at risk of developing, substance misuse problems and who may benefit from structured care planned treatment as part of a community sentence.

Race and diversity in the criminal justice system

A Home Office document published in July 2006, *Rebalancing the Criminal Justice System in Favour of the Law-Abiding Majority: Race Equality Impact Assessment Report* examines the functions of the criminal justice system and suggests that individuals from certain ethnic groups are disproportionately more likely to be arrested. It sets out what can be done to redress any potential imbalance within the criminal justice system (Home Office 2006m). A joint Race Equality Impact Assessment (REIA) is proposed for the Prolific and Other Priority Offenders programme and DIP (see above). REIAs systematically assess the effects that a policy has or is likely to have on people, depending on their racial group.¹⁴⁵

¹⁴⁴ See: <http://www.drugs.gov.uk/drug-interventions-programme/guidance/Programme-delivery-and-funding>

¹⁴⁵ For more information see: <http://www.cre.gov.uk/duty/reia/what.html#creres>

9.3.3 Other interventions relating to drug users in the criminal justice system in England and Wales

Drug courts

Two dedicated drug courts will pilot a new framework for dealing with offenders who carry out crimes often committed to feed a drug habit. When an offender is found guilty and is referred to the dedicated drug court (DDC) for sentence, the same magistrates or district judge will sentence the offender and provide continuity and stability in reviews of offenders on drug treatment orders.¹⁴⁶ The pilot will run until late 2006 and is being independently evaluated.

9.3.4 Criminal justice interventions for drug users in Northern Ireland

DTTOs are being initiated in Northern Ireland adopting the model currently used in Scotland (Probation Board Northern Ireland 2005).

9.3.5 Criminal justice interventions for drug users in Scotland

Arrest referral

Following an evaluation of arrest referral pilots (Birch *et al.* 2006) funding is being provided to run existing piloted schemes up until 2008 and to set up a new scheme in Aberdeen. Annual funding of €2 (£1.4) million will allow the scheme to be introduced across Glasgow, where it currently operates out of only one police station. Additional national funding totalling €878,000 (£600,000) is also being made available to increase the provision of treatment places needed to support arrest referral work. Between February 2004 and December 2005 a total of 2,791 people consented to referral into appropriate services. The evaluation found that 84 per cent of arrestees accessing the arrest referral schemes said they would recommend it (Scottish Executive 2006e).

Drug Courts

Drug courts in Glasgow and Fife will run for a further three years. This follows evidence that half of offenders had not committed crime within one year of being dealt with while 29 per cent had not re-offended within two years (McIvor 2006).¹⁴⁷

9.3.6 Research into the prevention of drug related crime

The link between drug and crime

Early findings of two major research programmes on how and why young people become criminals, and what can be done to change their lives are to be published. *Pathways into and out of Crime: Risk, Resilience and Diversity*, is being undertaken by a network of six universities exploring aspects of young people's lives linked to crime and anti-social behaviour. The research is due to be concluded in April 2006. It involved two years of intense work with more than 1,000 10 to 18 year olds.

A separate programme, the SCoPiC Network (Social Contexts of Pathways into Crime) is a major five-year investigation into what kind of people in which sort of circumstances turn to crime. Researchers are following a sample of 707 boys and girls who were 12 years old in March 2003, right through until they reach the peak

¹⁴⁶ For more information see: http://www.cjsonline.gov.uk/the_cjs/whats_new/news-3275.html

¹⁴⁷ A variety of qualitative and quantitative research methods were employed. They included: interviews with professionals associated with the Drug Courts and with Drug Court clients; collection of information from Drug Court records; observation of the Drug Courts in action; and the completion of individual client questionnaires by members of the supervision and treatment team

age for criminal activity at 14 to 15. The aim is to examine how far crime can be explained, on the one hand by adolescents' morality and ability to exercise self-control, and on the other by the social and moral environments in which they develop and operate.

The findings call into question some commonly held views about why young people become involved in crime and show that situations often thought of as leading to problem behaviour can actually be the opposite. For instance, a parent being in prison may provide a respite from what may have been a chaotic home life. Similarly, they question the inevitability of the link between drug use and crime, showing the complexity of this relationship and how offending can stop even though some kinds of drug use may continue (ESRC 2005).

Systematic review of the effectiveness of criminal justice and treatment programmes.

The Home Office commissioned a systematic review of the literature to examine the links between drug use and offending, and the literature covering the effectiveness of interventions to break these links. The results of the studies reviewed were generally positive with 44 out of 52 studies reviewed showing a reduction in crime on at least one measure. A meta-analysis of 28 studies for which raw data were available found that the odds of a reduction in criminal behaviour were 41 per cent higher among the experimental groups (those that had undertaken a treatment intervention of interest) than in the comparison groups (the non-treatment group or comparison intervention). The review also found that methadone treatment, heroin treatment, therapeutic communities, and psycho-social approaches are effective in reducing drug related crime, as are the use of drugs courts, probation and parole supervision. High intensity programmes were 50 per cent more likely to bring about a reduction in criminal behaviour than low intensity programmes, meaning that intensive programmes are more likely than non-intensive programmes to reduce crime (Holloway *et al.* 2005).

Research by Beynon *et al.* (2006) has identified less positive outcomes for drug users entering treatment through the criminal justice system.¹⁴⁸ This research found that increasing numbers in treatment is associated with an increased proportion dropping out and an ever smaller proportion of those leaving treatment drug free. In addition, it was found that rates of drop out were significantly higher for those who entered treatment via the criminal justice system.

Quasi-compulsory treatment of drug-dependent offenders

As part of a European study, Sweeney *et al.* (2006) reported findings from a study of drug users who entered treatment through the criminal justice system, and might therefore be regarded as coerced into it.¹⁴⁹ Those recruited to the study were all asked standardised and validated questions about their health, education, substance use, offending, victimisation, any pressure they felt to be in treatment and their motivation to change their drug-using behaviour. It was reported that there were sustained reductions in self-reported illicit drug use and offending behaviours over an 18-month follow-up period for both groups, with:

- substantial reductions in reported expenditure on illicit drugs;

¹⁴⁸ A longitudinal dataset of drug users (1997 to 2004/05, n = 26,415) was used to identify people who dropped out of, and were Discharger Drug Free from, services for years 1998 to 2001/02, and representations of these people in years to 2004/05.

¹⁴⁹ A random sample of 157 people who entered community-based drug treatment at one of ten sites between June 2003 and January 2004. Just over half of the eligible clients offered treatment across the ten sites were interviewed. Eighty-nine (57%) had entered treatment as part of a DTTO.

- modest improvements in mental health;
- reductions in reported risk behaviours (e.g. sharing injecting equipment);
- improvements in housing and personal relationships; but
- no change in (very high) rates of unemployment.

Importantly it was reported that there were no differences between those considered to be coerced into drug treatment and the comparison group of 'volunteers' in retention rates and other outcomes.

9.3.7 Interventions related to offences under the *Drugs Misuse Act 1971*

Presumption of intent to supply

Under the provisions of the *Drugs Act 2005* a number of laws have been implemented. Drug dealers who target schools or get children to act as couriers will face stiffer jail terms. Police have also been given powers to request x-rays from suspects they believe may have swallowed cocaine or heroin to avoid detection. Also, suspected drug "mules" can be held for 192 hours, as opposed to the previous 96 hours, to allow extra time for drugs to pass through their systems (see Chapter 1.2.2) (Home Office 2005c).

Prostitution

It should be noted that prostitution is not an offence *per se* in the United Kingdom. A strategy for prostitution in England and Wales has been published (Home Office 2006n). The strategy seeks to disrupt street prostitution and all forms of commercial sexual exploitation, and provides a framework for local authorities to enable them to disrupt sex markets and suggests that a, "coherent and coordinated strategy has a good chance of significantly improving lives of many of those at risk of or involved in prostitution, and reducing the impact of those affected by the existence of a sex market in their neighbourhood." (p.12).

The strategy includes:

- prevention – awareness raising, prevention and early intervention measures to stop individuals, particularly children and young people, from becoming involved in prostitution;
- tackling demand – responding to community concerns by deterring those who create demand and reducing the opportunity for street prostitution by linking enforcement with support;
- developing routes out – proactively engaging with those involved in prostitution to provide a range of support and advocacy services to help individuals leave prostitution;
- ensuring justice – bringing to justice those who exploit individuals through prostitution, and those who commit violent and sexual offences against those involved in prostitution; and
- tackling off-street prostitution – targeting commercial sexual exploitation, in particular where victims are young or have been trafficked.

The strategy suggests that every area in which street prostitution is an issue should have a dedicated support service to ensure access to a range of services, including healthcare, drug treatment where required and appropriate supported housing. Where individuals are unable or unwilling to accept help voluntarily offered, arrest referral and court diversion schemes will also route them into support programmes.

Additionally, the Government proposes to introduce a new order, as an alternative penalty for the offence of loitering or soliciting for the purposes of prostitution, which

will consist of a series of assessment sessions to address the underlying causes of a person's involvement in prostitution.

9.4 Responses to other social correlates and consequences

9.4.1 Drug related litter

The Department for the Environment, Food and Rural Affairs has published guidance on drug related litter (DEFRA 2005).

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 routes 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 United Kingdom by sea through Harwich, Felixstowe and Dover. In the United Kingdom, more 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 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.

10.2 Availability and supply

10.2.1 Availability in the adult population

The Drug Misuse in Scotland: Findings from 2004 Scottish Crime and Victimization Survey (Hope 2006), indicates that overall 12 per cent of respondents had been offered drugs in the last year. The proportion of respondents who had been offered

drugs in the last year decreased with age: 28 per cent of respondents aged between 16 and 29 had been offered drugs as opposed to 5 per cent of those aged 30 or over.

10.2.2 Availability amongst school children

The school survey for England asked pupils about whether they had been offered drugs (NatCen/NFER 2006)¹⁵⁰. Results show that:

- in 2005, 39 per cent of pupils had ever been offered drugs, an increase from 36 per cent in 2004;
- boys were more likely to have been offered drugs than girls, 41 per cent compared with 38 per cent;
- pupils were most likely to have been offered cannabis; 25 per cent saying they had ever been offered cannabis;
- 18 per cent of pupils had been offered volatile substances, 12 per cent had been offered poppers and 11 per cent had been offered magic mushrooms; and
- as with use of drugs, likelihood of having ever been offered drugs increased sharply with age, from 18 per cent among 11 year olds to 63 per cent among 15 year olds.

10.2.3 Production, sources of supply and trafficking patterns within the country and from and towards other countries

SOCA (2006b) suggests that United Kingdom based white British criminals involved in supply, particularly of heroin, are increasingly bypassing London-based ethnic Turkish traffickers who have been their traditional suppliers and are importing directly from Europe, mostly the Netherlands, but also Belgium and France.

10.3 Seizures

Data on seizures for the UK as a whole were not available at the time of writing. In England and Wales the number of seizures in 2004 was reported to be down by two per cent. Cannabis continues to be the most seized drug. Seizures of heroin and cocaine rose (Mwenda and Kaiza 2006).

10.4 Price/purity

10.4.1 Price of drugs at street level

In 2005, the average street price of heroin, ecstasy and cocaine was lower than 2004, while the price of cannabis, crack cocaine and LSD has remained stable. Having fallen in recent years the price of amphetamines increased by more than ten per cent in 2005 (Table 10.1).

¹⁵⁰ For information on the methodology see Chapter 2.4.

Table 10.1: The mean price of illegal drugs in Pounds and Euros in the United Kingdom, 2003 to 2005.

Drug (price per gram)	2003	2004	2005
	Exchange rate: €1.4246* = £1	Exchange rate: € 1.4401* = £1	Exchange rate: € 1.4725* = £1
Amphetamines	£9.00 €12.82	£8.00 €11.52	£10.00 €14.73
Cannabis herb	£2.54 €3.62	£2.54 €3.66	£2.64 €3.89
Cannabis resin	£2.32 €3.31	£2.00 €2.88	£1.94 €2.86
Cocaine	£55.00 €78.35	£51.00 €73.45	£49.00 €72.15
Crack (per 0.2g)	£19.00 €27.07	£18.00 €25.92	£19.00 €27.98
Ecstasy**	£5.00 €7.12	£4.00 €5.76	£4.00 €5.89
Heroin	£62.00 €88.33	£55.00 €79.21	£54.00 €79.52
LSD	£3.00 €4.27	£3.00 €4.32	£3.00 €4.42

*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

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 2005 and are shown in Table 10.2 together with data for 2003 and 2004. Potency of cannabis resin rose slightly in 2005, having fallen in the previous year, and potency of herbal cannabis continues to rise, again, only slightly. The purity of heroin continues to increase, 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). There was no data available for white heroin in 2003 and 2005. Whilst there were drops in the level of purity for cocaine, crack and amphetamines in 2004, there are signs of small increases for 2005. Ecstasy decreased slightly in 2004 after a rise in the previous year; data for ecstasy refer to actual drug content. There was no data available for heroin (white) in 2003 and 2005 (Table 10.2). It is of note that while the average purity of cocaine seized by the police has also fallen in this time, the purity of cocaine seized by HM Revenue and Customs, including seizures at ports, has remained more stable, suggesting increased adulteration of the drug within the United Kingdom (Mwenda and Kaiza 2006).

Table 10.2: Street level mean average in percentage of purity of drug in the United Kingdom, 2003 to 2005

Drug*	Year		
	2003	2004	2005
Cannabis resin	9.8	3.4	5.3
Herbal Cannabis	10.7	12.7	13.5
Heroin (brown)	32.7	39.9	46.5
Heroin (white)	-	50.0	-
Cocaine	51.2	42.4	42.7
Crack	69.6	63.7	64.8
Amphetamines	10.8	9.0	10.1
Ecstasy	64.5	66.7	66.3

*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

It should be noted that the small increases in purity of amphetamine, cocaine and crack in 2005 are of doubtful statistical significance; the same applies to ecstasy (L. King - personal communication).

The Central Drugs Trafficking Database (CDTD) is being developed by the Metropolitan Police Service to provide intelligence regarding drug trafficking in London. Detailed information is recorded regarding drug seizures, what police tactics were used, locations, details of those suspected and the outcome of the case. Various analysis techniques are being developed, including the use of artificial neural networks. Dr Les King is involved in this work and uses drug seizure data from the CDTD to analyse drug price and purity trends (Metropolitan police – personal communication).

10.5 Interventions to disrupt drug markets

Powers to seize smaller cash sums

The threshold for seizing suspect sums of money under the *Proceeds of Crime Act 2002* was lowered from €7,320 to €1,460 (£5,000 to £1,000). The lower threshold aims to give the police the opportunity to tackle those at the lower end of organised criminal networks, often operating within local neighbourhoods. It adds to a package of measures the Government has introduced to disrupt organised criminals at every level.¹⁵¹

10.6 New research on UK drug markets

The size of the United Kingdom Drug Market

New research into the size of the United Kingdom drug market is expected to be published in the Autumn of 2006.

Engaging communities to tackle crack cocaine-related harm

In a review of the literature by Webster and Hough (2006), the objectives were to review national and international literature on crack cocaine-related harms; provide an overview of community-engagement strategies that have been implemented in England and Wales to reduce crack cocaine-related harm; review national and

¹⁵¹ See:

<http://www.gnn.gov.uk/content/detail.asp?ReleaseID=217758&NewsAreaID=2&NavigatedFromSearch=True>

international evidence from evaluations of community engagement programmes tackling crack cocaine-related harm; and discuss policy and research implications and provide recommendations. The study found that:

- there was no clear evidence base about effective practice; and
- there was not one British impact evaluation examining community action against drugs.

Nevertheless, using evidence predominantly from the United States, they suggest that community involvement is an essential element in reducing local drug markets and, in particular, the amount of collateral damage, in terms of crime, violence and nuisance, suffered by local people.

Understanding drug selling in local communities

Findings from a study examining drug dealing in four English communities highlight the ambiguities that exist in the relationships between local drug markets, drug sellers and their 'host' communities. It also questions the effectiveness of policies based exclusively on punishing those who sell drugs (May *et al.* 2006)¹⁵². The study found that:

“The four drug markets were, to different degrees, linked with both the legal and illegal economies of the neighbourhoods in which they were situated. They had varying relationships with their communities – sometimes symbiotic, sometimes parasitic.”

It is suggested that police and campaigners against the spread of illegal drugs, should beware of stereotypes of drug-dealing areas as unpopular, socially-divided neighbourhoods. Although drug dealers find ways to exploit run-down areas, this research shows they can also thrive in neighbourhoods with a strong sense of community.

Low level Heroin Markets

In a study of low level drug markets a detailed picture of the buying and selling of heroin within three areas in Scotland is provided (Cyster and Rowe 2006). The aim of the study was to:

- provide a description of the extent, breadth and culture of heroin markets;
- assess the impact of heroin dealing on the local communities;
- assess the nature and impact of policing, and other interventions on low level heroin dealing; and
- generate research evidence that identifies lessons for improved practice in tackling the problems of low-level heroin markets in Scotland.

It was found that markets in each area were remarkably similar. The availability of heroin was considered high, users had multiple possible contacts to obtain heroin and therefore numerous choices as to where they took their custom. This means that markets become more open, as user/dealers become more desperate to sell. In addition, method and location of delivery were also seen to change, corresponding to the perceived or actual threat of police activity. However, the visibility of heroin markets in public spaces appeared to be the exception rather than the rule. It was acknowledged that some heroin users commit crime, but not all; funding their habit through state benefits or working. For those committing crime, shoplifting or low-

¹⁵² The study examined the relationship between street-level sellers and the local communities in which they sold drugs, in four areas of England. In all, 68 drug sellers, 124 professionals and 800 local residents were interviewed. Data from these interviews were supplemented by published statistics. All fieldwork was carried out during 2003/04.

level dealing were the principal methods chosen. Violent crime or crimes against the person were less frequent, but did occur. It is suggested that police are able to contain the size of the market, but not reduce it, other than for short periods of time.

The impact of the reclassification of cannabis

Following on from previous research on the policing of cannabis (May *et al.* 2002) the Joseph Rowntree Foundation has commissioned further research following reclassification of cannabis from Class B to Class C. The research is due to be completed in late 2006.

Merseyside middle market drugs unit evaluation

An evaluation of the Merseyside Middle Market Drugs Unit (MMDU) has been commissioned.¹⁵³

Street Level Up evaluation

An evaluation of the impact of the Street Level Up approach to tackling drug supply and identifying best practice has been commissioned by the Home Office.

Drug trafficker debrief

Research is to be commissioned on looking at the best practice in gaining information from drug traffickers who have been arrested. This is seen as a means to identify how traffickers and dealers operate and in particular, to provide information which will help to describe the relationship between the supply and demand for drugs and a better understanding of risks associated with trafficking and dealing.

¹⁵³ See: <http://www.matrixrcl.co.uk/casestudies/oldweb/cs20.htm>

PART B

SELECTED ISSUES

PART B: SELECTED ISSUES

SUMMARY

11. Drug use and related problems among very young people

Consideration of the evidence of drug use amongst very young people suggests a very small minority experiment with drugs at a very early age, for a few as young as 10 or less. Regular use is rarer still amongst the very young but becomes increasingly prevalent by the age of 15. Amongst those who start using substances preteen, evidence suggests that early experimentation leads to longer term use. In addition, there is strong evidence of progression from occasional use of one substance to both regular use of the same and other substances. The greatest increase in prevalence occurs between the ages of 13 and 14 as it does in the use of alcohol and tobacco.

Amongst the very young volatile substances are the 'drug' of first choice but cannabis becomes more prevalent amongst older children.

12. Cocaine and crack – situation and responses

Lifetime prevalence of powder cocaine is approximately 6.5 per cent, recent and current use is much lower at 2.3 and 1.0 per cent respectively. Latest information is for England and Wales for 2005/06 and shows a significant decrease both in lifetime and recent use amongst adults was seen since 2004/05. This decrease was not observed amongst young people aged 16 to 24 for recent (last year) use. Latest information amongst school children is for England for 2005. Amongst this group, however, recent use has increased in the last year (2004 to 2005) from 1.4 to 1.9 per cent. As with all drugs, males are more likely to use than women are.

Prevalence of powder cocaine is highest in urban, inner city areas that are described as 'rising', amongst those who are single and cohabiting couples who are more likely to visit pubs and wine bars, live in private rented accommodation, and belong to semi-skilled, skilled and managerial and technical occupations. The majority of cocaine users report beginning use in their early twenties.

Crack use is considerably less prevalent, less than one per cent of adults reporting lifetime use, appears to be used by those in deprived inner city areas, suffering unemployment. Amongst young people, the more vulnerable are more likely to use.

Major issues are with criminal activity associated with crack use and public health issues associated with injecting; with crack users showing high levels of risk behaviour.

Government effort has been to tackle the problem of crack, through information campaigns, supply reduction and improved treatment. As for the latter, there remain problems in attracting users into treatment and providing them with effective treatment, though there has been an increase in treatment demand.

13. Drugs and driving

There is no explicit mention of driving under the influence of drugs in the Updated Drug Strategy or within other UK drug strategies. However, it is an offence to be unfit to drive while impaired by drink or drugs. Convicted offenders face a minimum one year driving ban, a fine of up to €7,315 (£5,000), and six months imprisonment.

In the Government's strategy for improving road safety between 2000 and 2010 specific focus is placed upon driving under the influence of drugs. The current laws do not permit random or mandatory enforcement testing of drivers in the UK, and there is currently no indication that such schemes of (i.e. random testing) will be introduced.

Most work on providing estimates of drivers who have recently used drugs has been undertaken in Scotland where nine per cent of respondents reported ever having driven under the influence of any illegal drugs, most commonly cannabis. Drivers are most likely to be young males aged between 20 and 24; most believed cannabis use had little or no impact upon driving skills or performance. Though in Scotland around 53 road fatalities were associated with drug use in 2004.

Work is being undertaken to develop devices to detect drugs. A Field Impairment Test led to a sensitivity of 65 per cent (proportion of true positives that were correctly identified by FIT). A portable objective detection device proposed for screening of drug related impairments is being tested and work is being undertaken to investigate the feasibility of the development of a handheld impairment device which is expected to be able to detect all drugs, including illicit drugs, prescription and over-the-counter medicines.

11. Drug use amongst very young people

11.1 Drug use and problematic drug use amongst very young people

Estimates of prevalence in drug use amongst minors in most areas of the UK can be obtained through surveys of health behaviour undertaken in schools. In England, surveys of smoking, drinking and drug use have been undertaken annually since 1998 amongst 11 to 15 year olds. In Northern Ireland, the *Young Person's Behaviour and Attitudes Survey*¹⁵⁴ was undertaken in 2000 for the first time; a second survey was carried out in 2003. This is conducted amongst 11 to 16 year-olds. In Scotland, the *Schools Adolescent Lifestyle and Substance Use Survey* (SALSUS) has been undertaken since 2002. England, Scotland and Wales also take part in the *Health Behaviour in School-aged Children*¹⁵⁵ (HBSC) study organised through the World Health Organisation (WHO). This study began in 1982 and is carried out at four-year intervals; the latest survey was in 2001/2002. The target population of the HBSC study is young people attending school, aged 11, 13 and 15. For the first time in 2001/02, 15 year olds were asked about their use of cannabis. The UK also participates in the *European School Survey Project on Alcohol and Other Drugs* (ESPAD), undertaken every three years, but this samples 15 and 16 year olds only.

Information on drug use amongst minors in England and Wales is also available from the Offending, Crime and Justice Survey¹⁵⁶, and in Scotland from the Edinburgh Study of Youth Transitions and Crime (known as the Youth Transitions Survey).¹⁵⁷ In Northern Ireland a similar cohort study, the Belfast Youth Development Study¹⁵⁸ has been undertaken. In addition, the *Children's Mental Health Survey*, undertaken in 1999 and in 2004 (Green *et al.* 2005) provides information about drug use. Research suggests that children interviewed at home systematically under-reported their smoking, drinking and drug use compared with those interviewed in school and therefore rates presented in the report by Green *et al.* should not be taken as true estimates of prevalence. Their main value is in enabling comparisons to be made between children with a mental health disorder and other children (see 11.3.8).

Prevalence of drug use by age

Survey data on drug use amongst school children in the UK is primarily concerned with young people up to including age 15 and therefore much of the analysis includes young people up to age 15. Fifteen years olds are therefore included in much of the following analysis. It should also be noted that in law, 15 year olds are minors. Latest estimates of prevalence of drug use from school surveys are shown in Figure 11.1; prevalence is for recent (last year) use. This is based on surveys undertaken in different years, and using different methodologies, and therefore caution is required

¹⁵⁴ For more information see: <http://www.csu.nisra.gov.uk/surveys/survey.asp?id=11>

¹⁵⁵ For more information see: <http://www.hbsc.org/index.html>

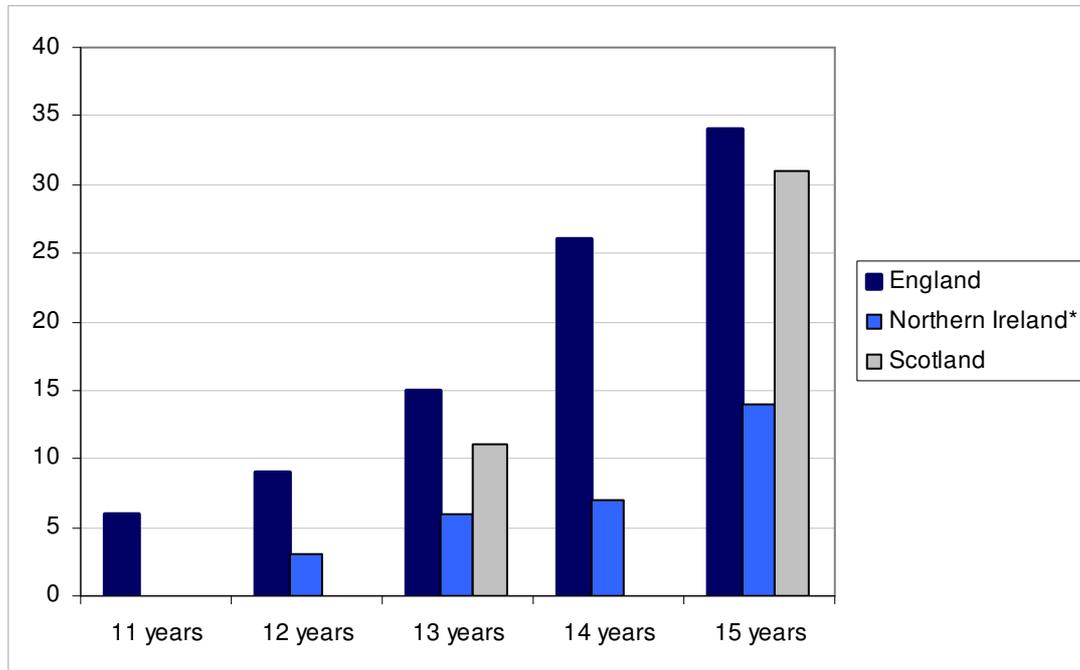
¹⁵⁶ The Offending, Crime and Justice Survey (OCJS) is the longitudinal, self-report household survey for England and Wales. It was first conducted in 2003 and will be repeated annually until 2006. The main aim is to examine the extent of offending, anti-social behaviour and drug use among the household population, particularly among young people aged 10 to 25.

¹⁵⁷ The Edinburgh Study of Youth Transitions and Crime is a longitudinal study of criminal offending and anti-social behaviour among young people. The study follows a single year group of approximately 4,300 young people who started secondary schools in Edinburgh in 1998.

¹⁵⁸ The aim of the study is to investigate the risk and protective factors associated with adolescent drug use. The study comprises a core sample of approximately 4,500 young people who entered secondary school in 2000.

in comparing the three areas. For England data are for 2005 (NatGen/NFER 2006), for Scotland for 2004 (Corbett *et al.* 2005) and for Northern Ireland for 2003 (CSU 2004).

Figure 11.1: Percentage prevalence of last year drug use by age in England, Northern Ireland and Scotland



*percentage for Northern Ireland is for 12 years and under at secondary school.
In Scotland data is for 13 and 15 year olds only

Source: Corbett *et al.* 2005; SMR 2005 ; NatGen/DFER 2006

This shows that older pupils are far more likely to have used drugs than young pupils; Scottish data is only available for 13 and 15 year olds, but English data show a large increase in prevalence between age 13 and age 14 and a further large increase by age 15. However, it should also be noted that a majority of young people had never used a drug.

Other evidence of drug use amongst young people is from the Edinburgh Youth Transitions Survey (EYTC). This study confirms evidence from the school survey undertaken in England of a rise in prevalence between the age of 13 and 14 followed by another significant rise at age 15 over all recall periods (McVie and Bradshaw 2005).

Similarly, the Offending, Crime and Justice Survey for 2004 (OCJS) shows that at age 10 and 11 very few young people report recent drug use (0.3%), amongst 12 to 13 year olds the proportion rises to just over one per cent, but for those aged 14 to 15 there was a sharp increase to 6.6 per cent (Budd *et al.* 2005).

Prevalence of drug use by gender

Table 11.1 shows that girls are only slightly less likely to have used drugs than boys. Totals are not available for Scotland.

Table 11.1: Percentage prevalence of lifetime, last year and last month drug use by gender in England, 2005 and Northern Ireland, 2003

Gender	Male	Female	Total
Lifetime			
England (11 to 15 years)	27.8	27.2	27.5
Northern Ireland (11 to 16 years)	25.1	19.7	22.3
Last year			
England (11 to 15 years)	19.3	18.8	19.1
Northern Ireland (11 to 16 years)	15.8	12.8	14.2
Last month			
England (11 to 15 years)	11.5	10.3	10.9
Northern Ireland (11 to 16 years)	7.9	5.8	6.8

Source: Standard Tables prepared for UK Focal Point based on school surveys

11.1.1 Patterns of drug use by age and gender

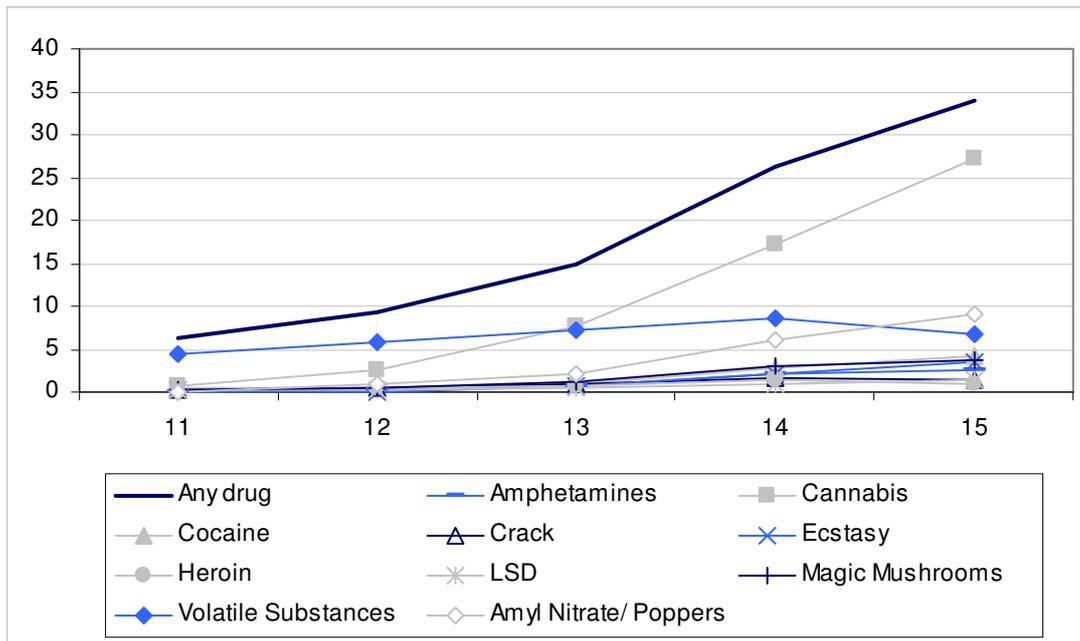
Patterns of drug use by age

Figure 11.2 shows recent use (in the last year) of drugs by age in England in 2005. Amongst 11 to 12 year olds volatile substances are the main drugs used, at age 13 cannabis is used by a slightly greater number and by age 14 cannabis is the main drug used. It is of note, that amongst 14 year olds volatile substances remains the second most used drug. Patterns of use amongst minors in Northern Ireland show a similar pattern to England with the youngest age groups being more likely to use volatile substances and the older age groups more likely to use cannabis.

This is consistent with data from the EYTC. This found that volatile substance use declines markedly at the age of 15 but use of cannabis increases, noting that by the age of 15, 97 per cent of the drug users reported using cannabis in the last year (McVie and Bradshaw 2005). In this report, as well as finding that the biggest increase in prevalence is seen between 13 and 14, use of some drugs showed a much greater increase; ecstasy by six times and poppers (amyl nitrite) by 24 times. The most commonly reported other drugs at age 14 and 15 were magic mushrooms, poppers, amphetamines and ecstasy, all of which were taken by one in ten drug users.

In addition, the Offending, Crime and Justice Survey confirms the use of drugs in the last year by a very small proportion of young people aged 10 and 11, 0.35 per cent reported use of volatile substances; at age 12 to 13, 2.6 per cent report use of any drug, but amongst those aged 14 and 15 prevalence is much higher at 16.9 per cent (Budd *et al.* 2005).

Figure 11.2: Percentage of young people who had used drugs in the last year, by age in England 2005



Source: Standard Table prepared for UK Focal Point based on school surveys

Patterns of use by age and sex

Table 11.2: Percentage prevalence of lifetime drug use by age and sex in England, 2005

Drug	Age									
	11		12		13		14		15	
	M	F	M	F	M	F	M	F	M	F
Cannabis	1.8	0.5	16.4	14.6	21.6	23.3	35.5	35.5	45.8	43.6
Cocaine powder	0.3	0.6	0.7	0.7	1.8	1.3	4.4	2.6	5.2	4.8
Crack	0.5	0.4	0.7	1.1	1.6	1.0	1.6	2.5	1.7	2.1
Ecstasy	0.1	0.4	0.1	0.2	1.0	1.0	2.7	2.6	4.3	4.6
Amphetamines	0.1	0.1	0.3	0.1	0.6	1.3	2.3	2.4	3.3	3.4
LSD	0.3	0.3	0.2	0.5	0.7	0.2	0.9	1.4	1.8	1.2
Magic mushrooms	0.5	0.5	0.6	1.1	1.4	1.7	4.6	3.6	6.9	4.6
Heroin	0.4	0.5	1.0	0.8	1.0	1.0	1.5	2.0	1.4	1.1
Volatile substances	11.0	11.6	11.0	11.3	12.7	16.3	15.8	18.8	15.4	18.0
Any drug	15.0	13.4	16.4	14.6	21.6	23.3	35.5	35.5	45.8	43.6
Base	680	670	864	836	904	877	881	929	967	940

Information on amyl nitrate by age and sex is not available

Source: Standard Table prepared for UK Focal Point based on school survey

Table 11.3: Percentage prevalence of last year drug use by age and sex in England, 2005

Drug	Age									
	11		12		13		14		15	
	M	F	M	F	M	F	M	F	M	F
Cannabis	1.1	0.3	2.8	2.4	8.0	7.0	17.5	16.9	28.3	25.9
Cocaine powder	0.3	0.6	0.6	0.1	1.0	1.0	3.4	2.2	4.6	4.0
Crack	0.3	0.3	0.4	0.5	0.9	0.9	1.3	1.9	1.4	1.6
Ecstasy	0.1	0.4	0.1	0.1	0.7	1.0	2.2	2.3	3.6	3.5
Amphetamines	0.0	0.1	0.2	0.1	0.5	1.0	1.7	2.2	2.3	2.7
Amyl Nitrate (Poppers)*	0	0	0	1	2	3	5	7	8	10
LSD	0.1	0.3	0.2	0.3	0.5	0.2	0.8	1.0	1.6	1.0
Magic mushrooms	0.3	0.4	0.4	0.3	1.1	1.3	3.3	2.7	4.2	3.4
Heroin	0.3	0.3	0.5	0.5	0.8	0.8	1.0	1.7	1.0	1.9
Volatile substances	4.0	5.0	6.4	5.3	6.7	7.4	7.5	9.9	5.5	8.2
Any drug	6.5	5.8	10.6	8.2	15.1	14.4	26.0	26.6	33.9	33.9
Base	673	668	858	827	899	870	867	927	956	931

*Information on amyl nitrate is from the published report on the 2005 school survey for England as this information is not asked for by EMCDDA in the Standard Table and is therefore only provided as a rounded figure.

Source: Standard Table prepared for UK Focal Point based on school survey.

Table 11.4: Percentage prevalence of last month drug use by age and sex in England, 2005

Drug	Age									
	11		12		13		14		15	
	M	F	M	F	M	F	M	F	M	F
Cannabis	0.9	0.3	0.7	0.6	4.4	4.1	11.5	10.2	18.0	13.1
Cocaine powder	0.1	0.3	0.1	0.1	0.4	0.4	1.8	1.3	1.9	1.5
Crack	0.1	0.3	0.2	0.1	0.5	0.2	0.5	0.7	0.8	0.8
Ecstasy	0.1	0.4	0.0	0.1	0.4	0.1	1.0	0.6	1.4	1.0
Amphetamines	0.0	0.1	0.0	0.0	0.2	0.4	0.9	0.9	0.9	0.9
LSD	0.1	0.1	0.0	0.2	0.2	0.1	0.4	0.3	0.6	0.3
Magic mushrooms	0.3	0.3	0.1	0.1	0.5	0.4	1.5	1.1	1.6	0.9
Heroin	0.3	0.3	0.3	0.1	0.6	0.4	0.3	1.1	0.4	0.3
Volatile substances	1.8	2.4	3.1	2.7	2.9	2.9	3.9	3.8	2.4	3.5
Any drug	3.7	2.8	4.6	3.8	8.1	7.5	16.4	15.9	21.9	18.7
Base	672	667	851	825	891	865	853	921	941	922

Information on amyl nitrate by age and sex is not available

Source: Standard Table prepared for UK Focal Point based on school survey

Looking at data for England, in the case of volatile substances, females are more likely to have ever used than males at all ages (Table 11.2). For cannabis use it is the opposite, with males being more likely to use than girls. For recent and current use the pattern is the same as lifetime use, though prevalence is lower. It is of note that the third most common drug amongst all pupils is reported as amyl nitrate (poppers), though information is only available on recent use by age and sex (Table 11.3). Interestingly amongst younger pupils, it is males, not females who are more likely to have recently used volatile substances. Males of all ages are more likely to have used cannabis recently. It is not possible to look at gender differences in Northern Ireland for very young people, as gender analysis is only undertaken for all pupils at secondary school.

In Scotland, by age 13 both boys and girls are more likely to have recently used cannabis than volatile substances recently and amyl nitrate is the second most used drug amongst 15 year olds (Table 11.5).

Table 11.5: Percentage of individuals who have used drugs in the last year, by age group and gender in Scotland, 2004

Drug	13 years			15 years		
	Males	Females	Total	Males	Females	Total
Cannabis	11	8	10	28	28	28
Cocaine	1	1	1	2	2	2
Crack	1	1	1	1	1	1
Ecstasy	1	1	1	3	3	3
Amphetamines	1	1	1	3	3	3
Amyl nitrate/ Poppers	1	1	1	7	6	7
LSD	1	0	1	1	1	1
Magic mushrooms	1	1	1	3	2	2
Heroin	1	1	1	1	1	1
Methadone	0	0	0	1	0	0
Volatile substances	2	3	2	4	4	4
Tranquillisers	1	1	1	2	1	1
<i>Base</i>	<i>1843</i>	<i>1756</i>	<i>3599</i>	<i>1702</i>	<i>1761</i>	<i>3463</i>

Source: Corbett *et al.* 2005

The pattern of use described earlier is confirmed by EYTC; it is reported that while patterns of drug use between the sexes is very similar, there is some slight gender difference in the types of drug used, with boys more likely to have used cannabis than girls at age 12, (55 per cent boys compared with 31 per cent, respectively), but thereafter girls and boys were equally likely to use cannabis. Girls, on the other hand, were more likely to report using volatile substances than boys up to age 12 ($p < .01$) and at age 15 ($p < .001$). There was no significant gender difference in the use of other types of substance. Similarly, there was little difference in the variety of drugs used or the frequency of drug use. At age 12, boys were more likely than girls ($p < .05$) to report using more than one type of drug (1.7% and 1.3%, respectively) and to use drugs on more than one occasion (3.3% compared with 2.3%, respectively); thereafter, there was no significant difference." (McVie and Bradshaw 2005, p. 16).

Age of first use

The EYTC looks at age of onset of drugs, showing the trend in age:

- around a quarter (27%) of drug users (10% of the cohort) said that they had tried a drug or volatile substance by age 13;
- a third of all drug users in the survey reported that they had used their first drug between the ages of 13 and 14; and
- 37 per cent of drug users reported using their first drug between age 14 and 15 (McVie and Bradshaw 2005).

However the Northern Ireland survey suggests that the peak age of onset is between 13 and 14 (SMR 2005).

Frequency

A number of surveys ask young people about their frequency of use, asking slightly different questions and therefore making an overall UK estimate difficult. However all surveys confirm that, even by age 14, very few pupils who report having used a drug

have used recently (in the last year) and even fewer report current use (in the last month). Frequency of use for England is shown in Table 11.6 and for Scotland in Table 11.7. The fact that a majority of those who report having ever used have not used recently suggests that while a small number of children have experimented with drugs many do not continue to use.

Table 11.6: Frequency of drug use by school age children in England, 2005 as a percentage

Frequency of use	Age				
	11	12	13	14	15
Most days	-	0	1	2	1
At least once a week	0	1	1	3	2
Once or twice a month	0	1	2	4	3
At least once a month	1	2	3	8	6
A few times a year	0	2	2	4	3
Once a year or less often	1	1	2	3	2
Taken drugs in last year, but only ever taken drugs once	2	2	4	6	4
Not taken drugs in last year	7	7	7	10	8
Never taken drugs	89	87	81	70	77
Base	1,440	1,785	1,841	1,831	1887

Source: NatCen/NFER 2006

Table 11.7: Frequency of drug use in Scotland amongst 13 and 15 year olds in 2004 as a percentage

Prevalence	13 year olds	15 year olds
Never used	86	65
Only used drugs once	6	10
Used to take drugs	2	6
A few times a year	2	6
Used once or twice a month	2	6
At least once a week	1	3
Most days	1	4
Base	3,451	3,315

Source: Corbett et al. 2005.

EYTC asks a rather different question, not when they last used but how many times they had used. Amongst those pupils who reported having ever used, amongst 12 year olds the majority (66%) had used only once or twice, and even by age 15, 71 per cent had used no more than four times (Table 11.8).

Table 11.8: Frequency of lifetime drug use amongst drug users, by age as a percentage

Number of times used drugs	Age			
	12	13	14	15
Once	39	29	22	18
Twice	27	24	20	20
Three times	3	10	6	3
Four times	16	19	24	30
Five times or more	16	19	29	30
Base	187	241	652	1,048

Source: McVie and Bradshaw 2005

Variety or number of types of drugs taken

The EYTC looked at the 'variety' or numbers of drugs taken, reporting that the average number of types of drugs taken was 1.5 at age 12, rising to just under two

each year after. However, a significant minority had used two or more types of substance and the likelihood of doing so increased with age (McVie and Bradshaw 2005) (Table 11.9).

Table 11.9: Percentage of drug users using a variety of drugs by age in Scotland,

Number of types of drug taken	Age			
	12	13	14	15
One	73	66	60	64
Two	14	20	19	19
Three	6	5	10	7
Four	3	2	5	3
Five or more	4	7	7	8
<i>Bases</i>	<i>187</i>	<i>241</i>	<i>652</i>	<i>1,048</i>

Source McVie and Bradshaw 2005

11.1.2 Social and geographical profiles

Location of drug use by age

The SALSUS (Scotland) asks young people about where they used drugs (Table 11.10). Outdoors was by far the most common location amongst the younger pupils, with use at someone else's house being the second most favoured location. However, over time use at someone else's house, particularly for girls becomes more usual.

Table 11.10: Percentage of drug users using in each location by age and gender in Scotland, 2004

Location	13 year olds			15 year olds		
	Males	Females	Total	Males	Females	Total
Outdoors	49	45	48	39	33	36
Someone else's house	16	23	19	26	36	31
At a party	10	9	9	15	16	16
At school	8	10	9	9	4	7
Own home	5	9	7	8	9	8
At a club/disco	4	6	5	3	4	4
Other	5	2	4	3	3	3
<i>Bases</i>	<i>291</i>	<i>220</i>	<i>511</i>	<i>611</i>	<i>631</i>	<i>1,242</i>

Corbett *et al.* 2005

Leisure time pursuits

SALSUS also asked young people about leisure time pursuits and findings suggest that pupils who reported drug use in the last month were more likely to report spending most evenings with friends. Also, pupils were asked how often they engaged in a range of activities in which young people in this age group commonly participate, previous research having indicated that adolescents who have the strongest 'street based' leisure orientation also have the highest levels of substance use. It was found that 78 per cent of pupils who used drugs in the last month hang around the street at least weekly; this compared with 41 per cent of pupils who had never used drugs (Corbett *et al.* 2005).

In EYTC data on lifestyle and leisure activities were separated into two types: organised or conventional leisure activities (stay at home most evenings; going to organised clubs, groups or sports centres most days; going shopping or out for something to eat at least once a week) and unorganised or unsupervised leisure activities (going to amusement arcades at least once a week; going to discos,

nightclubs or raves at least once a week and hanging around most evenings). It was found that non-users were the most likely of all the groups to stay at home most evenings and that the likelihood of staying in significantly diminished with increased variety of substance use at all three age bands Source (McVie and Bradshaw 2005).

Peer influence

EYTC also looked at the influence of peers suggesting that there was a dramatic incremental rise in the proportion of young people who said that most or all of their friends took these substances according to the extent of their own substance use. Overall, prevalence patterns for friends showed a similar pattern to those of the users themselves, although no causal relationship can be determined Source (McVie and Bradshaw 2005).

Parental supervision

SALSUS looked at the relationship between parental monitoring and drug use.¹⁵⁹ Pupils who reported using drugs in the last month were more likely to perceive lower than median levels of parental monitoring. Over two thirds (69%) of 15 year olds who used drugs in the last month had a lower than median level of monitoring by their mothers, compared with 43 per cent of pupils who had never used drugs. The same pattern was found for fathers monitoring, 56 per cent of 15 year olds who had used drugs in the last month had a lower than median level of monitoring compared with 36% of 15 year olds who had never used drugs. Researchers suggest that these findings reflect those of other studies which indicate that a lack of parental monitoring is associated with illicit drug use (Corbett *et al.* 2005). In the EYTC three aspects of parental supervision were measured.¹⁶⁰ Researchers report that non-users had a significantly higher ($p < .001$) parental supervision score than any of the substance user groups at all three sweeps (McVie and Bradshaw 2005).

Relative family wealth

SALSUS suggests that lower family affluence is also associated with drug use¹⁶¹ (Table 11.11).

Table 11.11: Percentage using drugs by family affluence and age in Scotland, 2004

Drug use status	Affluence level					
	13 year olds			15 year olds		
	Low	Medium	High	Low	Medium	High
Used in last month	10	7	6	24	22	16
Used drugs, not in last month	7	5	5	14	12	12
Never used drugs	84	89	89	62	67	72
<i>Base</i>	<i>626</i>	<i>1,540</i>	<i>1,171</i>	<i>637</i>	<i>1,621</i>	<i>926</i>

Source: Corbett *et al.* 2005

¹⁵⁹ Pupils' responses to a series of questions on how much knowledge they perceived their parents to have about their friends and activities (who their friends were, where they went to when they were out, what they spent their money on) were used to assess levels of parental monitoring. Each pupil was given a parental monitoring score, which was then compared with the overall median (mid-point) score for their age group and gender.

¹⁶⁰ Young people were asked, "When you went out during the last year, how often did your parents know where you were going, who you were going out with, and what time you would be home?" Response options were: always, usually, sometimes and never.

¹⁶¹ HBSC Family Affluence Scale was used as a measure of wealth.

Truancy and exclusion from school

In their review of drug prevention amongst school excludees, the National Collaborating Centre for Drug Prevention (Edmonds *et al.* 2005) state that it is estimated that everyday around 50,000 children in England miss school through truancy and that in 2002/03 there were 9,290 (12 in 10,000 pupils) permanent exclusions in England (DfES, 2004a). There is also a great deal of evidence from the UK suggesting a strong association between truancy and exclusion and drug use, though there is no evidence of causality. It has also been found that there is an association between lack of involvement with the education system and elevated levels of criminality and illicit drug use (MORI 2004; Powis *et al.* 1998). In addition, there is strong evidence to suggest that school attendance is a protective factor against drug misuse. Furthermore, individual students are more likely to initiate drug use in schools where truancy is high and student commitment to school is low.

In England, the 2004 school survey asked pupils for the first time about the number of trancies or exclusions in the last 12 months.¹⁶² It is noted that despite an additional visit being undertaken if four or more pupils were absent when the survey was first administered, it is likely that regular truants and those excluded from school during the fieldwork period will be under-represented in the sample.

Truancy

In 2005 data from the English School survey shows that:

- thirteen per cent of pupils had truanted at least once in the last year;
- pupils who had played truant in the last year were much more likely than those who had never truanted or those who had last truanted more than 12 months ago (past truants) to have taken drugs in the last month, 37 per cent compared with 23 per cent of past truants and 6 per cent of those who had never truanted; and
- these patterns existed for girls and boys.

Amongst pupils who had truanted in the last 12 months, the prevalence of drug use (and of smoking and drinking) increased with frequency of truanting. 29 per cent of those who had stayed away from school once or twice had taken drugs in the last month compared with 42 per cent of those who had truanted more than three times.

In Scotland, SALSUS provides a more detailed look at this.

- thirty-two per cent of 13 year olds and 47 per cent of 15 year olds had truanted at least once in previous year;
- these young people were more likely to have also used drugs in the previous 12 months, 56 per cent, compared to 28 per cent of non truants.
- Seventy-eight per cent of 15 years olds who had used drugs in the last month had also truanted in the current school year compared with 34 per cent of 15 year olds who had never used drugs. Pupils who used drugs in the last month also reported a higher frequency of truancy; 26 per cent of 15 year olds using drugs in the last month had truanted 10 times or more, compared with only 3 per cent of 15 year olds who had never used drugs.

Exclusion from school

In the English school survey there was also a relationship between exclusions and drug use (and smoking and drinking):

- ten per cent of pupils said they had been excluded from school at least once; and

¹⁶² For methodology used see chapter 2.

- pupils who had been excluded in the last 12 months were more likely than other pupils to have taken drugs in the last month, 36 per cent compared with 26 per cent of those who were last excluded more than a year ago and eight per cent of those who had never been excluded.

In Scotland, based on the SALSUS, information on the proportion excluded and the relationship between exclusion and drug use is not available for 13 year olds. Amongst 15 year olds:

- Exclusion from school was more frequently reported by pupils who had used drugs in the month than amongst pupils who had never used drugs: a third (30%) of 15 year olds who had used drugs in the last month had been excluded compared with seven per cent of 15 year olds who had never used drugs.

Victimisation

Analysis of EYTC suggests that there is a strong association between victimisation¹⁶³ and substance use, with only occasional non-significant differences between substance user sub-groups (those who took drugs, drank alcohol and smoked cigarettes). Non-users were significantly less victimised than all of the other groups ($p < .001$). Single users were also consistently victimised to a lesser extent ($p < .01$ or above) than the multiple users, whereas the triple users proved to be more highly victimised than any other group (McVie and Bradshaw 2005).

Sibling drug and alcohol use

Analysis of the Youth Lifestyle Survey (Goulden and Sondhi 2001)¹⁶⁴ found that rates of use of any drug in the last year were up to eight times higher for 12 to 16 year-olds with a sibling drug-user compared to those without, but less than twice as high for those aged 17 and over. Having an older sibling using drugs recently (in the last year) meant that higher rates were also observed among the younger siblings for recent use, with the rates of drug use by those with an older sibling who had never used drugs being very low. SALSUS, asking about the source of drugs found that, amongst 13 year old users, six per cent obtained drugs from a sibling and four per cent of 15 year olds (Corbett *et al.* 2005).

Problem drug use amongst the very young

There remains very little information about the extent of problem drug use amongst the very young (excluding the issue of volatile substance abuse). Surveys provide some evidence of the use of opiates and cocaine (see Figure 11.2 in section 11.1).

¹⁶³ Two measures of victimisation were included the EYTC: variety of victimisation (a count of the number of different types of victimisation the respondent reported experiencing); and volume of victimisation (the cumulative frequency of victimisation across all the types asked about). Five items of victimisation were used to create both of these measures. Pupils were asked, During the last year, did anyone: threaten to hurt you?; actually hurt you by hitting, kicking or punching you (fighting with you)?; actually hurt you with a weapon?; steal something of yours that you left somewhere?; use threats or force to steal or try to steal something from you? Response options: yes/no.

¹⁶⁴ The 1998/99 YLS sample was generated from the 1998 BCS, which sampled individuals aged over 16 living in private households but also captured information on non-interviewees living there. Of 14,947 BCS households interviewed in 1998, 5,117 were eligible for inclusion in the YLS core sample, of which 3,643 led to successful interviews (a response rate of 71%). A further 6,884 addresses next door to the BCS sample households were contacted (a process known as 'focused enumeration') with weighting towards high-crime areas. These households contained 1,895 addresses with at least one person aged between 12 and 30, of which 1,205 (64%) were interviewed as a booster sample for the YLS. In total, the response rate for the whole sample was 69 per cent.

Data suggest that prevalence of recent and current use of heroin is around 0.8 and 0.4 per cent, cocaine powder around 1.9 and 0.8 per cent respectively and crack use around one and 0.5 per cent respectively. Of particular note is the increased use of cocaine identified amongst school aged children in England in 2005 (from 1.4% in 2004 to 1.9% in 2005). Children as young as 11 report recent use of heroin (0.3%), cocaine (0.4%) and crack (0.3%) (NatGen and NFER 2006).

There are also a number of studies of vulnerable young people which point to the use of drugs associated with problematic use, though amongst the very young this remains rare. When the very young are identified as using drugs such as heroin this has been extensively reported by the media. In the UK there have been two such high profile incidents in 2006, the case of an 11 year-old in Glasgow¹⁶⁵ and a nine year old boy¹⁶⁶, both provided with drugs by a parent.

McKeganey *et al.* (2004) also looked at use of drugs amongst pre-teen children in Glasgow and Newcastle and found that, among the 2,000 participants aged 10 to 12 years, whilst 4 per cent had used drugs only a very small number had used heroin.

11.1.3 Trends in the last ten years

Trends in drug use in England are shown in Table 11.12. Current prevalence has remained stable since 2001 and has shown signs of a decrease in the last two years. The trends for recent use of individual drugs are shown in Figure 11.3.

Table 11.12: Percentage of pupils who had taken drugs in the last month by gender and age in England, 1998-2005

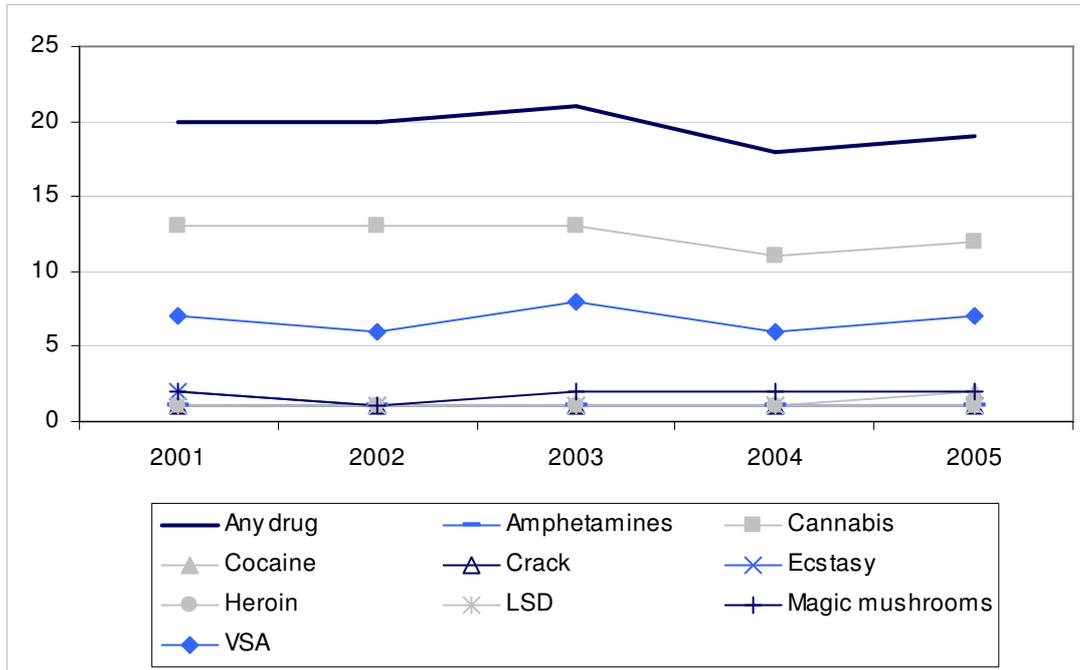
Gender/ Age	Year							
	1998	1999	2000	2001	2002	2003	2004	2005
Boys								
11 yrs	0	1	3	4	4	4	4	4
12 yrs	2	2	2	4	5	5	4	5
13 yrs	4	4	6	11	9	11	8	8
14 yrs	10	12	14	17	20	17	17	16
15 yrs	19	21	23	25	26	25	21	22
Total	7	8	10	13	14	13	11	11
Base	2,273	4,769	3,545	4,360	4,673	4,840	4,664	4,208
Girls								
11 yrs	0	1	2	2	3	3	1	3
12 yrs	2	2	3	4	3	5	4	4
13 yrs	3	5	5	9	8	8	7	8
14 yrs	9	9	11	15	15	18	13	16
15 yrs	16	17	19	22	19	22	20	19
Total	6	7	8	11	10	12	9	10
Base	2,293	4,539	3,314	4,439	4,473	4,818	4,422	4,200
Total								
11 yrs	0	1	3	3	4	4	3	3
12 yrs	2	2	3	4	4	5	4	4
13 yrs	4	5	5	10	8	9	7	8
14 yrs	10	11	13	16	18	17	15	16
15 yrs	18	19	21	24	23	23	21	20
Total	7	7	9	12	12	12	10	11
Base	4,566	9,308	6,859	8,799	9,146	9,658	9,086	8,408

Source: NatGen/NFER 2006

¹⁶⁵ See: <http://news.bbc.co.uk/1/hi/scotland/4659092.stm>

¹⁶⁶ See: <http://news.bbc.co.uk/1/hi/england/4797631.stm>

Figure 11.3: Percentage of pupils who had taken individual drugs in the last year in England, 2001 to 2005



Source: NatCen/NFER 2006

11.2 Treatment demand indicator data

In 2004/05 2,217 young people under the age of 15 were reported as entering treatment across the UK (2% of the total TDI population), of whom 64 per cent were known to be first treatment demands. (1,835 from England; 214 from Scotland; 95 from Wales; 75 from N Ireland).

Of the 2,217, two per cent were 10 year olds, three per cent were 11 year olds, nine per cent were 12 year olds, 28 per cent were 13 year olds and 58 per cent were 14 year olds; 68 per cent were boys and 32 per cent girls.

Boys and girls differed quite substantially in their declared drug use. The vast majority were cannabis users – 88 per cent of boys and 72 per cent of girls. Other proportions were as follows: opiates, two per cent of boys, five per cent of girls; stimulants, two per cent of boys, eight per cent of girls; volatile substances, five per cent of boys, ten per cent of girls; cocaine one per cent of boys, two per cent of girls.

11.3 Profile of the main groups of young people at risk of drug use and of problematic drug use

11.3.1 Children of drug users

Children affected by parental drug use were the subject of a major piece of work by the Advisory Council on the Misuse of Drugs (ACMD 2003). This report estimated that in the UK there were, at the time of the study, between 250,000 and 350,000 children living with parental drug misuse.

Research by Edinburgh University into children of substance misusing parents (drugs and alcohol), suggests that children who have parents with substance misuse problems are found across a wide range of the country's socio-economic groups, though parental drug misuse is more likely to be restricted to those from socio-

economically disadvantaged groups. It is noted that three times as many children live with parents who have a drink problem than with parents who misuse drugs (Bancroft *et al.* 2004).

Analysis of SALSUS found that one per cent of both 13 and 15 year olds reported obtaining drugs from a parent (Corbett *et al.* 2005).

McVie and Holmes' (2005) report based on the EYTC and looking at family functioning, found that at age 15 young people whose parent 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 parents had not used a drug (Table 11.13).

Table 11.13: Percentage of individuals at age 15 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

11.3.2 Children living in problematic families

McVie and Holmes (2005) in the above mentioned report on family functioning, suggest that family characteristics and parenting styles play a significant role in the substance using behaviour of young people¹⁶⁷. They suggest that there was evidence of a causal link with family related factors at age 15, predicting substance use at age 17. It was found that ineffective parenting consistently predicted involvement in drug use (and smoking and drinking alcohol), with ineffective parenting methods characterised by high levels of parent/child conflict, poor parental monitoring and lack of leisure time spent doing activities together. Further, substance using children were likely to conceal information about their social activities from their parents. They suggest that these findings are broadly supportive of social learning theory and indicate the need to provide information on methods of parenting which may be more effective in tackling various forms of problematic behaviour, including substance use.

Alcohol or drug using siblings,

See section 11. 1 for evidence of the influence of siblings on drug use.

11.3.3 Vulnerable groups

Analysis of the *Offending Crime and Justice Survey* looked at patterns of drug use (especially Class A drugs) amongst young people identified as vulnerable (Becker and Roe 2005). Five groups were identified: those who have ever been in care,

¹⁶⁷ Parenting styles were assessed by: parental monitoring or supervision of the child's activities while they were not at home; parental autonomy or lack of constraint afforded to the young person in certain aspects of their decision making; parent/child conflict in the form of verbal arguments; amount of time spent by the parent and child doing activities together (shared leisure time); propensity of the child to share information with the parents or keep secrets from them (child disclosure); frequency of parental punishment; extent to which negotiation is to resolve conflict by both parents and child; and consistency of parental control over the child.

those who have ever been homeless, truants, school excludees and serious or frequent offenders. Key findings were that:

- although those identified as vulnerable represented only 28 per cent of young people in the sample, they accounted for more than half (61%) of those using Class A drugs in the last year;
- five per cent of those who were not identified as vulnerable used drugs frequently during the last year compared to 24 per cent for those identified as vulnerable;
- those identified as being in more than one vulnerable group had higher levels of drug use than those in just one vulnerable group. So, frequent drug use in the last year for the former was 39 per cent, compared to 18 per cent for the latter; and
- those who had been in care or had been homeless reported the lowest levels of drug use while serious or frequent offenders and truants showed the highest. Therefore, Class A drug use in the last year was five per cent for those who had been in care or had been homeless, but 13 per cent for serious or frequent offenders and 16 per cent for truants.

Predictive and risk factors amongst vulnerable young people

Beckett *et al.* (2004)¹⁶⁸ suggested a relative hierarchy of such factors, which predict increased levels of problematic drug use among young people:

1. perceived lack of parental discipline;
2. whether the respondent's peers are using drugs;
3. their age during the interview;
4. whether they have a history of running away from home;
5. if there is a parental lack of concern about smoking or alcohol issues;
6. if there are problems in the area (such as assault or burglary);
7. perceived lack of local amenities;
8. the age at which substance use began;
9. if they have a poor school attendance (or left school before they were 16 years old); and
10. if they are not living in a household with adults.

Children living in government care

There have been a number of studies which have shown that 'looked after' young people are more likely than those living in private households to take drugs (and to smoke and drink alcohol) (Meltzer *et al.* 2003, Williams *et al.* 2001), and also tend to start using drugs at an earlier age, use at higher levels and do so more regularly than those not in care (Big Step Social Inclusion Partnership 2002; Newburn and Pearson 2002; Ward 1998; Save the Children 1995). In addition they are more likely to have experienced parental drug and alcohol misuse and may view excessive drugs and/or alcohol use as 'normal' (Ward *et al.* 2003, Newburn and Pearson 2002). There is no specific information on those aged 14 and younger.

Early school leavers

There is no information available

Homeless children

The NCCDP (Edmonds *et al.* 2005) reports that studies conducted on behalf of the Department of Health, Home Office, and the charity Crisis have indicated that whilst drug use was the same as in the general population, amongst homeless young people, prevalence and frequency of use was greater (Adamczuk 2000; Fountain and Howe, 2002; Wincup *et al.* 2003). Drug use was the second most common

¹⁶⁸ 103 young drug users (response rate 95%) completed a structured questionnaire in two study centres in England. Forty-six parents (response rate 70%) were also interviewed.

explanation for homelessness in one sample but this was not always perceived or treated as problematic use (Wincup *et al.* 2003). These reports focus on children of all ages under 18.

Youth offenders and delinquents

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; Hammersley *et al.* 2003; Borrill *et al.* 2003; Budd *et al.* 2005).

EYTC and the OCJS both looked at drug use and offending amongst young people, however only the former provides analysis, allowing consideration to be given to young people less than 15¹⁶⁹. This 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 EYTC looked at patterns of referral to Children's Hearings in Scotland (McAra 2005).¹⁷⁰ 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*. 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.

Young refugees and asylum seekers

Patel *et al.* (2004) examined the vulnerability of young refugees and asylum seekers to drug use¹⁷¹. Approximately one third of their interviewees reported lifetime use of an illegal drug, only three out of 67 were aware of the drug services available.

Children living in deprived places/neighbourhoods

There is a consensus of opinion that children living in deprived neighbourhoods are more vulnerable to drug use than other children (McVie and Norris 2006). However, information by age is not available.

¹⁶⁹ 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.

¹⁷⁰ 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.

¹⁷¹ Patel *et al.* (2005) interviewed 67 young people (aged between 16 and 25 years old) who were born in countries such as Nepal, Iraq or Zimbabwe and who had been in the UK for between six months and 13 years.

Children with Attention Deficit (and Hyperactivity) Disorders and Conduct Disorders

A *Children's Mental Health Survey* carried out in 2004 describes the prevalence of mental disorders among 5 to 16 year-olds in 2004 providing profiles of children in each of the main disorder categories (emotional, conduct, hyperkinetic and autistic spectrum disorders) and, where the sample size permits, profiles of subgroups within these categories (Green *et al.* 2005).¹⁷²

Hyperkinetic disorders

Young people with hyperkinetic disorders¹⁷³ were more likely than other young people to take drugs. 45 per cent of young people aged 14 to 16 who had a hyperkinetic disorder had used drugs compared with 16 per cent of other young people. Among the younger age group, 11 to 13, eight per cent of those with hyperkinetic disorders had used drugs compared with three per cent of those with no such disorder. Cannabis was the most commonly used drug, taken by 18 per cent of young people with a hyperkinetic disorder and seven per cent of other young people. Among the former, four per cent had taken amphetamines and three per cent had used inhalants. These substances were taken by only one per cent of other young people (Green *et al.* 2005).

Conduct disorders

Young people with conduct disorders¹⁷⁴ were much more likely than other young people to take drugs (and to smoke and drink alcohol). As was the case with emotional disorders, the largest differences were in smoking and drug taking. 28 per cent of young people with a conduct disorder had taken drugs at some time compared with only eight per cent of other young people. Differences were large even in the youngest age group: 13 per cent of 11 to 13 year-olds with a conduct disorder had taken drugs compared with two per cent of other young people. Among 14 to 16 year olds, the difference was very marked, 43 per cent compared with 15 per cent. Cannabis was the most commonly used drug, taken by 23 per cent of young people with a conduct disorder and six per cent of other young people. Among the former, five per cent had taken amphetamines and four per cent had taken inhalants. These substances had been taken by less than one per cent of other young people (Green *et al.* 2005).

Emotional Disorder

The survey found that young people with an emotional disorder¹⁷⁵ were more likely to take drugs (and to smoke, and drink alcohol) than other children. 20 per cent of young people with an emotional disorder had used drugs, mainly cannabis, compared with eight per cent of other young people (Green *et al.* 2005).

¹⁷² The surveyed population consisted of children and young people, aged 5–16, living in private households in Great Britain. The sample was drawn from Child Benefit records held by the Department for Work and Pensions' Child Benefit Centre (CBC). The set sample consisted of 12,294 families. 10,496 families were approached for interview. 7,977 were interviewed; 75 per cent of those approached, and 65 per cent of all cases.

¹⁷³ Hyperkinetic disorder is characterised by hyperactive, impulsive and inattentive behaviours. This type of disorder is sometimes referred to as Attention Deficit Hyperactivity Disorder (ADHD), which is the name for a broader (and therefore commoner but milder) disorder defined by the American Psychiatric Association.

¹⁷⁴ Conduct disorders are characterised by aggressive, disruptive or antisocial behaviour.

¹⁷⁵ Emotional disorders include separation anxiety, specific phobias, social phobias, panic disorder, agoraphobia, post traumatic stress disorder, obsessive-compulsive disorder and depression.

Children from ethnic minorities

Analysis of the 2005 school survey for England¹⁷⁶ suggest that pupils of mixed ethnicity were more likely than any other group to have taken drugs in the last year (25%) and in the last month (16%). The prevalence of drug taking in the last month among other groups ranged from eight per cent of Asian pupils to 11 per cent of white pupils; in the last year the proportions of pupils who had taken drugs ranged from 12 per cent of Asian pupils to 19 per cent of White pupils (NatCen/NFER 2006).

11.4 Correlates and consequences of substance use among very young people

11.4.1 Early alcohol and tobacco use

In Scotland, analysis of SALSUS shows that prevalence of reported drug use in the last month was higher among pupils who were regular smokers or weekly drinkers than among all pupils. Seven per cent of all 13 year olds and 20 per cent of all 15 year olds reported that they had used drugs in the last month. Among regular smokers, 59 per cent of 13 year olds and 64 per cent of 15 year olds reported that they had used drugs in the last month. Among weekly drinkers, 34 per cent of 13 year olds and 45 per cent of 15 year olds reported that they had used drugs in the last month, a lower prevalence than among regular smokers (Corbett *et al.* 2005).

The EYTC also looked at the relationship between alcohol, tobacco and drug use, reporting quite distinct patterns and trends. Analysis focused on those who were classed 'regular' users (i.e. those who smoked at least once a week, drank alcohol at least once a month or had either taken more than one type of drug or had used drugs on at least four occasions). Single substance users were predominantly alcohol users, this group accounted for only three per cent of the cohort up to age 12 but steadily increased to 26 per cent at age 15. Importantly, those who reported using all three substances showed the greatest increase in prevalence over time.

The proportion of the cohort who both drank alcohol and took drugs increased from 0.5 per cent at age 12 to 16 per cent at age 15; drinking alcohol and drug use proved to be strongly inter-connected, although drinking alcohol was far more common amongst drug users, than drug use was amongst alcohol users.

Table 11.14: Inter-relationship between alcohol and illicit drugs

Of the regular drinkers:	% regular drug users	% occasional drug users	% non-drug users
Up to age 12	15	12	73
At age 13	15	11	74
At age 14	23	18	59
At age 15	30	20	50
Of the regular drug users	% regular drinkers	% occasional drinkers	% non-drug drinkers
Up to age 12	28	63	9
At age 13	73	25	3
At age 15	84	13	2
At age 14	84	14	2

Source: McVie and Bradshaw 2005

¹⁷⁶ The survey used the 2001 census 'Level 2' classification of ethnicity.

Also, regular drug users were more likely to also drink and smoke regularly. It is suggested that this is likely, in part, to be due to the method of drug use itself, since most cannabis use involves smoking it together with tobacco.

Developmental progression of substance use

Table 11.15: Percentage of regular users who reported earlier occasional use, Scotland

Earlier use	Regular drinker	Regular smoker	Regular drug user
Occasional drinker	91	84	87
Occasional smoker	19	86	74
Occasional drug user	45	35	64

Source: McVie and Bradshaw 2005

The EYTC report shows a temporal progression of substance using behaviour (Table 11.15). It is however noted that the results do not demonstrate that occasional use of one substance 'caused' progression to regular use of that substance or another. Furthermore, regular drug users were the least likely to report occasional use at an earlier age, which might indicate that progression from occasional to regular drug use occurs more quickly amongst drug users than for drinking or smoking (McVie and Bradshaw 2005).

The 2005 school survey for England also looked at the correlation between smoking, drinking and drug use, though only amongst 15 year olds. As with those surveys referred to previously, it found that the relationship between recent use of all substances was positive. The strongest predictor of recent cannabis use was alcohol use with those having drunk alcohol in the last week twelve times more likely to have used cannabis recently than those who had never drunk alcohol. Smoking and the use of Class A drugs were also significant predictors of cannabis use. Pupils who had smoked cannabis in the last month had odds of using Class A drugs 17 times greater than those who had never smoked cannabis. Volatile substance use was the second strongest predictor of Class A drug use. (NatCen/NFER 2006).

11.4.2 Psycho-social and health problems related to substance use

Deaths related to inhalation of volatile substances

In a report on trends in death associated with volatile substance abuse (VSA), Field-Smith *et al.* (2006)¹⁷⁷ define volatile substance abuse as the deliberate inhalation of a volatile substance. In the UK, among those aged 10 to 14 years, the number of deaths associated with VSA was higher than the number associated with drug misuse for each year from 2000 to 2004, (30 VSA deaths, compared with four deaths from drug misuse over this period). Amongst 15 year olds, based on deaths in England and Wales from 2000 to 2004, the number of deaths associated with VSA was also higher than the number associated with drug misuse (18 compared with 13). In 2004 for the UK, among those aged 10 to 15 years there were eight deaths

¹⁷⁷ Information for England and Wales was provided from the following main sources: HM Coroners, Office for National Statistics, the Medical Toxicology Laboratory, Guy's and St Thomas' Hospital Trust, and press clippings agencies. For Scotland, information was supplied by the Crown Office and the General Register Office for Scotland. Details of Northern Ireland deaths were provided by the State Pathologist's Department, HM Coroner for Northern Ireland, and the General Register Office for Northern Ireland. The Deputy Viscount in Jersey, HM Greffier in Guernsey, and the High Bailiff in the Isle of Man supplied information for their areas. Data on "all cause" mortality and population estimates were supplied by ONS, and the General Register Offices for Scotland and Northern Ireland.

associated with VSA compared with three from drug misuse. At age 16 years, although the pattern was reversed (12 VSA deaths compared with 22 from drug misuse), VSA deaths were still of consequence.

Acute and chronic mental health problems

See 11.3.3

Problems directly attributed to alcohol and drug use

Studies from the UK suggest that while there is a strong association between drug and alcohol, attribution has not been shown (see 11.4.1).

Problems at school and in family

See 11.3.1

11.4. 3 Exposure to other drugs and drug use

See section 11.4.1.

11.4.4 Criminal behaviours

See section 11.3.3

Drug Offences

Analysis of the 2004 Offending, Crime and Justice Survey (Budd *et al.* 2005) provides information about the involvement of minors in perpetrating drug offences, suggesting such offending is very rare (Table 11.16).

Table 11.16: Percentage drug offending in last 12 months, by age and sex in England and Wales, 2004

Age	10 to 11 years	12 to 13 years	14 to 15 years
Male	-	1	3
Female	-	<1	2
Total	-	1	3

Source: Budd *et al.* 2005

11.5 Responses to drug problems among minors

11.5.1 National and legal developments

There are a number of developments in the area of drug use amongst minors. Not least are the policies around drug prevention, both universally and in particular around school prevention (see below). The main focus of work is around major initiatives designed to improve the health and well-being of all children. These include; *Every Child Matters* (see below) and in particular *Every child matters: change for children, young people and drugs* (DfES, HO and DH 2005); *The Children's National Service Framework*¹⁷⁸ (DH 2005), *Children at risk cross cutting review*¹⁷⁹, *Extended Schools* (DfES 2005) *Sure Start*¹⁸⁰ and *Youth Matters* (DfES 2006), *Choosing Health: making healthy choices easier* (DH 2004c), the *National*

¹⁷⁸ The Children's National Service Framework is a 10-year programme intended to stimulate long-term and sustained improvement in children's health. Setting standards for health and social services for children, young people and pregnant women, the NSF aims to ensure fair, high quality and integrated health and social care from pregnancy, right through to adulthood.

¹⁷⁹ See: http://www.hm-treasury.gov.uk/spending_review/spend_ccr/spend_ccr_child.cfm

¹⁸⁰ See: <http://www.surestart.gov.uk>

*Behaviour and Attendance Strategy*¹⁸¹, *National Health and Schools Programme and Blueprint*¹⁸².

In Wales initiatives include *The Framework for Partnership*¹⁸³, *The Children and Youth Support Fund*¹⁸⁴, the *Children's National Service Framework* (Welsh Assembly Government 2005b) and the Children's Commissioner for Wales¹⁸⁵. In addition, the Welsh substance misuse strategy (National Assembly for Wales 2000) includes supporting the children of problem substance misusers as an important objective.

In Scotland, *Children: Better Integrated Children's Services* (Scottish Executive 2001) highlighted the major impact of parental problem drug use on children and stresses that helping children with drug misusing parents is a task for health education and social services. Also, *The Changing Children's Services Fund*¹⁸⁶ was expected to be used, in part, to fund initiatives designed to help the children of problem drug users. *The Drugs Action Plan: Protecting Our Future* (Scottish Executive 2000) identified the children of drug misusing parents as a priority group. Good practice guidance for working with children and families affected by substance misuse were published in 2003. All Alcohol and Drug Action Teams (ADATs) and Area Child Protection Committees were required to have in place local policies on support to drug misusing parents and their children in line with national guidance. In addition *Sure Start Scotland*¹⁸⁷, *Social Inclusion Partnerships*¹⁸⁸ and *Starting Well* were initiatives, all designed to improve the well-being of children in disadvantaged areas

In Northern Ireland the *Children (Leaving Care) Act 2002* and the *Protection of Children and Vulnerable Adults Order 2003*. A new drug strategy for Northern Ireland, *New Strategic Direction for Alcohol and Drugs 2006-2011* (DHSSPSNI 2006a), has prevention as a core aim and also, in order to ensure effective and co-ordinated implementation has established a new Strategic Direction for Alcohol and Drugs Steering Group (NSDSG) to maintain an overview of the strategy; reporting to which will be four advisory groups, one of which will be concerned with children, young people and families.

Every Child Matters

In December 2003, the Government published the Green Paper *Every Child Matters* (HM Treasury 2003). The Paper sets out the need to ensure that every child is properly protected from risk and is supported in reaching their full potential. The *Children Act 2004* will help to embed its principles in legislation. Although the Paper and the legislation go beyond drug prevention, the Paper's five key outcomes are:

- being healthy;
- staying safe;
- enjoying and achieving;
- making a positive contribution to the community and society; and

¹⁸¹ See: <http://www.dfes.gov.uk/behaviourandattendance/index.cfm>

¹⁸² See: <http://www.drugs.gov.uk/young-people/blueprint/>

¹⁸³ See: <http://new.wales.gov.uk/topics/childrenyoungpeople/frameworkpartnership/?lang=en>

¹⁸⁴ See: <http://www.surestart.gov.uk/aboutsurestart/help/contacts/wales/>

¹⁸⁵ See: <http://www.childcom.org.uk/english/index.html>

¹⁸⁶ See: <http://www.scotland.gov.uk/Topics/People/Young-People/children-services/17842/10263>

¹⁸⁷ See: <http://www.surestart.gov.uk/aboutsurestart/help/contacts/scotland/>

¹⁸⁸ See:

http://www.communitiesscotland.gov.uk/stellent/groups/public/documents/webpages/cs_006369.hcsp

- economic well-being.

The exposure of young people to drug use is one of a number of issues the paper under the 'be healthy' outcome addresses. This paper and a consultation which followed, *Every child matters: next steps* (DfES 2004a), culminated in *Every child matters: change for children* (DfES 2004b), which sets out the national framework for local change programmes. These are intended to build services around the needs of children and young people so as to shift the focus from dealing with the consequences of difficulties in children's lives to preventing things from going wrong in the first place.

Every child matters: change for children, young people and drugs (DfES, HO and DH 2005) outlined the Government's strategy of linking the delivery of *Every Child Matters* to the National Drug Strategy by developing universal, targeted and specialist services to prevent drug harm and to ensure that children and young people are able to reach their potential. Local authorities are expected to progress towards meeting the required objectives and Drug (and Alcohol) Action Teams (D(A)ATs) and Directors of Children's Services are required to agree priorities and set targets with respect to young people.

Every Child Matters: change for children young people and drugs outlined the links between the Young People's strand of the Drug Strategy and *Every Child Matters* and highlighted three priorities to reduce drug use amongst young people:

- Reforming delivery and strengthening accountability.
- Ensuring provision is built around the needs of vulnerable children and young people through a greater focus on prevention and early intervention by all agencies providing services for children.
- Building service and workforce capacity.

The *Young People's Substance Misuse Grant*, pooling funding from a number of government departments, was introduced nationally in 2004, and is used in addition to mainstream funding to support the provision of a comprehensive range of support for young people as outlined in *Every Child Matters Change for Children Young People and Drugs*. Joint teams¹⁸⁹ based in Government Office (GO) regions are supporting and driving the implementation of this strategy locally. These teams are responsible for identifying local problems and challenges, provide performance management and interventions, and are involved in negotiating targets.

A number of High Focus Areas have been selected, which are expected to make more rapid and sustained progress in implementing the vision and priorities set out in this plan during 2005/06. The twin objectives of the work in the high focus areas 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.

High focus areas have been selected on a range of criteria based on local need and levels of current service provision and include deprived/high crime areas where drug misuse problems are prevalent (DfES, HO and DH 2005).

¹⁸⁹ With staff from Government Office drug and crime teams, the DfES, the Youth Justice Board, the National Treatment Agency for Substance Misuse, Public Health and various regional bodies.

Youth Matters

Following on from *Every Child Matters*, the Government also published a Youth Green Paper called *Youth Matters* (DfES 2005); this was a consultation document, seeking views on how to reform services in England to improve outcomes for all young people aged 13 to 19, especially those who are vulnerable. It aims to restructure young people's services so that they have more choice and influence, encourage young people to participate in voluntary and community work, provide better information to them on the subjects that interest them and in a way that suits them, and to provide better support to those who need it. Following consultation, the Government response, *Youth Matters: Next Steps* (DfES 2006) was published in March 2006 and sets out the vision for empowering young people, giving them somewhere to go, something to do and someone to talk to. Subject to Parliamentary approval, a new duty on local authorities will seek to ensure that young people have access to a wide range of positive activities. Statutory guidance on how national standards relate to the new duty is expected to be issued in late 2006.

National Healthy Schools Standard

In England, all schools in the most disadvantaged areas are to become 'Healthy Schools' by 2006 with all schools working towards Healthy School status by 2009/10 (see UK Focal Point Report 2004). The percentage of schools achieving the National Healthy Schools Standard (NHSS)¹⁹⁰ is one of the Key Performance Indicators of *Every Child Matters* (DfES *et al.* 2005).

Drugs education in schools

Drugs education is a key component of the UK drug strategy; guidance for schools has been published (DfES 2004c). In England and Northern Ireland, it is a statutory part of the national curriculum. The aim is to develop children's knowledge, skills, attitudes and understanding about drugs in order to resist them. In Scotland, while there is no statutory curriculum, the majority of schools provide drug education (Scottish Executive 2003). Guidance on drug education for schools in England (DfES 2004c) and in Northern Ireland (DENI 2004) was published in 2004. In these countries drugs education is teacher led. However, in Wales, the police-led *All Wales Schools Programme* encourages Police School Liaison Officers to work together with schools and Personal Social Education teachers under this aspect of prevention.

The Office for Standards in Education (Ofsted) is responsible for inspecting the quality of drugs education in schools in England and Her Majesty's Inspectorate of Education in Scotland.

Two initiatives have been developed by government to inform prevention work. Blueprint, launched in 2003 is a prevention based research programme examining the effectiveness of a multi-component approach to drug education (Baker 2006). The National Collaborating Centre for Drug Prevention (NCCDP), a research partnership between the National Institute for Health and Clinical Excellence (NICE) and the Centre for Public Health at Liverpool John Moores University has been funded to build the evidence base for drug prevention. By identifying the most

¹⁹⁰ The NHSS aims to support schools in creating an enjoyable, safe and productive learning environment. It covers eight areas: Personal, Social and Health Education (PSHE); citizenship; drug education (including tobacco and alcohol); emotional health and well being (including bullying); healthy eating; physical activity; safety; sex and relationship education; and local healthy school programmes. Health partnerships support schools in enabling them to become healthier places. Please see: <http://www.standards.dfes.gov.uk> for further details.

effective characteristics of programmes and interventions, which have the most impact upon preventing drug misuse, the NCCDP informs national and local policy and practice on drug misuse prevention and provides guidance for those delivering front line drug prevention services. The NCCDP has already conducted reviews of non-traditional evidence and scholarly articles, developed guidance on putting evidence into practice, assisted with the development and evaluation of prevention programmes and continues to provide a national information service.¹⁹¹

Several schools in Kent are introducing random drug testing of pupils in September 2006 as part of a pilot scheme to evaluate this approach to identifying drug use at an early stage. The scheme was introduced in one school in Kent in 2005. It is reported that the school saw an improvement in behaviour and exam results. DfES are now working with the former headmaster of this school to produce guidelines for other schools who may wish to adopt the scheme¹⁹². National policy remains unchanged on drug testing and it remains for individual head teachers in partnership with local agencies and in the context of appropriate provision to decide how to approach drug use in their schools. It is reported that the Scottish Executive is not considering drug testing in schools.¹⁹³

Specific regulations and level of enforcement of alcohol and tobacco restrictions

The current legislation covering the sale of tobacco products is contained in *The Children and Young Persons (Protection from Tobacco) Act 1991*. This imposes penalties for the sale of tobacco to persons under the age of 16 years.

The Licensing Act 2003 brought about changes in the law on the sale of alcohol to anyone under the age of 18. This new Act made it an offence to sell alcohol to young people anywhere, not just on licensed premises, or for a club to supply alcohol on club premises to a person under 18. It is also an offence for someone under 18 to purchase, or attempt to purchase alcohol, or be supplied with alcohol in a club; to send anyone under the age of 18 to obtain alcohol; to buy, or to attempt to buy alcohol for an under 18 or for an under 18 to consume alcohol on licensed premises. This does not apply if the purchase is for someone aged 16 or 17 and it is either beer, wine or cider and it is consumed at a table meal on the premises, and they are accompanied by someone aged 18 or over. Table meals do not include bar snacks.

In the case of both tobacco and alcohol, retailers are expected to be shown evidence of age, either through a photo driving license or a passport, or an accredited proof of age card, such as a Citizen Card, the Portman Card, or the Connexions Card.

Specific regulations on volatile substances

Volatile substance abuse is not an offence in itself, but the supply or sale of any product to a person under the age of 18 with the knowledge that they are going to inhale it for the purposes of abuse is an offence. The sale of butane is a priority; regulations under *The Consumer Protection Act 1987 (Section 12)* regarding offences of selling butane lighter refills are nationwide, although there are some differences in Scottish law; shopkeepers can be prosecuted under common law if it can be proved that they knew that the product would be abused by the purchaser irrespective of age. *The Cigarette Lighter Refill (Safety) Regulations 1999* banned

¹⁹¹ See: <http://www.drugpreventionevidence.info/>

¹⁹² See:

<http://www.teachernet.gov.uk/teachers/issue45/secondary/news/Randomdrugtestsforpupils/> and <http://news.bbc.co.uk/1/hi/education/5032902.stm> and <http://www.timesonline.co.uk/article/0,,2-2204492,00.html>

¹⁹³ See: <http://news.bbc.co.uk/1/hi/scotland/5341700.stm>

the supply or sale of butane cigarette lighter refills to people under the age of 18. The penalties for selling butane gas lighter refills to anyone under 18 are a sentence of up to six months' imprisonment, or a maximum fine of €7,315 (£5,000), or both. Also in Scotland, *the Solvent Abuse (Scotland) Act 1983* amended the 1968 Act and made VSA in itself a specific ground for referral to the Children's Reporter. Where statutory intervention is considered necessary, the Children's Reporter will arrange a Children's Hearing to consider what action is required. There is also a system of voluntary warning labels for aerosols and other products that can be abused.

Strategies and policies for social exclusion, ADD etc that refer to drug use among minors

See *Every Child Matters* and *High Focus Areas* referred to previously in this section.

11.3.2 Prevention and treatment

Specific treatment options for young problematic drug users

Provision is made available locally for young people through mainstream funding and the Young People's substance Misuse Partnership Grant. Local areas are asked to ensure that comprehensive support is available for young people. In addition for drug misusers identified through the criminal justice system specific responses are being piloted for young people.

Drug testing pilots for 14 to 17 year olds

Twenty-two custody suites are piloting drug testing for 14 to 17 year-olds who are charged with those crimes most often linked to drugs. The purpose is to identify those young people who may be at risk of developing a problem with drugs and offending, in order to intervene early. If a young person does test positive for a specified Class A drug after charge, the arrest referral scheme will be able to facilitate access to appropriate interventions or services, following an assessment of their needs.

10 to 17 year olds

From the 1st December 2004, there have been pilots of two community sentences for young people (Action Plan Orders and Supervision Orders), under new legislative powers within the *Criminal Justice Act 2003*. This new provision is targeted at young people who have or are at risk of developing substance misuse problems and who may benefit from structured care planned treatment as part of a community sentence. It provides the courts with a sentencing option for young offenders specifically designed to tackle their drug misuse, providing a credible alternative to custody. The pilots are being independently evaluated and will contribute to the evidence base of working with children and young people exhibiting risk-taking behaviour.

Institutional responses

Responses through social reintegration

See, *Every Child Matters* and *High Focus Areas* in section 11.3.1. In addition there are specific initiatives to encourage young people to undertake activities seen as alternatives to drug use. In Scotland 31 projects are to share €863,000 (£590,000) from the Scottish Drugs Challenge Fund. This scheme aims to unite the public, private and voluntary sector in helping communities stand up to the problems of drug misuse in Scotland at grassroots level (Scottish Executive 2006f). Projects include football based diversionary activities, helping young people with a drug problem to acquire skills, music and film-based diversionary projects; one project aims to teach young people fly-fishing. In England and Wales, Positive Futures is a national social inclusion programme using sport and leisure activities to engage with disadvantaged

and socially marginalised young adults . It is delivered across 119 partnership projects.¹⁹⁴ Also see Chapter 3.2.2.

Trends and changes in recent years

There has been a strong focus on vulnerable young people in the UK in recent years as seen in the *Every Child Matters* agenda, both in terms of prevention, through targeted responses and in the provision of specialist treatment, separate from adult treatment services, which should provide a holistic range of interventions (see below).

Early intervention strategies and indicated prevention for at risk children

Targeted interventions for young people foresee:

- Early assessment of all vulnerable children and young people in key risk groups for drug misuse problems, as part of wider needs assessment. Drug misuse issues are part of the Common Assessment Framework for children and young people, to enable practitioners' first assessments of need to pick up on drug misuse issues and to lead to effective intervention.
- Care management and appointment of a lead professional for all children and young people who need support and intervention on drug misuse, in line with *Every Child Matters: Change for Children*.
- Integrated information systems to help agencies work together to track interventions with individual children and young people with particular consideration given to provision for the following 'at risk' groups. It is expected that protocols be in place to provide prompt access to specialist services where required.

Vulnerable young people identified as at risk of developing problems around drugs are: children of problem drug users; persistent truants and school excludees; 'looked after' children; young offenders and others, including homeless young people, young people abused through prostitution, teenage mothers and young people not in education, employment or training.

Care Matters

The *Looked After Children Green Paper* published in 2006 includes proposals to ensure that drug use is identified through Health Assessments with Looked After Children and training is provided on drug issues to foster carers.

Volatile substance abuse

A *National Framework for VSA* published July 2005 (DH *et al.* 2005) sets out an action plan aimed specifically at reducing deaths and harms associated with VSA. It aims for:

- a progressive decline in the number of deaths from VSA by children, young people and adults;
- a reduction in the incidence of harm from accidents and trauma as a result of abusing volatile substances;
- an increase in public awareness of VSA and its risks;
- increased identification of children and young people abusing or at risk of abusing volatile substances; and
- a reduction in illegal under-age sales of volatile substances to children and young people.

¹⁹⁴ See: <http://www.drugs.gov.uk/young-people/positive-futures/>

Specific actions are to:

- provide effective education on VSA to all children and young people, including the most disadvantaged;
- provide effective targeted interventions for children and young people abusing or at risk of abusing volatile substances;
- reduce the availability and accessibility of volatile substances, with a focus on butane gas lighter refills;
- build the capacity of parents, carers and practitioners to identify and work effectively with children and young people who are abusing or at risk of abusing volatile substances; and
- increase the evidence base with regard to what works in reducing deaths and harm from VSA.

The effectiveness of the work will be monitored principally by the number of VSA deaths among children and young people each year.

The action plan identifies new interventions. A key priority area is to provide better information about VSA, including through the FRANK information helpline.

The Scottish Executive has also developed a comprehensive programme of action that includes providing advice on solvents through the Know the Score information line, the distribution of materials to retailers in 2005 to raise awareness of the law governing sales of the items in question and the provision of drug education, including about solvents, in nearly all schools.

In addition, throughout the UK Government's support proof-of-age cards.

Training for general practitioners, paediatricians, social services and families to identify and respond to risk profiles such as ADD, CD, ODD

Identifying these is part of the training offered to medical practitioners.

Early identification and treatment for Attention Deficit Disorders

Child and Adolescent Mental Health Services are expected to consider issues around substance misuse in the diagnosis and treatment of all referrals.

Selective prevention for families at risk

In response to the Hidden Harm Report (ACMD 2003) on the impact on family members, and particularly children, living with substance misusing parents, including the *Every Child Matters* programme introduced to ensure that children of drug using parents are provided for, known as the *Hidden Harm Agenda*. Specific reference has now been made to the children of drug using parents in local *Safeguarding Children's Board Guidance*. The ACMD¹⁹⁵, responsible for the 2003 report on the problems for the children of drug using parents (ACMD 2003) recommends that DfES to write to LSCB and the Home Office to DATs to ensure this is highlighted and also that this guidance is supported by specific reference being made to this group of children in other key documents. In particular they are concerned that the *Every Child Matters: Core Common Assessment Framework* (CAF) includes specific trigger questions in guidance and checklists, as this has been seen to identify a higher number of children at risk of parental substance misuse. It wishes DH to:

¹⁹⁵ See: <http://www.drugs.gov.uk/publication-search/young-people/acmd-letter-lscb?view=Binary#search=%22Local%20%20Safeguarding%20Children's%20Board%20Guidance.%20%20ACMD%20%22>

- screen all pregnant women for substance misuse and routinely record such information – this is not currently the case;
- provide specific guidance and protocols to support specialist care for pregnant drug users needs to be in place in all maternity hospitals - therefore need to check the progress of NICE referred to in recommendation 18 (plus 19 and 20 years olds in need).

Primary Care Trusts need to ensure that children of PDU's health and well being are being met with the Single Plan for Children and Young People, under the Staying Healthy outcome of *ECM*, as well as contributing to ensuring their safety under the Staying Safe outcome. Appropriate responses to this group of children are required within developing Children's Trusts and across mainstream health services. For children of drug using parents Sure Start¹⁹⁶ is also expected to play a key role.

The Scottish Executive commissioned a number of pieces of research and a scoping study by Templeton *et al.* (2006). It also established a *Think Tank* on the impact of parental drug use (Russell 2006). Following this work, the Scottish Executive strategy is set out in the strategy on children of drug using parents (Scottish Executive 2006c). Key actions include:

- initiating, across Scotland, by March 2007, a framework for automated messages to be sent to all practitioners involved whenever the social work system records a formal child protection activity;
- through the Social Work Inspection Agency, conducting a pilot multi-agency inspection of substance misuse services, which will include the impact of these services on the children of clients;
- ensuring all ADATs and Child Protection Committees have in place local protocols and policies for joint working across agencies with children and families affected by substance misuse (as set out in *Getting our Priorities Right*);
- promoting partnerships between local statutory agencies and voluntary organisations;
- continuing to encourage agencies, including those whose primary focus is on adults, to ensure staff have access to appropriate training, including multi-agency training where appropriate;
- monitoring the impact of the extra €18 (£12) million provided to local authorities for investment in local fostering services to ensure it meets the aims of improving recruitment, retention and placement choice;
- considering the findings of the audit of foster care commissioned from *The Fostering Network*¹⁹⁷, which includes recommendations about training, placement limits and allowances, and action as appropriate; and
- developing a new national fostering strategy, in 2006-2007.

In addition, the Executive and local agencies are to explore possible facilities for children and young people so that they can access direct help for themselves.

Drug tests for parents

It has been reported by the BBC that drug tests for parents are being discussed and suggests that if parents can prove they are drug free their children will be returned to them¹⁹⁸.

¹⁹⁶ Sure Start is the government programme to deliver the best start in life for every child. It brings together, early education, childcare, health and family support.

¹⁹⁷ For more information see: www.fostering.net

¹⁹⁸ For more information see: <http://news.bbc.co.uk/1/hi/scotland/4824122.stm>

12. Cocaine and crack

12.1 Prevalence, patterns and trends of cocaine and crack use

12.1.1 Cocaine use among the general population

15 to 64 years olds

A United Kingdom estimate of drug use in the general population produced in 2005 (Hay 2005), is based on the British Crime Survey (BCS)¹⁹⁹ for 2003/04, the Northern Ireland Drug Prevalence Survey (NIDPS)²⁰⁰ for 2002/03 and the Scottish Crime Survey (SCS)²⁰¹ for 2003.

Table 12.1 shows that lifetime, recent (last year) and current (last month) use in England and Wales is considerably higher than in Northern Ireland and Scotland, 6.8, 2.5 and 1.1 per cent respectively. Based on the Northern Ireland Crime Survey²⁰² for 2004, Northern Ireland has the lowest prevalence. Based upon the Northern Ireland Drug Prevalence Survey for 2002/03, estimates for lifetime, recent and current use are even lower; 1.6, 0.5 and 0.1 respectively.

Table 12.1: Percentage prevalence of drug use by drug and country among 15 to 64 year olds in the United Kingdom

Drug	BCS 2003/04	NICS 2003/04	NIDPS 2002/03	SCS 2003	UK*
	16 to 59	16 to 59	15 to 64	16 to 64	15 to 64
Lifetime prevalence					
Any drug	35.6	27.4	20.0	23.4	34.1
Cocaine (including crack)	6.7	3.3**	1.6	4.6	6.5
Last year prevalence					
Any drug	12.3	9.7	6.4	8.5	11.8
Cocaine (including crack)	2.4	1.1**	0.5	1.4	2.3
Last month prevalence					
Any drug	7.5	6.2	3.4	4.7	7.1
Cocaine (including crack)	1.1	0.6**	0.1	0.4	1.0
Base	24,422	3,104	3,516	4,665	35,707

¹⁹⁹ In England and Wales, the British Crime Survey (BCS) is a crime and victimisation household survey. It questions respondents, aged 16 to 59, about a number of crime-related topics including their experience of illicit drugs. In 2002, it became a continuous survey, reporting quarterly. The sample size for the drugs module was 24,422 in 2003/04.

²⁰⁰ The Northern Ireland Drug Prevalence Survey is based on the European Model Questionnaire and recommended methodology. The 2002/03 was the first such survey carried out in Northern Ireland. 3,516 people completed the Drug Prevalence Survey and 3,104 people completed the drugs component of the Northern Ireland Crime Survey.

²⁰¹ The Scottish Crime Survey (SCS) is a crime and victimisation survey. It asks comparable questions to those in the BCS but surveys all adults aged 16 years and over. 4,665 people completed the drugs section of the survey in 2003.

²⁰² The Northern Ireland Crime Survey is a crime and victimisation household survey. It questions respondents, aged 16 to 59, about a number of crime-related topics including their experience of illicit drugs.

* The United Kingdom estimate is achieved by combining the data from the British Crime Survey, the Northern Ireland Drug Prevalence Survey and the Scottish Crime Survey.

** These figures for the Northern Ireland Crime Survey are for cocaine only (and do not include data for crack).

Source: Standard Tables prepared for UK Focal Point

Young people

Young people have a higher prevalence of use in all three recall periods, with the wider age group (15 to 34) having higher lifetime and recent prevalence, but the younger age group (15 to 24) being more likely to have used currently. (Table 12.2)

Table 12.2: Percentage prevalence of drug use by drug and country amongst 15/16 to 24 and 15/16 to 34 year olds in the United Kingdom

Drug	BCS 2003/04		NICS 2003/04		NIDPS 2002/03		SCS 2003*		UK*	
	16/24	16/34	16/24	16/34	15/24	15/34	16/24	16/34	15/24	15/34
Lifetime prevalence										
Any drug	46.6	48.2	40.1	41.7	28.5	30.9	39.8	38.5	45.4	46.9
Cocaine (including crack)	9.1	11.6	5.4**	5.9**	2.6	2.9	10.8	8.7	9.0	11.1
Last year prevalence										
Any drug	27.8	22.1	24.0	18.3	14.5	11.6	25.9	18.0	27.2	21.4
Cocaine (including crack)	5.0	4.9	2.5**	2.5**	1.4	1.0	5.1	3.2	4.9	4.7
Last month prevalence										
Any drug	17.3	13.6	16.2	12.1	9.0	6.1	15.6	10.4	16.9	13.1
Cocaine (including crack)	2.7	2.4	1.5**	1.5**	0.2	0.2	1.3	0.9	2.5	2.2
Base	5,429	8,590	286	817	768	1,550	619	1,193	N/K	N/K

* The United Kingdom estimate is achieved by combining the data from the British Crime Survey, the Northern Ireland Drug Prevalence Survey and the Scottish Crime Survey.

** These figures for the Northern Ireland Crime Survey are for cocaine only (and do not include data for crack).

Source: Standard Tables prepared for UK Focal Point

Lifetime use in England and Wales and Scotland is much higher than in Northern Ireland, though for recent and current use the difference between parts of the UK is narrower.

12.1.2 Trends in cocaine use

Trends over time can be best seen through looking at data from each country individually.

Trends in cocaine and crack use in England and Wales: 1996 to 2005/06

The use of drugs in the general population in England and Wales has been measured since 1994 when the British Crime Survey first began to monitor drug prevalence; however published information based on the 1994 crime survey does not provide data on prevalence of cocaine (Ramsey and Percy 1996). Table 12.3 shows trends in use of cocaine powder (cocaine) and crack cocaine (crack) between 1996 and 2005/06 amongst the population aged 16 to 59 and Table 12.4 amongst the population aged 16 to 24.

Table 12.3: Percentage prevalence of adults aged 16 to 59 reporting having used any drug, cocaine and crack in England and Wales, 1996 to 2005/06

Drug	1996	1998	2000	2001/ 02	2002/ 03	2003/ 04	2004/ 05	2005/ 06
Any Drug								
Lifetime	30.5	33.6	35.7	34.0	35.7	35.6	34.5	34.9
Last year	11.1	12.1	11.9	11.9	12.2	12.3	11.3	10.5* **
Last month	6.7	7.1	7.2	7.4	7.4	7.5	6.7	6.3*
Cocaine								
Lifetime	3.0	3.7	5.5	5.1	6.1	6.7	6.0	7.2* **
Last year	0.6	1.2	2.0	2.0	2.1	2.4	2.0	2.4* **
Last month	0.2	0.4	0.7	0.9	0.9	1.1	0.9	1.2* **
Crack								
Lifetime	0.7	0.7	1.1	0.7	0.9	0.9	0.8	0.9
Last year	0.1	0.1	0.3	0.2	0.2	0.2	0.1	0.2
Last month	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.1*

*Statistically significant change at the 5% level from 1998 to 2005/06

**Statistically significant change at the 5% level from 2004/05

Source: Roe and Man 2006

Table 12.4: Percentage prevalence of 16-24 year olds reporting having used any drug, cocaine and crack in England and Wales, 1996 to 2005/06

Drug	1996	1998	2000	2001/ 02	2002/ 03	2003/ 04	2004/ 05	2005/ 06
Any Drug								
Lifetime	48.6	53.7	52.0	49.1	48.2	47.5	46.0	45.1*
Last year	29.7	31.8	29.9	30.0	28.5	28.3	26.5	25.2*
Last month	19.2	20.8	19.0	19.3	18.1	17.5	16.4	15.1*
Cocaine								
Lifetime	4.3	6.8	10.4	8.6	9.3	9.7	9.1	10.6* **
Last year	1.3	3.1	5.2	5.1	5.1	5.2	5.1	5.9*
Last month	0.5	0.9	1.8	2.2	2.1	2.7	2.1	3.0* **
Crack								
Lifetime	1.7	1.5	2.3	1.	1.3	1.6	1.1	1.3
Last year	0.2	0.3	0.9	0.5	0.5	0.4	0.1	0.4**
Last month	0.2	0.0	0.2	0.1	0.3	0.2	0.1	0.2

*Statistically significant change at the 5% level from 1998 to 2005/06

**Statistically significant change at the 5% level from 2004/05

Source: Roe and Man 2006

A report based on surveys from 1994 to 1998 suggested that cocaine was the one specific substance for which there was a significant increase, for recent use, for all respondents, both male and female and that amongst young people there were significant increases in its use for all three recall periods between 1996 and 1998 (Ramsey and Partridge 1999). In 2000, a comparatively large increase in use was again reported (Ramsey *et al.* 2001). From 2000 to 2003/04 recent use of cocaine remained broadly stable and in 2004/05 decreased amongst 16 to 59 year olds (as did the use of 'any drug') since the previous year (2003/04). Over that year there was also a significant decrease in use by young people aged 16 to 24. Nevertheless, amongst this group, in 2004/05 cocaine was the next most commonly used drug after cannabis, the latter used by 23.5 per cent recently, and 4.9 per cent currently. In 2005/06 the use of 'any drug' continued to fall but cocaine use increased significantly to 2003/04 levels or higher for lifetime and current use.

It is of note that the increase in use of cocaine may be related to the decrease in the use of amphetamines over the same period (see Figures 2.1 to 2.3 in Chapter 2).

Reported use of crack in England and Wales has remained essentially stable since 1996 but, after a significant fall in 2004/05, use amongst 16 to 24 year olds increased significantly in 2005/06 back to 2003/04 levels. (Tables 12.3 and 12.4) (Roe and Man 2006).

Trends in cocaine and crack use in Northern Ireland: 1998 to 2003/04

Trends in cocaine use in Northern Ireland can be best identified through the Northern Ireland Crime Survey (NICS) which has been reporting drug use since 1995 (Table 12.5). This shows an increase in lifetime use for both adults and young people over time. For 2002/03, data from the Northern Drug Prevalence Survey show lower prevalence. This might suggest that prevalence estimates based victimisation surveys produce higher estimates than results obtained from the European Model Questionnaire. Prevalence is again higher amongst young people.

Table 12.5: Percentage lifetime prevalence of any drug, cocaine and crack by age in Northern Ireland, 1998 to 2003/04

Drug	1998 NICS	2001 NICS	2002/03 NIDPS	2003/04 NICS 04
Age	16-59	16-59	15-64	16-59
Any drug	24	26	20.0	25.4
Cocaine	2.0	2.0	1.6	3.3
Crack	1.0	<1.0	0.2	0.8
Young people		16-24	15-24	15-24
Any drug		43		40.1
Cocaine		3.0	1.6	5.4
Crack		0.0	0.2	0.7

Source: Hague *et al.* 2000; McMullan and Kerr 2003; McMullan and Ruddy 2005; NACD and DAIRU 2005

Trends in cocaine use in Scotland: 1996 to 2004

Scotland shows a rise in use, particularly between 2000 and 2003 (Table 12.6). Analysis has not been undertaken for current prevalence over this time period.

Table 12.6: Percentage prevalence of illegal drug use amongst adults by drug in Scotland from 1993 to 2004

Drug	1993	1996	2000	2003	2004	%change 1993 to 2004
Lifetime prevalence						
Any drug	18.5	22.5	19.2	25.3	23.7	+5.2
Cocaine powder	1.5	2.6	2.5	4.6*	4.6	+3.1 **
Crack	0.4	0.7	1.0	1.2	1.2	+0.8 **
Last year prevalence						
Any drug	6.8	9.0	6.6	9.2	7.7	+0.9
Cocaine powder	0.4	1.0	0.7	1.4	1.5	+1.1 **
Crack	-	0.2	-	0.2	0.2	+0.2 *
Base	3,196	3,175	2,886	4,665	2,955	

Data for 1996 and 2000 are for those aged 16 to 59 reported by Fraser (2002), 2003 data are for those aged 16 to 64 and are derived from the Standard Table.

*significant at the 95 per cent confidence interval

** significant at the 99 per cent confidence interval

Source: Murray and Harkins 2006

For those aged 16 to 34 and 16 to 24 data are only available for 2003 and 2004. This shows a decrease in use of cocaine from 2003 to 2004 (Table 12.7).

Table 12.7: Percentage prevalence of illegal drug use among 16 to 24 and 16 to 34 year olds by drug in Scotland, 2003 and 2004

Drug	16 to 24 years		16 to 34 years	
	2003	2004	2003	2004
Lifetime prevalence				
Any drug	39.8	35.2	38.5	36.2
Cocaine (including crack)	10.8	5.6	8.7	8.1
Last year prevalence				
Any drug	25.9	24.0	18.0	15.7
Cocaine (including crack)	5.1	3.0	3.2	2.9
Last month prevalence				
Any drug	15.6	13.1	10.4	8.4
Cocaine including crack)	1.3	0.5	0.9	0.7

Base numbers not known

Source: Standard Tables prepared for UK Focal Point based on crime surveys

Estimated number of users in England and Wales 2004/05

Estimates of the actual number of cocaine and crack users are available for England and Wales (Table 12.8).

Table 12.8: Estimates of number of those who used cocaine and crack in the last month aged 16-59 and 16 to 24 in England and Wales, 2004/05 and 2005/06

Drug	16-59 years		16-24 years	
	2004/05	2005/06	2004/05	2005/06
Cocaine				
Best Estimate	279,000	368,000	127,000	188,000
Lower Estimate	241,000	325,000	103,000	158,000
Higher Estimate	324,000	418,000	155,000	223,000
Crack				
Best Estimate	16,000	25,000	4,000	13,000
Lower Estimate	9,000	16,000	1,000	7,000
Higher Estimate	30,000	41,000	13,000	26,000

Source: Roe 2005; Roe and Man 2006

Gender differences

As with use of most drugs, males are more likely to use than females (Tables 12.9 and 12.10).

Table 12.9: Percentage prevalence of use of any drug, cocaine (including crack) among adults aged 16-59 by gender in England and Wales 2005/06, Northern Ireland 2003/04 and Scotland 2004

Drug	BCS 2005/06		NICS 2003/04		SCS 2004	
	Male	Female	Male	Female	Male	Female
Lifetime						
Any Drug	40.6	29.4	31.6	23.7	25.7	18.9
Cocaine (including crack)	9.5	5.1	4.4*	2.3*	5.3	3.5
Last year						
Any drug	13.7	7.4	11.5	8.1	8.1	6.2
Cocaine (including crack)	3.4	1.6	1.5*	0.7*	1.5	1.2
Last month						
Any drug	8.6	4.0	7.4	5.1	4.9	2.6
Cocaine (including crack)	1.7	0.7	0.9*	0.3*	0.7	0.2
Base	13,434	16,170	957	1,164	1,685	1,765

* These figures for the Northern Ireland Crime Survey are for cocaine only (and do not include data for crack).

Source: Standard Table prepared for UK Focal Point based on crime surveys

Table 12.10: Percentage prevalence of use of any drug, cocaine (including crack) among 16-24 and 16-34 year olds by gender in England and Wales 2005/06 and Scotland 2004

Drug	BCS 2005/06				SCS 2004			
	16-24		16-34		16-24		16-34	
	Male	Female	Male	Female	Male	Female	Male	Female
Lifetime								
Any Drug	49.2	40.9	52.0	41.3	35.6	34.7	39.0	33.5
Cocaine*	13.3	8.2	15.3	8.9	3.8	7.3	9.0	7.2
Last year								
Any Drug	29.9	20.6	24.9	14.1	17.7	20.3	15.9	14.1
Cocaine*	7.6	4.3	6.5	3.3	2.1	3.8	2.8	2.8
Last month								
Any Drug	19.2	11.1	15.6	7.9	11.1	7.3	9.8	5.8
Cocaine*	4.1	2.0	3.2	1.6	1.0	0.0	1.1	0.3

*includes crack

data for this age group is not available by gender in Northern Ireland

Source: Standard Table prepared for UK Focal Point based on crime surveys

Age of first use

Analysis of age of first use in England and Wales in 2004/05 does not provide information by particular drugs. The 2004 SCVS suggests a majority of both men and women start to use cocaine in their early twenties (Murray and Harkins 2006). In Northern Ireland the average age of first use of cocaine powder was age 22; no regular female users of cocaine powder were identified in the survey (NACD and DAIRU 2006). In both surveys base numbers are small and therefore, findings should be treated with caution.

Regional differences

Differences in cocaine use between England and Wales, Northern Ireland and Scotland have been referred to previously. Within England and Wales, Ramsey and Partridge (1999) reporting on the 1998 BCS looked specifically at regional variations in use of cocaine and showed that it was more prevalent in London, the South and Merseyside than elsewhere in England and Wales. Roe (2005), reporting on the 2004/05 BCS found that London, the North West, (of which Merseyside is a part) and the South, (both South East and South West), continued to have a higher prevalence than the rest of England, all with recent prevalence of over two per cent, though

Wales also had a prevalence rate of 2 per cent. In 2005/06 a rise in recent cocaine use was reported across all regions apart from Wales where it had fallen. London continued to have the highest prevalence but use in the North East rose above other regions, having the second highest prevalence of recent cocaine use in England and Wales. The Eastern region also saw a large rise in cocaine use, having the third highest prevalence along with the South West and North West, in the South East recent cocaine use remained stable at 2.2 per cent (Roe and Man 2006).

Amongst 16 to 24 year olds in 2004/05, the South, (both South East and South West) had a higher prevalence than elsewhere in England and Wales, including London, although London and Wales had the next highest prevalence, with the North West in fifth place. In 2005/06 the pattern was markedly different with the South, both East and West, and Wales reporting a fall in recent cocaine use. The North East experienced a large rise and had the highest prevalence in the country, followed by the North West and London (Roe and Man 2006).

12.1.3. Analysis of prevalence by education, employment, risk perception and urbanisation level

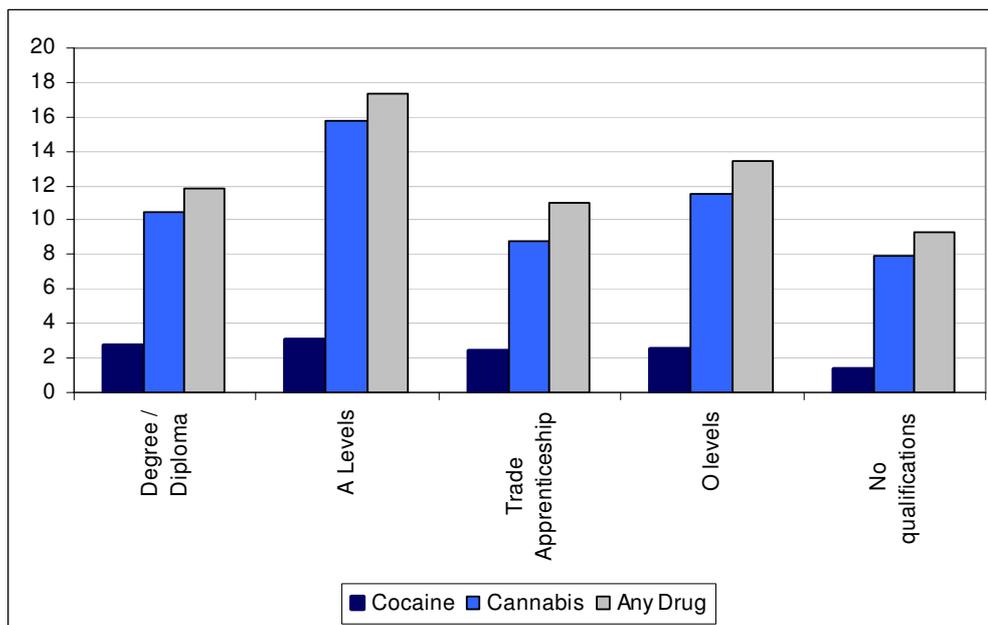
England and Wales

The report on the 1994 BCS noted that in the 1980s cocaine was referred to as the ‘yuppie’ drug providing evidence of its use amongst more affluent urban young people (Ramsey and Percy 1996). The 2003/04 BCS report undertook an in depth analysis of drug use by a number of social characteristics, these included education and employment (Chivite-Matthews *et al.* 2005).

Education

Figure 12.1 suggests that in the general population those without educational qualifications are less likely to have used drugs recently, including cocaine than those with the highest level of qualifications; a degree, diploma or A levels.

Figure 12.1: Percentage prevalence of 16 to 59 year olds reporting having used any drug, cannabis and cocaine in the last year by respondent’s highest level of education, England and Wales, 2003/04



Source: Chivite-Matthews *et al.* 2005

Analysis from the 2005/06 BCS also shows that people with no qualifications are least likely to use cocaine (Chivite-Matthews *et al.* 2005).

Employment

Analysis suggests that the unemployed are considerably more likely to have used any drug, including crack and cocaine, than those who are employed, though the latter are more likely to have used cocaine (though not crack) than those reported as being economically inactive. Crack use is more prevalent amongst the unemployed (Chivite-Matthews *et al.* 2005). Analysis from the 2005/06 BCS found similar results for cocaine use (Roe and Man 2006).

Risk perception

Risk perception in the use of cocaine and crack is not available for the 2004/05 BCS and the 2004 SCVS. Analysis of the Northern Ireland Drug Prevalence Survey provides information on risk perception in the use of cocaine. Those who had used cocaine were likely to perceive the risk to be lower than those who had not used (NACD and DAIRU 2006).

Urbanisation level

Analysis of the 2000 BCS (Ramsey *et al.* 2001) showed that affluent young urbanites were more likely to use cocaine than other groups. The 2003/04 BCS analysis shows that those living in inner city areas are more likely to use both cocaine and crack and those living in rural areas are the least likely (Chivite-Matthews *et al.* 2005).

Frequency of visits to pubs and wine bars

Frequency of visits to pubs and wine bars in 2003/04 was analysed by different age groups (Table 12.11) and suggests that younger people (age 16 to 29) who made three or more evening visits to pubs or wine bars had the highest proportion of cocaine use (as well as ecstasy and hallucinogen use). Similarly, amongst older respondents (aged 30 to 59) who visited pubs or wine bars three or more evenings per week in the last month levels of cocaine use were greater than those who made less frequent visits to pubs or wine bars respectively (Chivite-Matthews *et al.* 2005). Analysis from the 2005/06 BCS found similar results for cocaine (Roe and Man 2006).

Table 12.11: Percentage of 16-29, 30-59 and 16-59 year olds reporting having used drugs in the last year by frequency of visits to a pub or wine bar in the evening in the last month in England and Wales, 2003/04

Age group	16-29 year olds		30-59 year olds		16- 59 year olds		Total
	< 3 times a week	> 3 times a week	< 3 times a week	> 3 times a week	< 3 times a week	> 3 times a week	
Visits to pubs or wine bars							
Cocaine	3.7	13.1	1.0	3.1	1.7	8.3	2.4
Crack	0.4	0.6	0.1	0.1	0.2	0.4	0.2
Any Drug	21.9	42.2	6.2	14.1	10.3	28.6	12.3
Base	4,349	910	17,512	1,423	21,861	2,334	24,197

Source: Chivite-Matthews *et al.* 2005

Visits to discos and nightclubs

In 2003/04, analysis was also undertaken of recent drug use by frequency of visits to nightclubs or discos in the last month showing that use of cocaine by club goers of all

ages was much higher than those who do not visit such venues (Table 12.12). Analysis of the 2005/06 found similar results (Roe and Man 2006).

Table 12.12: Percentage of 16-29, 30-59 and 16-59 year olds reporting having used drugs in the last year by visits to discos and nightclubs in England and Wales, 2003/04

Age group	16-29 years		30-59 years		16- 59 years		Total
	None	Club goers	None	Club goers	None	Club goers	
Visits to night clubs or discos							
Cocaine	3.3	8.0	0.8	4.5	1.3	6.9	2.4
Crack	0.4	0.5	0.1	0.1	0.1	0.4	0.2
Any Drug	18.5	34.0	5.8	16.5	8.2	28.4	12.3
Base	2,898	2,362	17,125	1,811	20,023	4,173	24,197

Source: Chivite-Matthews *et al.* 2005

Other area characteristics analysed were: ACORN category whether lived in a council estate area; marital status; household structure; household income; accommodation type; social class; physical disorder and disability. Differences were found in the following.

Neighbourhood type

Analysis of both the 2000 BCS (Ramsey *et al.* 2001) and 2004/05 BCS (Chivite-Matthews *et al.* 2005) suggested that those living in 'rising' neighbourhoods were the most likely to use cocaine, while those in 'thriving' and 'expanding' neighbourhoods were the least likely to use. ACORN stands for 'A Classification of Residential Neighbourhoods' and is based on 40 census variables covering demographic structure, household composition, housing, socio-economic structure and residents' employment characteristics. Analysis of the 2005/06 BCS is based upon revised ACORN types and therefore differs from that of the previous BCS. However it shows that cocaine use is highest amongst those neighbourhoods described as 'urban prosperity' areas. Analysis is confined to cocaine use and does not allow comparison with use of any drug but previous analysis has shown the two are linked. (Table 12.13).

Table 12.13: Percentage of 16-59 year olds reporting having used drugs in the last year by ACORN category in England and Wales, 2005/06

ACORN	Wealthy Achiever	Urban Prosperity	Comfortably Off	Moderate Means	Hard Pressed	Total
Cocaine	1.5	4.8	2.3	2.3	2.4	2.4
Base	7,645	2,743	9,635	4,357	5,333	29,784

Source: Roe and Man 2006

Marital status

Single people and cohabiting couples were considerably more likely to use any drug as well as cocaine than those who were married, divorced or separated (Table 12.14).

Table 12.14: Percentage of 16-59 year olds reporting having used drugs in the last year by marital status in England and Wales, 2003/04

Drug	Marital Status						Total
	Married	Cohabiting	Single	Widowed	Divorced	Separated	
Cocaine	0.7	4.0	5.4	-	1.0	0.9	2.4
Cannabis	4.1	15.9	21.8	4.0	8.7	7.5	10.8
Any Drug	4.7	18.4	24.7	5.4	10.0	9.1	12.3
Base	12,005	2,537	6,203	390	2,179	875	24,197

numbers for crack were too small for analysis

Source: Chivite-Matthews *et al.* 2005

Household structure

Analysis by household structure suggests that those without children are the most likely to use cocaine, though a single adult living with children was more likely to use than households with more than one adult, plus children (Chivite-Matthews *et al.* 2005).

Household income

Analysis by household income shows that middle income families (those with an income of over £20,000, but less than £30,000) are less likely to use cocaine (and any drug) than either those on low incomes or the more affluent (Table 12.15).

Table 12.15: Percentage of 16-59 year olds reporting having used drugs in the last year by household income in England and Wales, 2003/04

	Household income %					Total
	Less than £5,000	£5,000 to less than £10,000	£10,000 to less than £20,000	£20,000 to less than £30,000	£30,000 or more	
Cocaine	2.2	2.6	2.6	1.7	2.6	2.4
Cannabis	13.1	13.7	10.6	8.7	10.2	10.8
Any Drug	15.4	15.1	12.2	9.9	11.6	12.3
Base	1,327	1,806	4,053	4,205	8,351	24,197

numbers for crack were too small for analysis

Source: Chivite-Matthews *et al.* 2005

Tenure

Analysis of the 2003/04 BCS by tenure confirms the analysis undertaken by Ramsey *et al.* (2001) of the 2000 BCS that those living in private rented accommodation are much more likely to use cocaine (and any drug) than those who either own a property or are social renters, the latter being more likely to use cocaine (and any drug) than the former (Table 12.16).

Table 12.16: Percentage of 16-59 year olds reporting having used drugs in the last year by tenure in England and Wales, 2003/04

	Tenure			Total
	Owner occupiers	Social renters	Private renters	
Cocaine	1.7	2.5	5.6	2.4
Crack	0.1	0.3	0.3	0.2
Cannabis	8.2	13.3	21.2	10.8
Any Drug	9.4	15.5	23.9	12.3
Base	17,244	4,036	2,874	24,197

Source: Chivite-Matthews *et al.* 2005

Accommodation type

Those living in flats or maisonettes are more likely to use any drug, including cocaine and crack than those living in any other type of accommodation, again confirming analysis undertaken by Ramsey *et al.* (2001) of the 2000 BCS (Table 12.17).

Table 12.17: Percentage of 16-59 year olds reporting having used drugs in the last year by accommodation type in England and Wales, 2003/04

	Accommodation type					
	All houses	Detached	Semi-detached	Terrace	Flats/maisonettes	Total
Cocaine	2.1	1.4	1.9	2.8	5.4	2.4
Crack	0.2	0.1	0.1	0.2	0.3	0.2
Cannabis	10.0	8.0	9.0	12.8	17.6	10.8
Any Drug	11.5	9.0	10.6	14.4	20.1	12.3
Base	20,679	5,656	7,970	7,053	2,457	24,197

Source: Chivite-Matthews *et al.* 2005

Social class

Professional people and skilled non-manual were least likely to use, with semi-skilled, skilled and managerial and technical people most likely to use cocaine (Table 12. 18)

Table 12.18: Percentage of 16-59 year olds reporting having used drugs in the last year by social class in England and Wales, 2003/04

Drug	Social Class						Total
	Professional	Managerial & technical	Skilled non-manual	Skilled manual	Semi-skilled	Unskilled	
Cocaine	1.8	2.6	1.5	2.9	3.3	2.1	2.4
Cannabis	7.7	10.0	9.5	12.3	11.4	11.3	10.8
Any Drug	8.4	11.4	11.1	13.9	13.4	12.9	12.3
Base	1,111	7,261	5,201	4,038	3,376	1,279	24,197

numbers for crack were too small for analysis

Source: Chivite-Matthews *et al.* 2005

No difference was found in whether individuals lived in a council estate or non-council estate area, or had a disability or physical disorder (Chivite-Matthews *et al.* 2005).

12.1.4 Analysis of use of cocaine and other substance (alcohol, amphetamine type stimulants, cannabis and opiates) within the same time frame (LTP, LYP)

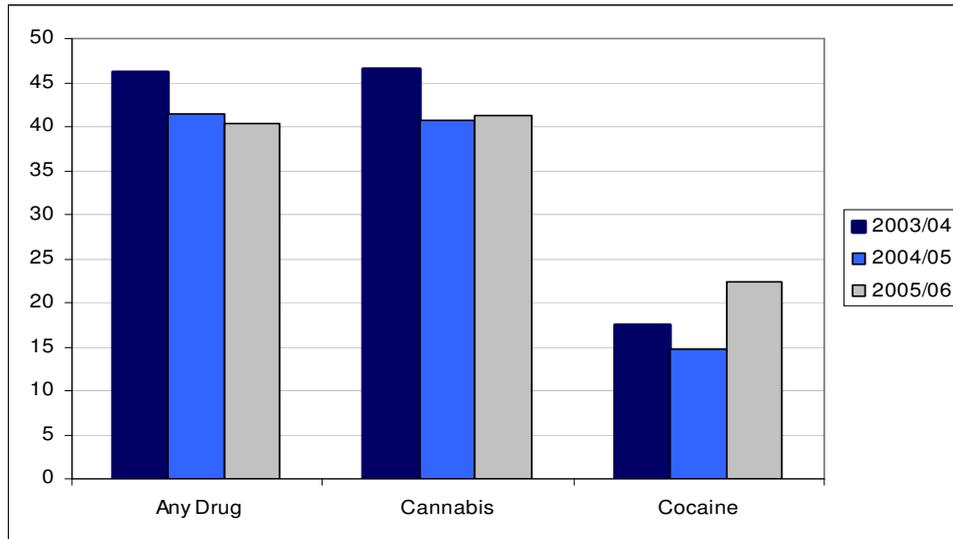
See Figure 2.1 in Chapter 2, which shows that recent use of cocaine continues to be much less prevalent than use of cannabis, but that over time it has replaced amphetamines as the second most used drug.

12.1.5 Analysis of frequency of use (use in last 30 days)

Even with the large numbers surveyed by the BCS numbers using recently are too small to provide reliable evidence of frequency of use and therefore are not considered in this report. However, analysis of frequency of use²⁰³ has been undertaken for those who report recent use rather than current use. This suggests that amongst young people aged 16 to 24, less than half use frequently and that the number of those using any drug, including cannabis, more than once a month has declined since 2003/04. The size of the sample using crack was too small for analysis to be undertaken. In 2004/05 frequent cocaine use decreased but then rose sharply in 2005/06 well above 2003/04 levels (Figure 12.2).

²⁰³ Frequent use, in the BCS, is defined as taking a drug more than once a month.

Figure 12.2: Percentage of 16-24 year olds using any drug, cannabis and cocaine more than once a month in the last year in England and Wales, 2003/04 to 2005/06



Source: Chivite Matthews *et al.* 2005; Roe 2005; Roe and Man 2006

12.1.6 Analysis on crack

With numbers so small less analysis has been undertaken on crack use within the general population, nevertheless it is more widespread than use of heroin, though less widespread than use of cocaine. Indications suggest that crack users, like cocaine users, are more likely to live in inner city areas, rent their accommodation (Table 12.16) and live in a flat/maisonette (Table 12.17) than non-crack users but unlike cocaine users are much more likely to be unemployed (see section 12.1.3).

12.2 Cocaine use among school students

Prevalence among 15/16 year olds and 17/18 year olds

School children aged over 15 do not take part in school surveys in the UK, except in Northern Ireland. At age 16, young people can leave school and therefore evidence amongst young people aged 16 to 18 is from general household surveys, when 17 and 18 year olds are not necessarily at school. In Northern Ireland, school children aged 16 report much higher use of cocaine than those aged 15; four per cent reporting ever having used, compared with 1.3 per cent of 15 year olds (SMR 2005).

Prevalence in school children aged 15 and under

School survey for England 2005

Table 12.19 shows use of cocaine and crack increases with age as does use of most drugs, with the exception of volatile substances.

Table 12.19: Percentage of pupils who have taken individual drugs in the last month, in the last year (including in the last month) and in lifetime by age in England, 2005

Drug	Age				
	11 years	12 years	13 years	14 years	15 years
Lifetime					
Any drug	14.2	15.5	22.4	35.5	44.7
Cocaine	0.4	0.7	1.6	3.5	5.0
Crack	0.5	0.9	1.3	2.1	1.9
Last year					
Any drug	6.2	9.4	14.8	26.3	33.9
Cocaine	0.4	0.4	1.0	2.8	4.3
Crack	0.3	0.4	0.9	1.6	1.5
Last month					
Any drug	3.3	4.2	7.8	16.1	20.3
Cocaine	0.2	0.1	0.4	1.5	1.7
Crack	0.2	0.2	0.4	0.6	0.8
Base	1350	1700	1781	1810	1907

Source: Standard Table prepared for UK Focal Point based on school survey.

Table 12.20 shows that boys are slightly more likely to use than girls.

Table 12.20: Percentage of pupils aged 11 to 15 who have taken individual drugs in the last month, in the last year (including in the last month) and ever, by sex in England, 2005

Drug	Lifetime			Last year			Last month		
	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total
Cocaine	2.6	2.1	2.4	2.1	1.7	1.9	0.9	0.7	0.8
Crack	1.3	1.5	1.4	0.9	1.1	1.0	0.5	0.4	0.5
Any drug	27.8	27.2	27.5	19.3	18.8	19.1	11.5	10.3	10.9
Base	4,296	4,252	8,548	4,253	4,223	8,476	4,208	4,200	8,408

Source: Standard Table prepared for UK Focal Point based on school survey

School surveys for Northern Ireland 2003

Data are from a Standard Table prepared for UK Focal Point and aggregated by three age groups, 11 to 12, 13 to 14 and 15 to 16. These data suggest that the effect of age on cocaine and crack use is not as large as its effect on any drug use (Table 12.21).

Table 12.21: Percentage of pupils who have taken individual drugs in the last month, in the last year (including in the last month) and ever by age in Northern Ireland, 2003

Drug	Age		
	11 to 12 years	13 to 14 years	15 to 16 years
Lifetime			
Any drug	9.6	16.9	34.0
Cocaine	1.7	2.0	2.1
Crack	1.0	1.8	1.6
Last year			
Any drug	5.5	11.2	21.6
Cocaine	1.2	1.5	1.6
Crack	0.6	1.4	1.1
Last month			
Any drug	2.9	5.8	9.8
Cocaine	1.0	0.9	0.8
Crack	0.4	0.5	0.5

Source: Standard Table prepared for UK Focal Point based on school survey

School survey for Scotland 2004

Data for Scotland show an increase in cocaine use with age (Table 12.22)

Table 12.22: Percentage of pupils who have taken individual drugs in the last month, in the last year (including in the last month) and in lifetime by age in Scotland, 2004

Drug	Age	
	13 years	15 years
Lifetime		
Any drug	13	35
Cocaine	1	3
Crack	1	1
Last year		
Any drug	11	31
Cocaine	1	2
Crack	1	1
Last month		
Any drug	7	20
Cocaine	0	1
Crack		

Source: Corbett *et al.* 2004

Frequency of using cocaine

Analysis of data for England and for Scotland does not look at frequency by particular drugs, by age. In Northern Ireland, among those who had ever used cocaine, eight per cent indicated that they had used the drug on a daily basis, with nine per cent using the drug a few times a week. The majority (60%) of users of cocaine reported that they either no longer used the drug (38%) or used it rarely (22%) (DAIRU 2005).

Number of Times Used Cocaine

Surveys in England do not report on how many times a drug has been used. In Northern Ireland 43 per cent of users reported that they had used cocaine only once, with a further 17 per cent reported using the drug on only two occasions. Amongst those pupils who said that they had ever used crack, 10 per cent reported daily use, but a majority (52%) reported that they either rarely used or do not use it any more (25%) In this survey one in three crack users reported that they had used the drug only once, with a further 19 per cent reporting using it on only two occasions (SMR 2005). These data are for secondary school children up to and including age 16.

Age of first use

SALSUS (Scotland) does not analyse age of first use of individual drugs. In England pupils reported having first tried cocaine and crack as young as 11 (NatGen/NFER 2005).

In Northern Ireland among those who could remember what age they started using cocaine, one quarter were aged 13 with 30 per cent aged 14. Among those who could remember what age they started using crack, 40 per cent said they were aged 16 but 11 per cent said they were aged 10 or younger (SMR 2005).

Ease of obtaining cocaine and crack

Analysis of data for England does not look at ease of obtaining particular drugs. Information on the perceived ease of obtaining crack, but not cocaine is available for Northern Ireland. The majority of survey respondents (73%) did not know how easy or difficult it would be to get crack if they wanted to, 13 percent reported that it would be either 'very easy' or 'easy', with a similar proportion (14%) saying it would be

either 'very difficult' (7%) or 'difficult' (7%), younger people were least likely to know (SMR 2005).

In Scotland younger people were also less likely to know about the ease of obtaining crack and cocaine. Twenty four per cent of 15 year olds believed it would be easy to obtain cocaine or crack compared to 12 per cent of 13 year olds. (Corbett *et al.* 2005).

Attitudes to cocaine use

Information is available on attitudes to cocaine use. In England very few pupils felt that it was acceptable to try or use cocaine, though acceptance increased with age (NatCen/NFER 2006).

In Scotland, a majority of 15 year olds felt that cocaine was dangerous, even those who had used it, though those who had used it were slightly less likely to think this (Corbett *et al.* 2005).

Trends in cocaine use

After a period of stability from a very low base there was a rise in last year prevalence in England in 2005 but it is not clear if this is the start of a trend or just an artefact of sampling. Until 2003, around one per cent of pupils had used cocaine, in 2004 1.4 per cent and in 2005 this figure rose to 1.9 per cent.

12.3 Prevalence and patterns of use among specific populations

12.3.1 Prevalence of problem cocaine and crack use: estimates of problem prevalence in the UK

A national, and 147 local estimates, of crack use have been undertaken for England; however these were not available at the time of writing.

Estimates of Problem Heroin Use and Cocaine Use in Northern Ireland.

National and local estimates of problem drug use have recently been published for Northern Ireland; these are for opiate users and for opiate and/or problem cocaine users (Hay *et al.* 2006). Results are shown in Table 12.23.

Table 12.23: Estimated number of opiate users and opiate and/or problem cocaine users aged 15 to 64 years old by HSSB area in Northern Ireland

HSSB Area	Opiate users			Opiate and/or problem cocaine users				
	Estimate	Rate	95% CI		Estimate	Rate	95% CI	
Eastern	725	1.68	1.07	3.04	1,612	3.74	2.75	5.40
Northern	360	1.29	1.04	1.70	663	2.38	1.85	3.09
Southern	130	0.65	0.27	2.41	4666	2.34	0.76	3.31
Western	180	0.99	0.48	3.60	562	3.08	1.75	7.00
Northern Ireland	1,395	1.28	1.21	1.75	3,303	3.03	2.84	3.95

Source: Hay *et al.* 2006

12.3.2 Surveys of different groups

Opioid substitution clients

See research by Sumnall *et al.* (2005) in section on injecting in 12.4.2.

Young people in nightlife settings

A survey of people who visit dance clubs is conducted annually via Mixmag, a specialist dance magazine with an approximate United Kingdom circulation of

50,000. Latest published data from this survey (2003) reports that almost 75 per cent of readers have ever used cocaine and 41 per cent currently use, with the mean age of first use around 20.4 years (McCambridge *et al.* 2005). While reported lifetime use of cocaine has remained fairly stable between 1999 and 2003, the percentage of those reporting current use increased slightly (from 36 per cent in 1999). Although there are no published data from this survey after 2003, latest figures from Mixmag suggest that the percentage of people reporting use of cocaine in the last month has increased considerably to 79 per cent (MixMag 2006). Furthermore, use of any drug in a nightclub setting (including cocaine) is closely associated with alcohol use, with around 95 per cent of those taking drugs also consuming alcohol (Deehan *et al.* 2003).

Sex workers

The Home Office suggest that sex and drug markets are seen as interconnected, so much so that when a police operation focusing on the crack market arrested 118 prostitutes, many were referred to drug treatment services (Home Office 2004). Surveys of sex workers in the UK have reported high levels of illegal drug use, particularly among street sex workers. One survey conducted in Leeds, Glasgow and Edinburgh found that 93 per cent of outdoor workers and 69 per cent of indoor workers had used an illegal drug in the past six months, including crack (32% outdoor, 4% indoor), and cocaine (17% outdoor, 15% indoor) (Church *et al.* 2001). Although heroin is often the most frequently used drug among sex workers, a number of reports have documented a rise in the level of reported crack use over the last 15 years. For instance in London, self reported use of crack among sex workers rose from 11 per cent in 1989-91 to 34 per cent in 1995-6 (Ward *et al.* 2000), while in Liverpool, self reported crack use among street sex workers increased from 17 per cent in 1996 to 75 per cent in 2004 (McCullagh *et al.* 1998; Bellis *et al.*, in press).

Ethnic minorities

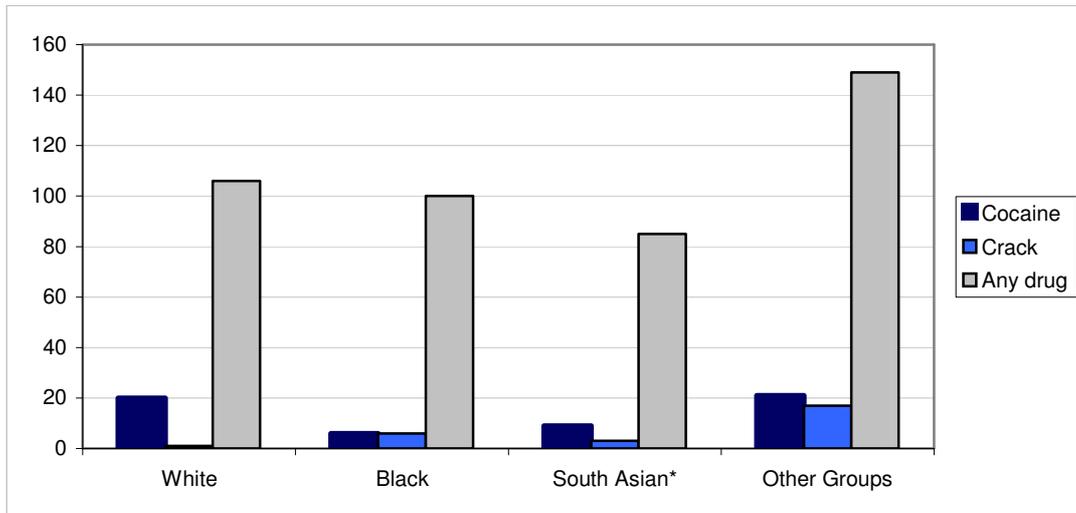
Analysis of ethnicity and drug use was undertaken for the 2001/02 British Crime Survey (Aust *et al.* 2003). This found higher levels of drug use among people from a mixed background compared to other ethnic groups. These higher levels of use mainly concerned cocaine (as well as cannabis and ecstasy).

Coulthard *et al.* (2002) in a survey of psychiatric morbidity among adults in England, Scotland and Wales carried out in 2000 for the Department of Health, the Scottish Executive Health Department and the National Assembly for Wales²⁰⁴ looked at and drug use (and tobacco and alcohol use) and dependence²⁰⁵, and their relationship to psychiatric morbidity. The survey found that Black and Asian groups were least likely to use crack and cocaine (Figure 12.3).

²⁰⁴ The survey was carried out between March and September 2000, of psychiatric morbidity among adults aged 16 to 74 living in private households in England, Scotland and Wales. The analysis covered in the report is based on 8,580 full or partial interviews.

²⁰⁵ Degree of drug dependence was assessed by a set of five questions which had been used in previous studies; if someone answered 'yes' to at least one question they were defined as dependent.

Figure 12.3: Rate of Illicit drug use in the past year by ethnicity (rate per thousand population) in England, Scotland and Wales



*Indian, Pakistani or Bangladeshi.

Other groups are defined as not being any of the other categories and include Chinese

Source: Coulthard *et al.* 2002

Clients of consumption rooms

There are no consumption rooms in the UK

Drug Use amongst university students

Friedman (2005) published a survey of 500 students in Edinburgh. It was reported that 23 per cent had used cocaine.

Cocaine and crack users reporting for treatment

Neale and Robertson (2004) examined 585 new treatment clients in Scotland and found that those who had recently used cocaine and/or crack had distinct characteristics as they were more likely to:

- have used non-prescribed benzodiazepines in the previous 90 days;
- be seeking residential treatment;
- have recently committed an acquisitive crime;
- have been robbed, attacked or assaulted in the last six months;
- have a spouse or partner; and
- have a longer history of problematic drug use.

Care leavers

Research was conducted with 200 young people (with an average age of 18 years) in the process of leaving or having recently left care and with young people who had left home at a young age ('runaways') (Ward *et al.* 2003). There were high levels of self reported drug use compared with general population surveys and 10 per cent had used cocaine within the last month. Lifetime prevalence of crack was around 10 per cent.

Analysis of the 2003 Offending Crime and Justice Survey considered the relationship between vulnerable groups and drugs use; these groups included those who had ever been in care, as well as truants, excludees and serious or frequent offenders (Becker and Roe 2005). It was found that those in vulnerable groups displayed much higher levels of drug use, including use of cocaine and crack, than those not in vulnerable groups (Table 12.24).

Table 12.24: Percentage of 10 – 24 year olds by vulnerability and drug use in the last year in England and Wales

Drug	Not in a vulnerable group	In any vulnerable group	In only one vulnerable group	In more than one vulnerable group
Cocaine	2.9	9.8*	8.3*	14.3*
Crack	0.0	1.9*	1.0*	3.0*
Any drug	15.6	40.7*	34.1*	57.7*
Base	2,894	1,140	774	304

* $p < 0.05$ using Pearson's chi-squared test for significance on 'any vulnerable group' versus 'no vulnerable group', 'one vulnerable group' versus 'no vulnerable group' and 'more than one vulnerable group' versus 'one vulnerable group'.

Source: Becker and Roe 2005

Within vulnerable groups, those who had been in care (and those who had been homeless) had much lower levels of drug use than other vulnerable groups and did not report use of crack or cocaine (Table 12. 25).

Table 12.25: Percentage of 10 to 24 year olds ever in care or homeless, truants, excludees and serious or frequent offenders who used drugs in the last year in England and Wales, 2003

Drug	Ever in care or homeless	Truants	Excludees	Serious or frequent offenders
Cocaine	-	10.3	7.9	9.7
Crack	-	0.9	0.8	1.4
Any drug	22.7	43.1	31.6	35.7
Base	64	111	241	359

- indicates that there was no response in that category

Source: Becker and Roe 2005

Young offenders

Analysis of the OCJS found that 9.7 per cent of serious or frequent offenders has had used cocaine and 1.4 per cent had used crack (see Table 12.25 above).

Homeless young people

A study into substance use amongst 160 homeless young people aged 25 years and under in England and Wales found that 95 per cent of them had used drugs (typically beginning experimentation aged 14 years). A substantial minority had used crack cocaine (18%) in the last month (Wincup *et al.* 2003). Also see findings from the OCJS in the previous section on care leavers.

12.4 Problems related to cocaine and crack use

12.4.1 Treatment demand for cocaine

In England, recruitment of primary crack cocaine users into treatment services in England has been lower than anticipate. According to the National Drug Treatment Monitoring System (NDTMS) figures for 2004/05, only five per cent of drug users in contact with treatment services reported crack as their primary drug, with a further four per cent reporting cocaine powder as their main drug. This is the same percentages as for 2003/04. However, in 2004/05, of the 41 per cent of drug users in treatment who reported a secondary drug, 12 per cent reported crack as their secondary drug of use, which may be an indicator of the levels of polydrug use in the treatment population (3% reported cocaine as their secondary drug).

Again, based on information for all those in treatment in England:

- for powder cocaine, the use is slightly higher in younger age groups. Over 5 per cent of 18 year olds entering treatment reported cocaine as their main drug, compared to around 4 per cent in all age bands between 19 and 44;
- variations in the use of powder cocaine between ethnic groups is not as pronounced as with crack cocaine, with the reported highest use (around 6%) in mixed race people (mixed white and black Caribbean and white and African), and the lowest at 3 per cent being amongst Pakistani drug users; and
- there are some regional differences in cocaine use, but much smaller than for crack. London and Eastern regions both reported almost 8 per cent of drug users in treatment have a primary cocaine problem, whereas East Midlands and Yorkshire and the Humber reported just over 1 per cent.

For crack:

- use is not higher in younger groups with 5 per cent of 19 to 24 year olds and 6 per cent of 35 to 39 year olds entering treatment reporting crack as their main problem drug;
- use is much higher in some ethnic minority treatment seeking groups, with 36 per cent of black Caribbean treatment seekers, and 18 per cent of mixed race black Caribbean and white treatment seekers reporting crack as their main drug, compared to only 4% of white treatment seekers; and
- there are large variations in rates of crack treatment seeking by region. While 14 per cent of drug users in treatment in London reported crack as their main drug, this was only the case for just over one per cent of the treatment population in both Yorkshire and Humberside and the North East.

In a study to ascertain the size of the crack cocaine problem in a rural county of England, Vivancos *et al.* (2006)²⁰⁶ estimated that 31 per cent (95% C.I., 26% to 37%) of drug users in treatment services have moderate/severe dependence on crack. In addition it was also found that factors associated with severe crack dependence are: severe dependence on benzodiazepines; the increasing number of drugs used, engaging in sex work and being of non-white ethnicity. Those with severe dependence were found to have a higher prevalence of hepatitis B and C compared with those with moderate or no dependence. The researchers suggest that users have 'a frenzied drug life' on entering treatment, requiring additional support to give structure to their lives so as to prevent relapse.

12.4.2 Other problems related to cocaine and crack use

Cocaine and crack-related deaths

Data on drug related deaths in England and Wales shows that from 1999 to 2004 deaths where cocaine is mentioned have increased substantially (Morgan *et al.* 2006) (Table 12.26).

²⁰⁶ A questionnaire on drug dependence and risk behaviour was completed by 306 users of drug treatment services, and focus groups were conducted with 45 self-selected crack/cocaine users.

Table 12.26: Number of deaths related to any drug and cocaine, England and Wales 1999 to 2004

	1999	2000	2001	2002	2003	2004
All drug misuse						
Number	1,571	1,666	1,628	1,565	1,255	1,427
Percentage change	-	6	4	0	-20	-9
Cocaine						
Number	88	80	96	139	113	147
Percentage change	-	-9	9	58	28	67

Source: Morgan and Griffith 2006

Acute or chronic use

No information available

Cardiovascular problems

Cocaine use and heart problems

A study on cocaine use among patients complaining of chest pains, conducted at the Accident and Emergency unit of St Mary's hospital in London during three years, shows that between seven and 10 per cent of the patients tested positive for cocaine. Figures are reported to be higher amongst people under the age of 40. Amongst this group, during weekdays, a third were found to have traces of cocaine in their urine, and at weekends around a half had taken the drug. Tests on a control group admitted without chest pains show results as low as three per cent.²⁰⁷ A full report of these findings is expected to be published in late 2006.

Mental health disorders

In the survey of psychiatric morbidity among adults in England, Scotland and Wales referred to earlier, Coulthard *et al.* (2002) looked at drug use (and tobacco and alcohol use) and dependence, and their relationship to psychiatric morbidity. Lifetime prevalence for use of cocaine was four per cent, and crack, less than one per cent. Younger people are more likely to be dependent on cocaine and crack (Table 12.27).

Table 12.27: Prevalence of drug dependence by age (rate per thousand population)

Drug	Age												
	16–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69	70–74	All
Cocaine	6	8	4	1	3	4	-	-	-	-	-	-	2
Crack	5	2	-	2	2	-	-	-	2	-	-	-	1
Any drug dependence	96	144	90	36	24	13	17	6	6	3	4	5	38
Base	334	460	730	953	1006	842	723	822	703	739	668	600	8,580

- indicates that there was no response in that category

Source: Coulthard 2002

Violence

It is reported in the National Crack Plan (see below) that primary crack use sometimes leads to greater levels of violence and acquisitive crime and has been linked to the use of guns (Home Office 2003).

²⁰⁷ See: http://www.drugscope.org.uk/news_item.asp?intID=1252

In research based on the Drug Outcomes Research in Scotland longitudinal study, Neale *et al.* (2005) found that one in five (18%) drug users entering treatment had committed assault in the previous three months and a quarter had been assaulted in the previous six months²⁰⁸. Amongst factors associated with committing an assault were having used crack in the last 90 days.

Injecting

Crack is regarded a major public health issue because of the sharing of injecting equipment. In a retrospective study of crack injecting amongst treatment populations between 1 April 1999 to 31 March 2002 in Merseyside, Sumnall *et al.* (2005)²⁰⁹ found that crack injectors were more likely to report use of injected heroin ($p < 0.001$), use of non-injected cocaine ($p < 0.01$), and less likely to report use of non-injected heroin ($p < 0.001$). It was also found that crack injection was significantly predicted by heroin injection ($p < 0.001$).

A community recruited cohort study of recently initiated injecting drug users in London undertaken by the Centre for Research on Drugs and Health Behaviour (CRDHB) in 2001/03 found evidence that the incidence of HIV was higher among those who reported injecting crack (around 6%) (Judd *et al.* 2005). Results from the Unlinked Anonymous Prevalence Monitoring Programme (UAPMP) enhancement pilot found a prevalence of 0.76 per cent among IDUs in England outside London, but those who reported injecting crack had a higher prevalence than those who did not (1.4% and 0.32% respectively) (HPA *et al.* 2006).

Combinations with opioids

See above

12.5 Responses and interventions related to cocaine and crack use

12.5.1 Treatment for cocaine and crack.

A number of services offer programmes for the treatment of cocaine and crack use; some using nutrition and nutritional supplements as an important component as part of a social education model of drug rehabilitation²¹⁰ and neuro-linguistic programming and hypnotherapy²¹¹.

In England the main focus has been on the treatment of crack users. The National Treatment Outcome Research Study (NTORS) showed that 56 per cent of crack users who entered and completed treatment remained crack free after five years (Gossop *et al.* 2002). On the basis of this research the NTA have suggested that crack users can do well in drug treatment (NTA 2002). Pilot services for crack users were initiated in 2003 with a resource pack for treatment providers to help ensure consistent standards, setting out the competencies expected of staff and the training that may be required (NTA 2003). Guidance is also offered by the Royal College of General Practitioners and Substance Misuse Management in General Practice (RCGP 2004; Ford 2005). It is expected that treatment be provided in the context of a structured programme of drug treatment, which includes abstinence and harm

²⁰⁸ Interviews were conducted with 560 drug users entering treatment.

²⁰⁹ A sample size of 4,055.

²¹⁰ For example: <http://www.drugrehab.co.uk/faq-cocaine.htm#top%20of%20page>

²¹¹ For example:

http://www.justbewell.com/help_stop_taking_cocaine_addiction_hypnotherapy_nlp_london.html

minimisation measures, such as counselling, residential rehabilitation, day services and needle exchange.

An impact evaluation of pilot service specification and treatment delivery models has been completed but is not yet published.

The Department of Health has commissioned research into effective approaches for treatment of cocaine and crack cocaine misuse in young people.

Pharmacological approaches

Cochrane review of the use of antidepressants in the treatment of cocaine use

A Cochrane review of the use of antidepressants in the treatment of cocaine use, found that these drugs are not proven to reduce cocaine dependence. However, it does suggest that this may be because people commonly stop using the antidepressants too soon (Lima *et al.* 2003).

Counselling

Counselling is the most widespread treatment offered for cocaine and crack use. The NTA suggest that early engagement with, and confidence in, treatment, and feelings that one's counsellor is understanding and helpful, promotes engagement with treatment programmes at a later date (NTA 2002).

Behavioural treatment

The NTA suggest that cognitive-behavioural therapies can be effective (NTA 2002).

Brief motivational interviewing among cocaine and ecstasy users

Marsden *et al.* (2006) did not find brief motivational interventions to be any more effective at inducing behaviour change than the provision of information alone.

Acupuncture

Services do offer acupuncture for the treatment of dependence, though the number is unknown.

Cochrane review of the use of auricular acupuncture for cocaine dependence

In a Cochrane Review of the use of auricular acupuncture for cocaine dependence Gates *et al.* (2005) found that there is currently no evidence that it is effective for the treatment of cocaine dependence; any evidence that is available was said not to be of high quality.

Responses to co-use of cocaine among opioid substitution clients

Historically heroin use has been the main drug problem in England and therefore the main focus of drug treatment services. This situation is now changing. Although the proportion of primary crack and cocaine users in treatment remains relatively low, poly-drug use is now the norm for the drug-using population evidence. Increasingly drugs services in England are adopting flexible treatment packages which reflect both the range of drugs used and the complex needs of drug users (NTA 2002).

Following their study of crack use in rural England, Vivancos *et al.* (2006) suggest that current service provision does not provide appropriate help to crack users and that given the lack of pharmacological treatment, programmes should offer a wide range of activities and interventions to provide structure to clients' lives.

12.5.2 Harm reduction responses to cocaine and crack

Availability of information materials

There is a large number of websites which provide information about crack and cocaine, in addition to the national information and helplines.²¹² In addition information is available through most treatment centres and general practitioners.

Distribution of drug consumption equipment

Injecting equipment is available free of charge through syringe exchange schemes throughout the UK. In addition, in 2003 an amendment was made to the *Misuse of Drugs Act 1971* which allowed certain named items of paraphernalia (swabs, ampoules of water for injection, citric acid, utensils for the preparation of a controlled drug and filters) to be supplied by practitioners, pharmacists and persons engaged in the lawful provision of drug treatment.

In 2005 regulation 6A of the *Misuse of Drugs Regulations 2001* was amended to include ascorbic acid in the list of articles that may be supplied by practitioners, pharmacists and persons engaged in the lawful provision of drug treatment services for administering or preparing controlled drugs. This is because ascorbic acid is used as an acidifier in the preparation of crack for injection (Home Office 2005d).

Policies at facilities for supervised drug consumption

There are no consumption rooms in the UK.

Provision and utilisation of quiet rooms, day hostels, 24-hour crisis intervention centres and other services

Such areas cannot be used for consumption of drugs.

12.5.3 Law enforcement activities in response to cocaine and crack use

Supply reduction activities

The police have the primary responsibility for seeing that drug markets are disrupted and those involved in selling drugs are arrested and brought to justice. *The Crime and Disorder Act 1998* places a requirement for the police and Local Authorities to work together to tackle local crime and disorder, including that related to drugs, in their area. The *Police Reform Act 2002* has added targets to cover the combating of drugs misuse as part of police activity.

As part of the national Crack Plan (see below) tool kits have been developed to enable the disruption of crack markets, aimed at the police, Crime and Disorder Reduction Partnerships (CDRPs), Drug and Alcohol Action Teams (D(A)ATs) and other law enforcement agencies (Home Office 2003). The purpose of these toolkits is:

- to offer practical suggestions to help the police and their partners disrupt crack markets;
- to help the police and their partners understand how crack is sold and used, and how buying is financed;
- to offer practical advice on mapping a crack market;
- to offer advice on tactics that may help disrupt a crack market;
- to offer advice on how to evaluate the success of police action; and
- to stimulate more action against crack markets using a variety of methods.

²¹² For example: www.cocaine.org

Activities targeting crack houses

The *Anti-Social Behaviour Act 2003* was introduced to tackle the problem of properties used for the sale and use of crack and other Class A drugs, which are associated with serious nuisance. The Act is part of both the national strategy on anti-social behaviour, which extends more widely than drug-related behaviour and the national crack strategy. The Act makes an explicit link between penalties and powers to control drug-related behaviour with nuisance arising from them. Previously the only punishable act was that of possessing or supplying (or producing or trafficking etc.) the drug itself. The new Act criminalises subsequent nuisance associated with such offences and its powers are targeted against properties, not people, as it enables the closure of premises used in connection with the production, supply or use of Class A drugs which are associated with disorder or serious nuisance.

An assessment of these powers found that closure under the new powers can be achieved swiftly, at its quickest, in less than 48 hours (Peters and Walker 2005).

Operation Crackdown

Operation Crackdown was launched in January 2005 and targeted local Class A drug markets (Home Office 2005e). Thirty-two Police forces worked together to close drug dens, disrupt local drug markets, seize illegal firearms and convict drug suppliers. At the end of the three month campaign, the Police forces had:

- closed 170 crack houses;
- seized over 100 kilograms of cocaine, 3 kilograms of crack, 100 kilograms of heroin and over 86,000 ecstasy tablets;
- charged 1,471 people with supplying Class A drugs;
- seized 483 firearms and 3,402 rounds of ammunition; and
- seized €4.8 million (£3.2 million) in cash assets.

12.5.4 Policies and strategies in response to cocaine and crack use

Tackling crack: A national plan was launched in 2002 (Home Office 2002). The purpose was to build on best practice developed in those areas where positive action has already been taken to tackle the crack problem, and to prevent escalation in those communities most at risk. In those areas most heavily affected, High Crack Areas (HCAs), it was expected that a much more comprehensive set of services would be delivered, including action to stem the trafficking, a programme of action by police in a number of key force areas to close local crack markets (see Operation Crackdown); improved capability of all drug services to meet the needs of users, backed by around 20 specialist programmes for crack users serving the HCAs (see Crack pilot programmes); new programmes to divert young people at risk from using crack and getting involved in related culture; media and communications campaigns to raise awareness of gun crime and crack risks; and new criminal justice interventions and increased services for offenders in HCAs, making arrest referral services more able to track crack users into treatment and offer flexible, crack specific Drug Testing Treatment Orders (DTTO) programmes; new research into the effectiveness of treatment; and new programmes to meet the needs of special client groups most affected by crack, such as sex workers. Since the report was published a Drug Interventions Programme has been established which seeks to ensure drug users, including users of cocaine and crack, involved in the criminal justice system, access treatment (see Chapter 9).

Crack strategy for London

A crack strategy for London was launched in 2004 (GLADA 2004).

12.6 Cocaine and crack-related crime

12.6.1 Property/acquisitive crime – crime committed under the influence of cocaine or crack

There is no evidence that property/acquisitive crimes are committed under the influence of cocaine or crack. However there is evidence that such crimes are committed to support use, mainly of crack.

12.6.2 Prostitution

Prostitution is not a crime in the UK. For information about sex workers see 12.3.2.

12.6.3 Crimes not directly linked to cocaine or crack

No information

12.7 Cocaine and crack markets

12.7.1 Local markets and differences

In research into local drug markets May *et al.* (2005) suggest that at street level, sellers of heroin and crack are often dependent users who sell drugs to fund their own use. Though they also suggest that some drug dealers move from retail sellers to middle-market distributors and vice versa, suggesting perhaps a fluidity in illicit markets.

12.7.2 Products and modes of preparation

Cocaine powder and crack are the primary products in the UK.

12.7.3 Perceived availability

See 12.2, section on ease of obtaining cocaine and crack

13. Drugs and driving

13.1 Policy

13.1.1 National drug policy

There is no explicit mention of driving under the influence of drugs in the Updated Drug Strategy (DSD 2002) or within other UK drug strategies (DHSSPSNI 2006a; Scottish Office 1999; National Assembly for Wales 2000).

13.1.2 Road safety policy

Tomorrow's roads: safer for everyone (Department of Transport 2000), outlines the Government's strategy for improving road safety between 2000 and 2010 in the UK. Specific focus is placed upon driving under the influence of drugs and the strategy places emphasis upon the development of equipment and techniques for roadside identification of offences; and special training for police officers to recognise offences.

The *Road Safety Act* introduced in July 2005 specifies a period of licence endorsement for individuals that fail to allow a biological specimen to be forensically tested for the presence of drugs or alcohol, and medical enquiries after disqualification for high risk offenders.

The Road Safety Strategy for Wales aims for the overall reduction of real and perceived danger for road and footway users in Wales (Welsh Assembly 2003). It outlines specific actions in relation to drugs and driving; to undertake a research study into the prevalence of drug driving in Wales; to undertake a national publicity campaign to highlight driving under the influence of drugs; and to consider how to integrate drug driving into existing drug education and rehabilitation initiatives.

13.1.3 The law

It is an offence under section 3A and 4 of the *Road Traffic Act 1988* for a person to be unfit to drive while impaired by drink or drugs. The law does not make a distinction between illegal or misused drugs and over-the-counter or prescription drugs taken as directed by a medical practitioner.

Convicted offenders face a minimum one year driving ban, a fine of up to €7,315 (£5,000), and six months imprisonment. The decision for conviction is based on demonstration that drug intoxication was the likely cause of driving impairment (Oliver *et al.* 2006; see Figure 13.1). However, there is no legal definition of impairment in the *Road Traffic Act*, and no offence of driving in breach of a prescribed limit, as is the case for drink-driving. This is because the presence of drugs alone is not evidence of impaired driving ability as some drugs such as cannabis can remain in the body for a period of time after its psychopharmacological effects have ceased. Furthermore, the *Misuse of Drugs Act 1971* does not class intoxication by drugs *per se* as an offence. Conviction is therefore based on the requirement of demonstrating impairment through the testimony of lay witnesses, police officers, and forensic medical examiners. During 2004, in England and Wales, all offences related to drugs or alcohol were dealt with by court proceedings (compared to offences such as obstruction waiting or parking offences which were predominantly dealt with by fixed penalties or penalty charge notices) (Fiti and Murray 2004).

It is a criminal offence (under the *Road Traffic Act 1988* and the *Motor Vehicles (Driving Licences) Regulations 1999* and punishable with a fine of up to €1,463 (£1000)) to fail to notify the Drivers Medical Group of the Driver and Vehicle Licensing Agency (DVLA)²¹³ of a medical condition that has developed or become worse since the issuing of a drivers licence. The Drivers Medical Group establishes whether drivers who have medical conditions are able to satisfy the medical standards required for safe driving. This is based upon both the medical condition and the means of treatment.

The implications of drug dependency upon driving licence issue and renewal have been outlined by the DVLA.²¹⁴

i) Persistent use of or dependency on cannabis, amphetamines, ecstasy and hallucinogens, confirmed by medical enquiry, will lead to licence refusal or revocation for a minimum six month period, during which the individual must be drug free (independent medical assessment and urine screen arranged by DVLA, may be required).

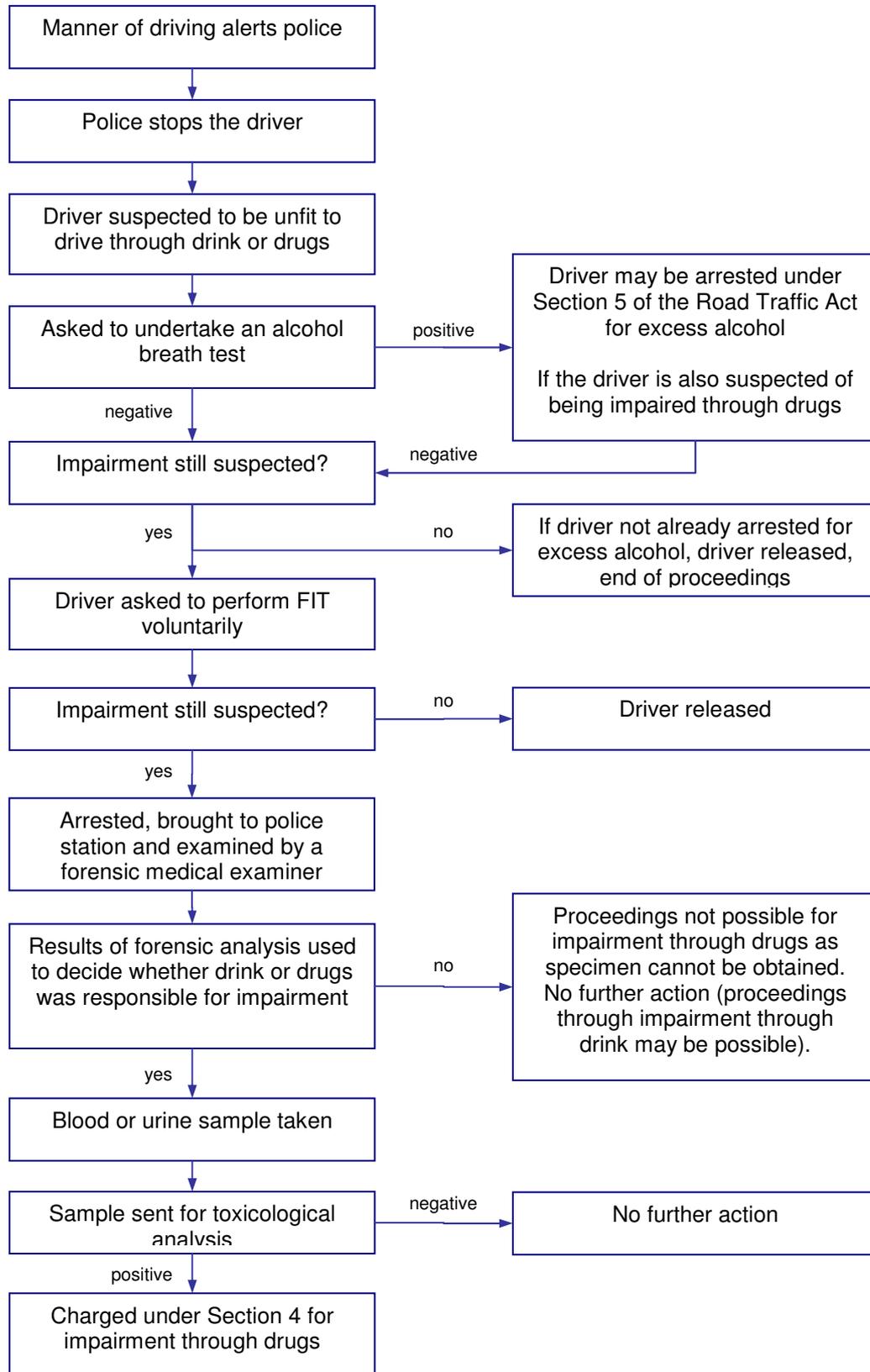
ii) Persistent use of, or dependency on opioids, and cocaine, as confirmed by medical enquiry, will lead to licence refusal or revocation, for a minimum one year period during which the individual must be drug free (independent medical assessment and urine screen arranged by DVLA, may be required). In addition, a favourable Consultant or Specialist report may be required on reapplication. Applicants or drivers complying fully with a Consultant supervised oral methadone maintenance programme may be licensed, subject to favourable assessment and, normally, annual medical review. Applicants or drivers on an oral buprenorphine programme may be considered under the same criteria.

iii) Persistent misuse of, or dependency on benzodiazepines, confirmed by medical enquiry, leads to licence refusal or revocation until a minimum one year period free of such use has been attained. An independent medical assessment and urine screen arranged by DVLA, may be required. In addition a favourable Consultant or Specialist report may be required on reapplication.

²¹³ The DVLA is an executive agency of the Department for Transport.

²¹⁴ See: <http://www.dvla.gov.uk/media/pdf/medical/aagv1.pdf>

Figure 13.1: Schematic representation of the procedure for investigating a driver suspected of being under the influence of drugs, with a proposed role for the Field Impairment Test (FIT) procedure



Source: Oliver *et al.* 2006

13.1.4 Particular relevance to cannabis

NO ADDITIONAL INFORMATION AVAILABLE

13.1.5 Particular relevance to benzodiazepines

NO ADDITIONAL INFORMATION AVAILABLE

13.2 Prevalence and epidemiological methodology

13.2.1 Prevalence estimates

Ingram and colleagues (2001) conducted interviews with 1,008 Scottish drivers aged 18-39 on behalf of the Scottish Executive. Nine percent of respondents reported ever having driven under the influence of any illegal drugs, most commonly cannabis (29% ever, 12% in the previous year). 'Drug drivers' were most likely to be young males aged between 20 and 24. Many of the respondents in follow up interviews that reported smoking cannabis stated that they believed it had little or no impact upon driving skills or performance. A similar number reported that they had accepted a lift in a car driven by someone they knew had been using drugs.

In a follow up study (Myant *et al.* 2006), there was no significant change in prevalence since 2000, six per cent reported drug driving in their lifetime, and 3.5 percent in the previous month. Drug drivers scored significantly higher on the Arnett Inventory of Sensation Seeking, a measure of risk taking. Thirteen percent reported ever having been a passenger of a drug driver, the majority of whom had also used drugs at the time. Respondents reported that driving after using drugs was more convenient than using other forms of transport.

In a batch of 377 samples from drivers submitted by 22 UK police forces for forensic analysis (and therefore already suspected of containing drugs), benzodiazepines were the most frequently reported drug, followed by opioids, and cannabinoids (Oliver *et al.* 2006). Polydrug use was evident in 63 per cent of the samples analysed, most commonly benzodiazepines and opioids (59%).

In their annual pre-Christmas campaign in 2005 addressing drink and drug driving, the Association for Chief Police Officers (ACPO) reported that 33 per cent (n =178) of the 540 drivers who were given a fit to drive test (see section 13.3.1) were arrested for drug offences (ACPO 2006).

In Northern Ireland, 136 drug drivers were detected in 2004, an increase of 54 from the previous year (PSNI 2005).

The Transport Research Laboratory investigated the presence of drugs in 1,184 road traffic fatalities between 1985 and 1987, and then again between 1996 and 1999 (Tunbridge *et al.* 2001). The results showed a six fold increase in the percentage of people testing positive for illegal drugs (with detection of cannabis increasing from 2.6% to 11.9%). Over the same period, the incidence of medicinal drugs (5.5%) and alcohol (35.0%) remained stable. Drug taking, overall, increased by a factor of three, and the proportion of those testing positive for multiple drugs increased dramatically.

In Scotland around 53 road fatalities were associated with ingestion of drugs in 2004 (Scottish Executive 2006).

In an informal survey by the RAC Foundation conducted with the readers of a UK motoring magazine it was reported that of the 474 respondents, 20 per cent reported that they operated motor vehicles whilst intoxicated by drugs every day, and 44 per

cent reported regularly driving with passengers in their car after taking drugs (RAC Foundation, 2006). Sixty-seven per cent believed that drink driving was 'worse' than drug driving, and 49 per cent thought they were unlikely to get caught.

Cannabis use

There is currently no data specifically addressing the prevalence of cannabis related driving offences. However, in the analysis of 377, referred to above, cannabinoids were detected in 25 per cent of cases (n = 17), but THC only confirmed in one of these (<1%) (Oliver *et al.* 2006). In combination with other drugs, cannabinoids accounted for 38 per cent of positive cases.

Benzodiazepine use

There is currently no data specifically addressing the prevalence of benzodiazepine related driving offences in the general population. However, the analysis of the 377 samples benzodiazepines were the most frequently detected drug (44%), and, in combination with other drugs, accounted for 59 per cent of positive analyses (Oliver *et al.* 2006).

13.2.2 Mandatory drug testing of drivers

The current laws do not permit random or mandatory enforcement testing of drivers in the UK, and there is currently no indication that such schemes of (i.e. random testing) will be introduced. Current provision already allows police officers to stop a vehicle at random and form a suspicion of drug or alcohol impairment on the basis of the subsequent interview with the driver.

13.2.3 Conclusions

There is little data available on the prevalence of driving whilst intoxicated with drugs. Offences under the *Road Traffic Act 1988* are not distinguished by substance and therefore it is not possible to conclude whether the number of incidents is increasing. Indirectly, survey data suggests that there are an appreciable number of individuals who engage in this type of behaviour.

13.3 Detection, measurement and law enforcement

13.3.1 Procedures for testing drivers

There is currently no approved objective test available for detecting impairment of driving as a result of drug ingestion.

New powers were introduced on roadside testing in September 2003 which amended section 6 of the *Road Traffic Act 1988*. In its place, schedule 7 contained six new sections giving new powers for the police to administer three preliminary tests including an impairment test to indicate whether a person is unfit to drive due to drugs ('field impairment test') and a test for the presence of drugs in a person's body ('drug screening test').

A new Code of Practice introduced in December 2004 detailed the tests to be undertaken, how they should be administered, the kind of observations that may be made and the inferences that may be drawn. It also deals with the training for officers and their authorisation by Chief Constables. The tests are a range of tasks including a pupillary examination, the walk and turn test and the one-leg stand. Other training helps officers to recognise the outward signs of drug impairment. Refusal to participate is an offence in the same way as failure to provide a breath test for alcohol.

The Department for Transport commissioned work to investigate the utility of the Field Impairment Test (FIT) by roadside officers from 22 UK forces (Oliver *et al.* 2006). See Figure 12.1 for these authors' proposed outline of how FIT could be used within current driving enforcement procedures). FIT is a five step procedure involving pupillary examination, the Romberg Test (estimation of the passing of 30seconds), the walk and turn task, the one legged stand test, and the finger to nose task. In general, the authors concluded that when administered by trained officers and verified by forensic analysis of biological samples, use of FIT lead to a sensitivity of 65 per cent (proportion of true positives that were correctly identified by FIT), a specificity of 77 per cent (the proportion of true negatives that were correctly identified by FIT), and an accuracy of 66 per cent (the proportion of cases correctly identified as being drug free or drug positive).

Researchers at the University of Surrey have developed a portable objective detection device proposed for screening of drug related impairments (Degia *et al.* 2006). This device records performance on tasks of tracking ability, sustained attention, divided attention, and reaction time. The Home Office Scientific Development Branch (HOSDB)²¹⁵ is also investigating the feasibility of the development of a handheld impairment device and is working with the Forensic Science Service, to develop a drug screening device for use at the roadside. This device is expected to be able to detect all drugs, including illicit drugs, prescription and over-the-counter medicines.

13.3.2 Number of offences

Between 2003 and 2004 there was a 1 per cent increase in the number of road offences related to driving after taking drugs or drinking alcohol in England and Wales (2003, 105,700; 2004, 107,200). There were no separate data for drug only offences. The average fine in 2004 for such offences was €318 (£217), and 27 per cent of guilty cases resulted in driving licence disqualification, and six per cent in immediate custodial sentence.

13.3.3 Mandatory police training involved in traffic control

Training is not mandatory but the Secretary of State for Transport has issued a preliminary Code of Practice for police officers undertaking such activities.²¹⁶ Only those police officers authorised by chief officer of the force to which they belong are allowed to conduct roadside impairment tests (Section 6B(6) *Road Traffic Act 1988*). Before applying for approval a police officer must undergo training and assessment in the use of Field Impairment Tests in accordance with the standards set in BS EN ISO 9001: 2000²¹⁷ and the Quality Manual held by the Association for Chief Police Officers (ACPO) and the Association of Chief Police Officers Scotland (ACPOS). In addition, officers must be trained in order to identify the signs and symptoms of drug influence.

²¹⁵ See: <http://scienceandresearch.homeoffice.gov.uk/hosdb/public-protection/road-safety-cameras/>

²¹⁶ See: http://police.homeoffice.gov.uk/news-and-publications/publication/operational-policing/Code_of_practice_order.pdf?view=Binary

²¹⁷ See: http://www.bsi-global.com/Quality_management/Management/bseniso9001.xalter

13.4 Prevention

13.4.1 Training or guidelines for professionals

The British Medical Association (BMA) published an internet resource²¹⁸ outlining relevant issues about driving under the influence of drugs, both legal and illegal (2003). Its target audience is both medical practitioners and the general public.

The Royal Pharmaceutical Society published *Medicines That Can Impair Driving* in 2000²¹⁹.

The British National Formulary (BNF)²²⁰, which is published jointly by the BMA and Royal Pharmaceutical Society of Great Britain, provides information on the labelling of medicines that might impair driving and the duties of prescribers to inform patients of such effects.

13.4.2 Publicity campaigns

The Department for Transport website THINK!²²¹ offers information on the effects of various drugs upon driving ability and is targeted at 17 to 35 year olds. No evaluation has yet been published.

Road Safety Scotland²²² ran TV, radio and ambient media campaigns highlighting drug driving in 2002 and in 2005. The 2002 TV campaign highlighted the use of FIT (see section 13.3.1) in response to research (Ingram et al., 2001), which suggested that drivers thought that driving under the influence of drugs was unlikely to be detected by Police. Campaign evaluation indicated high awareness and understanding of the core message, particularly in 17 to 25 year olds. However, doubts still remained about Police stopping drivers who had taken drugs but were not impaired in their driving. The core message of the 2005 campaign was: 'Drugs affect your judgement; drugs affect your driving; drugs can kill. If you're taking the car, don't take anything else.' No evaluation has yet been published for the 2005 campaign.

Road Safety Scotland distributes *Drivesafe* campaign materials to Scottish pharmacists to display in shops and to put on prescription bags containing medication that might affect driving ability. No evaluation of this campaign has been published.

Transport for London launched *Drug driving? you'd be off your head* in March 2006²²³. This campaign was targeted at drivers aged 17 to 25 and included radio advertisements, beer mats, and posters in over 400 London pubs, bars, and clubs. No evaluation of this campaign has been published.

Budgets

NO INFORMATION IS AVAILABLE

13.4.3 Enforcement outside nightclubs

NO INFORMATION IS AVAILABLE

²¹⁸ See: <http://www.bma.org.uk/ap.nsf/Content/Hubinternetresourcedrugsdriving>

²¹⁹ See: <http://www.rpsgb.org.uk>

²²⁰ See: <http://www.bnf.org.uk>

²²¹ See: <http://www.drugdrive.com>

²²² See: <http://www.road-safety.org.uk/>

²²³ See: <http://www.tfl.gov.uk/tfl/press-centre/press-releases/press-releases-content.asp?prID=740>

13.4.4 Provision of alternative transport at nightclubs

NO INFORMATION IS AVAILABLE

13.4.5 Driving schools

NO INFORMATION IS AVAILABLE

13.4.6 Youth/peer or community approaches

NO INFORMATION IS AVAILABLE

13.4.7 Medicinal packaging

In the UK, all medicines have an authorised Patient Information Leaflet explaining how the medicine acts, how it should be used and any side effects that might be experienced, including any influence on the ability to drive. Prescribers should also advise patients if treatment is likely to affect their ability to drive. In 1999, the UK Medicines Control Agency (MCA) updated the driving warnings in the patient information provided with benzodiazepines. Recommendations have also been made to update the standard warnings for pharmacists in the British National Formulary.

13.4.8 Classifying medicinal drugs

NO INFORMATION IS AVAILABLE

13.4.9 Media discussion

National media regularly reports new research and campaign launches concerning drugs (both legal and illicit) and driving (e.g. *Campaign to tackle drug driving*. BBC News Online, 30th March, 2006)²²⁴. National television programmes produced by the BBC have also addressed this issue (e.g. *Inside Out, Drugs and Driving* broadcast Wednesday 21st April 2004). The media is supportive of Government initiatives addressing such behaviour

²²⁴ See: <http://news.bbc.co.uk/1/hi/england/london/4859992.stm>

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and websites used in text

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List of figures and tables used in the text

Figure	Page
Figure 2.1: The proportion of 16-59 year olds reporting having used drugs in their lifetime in , England and Wales, 1996 to 2005/06	29
Figure 2.2: The proportion of 16-24 year olds reporting having used drugs in the last year and percentage change in England and Wales, 1996 to 2005/06	32
Figure 2.3: Last year and last month prevalence by age in England, 2005	35
Figure 2.4: Whether had taken any drug, volatile substance and cannabis in the last year, by age in England, 2005 as a percentage	37
Figure 2.5: Drug use amongst school children in England and Wales, 2001 to 2005	38
Figure 6.1: Number of deaths using EMCDDA DRD standard definition by country, UK, 1996-2004	74
Figure 6.2: Comparison of total number of deaths using three definitions, UK 1996 to 2004	75
Figure 6.3: Deaths by age and gender UK, 2004: EMCDDA definition	75
Figure 6.4: Prevalence of HIV infection among injecting drug users in England, Wales and Northern Ireland: 1992 to 2005	79
Figure 11.1: Percentage prevalence of last year drug use by age in England, Northern Ireland and Scotland	134
Figure 11.2: Percentage of young people who had used drugs in the last year, by age in England 2005	136
Figure 11.3: Percentage of pupils who had taken individual drugs in the last year in England, 2001 to 2005	145
Figure 12.1: Percentage prevalence of 16 to 59 year olds reporting having used any drug, cannabis and cocaine in the last year by respondent's highest level of education, England and Wales, 2003/04	167
Figure 12.2: Percentage of 16-24 year olds using any drug, cannabis and cocaine more than once a month in the last year in England and Wales, 2003/04 to 2005/06	172
Figure 12.3: Rate of Illicit drug use in the past year by ethnicity (rate per thousand population) in England, Scotland and Wales	177
Figure 13.1: Schematic representation of the procedure for investigating a driver suspected of being under the influence of drugs, with a proposed role for the Field Impairment Test (FIT) procedure	188

List of tables used in text

Table	Page
Table 1.1: Performance against PSAs	23
Table 2.1: The proportion of 16-59 year olds reporting having used drugs in their lifetime, in last year and in last month, in England and Wales, 1996 to 2005/06	28
Table 2.2: The proportion of 16-59 year olds reporting having used drugs in their lifetime, last year and last 2000 to 2004	30
Table 2.3: Use of any drug by gender in England and Wales, 2004/05 and 2005/06 and Scotland, 2004 as a percentage	30
Table 2.4: The proportion of 16-34 year olds reporting having used drugs in their lifetime, last year and last month in England and Wales, 2003/04 to 2005/06	31
Table 2.5: The proportion of 16-34 year olds reporting having used drugs in their lifetime, last year and last month in Scotland, 2003 and 2004	31
Table 2.6: The proportion of 16-24 year olds reporting having used drugs in their lifetime, last year and last month in England and Wales, 1996 to 2004/05	32
Table 2.7: The proportion of 16-24 year olds reporting having used drugs in their lifetime, last year and last month in Scotland, 2003 and 2004	33
Table 2.8: Frequency of use in the last year: proportion of 16-24 year olds (all respondents) who use more than once a month in England and Wales, 2002/03 to 2005/06	34
Table 2.9: Frequency of use in the last year: proportion of 16-24 year olds who use more than once a month	34
Table 2.10: Use of any drug by gender and age group (16 to 24 and 16 to 34) in England and Wales, 2004/05 and 2005/06 and Scotland, 2004	34
Table 2.11: Whether had taken individual drugs in the last year and last month, by age in England, 2005 as a percentage	36
Table 2.12: Whether had used individual drugs in the last month, in the last year and ever, by gender in England, 2005	37
Table 2.13: Prevalence of drug use in the last month amongst school children in England, 2001 to 2005	38
Table 2.14: Percentage who have taken drugs in the last year by ethnicity in England and Wales, 2003	40
Table 2.15: Vulnerability and use of drugs in England and Wales, 2004 as a percentage	41
Table 4.1: Estimated number of opiate users and opiate and/or problem cocaine users aged 15 to 64 years old by HSSB area in Northern Ireland, 2004	51
Table 4.2: Number and percentage of drug treatment presentations in 2003/04 in the United Kingdom by primary drug of use and by country	52
Table 6.1 UK drug mentions 2002 to 2004	76

Table 8.1: Persons found guilty, given a fiscal fine or dealt with by compounding for drug offences in the UK, 2000 to 2004	101
Table 8.2: Proportion of offenders who had taken alcohol or drugs at the time of an incident in England and Wales, 2004	103
Table 10.1: The mean price of illegal drugs in Pounds and Euros in the United Kingdom, 2003 to 2005	126
Table 10.2: Street level mean average in percentage of purity of drug in the United Kingdom, 2003 to 2005	127
Table 11.1: Percentage prevalence of lifetime, last year and last month drug use by gender in England, 2005 and Northern Ireland, 2003	135
Table 11.2: Percentage prevalence of lifetime drug use by age and sex in England 2005	136
Table 11.3: Percentage prevalence of last year drug use by age and sex in England 2005	137
Table 11.4: Percentage prevalence of last month drug use by age and sex in England, 2005	137
Table 11.5: Percentage of individuals who have used drugs in the last year, by age group and gender in Scotland, 2004	138
Table 11.6: Frequency of drug use by school age children in England, 2005 as a percentage	139
Table 11.7: Frequency of drug use in Scotland amongst 13 and 15 year olds in 2004 as a percentage	139
Table 11.8: Frequency of lifetime drug use amongst drug users, by age as a percentage	139
Table 11.9: Percentage of drug users using a variety of drugs by age in Scotland	140
Table 11.10: Percentage of drug users using in each location by age and gender in Scotland, 2004	140
Table 11.11: Percentage using drugs by family affluence, age group and gender in Scotland 2004	141
Table 11.12: Percentage of pupils who had taken drugs in the last month by gender and age in England, 1998-2005	144
Table 11.13: Percentage of individuals at age 15 using drugs by parental drinking and drug use, Scotland	146
Table 11.14: Inter-relationship between alcohol and illicit drugs	150
Table 11.15: Percentage of regular users who reported earlier occasional use, Scotland	151
Table 11.16: Percentage drug offending in last 12 months, by age and sex in England and Wales, 2004	152
Table 12.1: Percentage prevalence of drug use by drug and country among 15 to 64 year olds in the United Kingdom	161

Table 12.2: Percentage prevalence of drug use by drug and country amongst 15/16 to 24 and 15/16 to 34 year olds in the United Kingdom	162
Table 12.3: Percentage prevalence of adults aged 16 to 59 reporting having used any drug, cocaine and crack in England and Wales, 1996 to 2005/06	163
Table 12.4: Percentage prevalence of 16-24 year olds reporting having used any drug, cocaine and crack in England and Wales, 1996 to 2005/06	163
Table 12.5: Percentage lifetime prevalence of any drug, cocaine and crack by age in Northern Ireland, 1998 to 2003/04	164
Table 12.6: Percentage prevalence of illegal drug use amongst adults by drug in Scotland from 1993 to 2004	164
Table 12.7: Percentage prevalence of illegal drug use among 16 to 24 and 16 to 34 year olds by drug in Scotland, 2003 and 2004	165
Table 12.8: Estimates of number of those who used cocaine and crack in the last month aged 16-59 and 16 to 24 in England and Wales, 2004/05 and 2005/06	165
Table 12.9: Percentage prevalence of use of any drug, cocaine (including crack) among adults aged 16-59 by gender in England and Wales 2005/06, Northern Ireland 2003/04 and Scotland 2004	166
Table 12.10: Percentage prevalence of use of any drug, cocaine (including crack) among 16-24 and 16-34 year olds by gender in England and Wales 2005/06 and Scotland 2004	166
Table 12.11: Percentage of 16-29, 30-59 and 16-59 year olds reporting having used drugs in the last year by frequency of visits to a pub or wine bar in the evening in the last month in England and Wales, 2003/04	168
Table 12.12: Percentage of 16-29, 30-59 and 16-59 year olds reporting having used drugs in the last year by visits to discos and nightclubs in England and Wales, 2003/04	169
Table 12.13: Percentage of 16-59 year olds reporting having used drugs in the last year by ACORN category in England and Wales, 2005/06	169
Table 12.14: Percentage of 16-59 year olds reporting having used drugs in the last year by marital status in England and Wales, 2003/04	169
Table 12.15: Percentage of 16-59 year olds reporting having used drugs in the last year by household income in England and Wales, 2003/04	170
Table 12.16: Percentage of 16-59 year olds reporting having used drugs in the last year by tenure in England and Wales, 2003/04	170
Table 12.17: Percentage of 16-59 year olds reporting having used drugs in the last year by accommodation type in England and Wales, 2003/04	171
Table 12.18: Percentage of 16-59 year olds reporting having used drugs in the last year by social class in England and Wales, 2003/04	171
Table 12.19: Percentage of pupils who have taken individual drugs in the last month, in the last year (including in the last month) and in lifetime by age in England, 2005	173

Table 12.20: Percentage of pupils aged 11 to 15 who have taken individual drugs in the last month, in the last year (including in the last month) and ever, by sex in England, 2005	173
Table 12.21: Percentage of pupils who have taken individual drugs in the last month, in the last year (including in the last month) and ever by age in Northern Ireland, 2003	173
Table 12.22: Percentage of pupils who have taken individual drugs in the last month, in the last year (including in the last month) and in lifetime by age in Scotland, 2004	174
Table 12.23: Estimated number of opiate users and opiate and/or problem cocaine users aged 15 to 64 years old by HSSB area in Northern Ireland	175
Table 12.24: Percentage of 10 – 24 year olds by vulnerability and drug use in the last year in England and Wales	178
Table 12.25: Percentage of 10 to 24 year olds ever in care or homeless, truants, excludees and serious or frequent offenders who used drugs in the last year in England and Wales, 2003	178
Table 12.26: Number of deaths related to any drug and cocaine, England and Wales 1999 to 2004	180
Table 12.27: Prevalence of drug dependence by age (rate per thousand population)	180

List of abbreviations used in the text

A&E	Accident and Emergency
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
ADCTs	Alcohol and Drugs Coordination Teams
ADD	Attention Deficit Disorders
AIDS	Acquired Immunodeficiency Syndrome
Anti-HBC	Antibodies to hepatitis B virus
Anti-HCV	Antibodies to hepatitis C virus
BBC	British Broadcasting Corporation
BCS	British Crime Survey
BCU	Basic Command Unit
BMA	British Medical Association
BNF	British National Formulary
BSC	Building Safer Communities
CAF	Common Assessment Framework
CAHRU	Child and Adolescent Health Research Unit
CAPs	Corporate Action Plans
CARATS	Counselling, Assessment, Referral, Advice and Through-care Services
CATs	Community Addiction Teams
CBC	Child Benefit Centre
CCTV	Closed Circuit Television
CDR Weekly	Communicable Disease Report Weekly
CDRPs	Crime and Disorder Reduction Partnerships
CDSC (NI)	Communicable Disease Surveillance Centre Northern Ireland
CDTD	The Central Drugs Trafficking Database
CI	Confidence Interval
CJIT	Criminal Justice Intervention Team
CJITs	Criminal Justice Integrated Teams
CPS	Crown Prosecution Service
CSPs	Community Safety Partnerships
CSU	Central Survey Unit
D(A)ATs	Drug and Alcohol Action Teams
DAIRU	Drug and Alcohol Information and Research Unit
DAP	Diversity Assessment Package
DATs	Drug Action Teams
DCLG	Department for Communities and Local Government
DDC	Dedicated Drug Court
DEFRA	Department for the Environment, Food and Rural Affairs
DfES	Department for Education and Skills
DH	Department of Health
DHI	Drug Harm Index
DHSSPSNI	Department of Health, Social Services and Public Safety Northern Ireland
DIP	Drug Interventions Programme
DIR	Drug Interventions Record
DMRI	Drug Misuse Research Initiative
DOE	Department of the Environment
DORIS	Drug Outcome Research in Scotland
DRD	Drug Related Deaths
DRR	Drug Rehabilitation Requirement
DSD	Drug Strategy Directorate
DT	Department of Transport
DTORS	Drug Treatment Outcomes Research Study
DTTO	Drug Treatment and Testing Order
DVLA	Driver and Vehicle Licensing Agency
DWP	Department for Work and Pensions

UNITED KINGDOM FOCAL POINT REPORT 2006

ECM	Every Child Matters
EDDRA	Exchange on Drug Demand Reduction Action
EIU	Effective Interventions Unit
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESI	Education Sector Initiative
ESPAD	European School Survey Project on Alcohol and Other Drugs
ESRC	Economic and Social Research Council
ETE	Education, Training and Employment
EU	European Union
EYTC	Edinburgh Youth Transitions Survey
FIT	Field Impairment Test
FIUI	Fatal injuries due to psychoactive drug intoxication
FSS	Forensic Science Service
FUP	File Upload Portal
GCSE	General Certificate of Education
GHB	Gamma hydroxybutyrate
GLADA	Greater London Alcohol and Drug Alliance
GMR	General Mortality Register
GO	Government Office
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
HCA	High Crack Areas
HCV	Hepatitis C Virus
HDA	Health Development Agency
HIV	Human Immunodeficiency Virus
HMPS	Her Majesty's Prison Service for England and Wales
HMSO	Her Majesty's Stationary Office
HOSDB	Home Office Scientific Development Branch
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
IDTS	Integrated Drug Treatment System
IDUs	Injecting Drug Users
ISD	ISD Information Services Division
ITMDF	Integrated Team Monitoring Data Form
KPI	Key Performance Indicator
LAAs	Local Area Agreements
LCJBs	Local Criminal Justice Boards
LDP	Local Delivery Plan
LDPF	London Drug Policy Forum
LSCB	Local Safeguarding Children Boards
LSCB	Local Safeguarding Children's Boards
LSD	Lysergic Diethylamide acid
LSPs	Local Strategic Partnerships
LST	Life Skills Training
MCA	Medicines Control Agency
MDA	Methylenedioxymethamphetamine
MDMA	3,4-Methylenedioxy-n-methylamphetamine
MDT	Mandatory Drug Tests
MHRA	Medicines and Health Care Products Regulation Agency
MMDU	Merseyside Middle Market Drugs Unit
MRC	Medical Research Council

MRSA	Methicillin resistant Staphylococcus aureus
NACD	National Advisory Committee on Drugs
NatCen	National Centre for Social Research
NCCDP	National Collaborating Centre for Drug Prevention
NCIS	National Criminal Intelligence Service
NDEC	National Drug Evidence Centre
NFER	National Foundation for Educational Research
NHS	National Health Service
NHSS	National Healthy Schools Standard
NICE	National Institute for Clinical and Health Excellence
NICS	Northern Ireland Court Services
NICS	Northern Ireland Crime Survey
NIDPS	Northern Ireland Drug Prevalence Survey
NIO	Northern Ireland Office
NOMS	National Offender Management Service
np-SAD	National Programme on Substance Abuse Deaths
NSDSG	New Strategic Direction for Alcohol and Drugs Steering Group
NTA	National Treatment Agency
NTORS	National Treatment Outcome Research Study
OCJS	Offending Crime and Justice Survey
OCJS	Offending, Crime and Justice Survey
ODPM	Office of the Deputy Prime Minister
Ofsted	Office for Standards in Education
ONS	Office for National Statistics
OPSI	Office of Public Sector Information
OR	Odds ratio
p2w	Progress2Work
PCTs	Primary Care Trusts
PDI	Partnership Drugs Initiative
PF	Positive Futures
PHSE	Personal, Social and Health Education
POCA	Proceeds of Crime Act
PPO	Prolific and other Priority Offender
PSA	Public Service Agreement
PSHE	Personal, Social and Health Education
PSHE	Personal, Social and Health Education
PSNI	Prison Service Northern Ireland
RAC	Royal Automobile Club
RCGP	Royal College of General Practitioners
RDS	Research Development and Statistics-
REIA	Race equality impact assessment
RoB	Restriction on Bail
RoB	Restriction on Bail
SACDM	Scottish Advisory Committee on Drugs Misuse
SAD	Scotland Against Drugs
SALSUS	Scottish Schools Adolescent Lifestyle and Substance Use Survey
SCDEA.	Scottish Crime and Drug Enforcement Agency
SCHWL	Scottish Centre for Healthy Working Lives
SCIEH	Scottish Centre for Infection and Environmental Health
SCoPiC	Social Contexts of Pathways into Crime
SCS	Scottish Crime Survey
SCVS	Scottish Crime and Victimisation Survey
SDEA	Scottish Drug Enforcement Agency
SHAs	Strategic Health Authorities
SMATs	Substance Misuse Action Teams
SMMGP	Substance Misuse Management in General Practice
SMR	Special Mortality Register
SOCA	Serious Organised Crime Agency
SPS	Scottish Prison Service
SSLP	Sure Start Local Programmes

UNITED KINGDOM FOCAL POINT REPORT 2006

STI	Sexually Transmitted Infection
TAS	Throughcare Addiction Service
TC	Therapeutic community
TDI	Treatment Demand Indicator
UAPMP	Unlinked Anonymous Prevalence Monitoring Programme
UKADCU	United Kingdom Anti Drugs Co ordination Unit
VDT	Voluntary Drug Testing
VSA	Volatile Substance Abuse
WHO	World Health Organisation
YOT	Youth Offending Team
YPBAS	Young Persons Behaviour and Attitudes Survey
YPSMG	Young People Substance Misuse Partnership Grant

List of websites used in the text

Aberlour

www.aberlour.org.uk

Bank of England

www.bankofengland.co.uk

British Broadcasting Corporation

www.bbc.co.uk

British Medical Association

www.bma.org.uk

British National Formulary

www.bnf.org.uk

Central Survey Unit, Northern Ireland

Statistical Research Agency (NISRA)

www.csu.nisra.gov.uk

Centre for Drug Misuse Research, University of Glasgow

www.gla.ac.uk/centres/drugmisuse

Centre for Public Health, Liverpool John Moores University

www.cph.org.uk

Cocaine Organisation

www.cocaine.org

Communicable Disease Surveillance Centre, Northern Ireland

www.cdscni.org.uk

Commission for racial equality

www.cre.gov.uk

Criminal Justice System in England and Wales.

www.cjonline.gov.uk

Department for Communities and Local Government

www.communities.gov.uk

Department for Education and Skills

www.dfes.gov.uk

Department for Transport

www.dft.gov.uk

Department for Transport, Local Government and the Regions

www.dltr.gov.uk

Department for Environment, Food and Rural Affairs

<http://www.defra.gov.uk>

Department of Health

www.dh.gov.uk

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

www.dhsspsni.gov.uk

Driver and Vehicle Licensing Agency

www.dvla.gov.uk

Department of Transport Drug Drive

www.drugdrive.com

Drug Treatment Monitoring Unit (DTMU)

www.dtmu.org.uk

Northern Ireland drugs and alcohol website for professionals

www.drugsalcohol

Drug Information in Northern Ireland

www.nics.gov.uk

Drugs Misuse Information Scotland

www.drugmisuse.isd.scotland.org

National Collaborating Centre for Drug Prevention

www.drugpreventionevidence

Drug Rehab and Alcohol Treatment Centre

www.drugrehab.co.uk

Drugs Strategy Directorate, Home Office

www.drugs.gov.uk

DrugScope

www.drugscope.org.uk

Drug Treatment Outcomes Research Study

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

Edinburgh Law School

www.law.ed.ac.uk

Every Child Matters

www.everychildmatters.gov.uk

FRANK

www.talktofrank.com

The Fostering Network

www.fostering.net

General Register Office

www.gro.gov.uk

Government News Network

www.gnn.gov.uk

General Register Office for Scotland
www.gro-scotland.gov

General Register Office Northern Ireland
www.groni.gov.uk

Health Behaviour in School-aged Children
www.hbsc.org

Health Protection Agency
www.hpa.org.uk

Health Protection Scotland
<http://www.hps.scot.nhs.uk/>

Healthcare Commission
www.healthcarecommission.org.uk

Her Majesty's Prison Service for England and Wales
www.hmprison.gov.uk

Her Majesty's Treasury
www.hm-treasury.gov.uk

Home Office
www.homeoffice.gov.uk

The Information Centre, National Health Service
www.ic.nhs.uk

Information Services Division, Scotland
www.isdscotland.org

Joseph Rowntree Foundation
www.jrf.org.uk

JustBeWell.com Hypnotherapy and NLP
www.justbewell.com

Keele University
www.kcl.ac.uk

King's College, University of London
www.kcl.ac.uk

Know the Score
www.knowthescore.info

London government
www.london.gov.uk

Loughborough University
www.lboro.ac.uk

Matrix Research and Consultancy
www.matrixcl.co.uk

Medical Research Council
www.mrc.ac.uk

Mental Health Care
www.mentalhealthcare.org

National Collaborating Centre for Drug Prevention
www.cph.org.uk/nccdp

National Institute for Health and Clinical Excellence
www.nice.org.uk

National Treatment Agency for Substance Misuse
www.nta.nhs.uk

Northern Ireland Office
www.nio.gov.uk

Office of Public Sector Information
www.opsi.gov.uk

Office for National Statistics
www.statistics.gov.uk

Office for Standards in Education
www.ofsted.gov.uk

Police Service Northern Ireland
www.psni.police.uk

Politics.co.uk
www.politics.co.uk

Probation Board Northern Ireland
www.pbni.org.uk

Queen's University, Belfast
www.qub.ac.uk

RAC Foundation
www.racfoundation.org

Race and Drugs Project
www.raceanddrugsproject.co.uk

Re-solv
www.re-solv.org

Royal College of General Practitioners
www.rcgp.org.uk

The Royal Pharmaceutical Society of Great Britain
www.rpsgb.org.uk

School of Law, University of Edinburgh
www.law.ed.ac.uk

Scottish Drug Enforcement Agency
www.sdea.police.uk

Scottish Executive
www.scotland.gov.uk

Scottish Police Forces
www.scottish.police.uk

Scottish Prison Service
www.sps.gov.uk

Scottish Road Safety Campaign
www.srsc.org.uk

Serious Organised Crime Agency
www.soca.gov.uk

Skills for Justice
www.skillsforjustice

University of Sheffield
www.shef.ac.uk

Sure Start
www.surestart.gov.uk

Standards Site, Department for Education
and Skills
www.standards.dfes.gov.uk

The Stationary Office
www.official-documents

Substance Misuse Management in General
Practice
www.smmgp.demon.co.uk

Road Safety for Scotland
<http://www.road-safety.org.uk>

Teachernet
www.teachernet.gov.uk

Transport for London
www.tfl.gov.uk

Think
www.drugdrive.co.uk

Times
www.timesonline.co.uk

Turning Point
www.turning-point.co.uk

The United Kingdom Parliament
www.parliament.uk

United Kingdom Parliament
www.parliament.uk

VSA Reports
www.vsareports.org

Welsh Assembly Government
www.wales.gov.uk

Welsh Local Government Association
www.wlga.gov.uk

Wired for Health
www.wiredforhealth.gov.uk

World Health Organisation Regional Office for
Europe
www.euro.who.int

Youth Justice Board
www.youth-justice-board.gov.uk

