



European Monitoring Centre  
for Drugs and Drug Addiction



2013 NATIONAL REPORT (2012 data)  
TO THE EMCDDA  
by the Reitox National Focal Point

UNITED KINGDOM  
New Developments and Trends

REITOX

# **United Kingdom drug situation: Annual report to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2013**

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## The United Kingdom Focal Point on Drugs

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

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

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

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

## 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.

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

The remainder of each chapter is concerned with **New Developments and Trends** that have not been included in previous annual reports. Generally, this covers developments that have occurred in the second half of 2012 or the first half of 2013. 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 2014.

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## Technical Notes

### Standard Tables

References in the text to Standard Tables (sometimes abbreviated to ST01, ST02 etc.) are to standardised reporting formats specified by the EMCDDA. All National Focal Points provide data using these Standard Tables in order to facilitate the collection of information in a consistent and comparable format across Europe.

The standard tables usually include the source of the data and details of methodology. A list of standard tables referred to in this report is included in Part C of the document.

### Exchange Rates

There have been considerable changes in the Sterling/Euro exchange rate. Due to the fluctuations in the exchange rate, data within the text are presented in Pounds Sterling only and have not been converted into Euros. Euro values have been provided in relation to drug prices, although care must be taken when interpreting trends in Euros. Euro values have been derived using the annual average spot exchange rate published by the Bank of England for the most appropriate calendar year. (For example, for 2007/08 financial year values the exchange rate for 2007 has been used). The 2013 exchange rate is based on the monthly average until the end of September 2013.

Exchange rates used in the report are shown in the table below.

Year	Euro rate (£1 = )
2003	1.4456
2004	1.4739
2005	1.4629
2006	1.467
2007	1.4619
2008	1.2588
2009	1.1233
2010	1.1752
2011	1.1462
2012	1.2337
2013	1.1736

### References to Specific Drugs

Cocaine. Where appropriate, this report distinguishes between 'cocaine powder' and 'crack cocaine'. When the word 'cocaine' is used it should be interpreted as meaning both forms of the drug.

Amphetamine(s) The term used in the text is the same as that used in the survey or study being described. In the UK methyl amphetamine is the term used in legislation for what is more generally known as methamphetamine.

Ecstasy The term refers to MDMA in any form.

### Use of term 'significant'

When the word significant is used it should be interpreted as meaning statistically significant at the 5% level or better.

### Research

All research articles have been obtained from peer-reviewed journals as a result of a search protocol. A copy of the inclusion criteria is available on request.

## The United Kingdom and its constituent countries



The United Kingdom population was estimated to be 63.7 million according to the 2012 mid-year estimate. Eighty-four per cent (53.5 million) live in England, eight per cent (5.3 million) in Scotland, five per cent (3.1 million) in Wales and three per cent (1.8 million) in Northern Ireland.

## Summary

### Chapter 1. Drug policy: legislation, strategies and economic analysis

#### Legal framework

Under the *Misuse of Drugs Act (Amendment) Order 2013*, O-desmethyltramadol, new categories of synthetic cannabinoids, methoxetamine and other compounds related to ketamine and phencyclidine were all made Class B drugs. The government also announced plans to control khat as a Class C drug.

'NBOMe' and 'Benzofury' became subject to a Temporary Class Drug Order (TCDO) in June 2013 for a period of up to 12 months.

In April 2013, a cannabis-based medicine, Sativex, was excluded from Schedule 1 of *The Misuse of Drugs Regulations 2001*, allowing it to be prescribed by medical professionals without the need for a Home Office licence.

The ACMD recommended that tramadol, zaleplon and zopiclone be controlled as Class C drugs, and lisdexamfetamine as a Class B drug under the *Misuse of Drugs Act 1971* and listed in the appropriate Schedules of the *Misuse of Drugs Regulations 2001*.

In July, 2013 the government announced it will enable the lawful provision of foil in drug services.

A consultation on proposals to allow law enforcement agencies search for, seize and detain substances suspected of being used as drug cutting agents was held ran between May and July 2013.

The government set out proposals to create an offence of driving with a concentration of a specified drug above a specified limit, under the *Crime and Courts Act 2013*. The proposals were set out in a consultation document with the secondary legislation expected in 2014.

#### National Action Plans and Strategies

The Welsh Government published its Substance Misuse Delivery Plan, 2013-2015, setting out key actions and performance measures for each of the Substance Misuse Strategy's key aims. An evaluation of the first three years of the Substance Misuse Strategy for Wales was published in June 2013.

In May, 2013 a report was published assessing the progress made in tackling the substance misuse problem in Northern Ireland.

The Home Affairs Committee published its review of drug policy in December 2012.

#### Treatment funding

From April 2013, responsibility for public health in England was devolved to local authorities. Central funding will no longer be provided directly for the treatment of substance using offenders (historically through the centrally funded Drugs Intervention Programme) and Police and Crime Commissioners will decide, at a local level, how much of their allocation from the Community Safety Fund to spend on this.

### Chapter 2. Drug use in the general population and specific groups

The *Crime Survey for England and Wales* (CSEW) shows a significant decrease in recent drug use between 2011/12 and 2012/13 (from 8.9% to 8.2%) mainly driven by a decrease in

cannabis use, from 6.9% to 6.4%. There were also decreases in the use of magic mushrooms, ketamine and mephedrone.

Data for 2012 from *Smoking, drinking and drug use amongst young people in England* showed 11.9% of pupils aged 11 to 15 years had used drugs in the last year. This remains fairly stable following a sharp fall from 14.8% to 12.5% between 2009 and 2010. As in previous years, cannabis was the most commonly used substance (7.5% of pupils used it in the last year) followed by volatile substances (3.6%).

Prevalence of use of new psychoactive substances remains relatively low in surveys on drug use.

### **Chapter 3. Prevention**

#### **Universal prevention**

The government advised schools to provide drug education within the non-statutory Personal Social and Health Education (PSHE). A consultation on PHSE showed one-fifth thought drugs and alcohol education should be statutory. The effect of substances on the body has been included as a statutory part of the Science curriculum for schools in England.

An Alcohol and Drug Education and Prevention Information Service (ADEPIS) was launched in 2013, funded by the Department for Education.

The Welsh Government published *Guidance for Substance Misuse Education*, which supports delivery of appropriate substance misuse education. The *All Wales School Liaison Core Programme* (AWSLCP) recently added lessons on new psychoactive substances and image enhancing drugs such as steroids

#### **Mass media and campaigns**

Communication programmes aiming to prevent drug use through providing information continued across the UK. For example, *'Talk to Frank'* in England, *'Know the Score'* in Scotland and the Welsh and English-speaking helpline *'Dan 24/7'* in Wales. In Northern Ireland, the Public Health Agency developed information campaigns for various groups.

The recent *Smoking, drinking and drug use amongst young people in England* survey included a question about sources of helpful information on drugs. Teachers (66%), parents (63%) and television (60%) were the most commonly cited sources and the *Talk to Frank* campaign was mentioned by 22% of pupils, a decrease from previous years.

#### **Community prevention**

The *Positive Futures* programme, which targeted vulnerable 10-19 year olds from deprived communities in England and Wales and engaged them in sports and arts-based activities has now ended. In Scotland, the Cashback for Communities scheme reinvests money recovered under the Proceeds of Crime Act 2002, in community activities mainly for young people. The scheme and projects within it are currently being evaluated.

Healthy Working Wales provides free support and advice to employers to develop health and well-being policies and initiatives in the workplace. A number of employers including small businesses have engaged with the programme.

### **Chapter 4. Problem drug use**

In England, in 2010/11, there were an estimated 298,752 opiate and/or crack cocaine users, and an estimated 93,401 injectors who use opiates and/or crack cocaine. Between 2005/6

and 2010/11 there was a significant decrease in the estimated number of opiate and/or crack cocaine users, crack cocaine users and injectors of opiates and/or crack cocaine.

Combining the 2010/11 estimates for England with the most recent estimates for Wales (2009/10), Northern Ireland (2004) and Scotland (2009/10), it is estimated that there are around 376,136 problem drug users in the United Kingdom, (9.15 per 1,000 population aged 15 to 64) and 133,112 people who inject drugs (primarily opiates or crack cocaine).

There are concerns about a growing number of people injecting steroids. Data collected in Wales through the Harm Reduction Database from needle and syringe exchange programmes show that around one third of attendees were steroid injectors.

## **Chapter 5. Drug-related treatment: treatment demand and treatment availability**

### **England**

In April 2013 the National Treatment Agency functions transferred to a new executive agency of the Department of Health, Public Health England (PHE). Local authorities in England became responsible for commissioning public health services including substance misuse services.

'Payment by results' pilots began in England in 2012 and an early report of 11 months' treatment data showed mixed results. Rates of abstinence from presenting drug improved but successful treatment completions decreased. The scheme is being evaluated.

To support the focus on recovery, PHE published a new manual and a recovery diagnostic tool for treatment providers in England. The National Institute for Health and Care Excellence (NICE) has published new quality standards for the treatment of drug use disorders.

### **Scotland**

In Scotland, the independent expert review of opioid replacement therapies published its report, including 12 recommendations. The drug treatment target that by March 2013 90% of clients would wait no longer than three weeks between referral and treatment, was exceeded early in 2012 and has evolved to become a standard for sustained performance.

### **Wales**

In Wales a Substance Misuse Treatment Framework for Recovery has been developed to provide guidelines to service planners and providers. New guidance has also been issued for improving access for veterans, to substance misuse treatment.

### **Treatment Demand Indicator**

There were 113,814 treatment presentations in the UK 2011/12 (those starting a new treatment episode), a decrease of five per cent since 2010/11.

Over half of treatment presentations in the UK were for primary opiate use although opiate presentations have decreased since 2010/11, particularly first ever opiate presentations. Just over one-fifth of treatment presentations were for primary cannabis use with cannabis the most common primary drug reported by first ever presentations to treatment (37% of first ever presentations). Primary cannabis presentations have increased substantially since 2003/04.

Primary cocaine presentations increased each year from 2003/4 to 2008/09, fell in 2009/10 and 2010/11 and then increased again in 2011/12.

### Treatment Outcomes

In England, amongst clients who received a review in 2011/12, 51% of opiate only users were abstinent from illicit opiates and 23% had improved. Analysis of treatment outcomes data in Wales showed that on exit from treatment in 2012, 34% of primary opiate users were abstinent from opiates and the average number of days of using had decreased by 29%. Follow-up data from Scotland's new reporting system showed that, by 3 month follow-up, nearly one-third of clients reported not using illicit drugs in the past month and for those with 12 month follow up data, 46% said they had not used illicit drugs in the last month.

## Chapter 6. Health correlates and consequences

### Drug-related infectious diseases

The prevalence of HIV infection amongst people who inject drugs (PWID) remains fairly stable. In 2012, it was 1.3% in England, Wales and Northern Ireland amongst PWID taking part in the Unlinked Anonymous Monitoring (UAM) survey. In Scotland, HIV prevalence was 0.4% amongst PWID undergoing testing in 2010.

Hepatitis C prevalence was 47% amongst PWID taking part in the 2012 UAM survey, with marked regional variations. Amongst PWID surveyed in needle exchanges in Scotland in 2011/12 Hepatitis C prevalence was 53%. Hepatitis B prevalence amongst PWID in England, Wales and Northern Ireland, taking part in the UAM survey was 17% in 2012.

### Drug-related deaths

Using the EMCDDA definition, 1,666 drug-related deaths were registered in the UK in 2012, a decrease of 6.7% since 2011, continuing the pattern of decreases over the previous three years. Numbers of deaths using the former UK Drug Strategy definition and the much wider ONS definition similarly showed decreases in 2012 compared to 2011.

As in previous years, the largest number of deaths were associated with heroin/morphine. The number of heroin/morphine associated deaths in 2012 (825) was similar to the number in 2011 (820), following a drop from 1,063 deaths in 2010. The number of methadone deaths fell to 660 in 2012, following an increase between 2010 and 2011. Deaths associated with cocaine, diazepam and ecstasy increased in 2012. Deaths associated with Tramadol again increased; by 24%, continuing the pattern of year-on-year increases since 2003.

## Chapter 7. Responses to health correlates and consequences

### Reducing drug-related deaths

There are systems in place within each UK country to explore the circumstances around drug-related deaths. The Scottish Government published a report (based on 2011 data from the National Drug-related Deaths Database) reviewing the social circumstances and background details surrounding a cohort of 438 drug-related deaths. In Wales, the process for reviewing drug-related deaths is currently being revised to establish more immediate reviews.

In England, the preliminary stage of a trial of issuing take-home naloxone kits on release from prison is complete and, in Northern Ireland, a pilot naloxone scheme is in progress. In Scotland and Wales, national take-home naloxone programmes exist and three trials are being carried out in Wales to assess the feasibility of widening access to naloxone in custody suites, emergency departments and through paramedics.

### Needle and Syringe Programmes (NSPs)

NSPs continue to be widely available throughout the UK. Scotland and Northern Ireland routinely publish data on needle and syringe provision. Wales recently published a report from the first 18 months of the Harm Reduction Database including details of NSP use.

In 2012, 83% of UAM survey participants in England, Wales and Northern Ireland who had injected during the preceding year said they had used an NSP during that time. However, almost one third (33%) of UAM survey participants in England who had injected during the preceding 4 weeks said they had done so with a needle that had previously been used.

### Strategy and guidance

NICE published new guidance on promoting testing for hepatitis B and C for people at increased risk of infection.

The Welsh Government published guidance on substance misuse harm reduction, with recommendations for action under different aspects of healthcare.

## Chapter 8. Social correlates and consequences

### Housing

Fourteen per cent of people entering drug treatment in Scotland in 2011/12 reported being homeless. In England in 2011/12, 9% of clients were recorded as having no fixed abode and 15% were in temporary accommodation such as a hostel or with friends or family. In Wales, 8% of those entering the Drug Interventions Programme had no fixed abode in 2010/11, and 25% were in temporary accommodation.

### Employment

Amongst people presenting for drug treatment in England, Scotland and Northern Ireland in 2011/12, 58% were unemployed, similar to rates in 2010/11.

In May 2011 34,080 people in the UK claimed Incapacity Benefit and Severe Disablement Allowance and 10,140 claimed Employment and support Allowance due to drug abuse.

### Families

Data from the Scottish Drug Misuse Database showed that 38% of individuals assessed for treatment in 2011/12 had a dependent child under age of 16. In Northern Ireland, 13% of people entering treatment in 2010/11 lived with a child. National Drug Treatment Monitoring System data for 2011/12 showed 21% of adult clients in treatment were parents living with their own children, 13% were living with children who were not their own and 20% were parents not living with their children.

### Reintegration

In England, two new Work Programme pilot programmes, 'Recovery Works' and 'Recovery and Employment' were announced. A National Treatment Agency report showing how drug treatment helps families and a report of evidence from the Troubled Families Programme were published.

In Wales the ESF Peer Mentoring Scheme had worked with 8,800 participants of whom 800 had entered paid work by June 2013. Integrated Family Support Services have been introduced in all but two areas of Wales.

The Scottish Government has updated good practice guidance for those working with families affected by problem alcohol and/or drug use.

Adfam and the UKDPC have each published reports to help challenge stigma around drug issues.

## Chapter 9. Drug-related crime, prevention of drug-related crime and prison

### Drug Offences

Recorded drug offences in the UK decreased by eight per cent between 2011/12 and 2012/13. While there have been decreases in England, Wales and Scotland in the last five years, the number of offences in Northern Ireland increased substantially over this period.

Use of stop and searches for drugs in England and Wales decreased by three per cent in 2011/12, following a long trend of increased use. A consultation on the police powers to stop and search took place in July to September, 2013. Release published a report on ethnic disparities in the policing and prosecution of drug offences in England and Wales.

Arrests for drug offences in England and Wales fell by three per cent between 2010/11 and 2011/12 while arrests for drug offences in Northern Ireland increased by four per cent.

The number of convictions and cautions for drug offences in the UK was similar in 2011 and 2010 although there were differences in those related to particular drugs. Convictions for heroin fell by around one-quarter, possibly reflecting the reduced supply of heroin in late 2010 and early 2011. Cannabis convictions in the UK increased by five per cent in 2011 and convictions for ecstasy offences increased in 2011 following a large decrease in 2010.

Cannabis *possession* offences dealt with by the criminal justice system in England and Wales in 2012 decreased by ten per cent compared with 2011.

### Prevention of drug-related crime

The Government grant for the Drug Interventions Programme (DIP), which helped 88,000 individuals into drug treatment and recovery services, including non-structured treatment, has now ended. The new Community Safety Grant replaces these individual programme grants.

### Interventions in the criminal justice system

The Ministry of Justice presented *Transforming Rehabilitation: A Strategy for Reform* to parliament, following a consultation. It proposes to make every offender released from custody subject to supervision and rehabilitation for a minimum of 12 months. It also proposes introducing competition to the market for provision of rehabilitation services for low risk and medium risk offenders, and extending payment by results to these services.

In England and Wales, a similar number of Drug Rehabilitation Requirements were started in 2012 as in 2011, although this was 24% fewer than in 2008. In Scotland, there was a substantial increase in diversion of 16 to 17 year olds from prosecution, into drug treatment/education while the number of Drug Treatment and Testing Orders (DTTOs) started in 2011/12 decreased in number compared to the previous year.

The first report of the Offender Management Community Cohort Study, (based in England and Wales) was published, exploring which offenders are sentenced to community orders; the needs assessment process; sentence planning; and how sentences are tailored.

### Drug treatment and use in prisons

In Scotland, 72% of prisoners tested positive for illegal drugs on reception to prison in 2012 (as in 2011) and 23% tested positive on release. The percentage of prisoners testing positive for illicit buprenorphine use has increased.

In 2011/12 64,916 prisoners in England and Wales received a clinical drug intervention. Around half of these prisoners received an opioid substitute maintenance prescription. In Northern Ireland, 640 individuals presented to drug treatment in prisons.

## Chapter 10. Drug markets

### Availability

The proportion of school children reporting that they have been offered drugs remained stable in 2012 at 28%.

### Seizures

The number of drug seizures in the UK remained fairly stable in 2011/12, following decreases in 2009/10 and 2010/11. Cannabis was the most seized drug and the number of herbal cannabis and cannabis plant seizures has increased since 2010/11. There were also increases in the number of seizures of ecstasy type substances, and mephedrone.

In terms of *quantities* of seizures, the quantity of heroin and ecstasy seized more than doubled in 2011/12 compared to 2010/11, after previous decreases. The quantity of cocaine powder seized increased by 40% in 2011/12 and the quantity of amphetamines increased by 20%. The number of cannabis plants seized decreased again.

### Price/purity

Data provided by law enforcement agencies show that the wholesale price of drugs has remained fairly stable in 2012 apart from the wholesale price of heroin which continued to increase. Data from the Serious Organised Crime Agency (SOCA) suggest fairly stable street level prices apart from an increase in the street price of crack cocaine and a decrease in the street price of ketamine.

Mean street-level purity of cocaine powder and the MDMA content of ecstasy tablets increased in 2012. The purity-adjusted price of cocaine powder is at its lowest since 2005. Following a large drop in heroin purity in 2011, it has stabilised in 2012.

# PART A

New developments and trends

# 1. Drug policy: legislation, strategies and economic analysis

## 1.1 Introduction

The United Kingdom (UK) consists of England, Wales, Scotland and Northern Ireland. England accounts for 84% of the UK population. A number of powers have been devolved from the United Kingdom Parliament to Wales, Scotland, and Northern Ireland, but each has different levels of devolved responsibilities.

*The Misuse of Drugs Act, 1971* is the principal legislation in the United Kingdom for the control and supply of drugs that are considered dangerous or otherwise harmful when misused. This Act divides such drugs into three Classes (A, B and C) to broadly reflect their relative harms and sets maximum criminal penalties for possession, supply and production in relation to each class.

Drugs in Class A include cocaine, ecstasy, LSD, magic mushrooms, heroin, methadone, methylamphetamine and injectable amphetamines. Class B drugs include amphetamine, cannabis and synthetic cannabinoids, synthetic cathinone derivatives including mephedrone, as well as, since 2012, pipradrol related compounds including desoxypipradrol (2-DPMP) and diphenylprolinol (D2PM) and, since 2013, methoxetamine and related compounds. Class C drugs include anabolic steroids, tranquillisers, ketamine, benzodiazepines and piperazines (such as BZP).

Most drugs controlled under the Act are placed in one of five schedules to the *Misuse of Drugs Regulations 2001* based on an assessment of their medicinal or therapeutic usefulness and the need for legitimate access and their potential harms when misused.<sup>1</sup>

*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 the supply of drugs. The *Police Reform and Social Responsibility Act 2011* added provisions for 12-month temporary class drug orders (TCDOs) enabling law enforcement activity against those trafficking and supplying temporary class drugs. Methoxetamine became the first drug subject to a TCDO in the UK in 2012 and, in June 2013, two groups of substances, known as 'NBOMe' and 'Benzofury' compounds (14 in total), were also placed under a TCDO.

The United Kingdom Government is responsible for setting the overall strategy and for its delivery in the devolved administrations only in matters where it has reserved power (SQ32). A new drug strategy was launched in December 2010 (HM Government 2010) replacing that of the previous Government, which was published in 2008 (HM Government 2008). The 2010 Strategy places a much greater emphasis on supporting those who are drug dependent to achieve recovery – and also widens the focus on dependence to prescription and over-the-counter medicines and tackling emerging new psychoactive substances (NPS). Within the strategy, policies concerning health, education, housing and social care are confined to England; those for policing and the criminal justice system cover England and Wales.

The Scottish Government and Welsh Government's national drug strategies were published in 2008, (Scottish Government 2008a; WAG 2008a) the latter combining drugs, alcohol and addiction to prescription drugs and over-the-counter medicines. Each strategy aims to make further progress on reducing harm and helping individuals recover from their drug problems.

<sup>1</sup> See: <https://www.gov.uk/government/policies/reducing-drugs-misuse-and-dependence/supporting-pages/classifying-and-controlling-drugs>

The Scottish and Welsh strategy documents are also accompanied by an action or implementation plan, providing a detailed set of objectives; actions and responsibilities; expected outcomes; and a corresponding timescale for delivery (Scottish Government 2008a; WAG 2008b; Welsh Government 2013a). Each plan reflects the devolution of responsibilities to the national Government.

Northern Ireland's strategy for reducing the harm related to alcohol and drug misuse, the *New Strategic Direction for Alcohol and Drugs* (NSD), was launched in 2006. The NSD contained actions and outcomes, at both the regional and local level, to achieve its overarching aims (DHSSPSNI 2006). A review of the NSD was conducted in 2010, and, after consultation, a revised strategy, the *New Strategic Direction for Alcohol and Drugs Phase 2, 2011-2016*, was launched in January 2012 (DHSSPSNI 2011).

The drug strategies in Wales and Northern Ireland are underpinned by performance management frameworks, including Public Service Agreements (PSAs) and associated sets of performance indicators, which progress is measured against. In Scotland, the Alcohol and Drug Partnership (ADP) Planning and Reporting Guidance for 2012-15 aims to support the embedding of outcomes-based planning and reporting at the local level. This guidance identified nationally agreed core outcomes and indicators that all ADPs are expected to deliver against.

Labelled public expenditure on drugs is estimated at around £1.1 billion per annum. Data on labelled public expenditure on drugs have been provided to the UK Focal Point annually from government departments and the devolved administrations but changes to drug funding in England makes the identification of drug-specific expenditure increasingly difficult. A recent estimate of the economic and social costs of drug supply in the UK for 2010/11 put the cost at around £10.7 billion (Mills et al. 2013). Using a similar methodology to a social and economic costs study in England and Wales for 2003/04 (Gordon et al. 2006), it was estimated that the economic and social costs of illicit drug use in Scotland were £3.5 billion in 2006 (Casey et al. 2009).

## 1.2 Legal Framework

### 1.2.1 Changes to drug misuse legislation

#### *Misuse of Drugs Act (Amendment) Order 2013*

In March 2012, methoxetamine became subject to a Temporary Class Drug Order (TCDO). Following advice from the Advisory Council on the Misuse of Drugs (ACMD (ACMD 2012), the *Misuse of Drugs Act (Amendment) Order 2013*<sup>2</sup> made methoxetamine and other compounds related to ketamine and phencyclidine, Class B drugs.

Under the same order, and following advice from the ACMD, the 2009 generic definition of controlled synthetic cannabinoids was extended to capture new related compounds and new categories of synthetic cannabinoids as Class B drugs under the *Misuse of Drugs Act 1971*.

O-desmethyltramadol also became a Class B drug under the Order after a report by the ACMD suggested that it was being sold as a 'legal high' substance or as an ingredient in so-called 'legal high' products.<sup>3</sup>

#### Sativex

<sup>2</sup> See: [http://www.legislation.gov.uk/ukdsi/2013/9780111532980/pdfs/ukdsi\\_9780111532980\\_en.pdf](http://www.legislation.gov.uk/ukdsi/2013/9780111532980/pdfs/ukdsi_9780111532980_en.pdf)

<sup>3</sup> See: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/119152/ACMD-O-desmethyltramadol.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/119152/ACMD-O-desmethyltramadol.pdf)

Under *The Misuse of Drugs (Amendment No. 2) (England, Wales and Scotland) Regulations 2013*<sup>4</sup>, which came into force in April 2013, the cannabis-based medicine ‘Sativex’ was listed in Schedule 4 of the *Misuse of Drugs Regulations 2001*, as recommended by the ACMD, enabling it to be available through healthcare providers on prescription (without the need for a Home Office licence).

### 1.2.2 Temporary Drug Class Orders

In June 2013, two groups of substances known as ‘NBOMe’ and ‘Benzofury’ compounds became subject to a Temporary Class Drug Order (TCDO) for a maximum period of 12 months.<sup>5</sup> The ACMD is due to advise the Government on the harms of these drugs in relation to permanent control under the *Misuse of Drugs Act 1971*.

### 1.2.3 Khat

Having consulted the ACMD, who produced a report on khat in January 2013 (ACMD 2013a; see section 1.2.5), the Government announced its decision to control khat as a Class C drug under the *Misuse of Drugs Act 1971*. The legislative proposal was laid before Parliament in October 2013 for its consideration.

### 1.2.4 Provision of foil in drug services

In February 2013, the ACMD responded to a request from the Home Secretary to provide further advice on whether the provision of foil would help people stop using drugs in line with the aims of the Drug Strategy<sup>6</sup>. In its response, the ACMD stated that as an intervention, evidence suggested that the provision of foil can support an individual in their first steps into treatment and towards recovery.<sup>7</sup>

In July 2013, the Government, announced its decision to enable the lawful provision of foil in drug services, subject to the condition that its provision was part of structured efforts to engage drug users into recovery-orientated treatment, with monitoring arrangements put in place.

### 1.2.5 Advisory Council on the Misuse of Drugs advice

#### Khat

The ACMD undertook a review of the available evidence on khat and provided advice to the Government, including in relation to control under the *Misuse of Drugs Act 1971*. The ACMD’s report, published in January 2013, reviewed the evidence available since the previous 2005 report (ACMD 2005; see UK Focal Point Report 2006), particularly with regards to societal harms (ACMD 2013a; see section 6.3.7 and 8.2.7). After reviewing the evidence base, the ACMD considered that the evidence on the potential health and social harms associated with khat was insufficient to justify control and made other recommendations for tailored health and community-based interventions, as well as monitoring impact, to address these harms.

#### Advice on tramadol

The ACMD reviewed the harms associated with non-medicinal use of tramadol (ACMD 2013b; see section 6.3.7) and recommended that it be controlled as a class C substance

<sup>4</sup> See: [http://www.legislation.gov.uk/uksi/2013/624/pdfs/uksi\\_20130624\\_en.pdf](http://www.legislation.gov.uk/uksi/2013/624/pdfs/uksi_20130624_en.pdf)  
<http://www.legislation.gov.uk/uksi/2013/625/regulation/7/made>

<sup>5</sup> See: [http://www.legislation.gov.uk/uksi/2013/1294/pdfs/uksi\\_20131294\\_en.pdf](http://www.legislation.gov.uk/uksi/2013/1294/pdfs/uksi_20131294_en.pdf)

<sup>6</sup> See: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/144119/Request-ACMD-advice-foil.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/144119/Request-ACMD-advice-foil.pdf)

<sup>7</sup> See: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/144109/acmd-advice-foil-2013.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/144109/acmd-advice-foil-2013.pdf)

under the *Misuse of Drugs Act 1971* and listed in Schedule III of the *Misuse of Drugs Regulations 2001*. The Government, in a letter to the ACMD, accepted this advice in principle subject to the outcome of a public consultation to assess the impact of listing tramadol in Schedule III to the *Misuse of Drugs Regulations 2001*.

#### Advice on lisdexamfetamine

In its advice to the Government, the ACMD recommended that lisdexamfetamine, which is metabolised to dexamphetamine (a controlled drug in the UK) be controlled under Class B of the *Misuse of Drugs Act 1971* and in Schedule II of the *Misuse of Drugs Regulations 2001*.<sup>8</sup> The Government, in a letter to the ACMD in September 2013, accepted this advice.

#### Advice on control of Z-drugs

In its advice to the Government, the ACMD recommended that zaleplon and zopiclone, like the already-controlled zolpidem, be controlled under the *Misuse of Drugs Act 1971* as Class C substances and listed under Schedule IV, Part 1 of the *Misuse of Drugs Regulations 2001* (ACMD 2013c; see section 6.3.7). The Government, in a letter to the ACMD in September 2013 accepted this advice.

#### Advice on the extension of independent prescribing to allied health professionals

In February 2013, the ACMD provided advice recommending the extension of independent prescribing responsibilities to physiotherapists and chiropodists/podiatrists (allied health professions).<sup>9</sup> The recommendation was that prescribing of oral temazepam, lorazepam, diazepam and dihydrocodeine be extended to both groups with physiotherapists additionally permitted to prescribe oral and injectable morphine, transdermal fentanyl and oral oxycodone. The extension would require changes to the *Misuse of Drugs Regulations 2001* and would follow the extension of independent prescribing to nurses in 2012<sup>10</sup>.

### 1.2.6 Proposed revisions to the legal framework

#### New powers related to cutting agents

The Government's Drug Strategy made a commitment to "develop a robust approach to stop criminals profiting from the trade in cutting agents" (HM Government 2010). A consultation on new powers to allow law enforcement agencies to seize and detain chemical substances suspected of being used as drug cutting agents ran between May and July 2013.<sup>11</sup> The proposed powers include:

- The power to enter and search premises for specified chemical substances if a law enforcement officer has reasonable grounds to suspect they are intended for use in unlawful conduct (ie drug trafficking);
- The power to seize such substances if a law enforcement officer has reasonable grounds to suspect they are intended for use in unlawful conduct; and
- The power to detain any such substances for an initial period of 30 days.

It is proposed that these substances will be specified in secondary legislation and will apply to benzocaine, lidocaine and phenacetin, commonly found as adulterants in cocaine (see section 10.4.4).

#### Drug driving

<sup>8</sup> See:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/237035/ACMD\\_advice\\_Lisdexamfetamine.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/237035/ACMD_advice_Lisdexamfetamine.pdf)

<sup>9</sup>

See: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/144117/independ-prescribing-advice.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/144117/independ-prescribing-advice.pdf)

<sup>10</sup> See: [http://www.legislation.gov.uk/ukxi/2012/973/pdfs/ukxi\\_20120973\\_en.pdf](http://www.legislation.gov.uk/ukxi/2012/973/pdfs/ukxi_20120973_en.pdf)

<sup>11</sup> See: <https://www.gov.uk/government/consultations/cutting-agents-consultation>

See:

As part of the *Crime and Courts Act 2013*, a specific offence of driving with a concentration of a specified drug over a specified limit will be created. An expert panel was convened to advise on the specified drugs and limits for each drug under the legislation and the panel reported on its findings in March 2013 (Wolff et al. 2013)<sup>12</sup>. The panel reviewed the available evidence to determine which drugs should be included, the odds ratio risk of having a road traffic accident while under the influence of drugs, and it recommended thresholds that should be used to determine whether someone represents a road safety risk after consuming a drug.

The Government accepted the Expert Panel's recommendations on the drugs to be specified in regulations with a two further controlled drugs added. The Government also accepted the limits recommended for eight drugs most associated with medical uses but for those drugs most associated with illegal use it has proposed a zero tolerance approach to the specified limits. The proposals have been set out in a consultation document<sup>13</sup> with the secondary legislation expected in 2014. The consultation was extended to Scotland but it is for the Scottish Government to make a final decision on the drugs and their limits to be specified in regulations in relation to the offence in Scotland.

The consultation closed on 17 September and the Department for Transport (DfT) and Scottish Government are both currently considering the responses. A further shorter consultation is required to propose a limit for amphetamine as a question on what a suitable limit might be was not included in the earlier consultation. No decision has yet been taken on what that limit might be or when a further joint DfT / Scottish Government is to take place, but is expected to be before the end of the year. A response to both consultations is therefore expected early in 2014 and the regulations will be finalised before seeking a Parliamentary slot. It is expected that the regulations will be approved by Parliament and come into force in summer 2014.

The *Drug Driving (Assessment of Drug Misuse) Bill 2013-14* was introduced to Parliament in June 2013.<sup>14</sup> Currently, no provision exists to enable the police or courts to require drug drivers who misuse Class A drugs to attend assessments with a drug worker in the same way that other drug users can be required to attend assessments in relation to other offences. The Bill would insert a provision in the *Drugs Act 2005* to enable police and the courts to require drug drivers to attend up to two assessments with a drugs worker if they test positive for a specified Class A drug.

### **1.3 National action plan, strategy, evaluation and co-ordination**

#### **1.3.1 National Action Plans and Strategies**

##### **Scotland**

The Scottish Government's national drugs strategy, *The Road to Recovery*, published in 2008, is a long-term strategy focused on recovery (Scottish Government 2008a). A debate on Scotland's drugs strategy took place in the Scottish Parliament in November 2012 with Parliament recognising the progress made in delivering the national strategy.<sup>15</sup>

##### **Wales**

The Welsh Government published its Substance Misuse Delivery Plan, 2013-2015 (Welsh Government 2013a) setting out key actions and performance measures for each of the

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<sup>12</sup> See: <https://www.gov.uk/government/publications/driving-under-the-influence-of-drugs--2>

<sup>13</sup> See: [www.gov.uk/government/consultations/drug-driving-proposed-regulations](http://www.gov.uk/government/consultations/drug-driving-proposed-regulations)

<sup>14</sup> See: <http://services.parliament.uk/bills/2013-14/drugdrivingassessmentofdrugmisuse/documents.html>

<sup>15</sup> See: [http://www.scottish.parliament.uk/parliamentarybusiness/28862.aspx?r=7501&mode=html#iob\\_68396](http://www.scottish.parliament.uk/parliamentarybusiness/28862.aspx?r=7501&mode=html#iob_68396)

Substance Misuse Strategy's key aims: preventing harm; supporting substance misusers to improve their health and aid and maintain recovery; supporting and protecting families; and tackling availability and protecting individuals and communities via enforcement activity. The plan also sets out measures to deliver the strategy and support partner agencies and provides delivery dates for the work.

### 1.3.2 Implementation and evaluation of national action plan and/or strategies

#### Annual Report on the Forensic Early Warning System (FEWS)

The Forensic Early Warning System (FEWS) was set up in January 2011 to forensically identify new psychoactive substances (NPS) in a prompt manner, in order to assist the ACMD and Government to tackle the threat posed by emerging substances (see UK Focal Point Report 2012). It forms part of the Government's wider action on NPS, as set out in the NPS Action Plan (Home Office 2012a). A report on the activities of FEWS was published in July 2013 showing that around 2,000 samples were obtained from FEWS collection plans during 2012-13 (Home Office 2013a). Ten NPS that had not previously been seen in the UK were identified from these samples, bringing the total number of newly identified substances through FEWS to 27. Of the 10 substances identified in 2012-13, three were synthetic cannabinoids, one was a phenethylamine, two were cathinones and four were classified as 'other'. Seven out of the ten samples were obtained through the UK Border Force with the remaining three purchased via the Internet. Since FEWS' inception, the Internet has been the source that has provided the largest number of samples of non-controlled NPS.

Other findings from FEWS Annual Report include;

- 81% of samples that contained NPS were a mixture of either two or three different active compounds;
- products with the same brand name were found to have different mixtures of active compounds (including those from the same supplier); and
- products advertised as legal alternatives to controlled drugs were not always legal.

In 2013/14, FEWS is also looking to obtain further drug reference standards for the identification of NPS (31 have been obtained by FEWS thus far) and to enhance national and international collaborations. FEWS is currently funded until April 2014.

#### Wales

The Welsh Government published its annual report on substance misuse in October 2012 setting out progress on the delivery of the substance misuse strategy and information on actions carried out under each of the strategy's domains (Welsh Government 2012a). Further information on the actions taken in 2012 is contained in the relevant sections of this report.

An evaluation of the first three years of the substance misuse strategy for Wales was published in June 2013 (Welsh Government 2013b). The report first examined the development of the Strategy and whether it is based on evidence about effective ways of tackling substance misuse and then explored the implementation of the Strategy, including the appropriateness of the structures and governance arrangements for implementation. The report also assessed evidence and views on the success of the arrangements and made recommendations based on its findings.

The evaluation found that the content of the strategy is broadly in line with the international evidence and is based on principles with wide support across Wales. The evaluation also confirmed that all main elements of the strategy had been implemented (although it was noted that considerably more resources had been devoted to 'supporting substance misusers' than to other action areas) and good progress had been made in the provision of

wraparound support, although this remained patchy across Wales. A number of fundamental tensions were identified in the implementation of the strategy:

- Differing views about how and how far to adapt the implementation of the strategy in response to changing expert views, new evidence, or political or media concerns, as well as in response to the emergence of new drugs or new patterns of substance misuse.
- Tensions between the aim of implementing reasonably consistent services across Wales, and the aim of responding effectively to local needs.
- Tensions in commissioning between competition, collaboration, and the need for continuity.

The research found that few stakeholders viewed the key performance indicators as accurate or valuable but the imminent move to more outcome-focused measures was welcomed. The Implementation Board was seen as too big and unwieldy and a broader level of oversight of the Strategy was advocated. There were also concerns that the Welsh National Database on Substance Misuse was not able to measure performance or outcomes accurately, due to poor compliance and the inability to track changes over time for individuals. The report concludes with 11 recommendations for improvement. Further findings from the evaluation are reported in section 1.3.4.

### Northern Ireland

A report outlining the progress in tackling the substance misuse problem in Northern Ireland was published in May 2013 (DHSSPSNI 2013). An assessment of the progress achieved in meeting the short-term outcomes contained within the Drug Strategy, the *New Strategic Direction for Alcohol and Drugs Phase 2* showed that 77% of the outcomes listed in the document were on track for achievement with the remainder assessed as having made progress but behind schedule. No outcomes were assessed as not on track for achievement.

### 1.3.3 Co-ordination arrangements

The Drugs Strategy, *Reducing Demand, Restricting Supply, Building Recovery* (HM Government 2010) is a cross-government strategy led by the Home Office. The Inter-Ministerial Group on Drugs (IMG) brings together Ministers from across Government. This includes the Home Office, Department of Health, Department for Education, Department for Work and Pensions, Ministry of Justice, Department for Communities, Local Government, the Cabinet Office and HM Treasury.

Between May 2010 and July 2012 the IMG met 15 times (HAC 2012). One of the recommendations of the Home Affairs Committee in its report on drug policy (see section 1.3.5) was that the agenda, a list of attendees and minutes of the IMG's meetings be published on a government website. The Committee also recommended that the Secretary of State for Health be given joint responsibility for co-ordinating drug policy with the Home Secretary to acknowledge the fact that drug misuse is a public health as well as criminal justice problem.

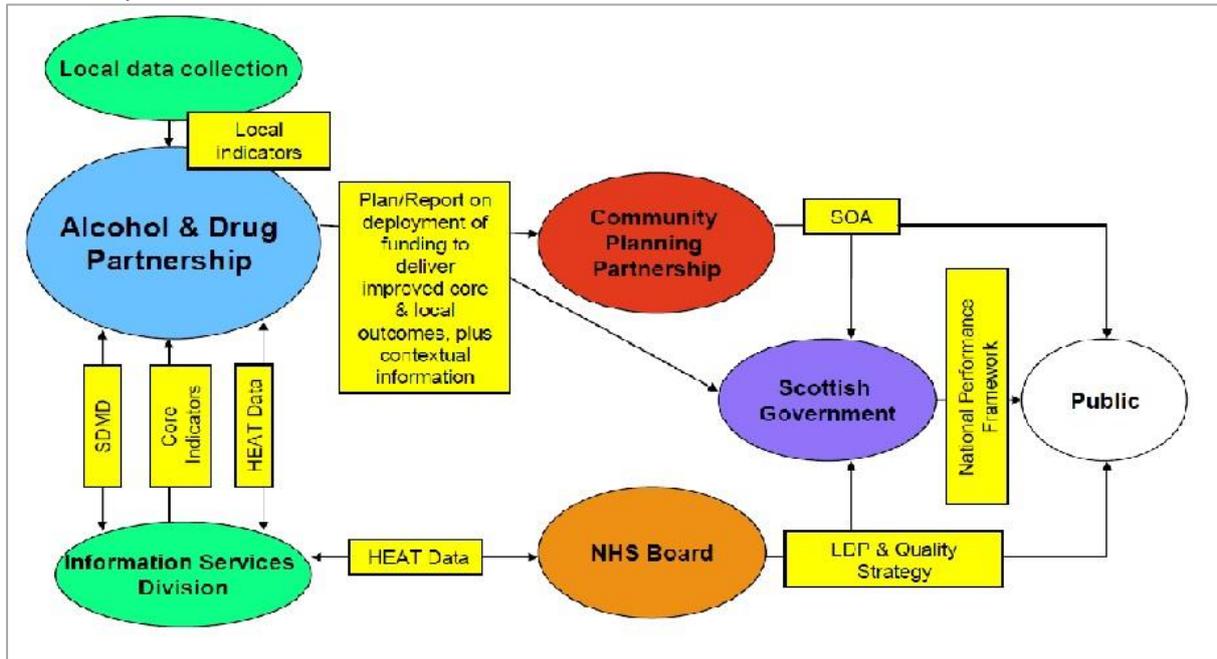
In its response, the Government stated that it supported the principle of transparency but that some of the documents related to the IMG have been assessed as exempt from the *Freedom of Information Act 2000* (HM Government 2013). It also stated that drug-related crime accounts for around 90% of the social and economic costs of drugs, so therefore the Home Office is the most appropriate co-ordinating authority.

### Scotland

The Convention of Scottish Local Authorities (CoSLA) published updated guidance for Alcohol and Drug Partnerships (ADPs) in Scotland on planning and reporting arrangements (CoSLA et al. 2013) with the aim of supporting the establishment of outcomes-based

planning and reporting at a local level. Figure 1.1 provides an overview of the proposed planning and reporting arrangements for Alcohol and Drug Partnerships in Scotland.

**Figure 1.1** Overview of proposed planning and reporting arrangements for Alcohol and Drug Partnerships in Scotland



Source: COSLA et al. 2013

### Wales

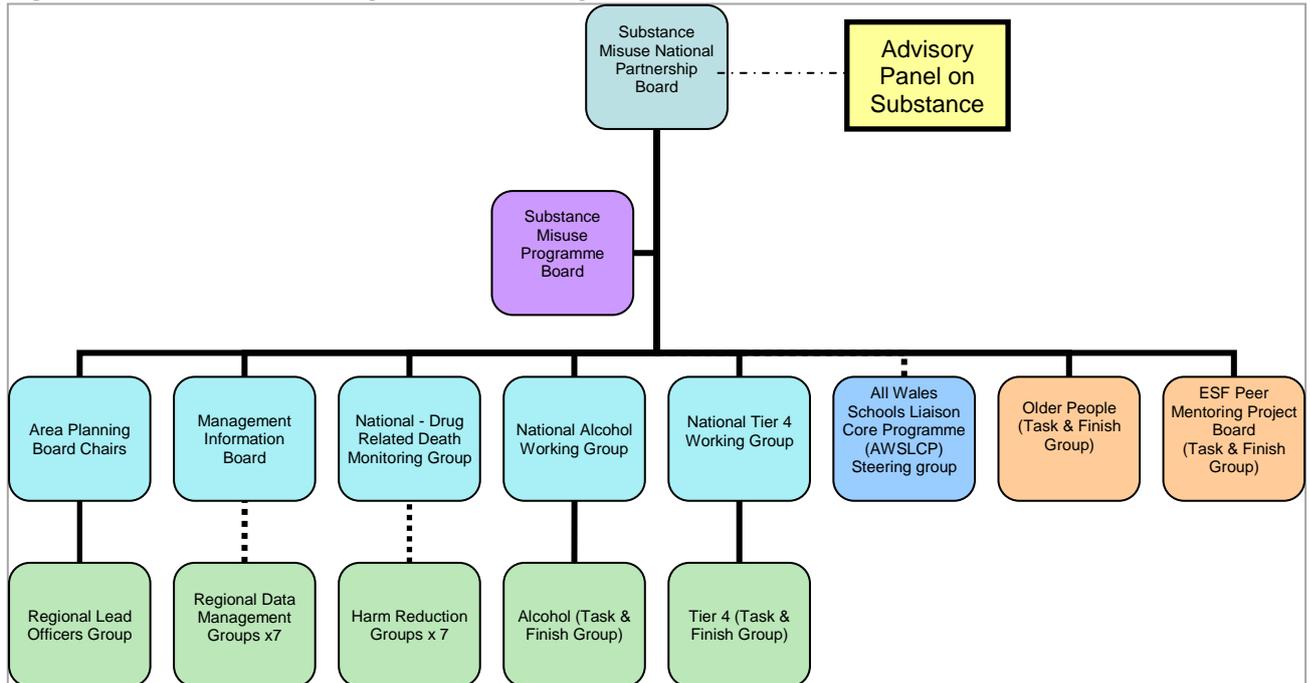
Area Planning Boards (APBs) were established in Wales in 2010 as part of the new arrangements to deliver the Welsh Government Substance Misuse Strategy, *Working Together to Reduce Harm* (Welsh Assembly Government 2008a). The APBs were intended to provide a regional framework, to:

- strengthen partnership working and strategic leadership in the delivery of the substance misuse strategy; and
- enhance and improve the key functions of planning, commissioning and performance management.

Following a review that commenced in September 2011, new guidance for APBs was issued to support partner agencies in implementing the outcomes of the Review (Welsh Government 2013c). The guidance sets out the national and local structures and the role, membership and responsibilities of APBs and their members.

Figure 1.2 shows the national substance misuse governance arrangements in Wales and the interaction with regional groups.

**Figure 1.2 Substance misuse governance arrangements in Wales**



Source: Welsh Government, personal communication

### Northern Ireland

The New Strategic Direction for Alcohol and Drugs (NSD) Steering Group oversees and drives forward work to achieve the outcomes contained in the local NSD. The Chief Medical Officer for Northern Ireland chairs the Steering Group, and membership includes relevant professionals, statutory bodies and agencies, Government Departments, and voluntary/community sector representatives. The Steering Group reports progress to the Ministerial Group on Public Health and is supported by a range of advisory groups. The overall structure is shown in Figure 1.3.

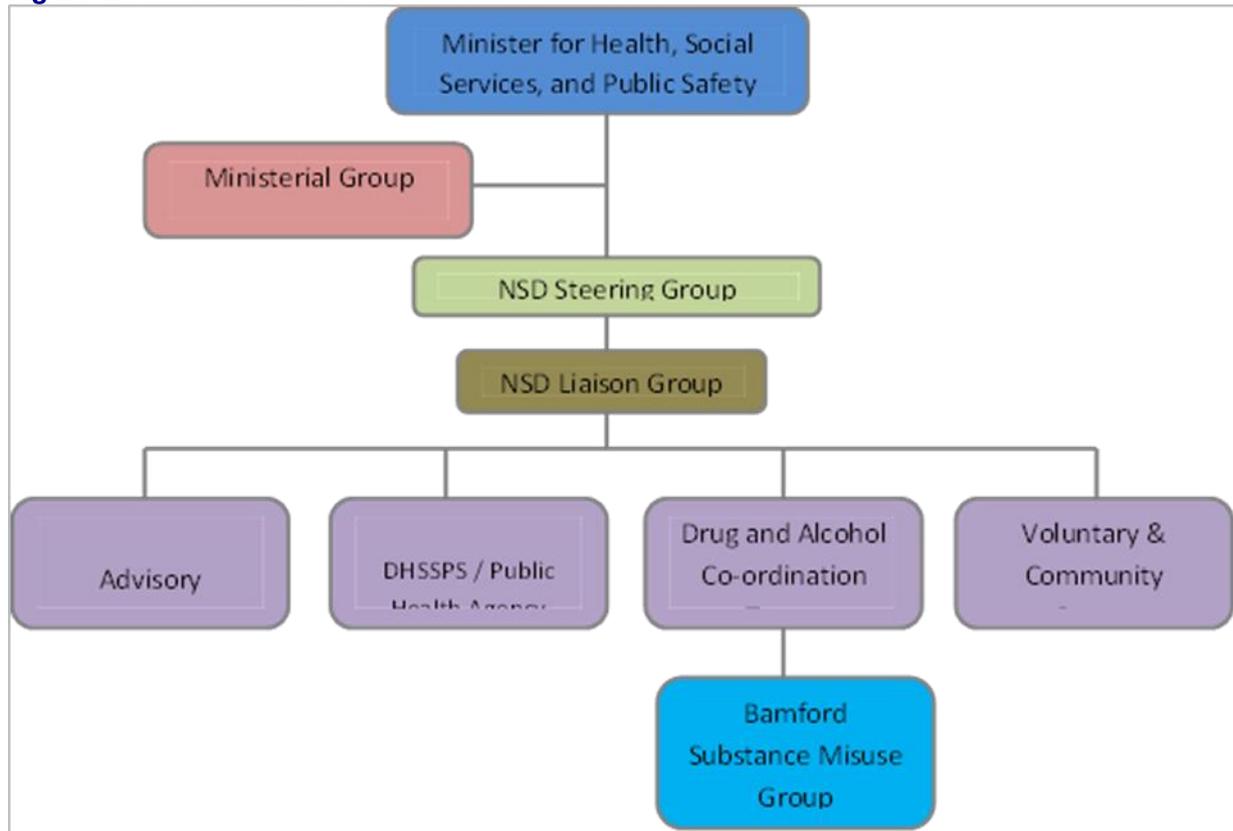
#### 1.3.4 Research structures

The Home Affairs Committee recommended that the Government should allocate ring fenced funding to drugs policy research and that the ACMD is the most appropriate body to co-ordinate the gathering of evidence on drugs (HAC 2012). The Government response stated that there are a number of funding routes for drug research and data collection, and that government departments are best placed to identify and take responsibility for evidence in relation to their policy areas (HM Government 2013).

One of the recommendations contained within the evaluation of the implementation of the Welsh Substance Misuse Strategy (Welsh Government 2013b) was that a coherent evaluation and research strategy should be part of implementation plans and that there should be a planned programme of broader research. This is currently being taken forward by the Advisory Panel on Substance Misuse (APoSM). The following projects, funded by the Welsh Government, are currently close to completion:

- Evaluation and comparison of two recovery organisations operating differing approaches to recovery.
- Non-fatal overdose study.
- Mephedrone and violence study.
- Paramedic feasibility study for take home Naloxone.

**Figure 1.3** Substance misuse structure in Northern Ireland



### 1.3.5 Commentary on drug policy

#### Drugs: Breaking the Cycle: Home Affairs Select Committee Report

The Home Affairs Select Committee<sup>16</sup> carried out a review of drug policy in 2012 and reported its findings in December 2012 (HAC 2012). The review made reference to the findings of the previous Home Affairs Select Committee report on drugs policy carried out in 2002 and took oral and written evidence from a number of experts and people in the public eye. Some of the Committee’s findings are mentioned in the relevant sections of this report. One of the recommendations related to drug policy is that the principal aim of the Government’s drug policy should be to minimise the damage caused to the victims of drug-related crime, drug users and others.

In relation to the *Misuse of Drugs Act 1971*, the report recommended that a Royal Commission be established to review UK drug policy in the international context and that the Government’s position on tackling drugs should be informed by the global situation and possible alternative policies. The report suggested visiting Portugal to learn from their policy and initiating a discussion with the Committee on Narcotic Drugs<sup>17</sup> about alternative ways of tackling the drugs problem. The Committee also expressed concerns about the possibility of regulation leading to a displacement of substances and suggested that this should be explicitly considered by the ACMD. Other recommendations about specific actions or strands of UK drug policy are discussed in the relevant sections of this report.

<sup>16</sup> For further information on the role of Select Committees see:

<http://www.parliament.uk/about/how/committees/select/>

<sup>17</sup> See: <http://www.unodc.org/unodc/commissions/CND/>

The Government responded to the Home Affairs Committee Report in March 2013 (HM Government 2013). The response stated that the Coalition Government does not believe that there's a case for a re-think of drug policy and that there is no need for a Royal Commission on drugs.

It did, however, reconfirm its commitment to review the Drugs Strategy on an annual basis and evaluate the effectiveness and value for money of the current Drug Strategy. It also stated its intention to carry out a review of other countries' approaches to drug policy and assess their effectiveness in reducing drug use and harm to individuals and communities. An annex to the response set out the aims of the international review:

- To consider the effectiveness of the policy and operational responses adopted in each of the identified countries in terms of impact on individuals, communities, harm reduction and criminality.
- To identify benefits and negative consequences of each of these approaches; and
- To compare the approaches against those being implemented via the 2010 UK Drug Strategy.

#### All-Party Parliamentary Group for Drug Policy Reform's Inquiry into New Psychoactive Substances

The All-Party Parliamentary Group for Drug Policy Reform (APPG-DPR)<sup>18</sup> conducted an inquiry into new psychoactive substances (NPS) during 2012.<sup>19</sup> The findings from the Inquiry and recommendations are contained in a report, *Towards a Safer Drug Policy: Challenges and Opportunities arising from 'legal highs'* (APPG-DPR 2012). The Group recommended reviewing current forms of regulation and their effectiveness for dealing with NPS. It suggested that enhancing the role of trading standards and adopting an approach similar to the approach taken in New Zealand<sup>20</sup> could be effective ways of dealing with NPS. It also states that all NPS policies should be evidence-based and subject to evaluation.

#### Drug policy governance

The United Kingdom Drug Policy Commission<sup>21</sup> (UKDPC 2012a), in a review of drug policy governance, identified a number of cross-cutting themes from the research. Some issues identified were; the polarised and contested debate that hinders open discussion; and the law enforcement emphasis that, it is felt, skews drug policy responses. Furthermore, the report stated that discussions on drug harms are often carried out in the media using weak evidence and thus distorting the debate. To tackle these issues, the UKDPC recommended creating a cross-party political forum to discuss the direction of future policy, moving the political lead for national drug policy from the Home Office to the Department of Health, carrying out a formal review of the ACMD's powers and remit and exploring different options for the assessment of harms and the classification system. Other recommendations included: embedding evaluation into the policy process; establishing an independent body to co-ordinate drug research and carry out policy analysis; putting in structures that scrutinise and evaluate local approaches; and finding ways of engaging with the public to elucidate the complexities of the evidence base and goals and options for drug policy.

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<sup>18</sup> See: <http://www.drugpolicyreform.net/>

<sup>19</sup> After carrying out a study of different regulatory systems and processes in the UK and abroad, a targeted call for written evidence was issued in January 2012. Evidence was received from regulatory bodies, other government bodies, professional associations and experts

<sup>20</sup> The Psychoactive Substances Act 2013 commenced on 18 July 2013 in New Zealand. The new legislation regulates the importation, manufacture and supply of psychoactive substances. See: <http://www.health.govt.nz/our-work/regulation-health-and-disability-system/psychoactive-substances>

<sup>21</sup> The UKDPC was an independent charity that commissioned research and collected evidence about what works in drug policy. The work of the UKDPC ended in December 2012.

### Reviews of drug policy

Monaghan (2012) reviewed drug policy literature, UK drug strategies and policy documents, arguing that, while drug-related crime remains the main focus of drug policy, the approach to addressing this has evolved and is characterised by a belief in behavioural change. This, Monaghan argued, reflects increasing moralisation in social policy. The author suggested that the recovery agenda is hindered by a lack of clarity over what recovery means and by cuts to wider services that could otherwise support recovery objectives.

A further article explored the implications for methadone maintenance clients of connecting drug policy with welfare policy (Monaghan and Wincup 2013).<sup>22</sup> The authors suggested that current welfare policy is insufficiently flexible to accommodate the diverse needs of problem drug users and that the focus on individual rather than structural barriers to employment exacerbates this. Certain elements of the welfare system including payment by results for employment services and the use of sanctions were seen by the authors as likely to cause difficulties for problem drug users. The article concluded that welfare reform could undermine the recovery of methadone maintenance clients and that there is a need to identify best practice examples of the successful linking of welfare and drug policies.

Duke (2012) traced the key developments in UK drugs policy from 1997 onwards, with a particular focus on the link between drugs and crime and the role of the criminal justice system. As well as describing changes since 1997, the author identified elements that have remained consistent. Changes in the wider economic, social and political context that have influenced the development of drugs policy, and the influences leading to the current emphasis on recovery from drug dependence were discussed. The author also posed questions about how the delivery of drugs services within the recovery framework will be affected by the economic climate and how 'payment by results' (see section 5.3.1) may make it more difficult for those individuals with multiple social problems alongside severe drug problems to become engaged in treatment.

### Evidence in drug policy

MacGregor (2013) discussed the barriers to the influence of evidence on drug policy,<sup>23</sup> highlighting the role of the media in creating narratives that are rarely challenged by politicians. The tension between evidence and values and the political environment in which drug policy is formulated were also explored. The author concluded that for a paradigm shift to occur, evidence alone will not suffice. Instead, it requires an opening of a window of opportunity through crisis, change in the balance of forces or exceptional leadership.

Strang et al. (2012) reviewed the evidence on effective interventions for supply control, prevention, prescription drug control, and health and social services for drug users. The authors argued that, while drug policy initiatives are rarely informed by scientific evidence, there are opportunities for science to play a role in policy deliberations and to help policymakers choose policies that maximise the public good. These policy choices, it was argued, should be focused on interventions with the largest population effect and with the strongest evidence of effectiveness and cost-effectiveness. To build the evidence base around this, the authors contend, researchers and funders should focus on more policy-relevant areas of addiction.

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<sup>22</sup> The authors undertook a critical analysis of policy documents, including drug strategies, green and white papers and welfare reform legislation in addition to carrying out a review of relevant academic literature.

<sup>23</sup> The article draws upon findings from 50 interviews with key informants, a review of policy documents and publications from think tanks, charities and pressure groups.

## 1.4 Economic Analysis

### 1.4.1 Funding

#### England

On 1<sup>st</sup> April 2013, local authorities became responsible for public health in England supported by a ring-fenced public health grant of £2.66 billion in 2013/14 and £2.79 billion in 2014/15. Historically, 34% of national spend on public health has been on substance misuse. Activity and performance on drug treatment influenced how much money local areas received in 2013-14 and will continue to be recognised in the target formula for the public health grants. This funding is no longer ring-fenced for the provision of drug treatment services (see section 5.2.2). In addition, there is no longer central funding for the routing of offenders into treatment, historically called the Drug Interventions Programme (DIP), which provided funding of £32 million for England and £5.1 million for Wales in 2012/13.<sup>24</sup> Alongside other crime, community and drugs grants, funding ended in March 2013. The Community Safety Fund is providing £90 million to Police and Crime Commissioners in 2013/14 for them to decide what to fund at a local level.

Previously, Focal Point estimates of drug-related expenditure have assumed that funding allocations equate to expenditure since these were primarily ring-fenced grants. With the removal of this ring-fence, collecting data on drug-related expenditure will require reports of actual expenditure. From 2013/14 onwards, local authorities will be required to report on spending from the Public Health Grant on an annual basis. There are categories for adult drugs, adult alcohol and young people's drug and alcohol spending. Estimated expenditure on drug misuse services for adults by local authorities is £569.1m for 2013/14, with a further £55.0m projected to be spent on drug and alcohol services for young people (DCLG 2013).<sup>25</sup> These two elements of planned expenditure account for almost one-quarter (23%) of projected public health expenditure by local authorities. There are no requirements to report centrally on other income streams such as the Community Safety Fund.

#### Wales

From April 2013, the allocation of both the revenue and capital elements of the Substance Misuse Action Fund (SMAF) was made at a regional rather than local level with Area Planning Boards receiving the funding instead of Community Safety Partnerships. Substance misuse funding in Wales is shown in Table 1.1. It shows an increase in overall funding since 2006/07, with a doubling of funding for the Substance Misuse Action Fund over this period. Reductions since 2010/11 are principally due to funding decreases for the Drug Interventions Programme (DIP).

#### Scotland

In 2013/14, £30.3 million was allocated to Alcohol and Drug Partnerships (ADPs) to support the delivery of improved outcomes for drugs, similar to the figure for the previous year (£30.2 million).

Guidance for ADPs on planning and reporting suggests that ADPs should go beyond the reporting of direct Scottish Government investment. Expenditure should map all resources used in responding to the drug problem (COSLA et al. 2013). This includes criminal justice services, hospital admissions, sexual health and blood-borne virus interventions, and child protection services with the guidance stating that this will "provide a fuller picture of the full costs of problem drug and alcohol use for local partners and will help inform long term strategic planning and service redesign to support early intervention and prevention."

<sup>24</sup> See: <https://www.gov.uk/government/publications/drug-intervention-programme-main-grants-for-drug-action-teams-from-2007-08-onwards>

<sup>25</sup> These estimates are based on budget returns submitted by local authorities in England, reflecting recent expenditure and capital charges.

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**Table 1.1 Substance misuse funding in Wales, 2006/07 to 2013/14**

Expenditure item	2006/07 (£/€ million)	2007/08 (£/€ million)	2008/09 (£/€ million)	2009/10 (£/€ million)	2010/11 (£/€ million)	2011/12 (£/€ million)	2012/13 (£/€ million)	2013/14 (£/€ million)
Substance Misuse Action Fund (SMAF)	10.30	14.78	18.17	20.13	21.94	22.26	22.26	22.66
SMAF Capital	15.10	21.61	22.87	22.61	25.78	25.51	27.54	26.59
Local Health Board*	4.31	3.69	6.43	5.95	6.47	6.12	5.69	5.07
Drug Interventions Programme (DIP)*	6.32	5.39	8.09	6.68	7.60	7.01	7.04	5.95
Drug Testing on Charge (DIOC)*	9.70	10.36	10.87	11.09	17.13	17.13	17.13	17.13
Operation Tarian	14.20	15.15	13.68	12.46	20.13	19.63	21.19	20.10
Policy Initiatives	5.65	5.65	6.47	6.47	5.98	5.51	5.07	-
Total	8.29	8.26	8.06	7.27	7.03	6.32	6.27	-
	0.82	0.82	-	-	-	-	-	-
	1.20	1.20	-	-	-	-	-	-
	0.64	0.64	0.64	0.64	0.64	0.64	0.64	0.64
	0.94	0.94	0.81	0.72	0.75	0.73	0.79	0.75
	2.40	2.75	3.22	3.98	4.71	4.57	4.57	4.17
	3.52	4.02	4.05	4.47	5.54	5.24	5.65	4.89
	33.82	38.69	45.80	48.26	56.87	56.23	55.36	49.67
	49.57	56.57	57.65	54.21	66.83	64.45	68.48	58.29

\* DIP and DIOC budgets aggregated from 2008/09

Source: Welsh Government, personal communication

### Northern Ireland

The majority of the funding for the New Strategic Direction for Alcohol and Drugs was devolved to the Public Health Agency (PHA) in 2009. Given that the Strategy is combined, it is difficult to provide data for 'drugs only' expenditure. In 2012/13, the PHA allocated just under £7 million to alcohol and drug-related services. In addition, almost £8 million is allocated to the provision of alcohol and drug treatment services within the Health and Social Care Trust. The Department retains a small amount of funding (£518,000 in 2012/13) for the provision of regional functions such as research and evaluation. Total substance misuse funding in 2012/13 was therefore in the region of £15,518,000, similar to previous years. Figures for 2013/14 are not available at this stage.

### 1.4.2 Estimates of costs

#### Social and economic costs of drug supply

A Home Office report estimating the social and economic costs of organised crime in the UK, estimated that the social and economic costs of drug supply were £10.7 billion in 2010/11 (Mills et al. 2013). The overall costs of organised crime were estimated at £24 billion. The estimates of the costs of drug supply included the costs of: acquisitive crimes committed to fund addiction; drug offences under the *Misuse of Drugs Act 1971*; health harms resulting from drug use; drug treatment; and public expenditure directly aimed at tackling illegal drugs supply and demand in the UK. Of the £10.7 billion, £5.8 billion was the result of drug-related crime, with burglary accounting for around half of this cost. The costs of drug-related acquisitive crime varied from £5.3 billion to £6.6 billion depending on the drug user definition used.<sup>26</sup> Drug-related deaths also accounted for a large proportion of the overall social and economic costs (£3.0 billion) (Table 1.2)

<sup>26</sup> The estimate of was based on arrestees reporting use of heroin, crack cocaine, or cocaine powder (HCC) more than twice a week in the Arrestee Survey (Boreham et al. 2006). Changes in drug user definitions were based on frequency of HCC use.

**Table 1.2** *Estimates of the social and economic costs of illicit drugs in the United Kingdom, 2010/11*

Type	Cost (£m)	Cost (€m)
Drug-related crime	£5,800	€6,816
NHS costs	£80	€94
Drug-related deaths	£3,000	€3,526
Drug treatment	£720	€846
Enforcement costs	£1,100	€1,293
<b>Total</b>	<b>£10,700</b>	<b>€12,575</b>

Source: Mills et al. 2013

The authors note that the study was hampered by a lack of hospital data. It is possible that this study, therefore, underestimates the overall social and economic costs and distorts the balance between crime and health costs. Estimates of the size of the illicit drug market were also published (see section 10.2.2).

#### Cost-benefit analysis of licensing and regulating the cannabis market

The Institute for Social and Economic Research (ISER) published a cost-benefit analysis of licensing and regulating the cannabis market in England and Wales (Bryan et al. 2013). It takes into account various possible market responses to reform and provides costs for three different market responses; low (15% quantity increase and 10% fall in THC<sup>27</sup>), mid (20% quantity increase and 5% increase in THC), and high (40% quantity increase and 25% increase in THC). These scenarios, the authors suggest, are highly uncertain given a lack of knowledge about market demand for different types of cannabis and the demand behaviour that underlies the decrease in cannabis use in the past 10 years.

The benefits from cannabis licensing are costed using a unit cost approach and include savings on policing, court procedures, custodial sentences, community sentences and loss of earnings through incarceration. These are fixed savings across all three market response scenarios. Costs of cannabis-related accidents, cannabis dependency treatment and cannabis-induced crime vary across the scenarios as do the costs for ensuing mental illness and physical illness. The increased cost of market regulation/health promotion and the cost reduction from the removal of criminal record scarring are fixed across scenarios. The total net external benefit to society for the most plausible mid-response scenario is estimated to be between £98m and £415m with the high-response scenario providing a wide range of £1,300m to £400m and the low-response scenario benefit estimated as between £277m and £461m.

When estimating government budget implications (which include tax revenue), the mid-response scenario estimate suggests a benefit of between £645m and £1,000m, mainly through tax revenues from licensed cannabis (£436m to £674m). Across all three market response scenarios there is an estimated net benefit to the Government budget of between £525m (high-response) to £1,225m (low response).

The authors suggest that, in order to improve future estimates, further research is required on drug-related crime and drug demand behaviour, particularly at the individual level. The absence of representative price and purity data, they argue, restricts the ability to analyse demand and assess the market response to changes in regulation. Furthermore, the gap in knowledge of policing and criminal justice unit costs<sup>28</sup> should be closed by carrying out, what the authors suggest, is relatively straightforward research in this area.

<sup>27</sup> Tetrahydrocannabinol (THC) is the active chemical in cannabis

<sup>28</sup> For example unit costs for an arrest, caution, warning etc.

## 2. Drug use in the general population and specific groups

### 2.1 Introduction

The *Crime Survey for England and Wales (CSEW)*<sup>29</sup> provides estimates of the prevalence of drug use in the general population in England and Wales. Scotland<sup>30</sup> and Northern Ireland<sup>31</sup> also undertake similar surveys. Combining data from surveys undertaken in 2010/11, the UK Focal Point estimates that 35.6% of the adult population in the United Kingdom, aged between 16 and 59, had used an illicit drug at some point in their lifetime.

In England and Wales, for which the most complete time series data are available, prevalence of last year use of any illicit drug had been fairly stable at around 12% from 1998 to 2003/04, decreasing to 9.6% in 2007/08; and then falling again to 8.6% in 2009/10. Since then, prevalence stabilised at 8.9% in 2011/12 before decreasing again to 8.2% in 2012/13.

Males are more likely to report drug use than females but the difference varies according to age; the difference being more pronounced in the older age groups (ST01).

Amongst the school age population, surveys of drug use prevalence have been undertaken in each of the four administrations of the United Kingdom.<sup>32</sup> In England, for which the longest time series are available, drug use increased between 1998 and 2003 to a high of 22%, but decreased steadily to 12% in 2010, since when it has been stable.

Cannabis continues to be the most commonly used drug throughout the UK with prevalence rates close to those of overall drug use. The use of other drugs is considerably lower. Since

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<sup>29</sup> The *Crime Survey for England and Wales (CSEW)* (formerly the *British Crime Survey (BCS)*) is an annual survey, which gathers information about experience of crime in England and Wales. It is designed to provide a complementary measure of crime to police recorded crime statistics. It was first carried out in 1982 and since 2001/02 it has become a continuous survey. Since 1996, it has also asked respondents aged 16 to 59 about their use of illicit drugs in a self-completion module using Computer Assisted Self Interviewing (CASI).

<sup>30</sup> The *Scottish Crime and Justice Survey (SCJS)* (previously the *Scottish Crime and Victimization Survey (SCVS)* and the *Scottish Crime Survey*) is similar in scope and aims to the CSEW although questions on drug use are asked of all those aged over 16 years. The latest published results are for 2010/11. Surveys were carried out as part of the former BCS in 1982 and 1988; as the independent *Scottish Crime Survey* in 1993, 1996, 2000, 2003; as the SCVS in 2004, 2006; and as the SCJS in 2008/09, 2009/10, 2010/11 and 2012/13. Findings from the 2010/11 survey were published in 2012 and findings from the 2012/13 survey are due to be published in 2014. The survey asks questions about drug use using Computer Assisted Personal Interviewing (CAPI).

<sup>31</sup> The *Northern Ireland Crime Survey (NICS)* is also similar to the CSEW. Surveys containing a drug use module were carried out in 1994/95, 1998, 2001 and 2003/04 and the survey was continuous between January 2005 and March 2009 with the drugs module being dropped thereafter. The last published results were for 2008/09. In addition, a *Drug Prevalence Survey*, based on the EMCDDA model questionnaire, was carried out in Northern Ireland (and Ireland) in 2002/03, 2006/07 and 2010/11 amongst people aged 15 to 64 years old using CAPI.

<sup>32</sup> Amongst the school age population the main sources of information on drug use prevalence are surveys undertaken in schools. In England, a survey of the prevalence of drug use, smoking and drinking amongst young people (11 to 15 year old school children) has been undertaken annually since 1998. In Scotland, the *Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)* is undertaken every two years, the most recently published data are for 2010. A review of the questionnaire took place in 2012 with the next survey taking place in 2013. The *Young Person's Behaviour and Attitudes Survey* was undertaken in Northern Ireland in 2000 for the first time and repeated in 2003, 2007 and 2010. A survey is being carried out in 2013. The *Health Behaviour in School Age Children Survey (HBSC)* provides data from Wales and is undertaken every four years with a two-year interim survey. The most recently published survey results are for 2009/10 and the survey will run again in Autumn 2013.

1996, the *Crime Survey for England and Wales* shows that last year use of cocaine powder increased until 2008/09 to a peak of three per cent, with a corresponding decline in amphetamines over the same period, although cocaine use has since decreased to two per cent. Some questions on new psychoactive substances have been added to the last three surveys and data show statistically significant decreases in reported mephedrone use amongst both adults and young people since the 2010/11 survey.

## 2.2 Drug use in the general population

Prevalence of drug use throughout this chapter is measured using the following recall periods: lifetime (ever use); last year (recent use); last month (current use). Since the last UK Focal Point Report, results have been published for the 2012/13 CSEW. The *Scottish Crime and Justice Survey* (SCJS) ran between April 2012 and March 2013 but results are not expected until early 2014.

### 2.2.1 Crime Survey for England and Wales

In the 2012/13 survey questions on last month use were not asked. Main findings from the survey were:

- Lifetime use amongst all adults aged 16 to 59 years old was 35.9%.
- Last year use was 8.2%.
- Last year drug use amongst males was around twice as high as amongst females.
- Cannabis was again the most commonly used drug, reported by 6.4% of adults (Table 2.1).

**Table 2.1** Percentage of 16 to 59 year olds reporting lifetime and last year use of individual drugs in England and Wales, 2012/13

	Lifetime use			Last Year use		
	Male	Female	Total	Male	Female	Total
Any drug	41.9	29.9	35.9	11.0	5.4	8.2
Amphetamines	13.0	8.2	10.6	0.9	0.4	0.7
Cannabis	35.5	24.5	30.0	8.6	4.1	6.4
Cocaine	11.6	6.3	9.0	2.8	1.1	2.0
Ecstasy	10.8	5.9	8.3	1.9	0.7	1.3
LSD	7.2	2.9	5.1	0.3	0.0	0.2
Magic mushrooms	10.0	4.3	7.2	0.5	0.0	0.3
Opiates	1.2	0.4	0.8	0.2	0.1	0.1
Base	9,688	11,813	21,501	9,614	11,749	21,363

Source: Standard Table 01

It is estimated that about 11.8 million people aged 16 to 59 in England and Wales have taken an illicit drug at some point in their lifetime with about 2.7 million people having taken drugs in the last year (Home Office 2013b).

### Factors related to drug use<sup>33</sup>

As in previous years, last year drug use increased with the frequency of pub/wine bar visits and frequency of alcohol consumption demonstrating the association between drug and alcohol use (see section 5.4.2 and 2.2.1.). One-fifth (21%) of adults visiting a pub or wine bar nine times or more in the past month used drugs in the last year (compared to 5% of individuals with no visits). Similarly, last year drug use increased with the frequency of nightclub visits.

Single people were more likely than others to report recent drug use but this may be due, at least in part, to single people generally being younger. Unemployed individuals were more

<sup>33</sup> While these comparisons provide useful information, many of these factors are interrelated or relate to other factors such as age or sex, which also have an association to the likelihood of drug use and indeed may be responsible for these observed associations.

likely than those in employment to report recent drug use and, amongst occupational groups, those in routine and manual occupations were more likely to report recent drug use than those in managerial and professional or intermediate occupations. However, these differences were largely due to a higher prevalence of cannabis use. There was no significant difference in last year cocaine use and 'any stimulant' use.

As in previous surveys, respondents living in urban areas reported higher prevalence of drug use than those living in rural areas (8.6% compared to 6.4% respectively) (Home Office 2013).

### Frequency of drug use

The CSEW asks a question on the frequency of cannabis use for those who have used cannabis in the last year. However, even in a survey with a large sample size such as the CSEW<sup>34</sup> and asking the question of all those who had used cannabis in the last year, rather than just the last month<sup>35</sup>, the number of users in each category was small, particularly amongst the older age groups (ST01). Therefore, caution should be taken when interpreting the data, particularly when looking at trends.

In 2012/13, 8.8% of last year cannabis users aged 16 to 59 years old reported being daily or almost daily cannabis users, a higher prevalence than amongst those aged 16 to 34 years old (7.2%). Although young people aged between 16 and 24 were most likely to be recent cannabis users, they were less likely than adults aged between 35 and 54 to report daily or almost daily use of cannabis. As in previous years, those aged 35 to 44 years old were most likely to report daily or almost daily cannabis use (Table 2.2).

**Table 2.2** Percentage of last year cannabis users reporting daily or almost daily use in England and Wales, 2011/12 and 2012/13, by age group

Age	2011/12	2012/13
16 to 24 years	10.3	7.4
25 to 34 years	10.3	7.0
35 to 44 years	17.5	14.1
45 to 54 years	16.2	11.6
55 to 59 years	9.7	6.5
Base	1,521	1,140

Source: Standard Table 01

### Trends in drug use

Data show that, compared with 1996, lifetime use of almost all individual drugs was higher in 2011/12 (except anabolic steroids, LSD and tranquilisers which have been stable over the whole period) although in recent years prevalence has stabilised. In terms of last year drug use, there was a steady decrease in the use of any drug between 2003/04 and 2009/10 driven mostly by a decrease in cannabis use (recent cannabis use fell from 10.8% in 2003/04 to 6.6% in 2009/10). Thereafter prevalence of any drug use remained stable but there has been a decrease between the 2011/12 and 2012/13 surveys from 8.9% to 8.2%. Again this is predominantly driven by a decrease in cannabis use, which decreased from 6.9% to 6.4% although there have also been decreases in the use of magic mushrooms, ketamine and mephedrone between these surveys.

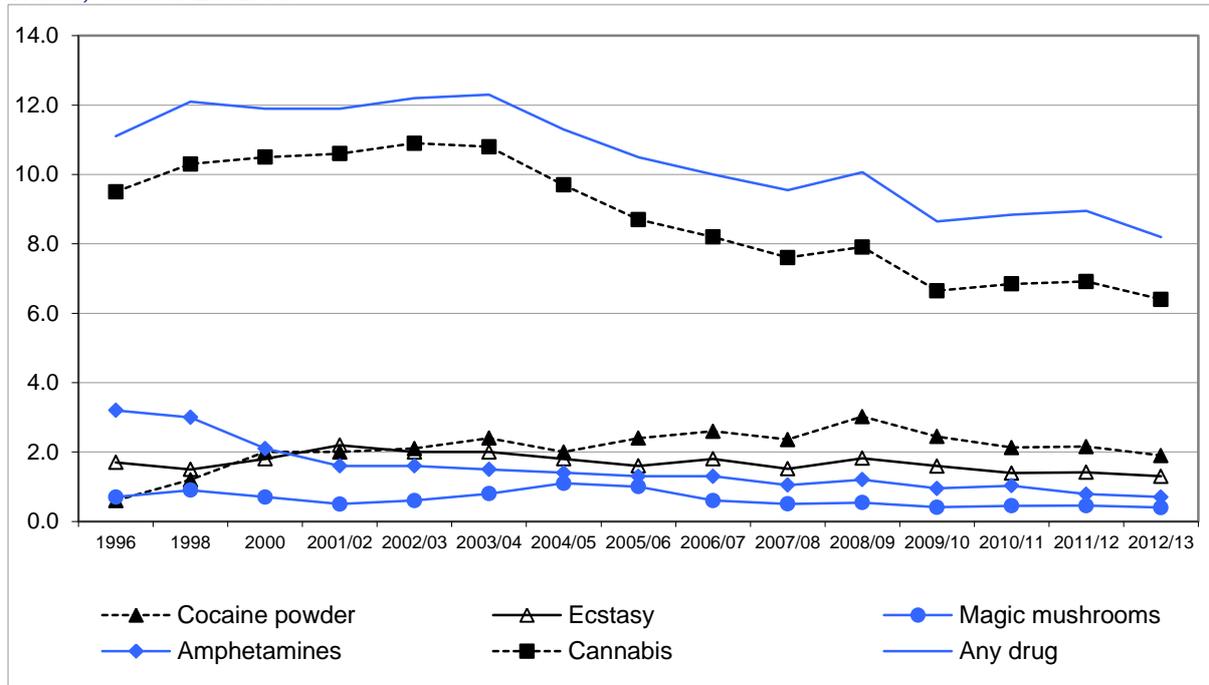
<sup>34</sup> Sample size for the drug misuse module was 26,663 adults aged 16 to 59. The response rate for the survey was 73%.

<sup>35</sup> As recommended by the European Model Questionnaire (EMQ). See: [http://www.emcdda.europa.eu/attachements.cfm/att\\_58103\\_EN\\_Handbook%20for%20surveys%20on%20drug%20use%20amongst%20the%20general%20population%20-%202002.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_58103_EN_Handbook%20for%20surveys%20on%20drug%20use%20amongst%20the%20general%20population%20-%202002.pdf)

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Since data collection began in 1996, last year use of amphetamines has decreased significantly from 3.2% to 0.6% with cocaine powder use increasing over the same time period from 0.6% to 1.9%. However, reported cocaine powder use in 2012/13 was lower than in 2008/09 when prevalence of use was 3.0% and it is now at the same level as the beginning of the 2000s (Figure 2.1).

**Figure 2.1** Percentage of 16 to 59 year olds reporting last year use of individual drugs in England and Wales, 1996 to 2012/13



Source: Standard Table 01

### Emerging substances

Questions on some new psychoactive substances were added to the British Crime Survey in October 2009 with mephedrone added for the 2010/11 survey. In the 2012/13 survey, questions on salvia and nitrous oxide were added, replacing questions on GBL/GHB, BZP, Spice and Khat.

In 2012/13, last year use of mephedrone was recorded at 0.5% amongst adults aged 16 to 59 years old, a significant decrease from 1.1% in 2011/12 and 1.4% in 2010/11. Use of nitrous oxide was higher at 2.0% while all other substances asked about in the three surveys have a low reported prevalence of use (Table 2.3).

**Table 2.3** Percentage of 16 to 59 year olds reporting last year use of emerging substances, 2010/11 to 2012/13

	2010/11	2011/12	2012/13
Mephedrone	1.4	1.1*	0.5*
GBL/GHB	0.0	0.1*	-
BZP	0.1	0.1	-
Spice (and other cannabinoids)	0.2	0.1	-
Khat	0.2	0.2	-
Nitrous oxide	-	-	2.0
Salvia	-	-	0.3
Base	27,450	26,834	21,621

\*Statistically significant change since previous survey

Source: Home Office 2012; 2013b

### 2.3 Drug use amongst young adults

Additional analyses have been undertaken from United Kingdom population surveys for the UK Focal Point to provide data for the 16 to 34 age group used by the EMCDDA. The surveys also routinely report data for 16 to 24 year olds.

#### 2.3.1 Crime Survey for England and Wales

Recent drug use was 13.3% amongst 16 to 34 year olds and 16.3% amongst 16 to 24 year olds (Table 2.4). Recent use of any drug decreased with age; 12.8% of 25 to 29 year olds and 8.6% of 30 to 34 year olds reported recent drug use. After age 25, there was a fairly steady decline with age. Recent cannabis use was also much lower amongst 25 to 34 year olds (7.9% compared to 13.5% for 16 to 24 year olds). The difference between age groups is most pronounced amongst females where more than twice as many 16 to 24 year olds are recent cannabis users compared to 25 to 34 year olds (10.2% compared to 4.4%). Cocaine is the only individual drug where use is higher in the older age group (ST01).

**Table 2.4** Percentage of 16 to 24 year olds and 16 to 34 year olds reporting last year use of individual drugs in England and Wales, 2012/13 by gender

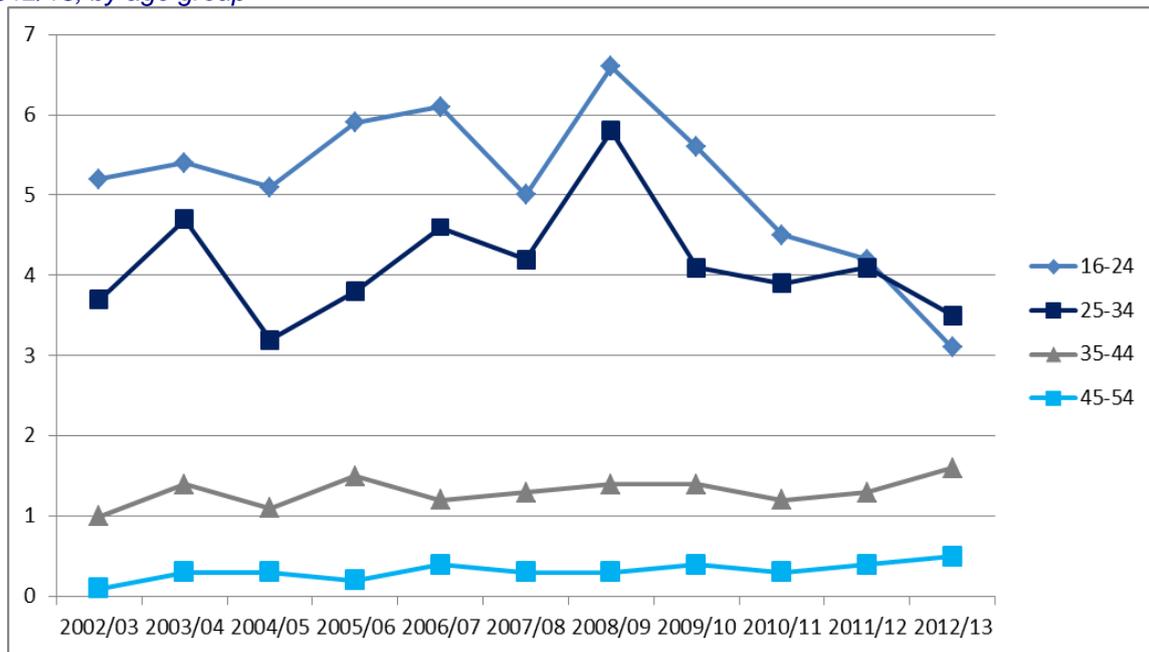
	16-24 year olds			16-34 year olds		
	Male	Female	Total	Male	Female	Total
Any drug	19.9	12.5	16.3	17.3	9.2	13.3
Amphetamines	1.7	1.0	1.4	1.4	0.7	1.1
Cannabis	16.8	10.2	13.5	13.8	7.1	10.5
Cocaine	3.6	2.7	3.1	4.4	2.2	3.3
Ecstasy	3.7	2.0	2.9	3.5	1.4	2.4
LSD	0.8	0.0	0.4	0.6	0.1	0.3
Magic mushrooms	1.1	0.1	0.6	1.0	0.1	0.5
Base	1,240	1,443	2,683	3,296	4,235	7,531

Source: Standard Table 01

#### Trends in drug use

When looking at changes in last year cocaine use by age group, it is evident that the 16 to 24 year old age group is responsible for much of the decrease since the 2008/09 and 2009/10 surveys with prevalence of use now around half the level it was during this period (3% compared to around 6%). Prevalence of last year cocaine use is now highest amongst those aged 25 to 34, where the trend has been relatively stable since 2002/03, whereas use amongst the 16 to 24 year age group has decreased over this period. Figure 2.2 also shows a stable or slightly increasing trend in last year cocaine use amongst older age groups over the past 10 years.

**Figure 2.2** Trends in last year cocaine use amongst adults in England and Wales, 2002/03 to 2012/13, by age group

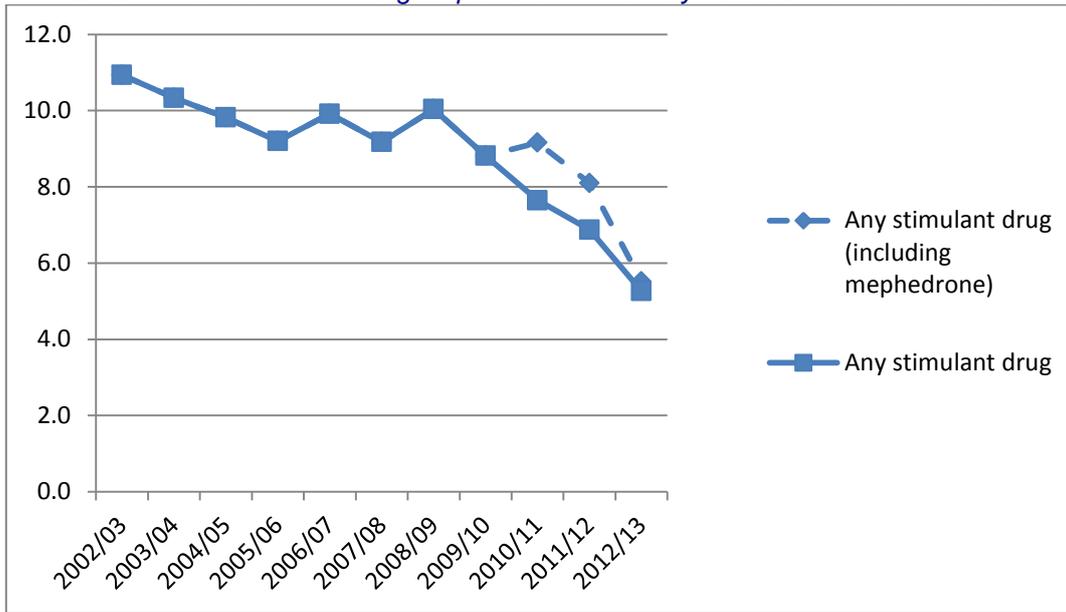


Source: Standard Table 01

Analysis of the CSEW includes a composite any stimulant drug<sup>36</sup> category that has shown sharp decreases amongst 16 to 24 year olds since 2008/09. However, the addition of mephedrone to the measure changes the trend with stimulant use more stable before a large decrease in the 2012/13 survey when last year mephedrone use decreased substantially to 1.6% from 3.3% in the previous survey (Figure 2.3). The large difference between the two any stimulant measures in 2010/11 (7.6% excluding mephedrone and 9.2% including mephedrone) and 2011/12 (6.9% and 8.1% respectively), which was less pronounced in 2012/13 when mephedrone use had decreased substantially (5.3% without mephedrone and 5.5% with mephedrone) suggests that for some young people, mephedrone replaced more traditional stimulants. However, the subsequent decrease in the use of mephedrone does not appear to have precipitated a move back to traditional stimulants. It is uncertain whether the decrease in the any stimulant measure in 2012/13 reflects an actual decrease in use or whether the CSEW is failing to capture other stimulants being used by these young adults.

<sup>36</sup> 'Any stimulant drug' comprises powder cocaine, crack cocaine, ecstasy, amphetamines and amyl nitrite plus, since 2008/09, methamphetamine.

**Figure 2.3** Trends in 'any stimulant drug' use amongst 16 to 24 year olds in England and Wales, 2002/03 to 2012/13 and effect of adding mephedrone to the any stimulant measure from 2010/11



Source: Home Office 2013b

Overall, recent drug use amongst 16 to 24 year olds has decreased in the past 10 years with decreases in every individual drug apart from anabolic steroids where use has been stable. Recent cannabis use decreased again and, at 13.5%, use in 2012/13 is half the level that it was at the beginning of the 2000s. Compared with 1996, the only drug for which prevalence of use was higher was cocaine powder, which despite recent decreases, was 3.1% in 2012/13 and 1.3% in 1996.

Since 2011/12 there have been decreases in the use of cannabis, magic mushrooms, ketamine and mephedrone, with use of all other individual drugs stable.

## 2.4 Drug use in the school and youth population

### 2.4.1 England

Data from *Smoking, drinking and drug use amongst young people in England* (Fuller 2013) show that in 2012, 17.1% of pupils aged 11 to 15 years old had ever taken drugs, 11.9% had used drugs in the last year (recently), and 6.5% had used drugs in the last month (Table 2.5). Cannabis was the most prevalent drug with 7.5% of pupils using it in the last year. Volatile substances<sup>37</sup> were the second highest, with 3.6% of pupils having used them recently. Recent use of all other drugs was below one per cent. Reported prevalence of use of drugs was mostly higher amongst boys, but generally this did not reach statistical significance.

<sup>37</sup> Glue, gas, aerosols or solvents.

## UNITED KINGDOM FOCAL POINT REPORT 2013

**Table 2.5** Percentage of pupils aged 11 to 15 years reporting lifetime, last year and last month use of individual drugs in England in 2012, by gender

	Lifetime use			Last Year use			Last Month use		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug	17.4	16.9	17.1	12.3	11.5	11.9	7.1	5.8	6.5
Amphetamines	0.8	0.8	0.8	0.8	0.7	0.7	0.3	0.3	0.3
Cannabis	9.8	8.2	9.0	7.9	7.1	7.5	4.6	3.3	4.0
Cocaine powder	1.2	1.1	1.2	1.0	0.8	0.9	0.4	0.4	0.4
Crack cocaine	0.7	0.6	0.7	0.7	0.3	0.5	0.4	0.2	0.3
Ecstasy	1.3	0.9	1.1	1.1	0.7	0.9	0.7	0.2	0.5
LSD	0.5	0.5	0.5	0.4	0.4	0.4	0.2	0.2	0.2
Magic mushrooms	1.5	1.3	1.4	1.0	0.8	0.9	0.6	0.3	0.5
Mephedrone	0.9	0.6	0.8	0.8	0.6	0.7	0.4	0.3	0.3
Opioids	0.9	0.5	0.7	0.3	0.4	0.5	0.4	0.2	0.3
Volatile substances	6.8	8.6	7.7	3.2	3.9	3.6	1.5	1.6	1.6
Base	3,520	3,504	7,024	3,513	3,491	7,004	3,500	3,477	6,977

Source: Fuller 2013

### Type of drug by age

As in previous years, volatile substances were the most commonly used drug in the last year amongst the younger pupils while the use of cannabis increased substantially at age 13 years and was the most commonly used drug from 14 years on (Table 2.6). Use of other drugs was relatively low amongst the younger age groups with the prevalence of cocaine powder reaching over one per cent at the age of 14 years and ecstasy use at the age of 15 years. Unlike in the general population, ecstasy use was as common as cocaine powder amongst the oldest pupils.

In 2012, three-quarters of pupils who had taken drugs in the last year reported only having taken one type of drug with one-quarter reporting taking two or more drugs in the last year. Of those reporting any drug use in the last year, older pupils were more likely than younger pupils to have taken two or more types of drug in that time (17% of 11 to 13 year olds compared to 29% of 15 year olds). (Fuller 2013).

### Factors related to drug use

Odds ratios were estimated for individual and school-level measures. Pupils who reported drinking alcohol in the past week were eight times more likely than pupils who were non-drinkers to have used drugs in the last year and regular smokers were 15 times more likely than non-smokers to have used drugs in the last year.

## UNITED KINGDOM FOCAL POINT REPORT 2013

**Table 2.6** Percentage of pupils aged 11 to 15 years reporting last year use of individual drugs in England in 2012, by age

	11yrs	12yrs	13yrs	14yrs	15yrs
Any drug	3.7	4.4	8.9	13.4	23.7
Amphetamines	0.1	0.2	0.3	0.8	1.7
Cannabis	0.1	0.8	4.2	9.1	18.6
Cocaine powder	0.1	0.3	0.3	1.1	2.2
Crack cocaine	.	0.2	0.6	0.7	0.8
Ecstasy	.	0.2	0.6	0.8	2.4
LSD	0.1	0	0.4	0.4	0.8
Magic mushrooms	0.2	0.2	0.4	0.7	1.4
Ketamine	0.2	0.1	0.4	0.7	0.9
Opioids <sup>38</sup>	0.2	0.1	0.8	0.6	0.9
Volatile substances	2.6	3.1	4.2	4.2	3.5
Mephedrone	.	0.3	0.4	0.5	1.7
Base	1,026	1,371	1,391	1,437	1,779

Source: Standard Table 02; Fuller 2013

### Frequency of use

Two per cent of pupils reported having taken drugs on more than 10 occasions and the same percentage reported using drugs at least once a month (Fuller 2013). Pupils aged 15 years were more likely to report having taken drugs on more than 10 occasions and using at least once a month (5% for both).

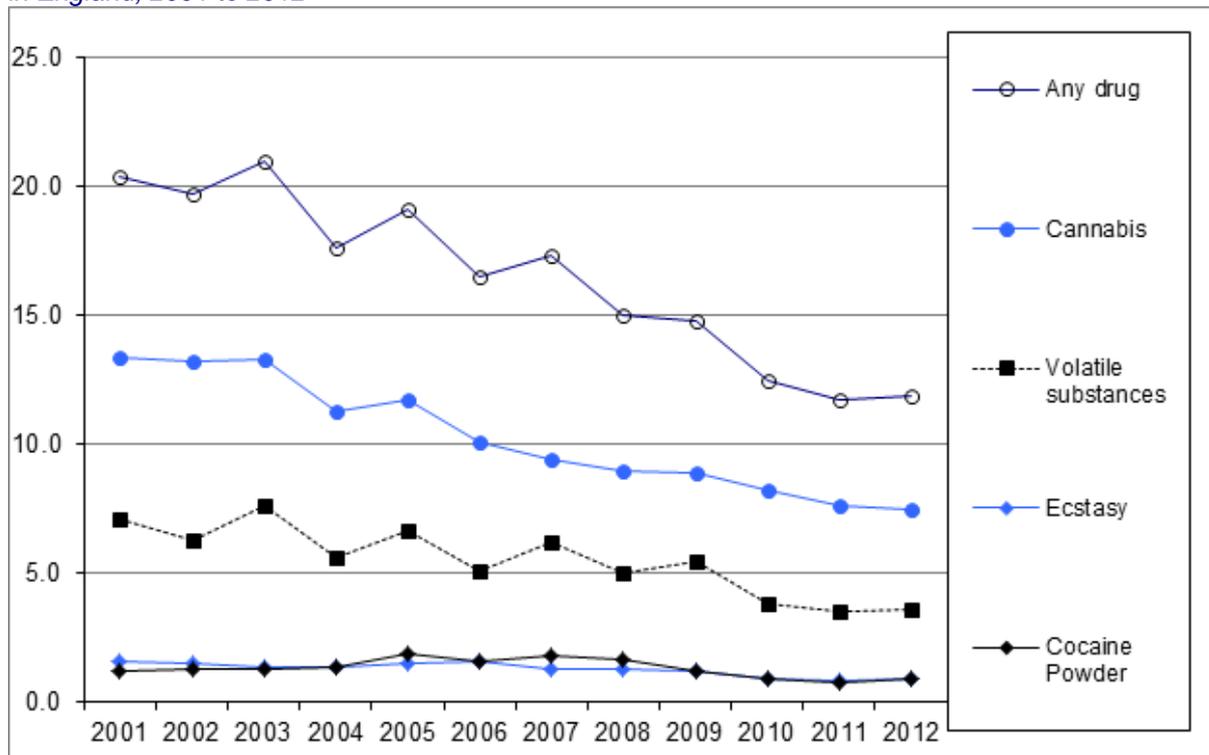
### Trends in drug use

From 2003, there was a general decrease in recent and current drug use amongst the school population in England until 2010. Since then, recent use has been stable at around 12% with current use stable between 2011 and 2012. The downward trend in overall drug use since 2003 resulted from marked declines in the use of several of the most commonly used drugs. In 2003, recent use of cannabis was reported by 13.3% of pupils whereas in 2012 it was 7.5%, a similar level to the previous year. There had also been a decline in recent use of other drugs, particularly in the use of any stimulant, which decreased from 6.1% in 2003 to 2.6% in 2012, again the same level as in the previous survey. Use of volatile substances has halved since 2003, although it has been stable in the last three surveys (Figure 2.4).

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<sup>38</sup> Heroin and methadone.

**Figure 2.4** Percentage of pupils aged 11 to 15 years old using some individual drugs in the last year in England, 2001 to 2012



Source: Fuller 2013

#### 2.4.2 Other studies on drug use in the school and youth population

Hale and Viner (2013) used data from the *Smoking, drinking and drug use amongst young people* survey to examine demographic risk factors and trends for multiple substance use in schoolchildren between 1998 and 2009. The analysis showed that across all survey years, risky drinking<sup>39</sup> was significantly associated with illicit drug use and smoking. Risky drinking, smoking and illicit drug use all peaked in the late 1990s before declining steadily thereafter, a trend mirrored for multiple substance use. Males were more likely to be risky drinkers and regular illicit drug users, while females had higher rates of smoking prevalence. Females had a significantly higher prevalence of concurrent use of all three substances (increased odds of 22%). White young people had higher prevalence of multiple substance use than Asian, black and other ethnicities but there were no differences between white and mixed race young people. Those eligible for free school meals had a 30% higher prevalence of illicit drug use and a 73% higher prevalence of smoking but there was no difference for risky drinking.

Perra et al. (2012) used data from the Belfast Youth Development Study<sup>40</sup> to examine school-related predictors of smoking, drinking and drug use. They found that having a positive relationship with teachers reduced the likelihood of being a weekly cannabis user by 52% whilst reporting being in a fight at school increased the risk of weekly cannabis use by 43%. Last year cannabis use was the only outcome independently associated with school-related factors after full adjustment.

<sup>39</sup> Defined as heavy regular drinking (at least one drink once a week on average) or binge drinking (seven or more units in the previous week).

<sup>40</sup> A longitudinal study of young people's health and development carried out in three areas of Northern Ireland. In 2001, first year students (11-12 yrs) were recruited in 38 secondary schools and followed up in each subsequent year (years 2 to 5). A total of 5,371 young people participated in at least one wave. Data analysed here are from year 3 (13-14 yrs).

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

### 2.5.1 Drug use amongst club goers

#### Global Drug Survey

A non-representative online survey of clubbers who were predominantly drug users<sup>41</sup> was carried out at the end of 2012 (Mixmag 2013; Table 2.7). Two-thirds (67.0%) of respondents had used ecstasy in the last year with respondents more likely to have used MDMA powder/crystals (60.8%) than pills (42.4%). Unlike in the general population, ecstasy was more commonly used than cocaine powder (41.5%). Around one-third (31.5%) of respondents had used ketamine in the last year but use had fallen from 40% the previous year. Use of mephedrone amongst regular clubbers also decreased in the 2012 survey to 13.8% compared with 19.5% in the previous study. The authors posit that this may be due to the bad comedown effects since mephedrone was rated the worst drug for feeling lousy/not being able to function the next day and unwanted effects on mental health. Use of other new psychoactive substances such as Benzo Fury and methoxetamine was low with less than three per cent reporting having tried each of them.

**Table 2.7** Lifetime and last year use of individual drugs by regular clubbers in the UK in 2012

	Lifetime	Last year
Cannabis	91.6	78.8
Ecstasy	79.0	67.0
Cocaine powder	59.9	41.5
Ketamine	50.6	31.5
Nitrous oxide	39.9	26.9
Magic mushrooms	43.1	16.5
LSD	31.2	14.5
Mephedrone	36.1	13.8
Amphetamine	34.9	13.6

Source: Mixmag 2013

#### Synthetic cannabis use

A further analysis of the 2011 Global Drug Survey<sup>42</sup> compared patterns of use of synthetic cannabis with natural cannabis and the differences in perceived effects (Winstock and Barratt 2013). Of the participants who responded, 17% reported having ever used synthetic cannabis with 41% of these reporting last year use. Those living in the US were most likely to report last year use. From the numbers reported in the paper, around three per cent of UK respondents reported last year use of synthetic cannabis. For all respondents, the vast majority (95%) of those reporting use of synthetic cannabinoids in the last 12 months also reported use of natural cannabis in the last 12 months. When asked about frequency of use, 80% of synthetic cannabis users reported using natural cannabis on a greater number of days than synthetic cannabis with 8% reporting using synthetic cannabis on more days than natural cannabis. Last year synthetic cannabis users were also likely to report use of other

<sup>41</sup> The 'Global Drug Survey' is an online, cross-sectional, self-reported, self-selecting survey and as such it is not representative of the general population. The survey was hosted by the Guardian newspaper and Mixmag dance music magazine. The survey collected data on drug users' experiences during a four week period between November and December 2012. The survey was advertised on social media sites and via the Guardian and Mixmag. See: <http://globaldrugsurvey.com/about> and <http://globaldrugsurvey.com/run-my-survey/methods> and <http://www.guardian.co.uk/society/2013/apr/18/drug-users-taken-advantage-sexually> and <http://www.guardian.co.uk/society/datablog/2012/mar/15/global-drug-survey-us-uk>. The results published in Mixmag focused on regular clubbers defined as those who had been to a club in the last month.

<sup>42</sup> An online survey carried out between November 23 and December 21 2011 with a total of 15,200 responses; 7,719 from the UK (see UK Focal Point Report 2012).

drugs with half (51%) reporting use of MDMA in the last year and one-third (34%) reporting use of cocaine in the last year.

#### Detecting drugs used through pooled urine analysis

Archer et al. (2013a) analysed pooled urine samples collected from a nightclub in London to assess the feasibility of using this method to detect use of individual drugs.<sup>43</sup> A total of 72 parent drugs and their metabolites were detected, which were grouped into classical recreational drugs, new psychoactive substance, potential adulterants, and prescription/over-the counter medicines. GHB was found at the highest concentration of all the other recreational drugs followed by mephedrone, ketamine and MDMA. Cocaine, methamphetamine and amphetamine were also found. Two new psychoactive substances, TFMPP and 2-AI, were also detected. The authors conclude that the study shows it is possible to collect anonymous pooled urine samples from within a club environment in order to provide information on the actual drugs being used.

#### New psychoactive substances

A further analysis of results from a 2010 survey of club attendees in south London<sup>44</sup> (Measham et al. 2011; see UK Focal Point on Drugs Report 2012) explored whether new psychoactive substances displace established club drugs, supplement them or act as drugs of initiation. (Moore et al. 2013). The findings suggest that mephedrone was predominantly added to existing club drug use rather than replacing use of MDMA and cocaine. Three-quarters of those reporting ecstasy use in the last month also reported use of mephedrone while two-thirds of those reporting last month cocaine use also used mephedrone in the last month. Under half of those reporting that they had taken or planned to take ecstasy pills (49%), MDMA powder (46%) or cocaine (41%) that night reported that they had also taken or planned to take mephedrone that night.

#### 2.5.2 Drug use amongst university students

Holloway et al. (2013) report on the findings from an online survey of university students exploring the misuse of prescription drugs in one university in Wales.<sup>45</sup> Forty-six per cent of respondents reported misusing one or more prescription drugs in their lifetime. The most common type of prescription drugs misused were 'pain relievers', (65%) and tranquilisers (23%). The article goes on to explore the characteristics and reported consequences of misuse, with 11% of those who had misused prescription drugs reporting that they had experienced a problem as a result of their misuse.

A number of online surveys of drug use amongst university students have published results. Caution should be taken when interpreting the findings due to the self-selecting nature of online surveys and, in some cases, a lack of methodological information regarding recruitment to the surveys. Across the three surveys<sup>46</sup> presenting results, cannabis was the

<sup>43</sup> The study was undertaken in a large nightclub in London catering predominantly to gay men. A portable four person urinal was set up with club attendees free to use the non-study urinals if they preferred. Multiple pooled samples were taken on two consecutive nights in July 2011 and were analysed with a method based on liquid chromatography coupled to tandem mass spectrometry (LC-MS/MS), electrospray ionisation-gas chromatography with mass spectrometry (EI/GC-MS) and head space gas chromatography with flame ionisation detection (GC-FID).

<sup>44</sup> A total of 308 respondents participated in the survey carried out in two south London gay dance clubs across three nights in July 2010. The two-page survey recorded socio-demographic details and use of licit and illicit drug.

<sup>45</sup> The survey was completed by 558 students at a university in north Wales. Respondents were recruited through email, posters, news bulletins and announcements. As such it was a non-representative, self-selecting sample.

<sup>46</sup> The studentbeans.com survey was carried out online. Total sample size was 1,903 university students in the UK. Fieldwork was undertaken between 20th July and 9th August 2012. See: <http://www.guardian.co.uk/education/interactive/2012/oct/12/university-drug-culture-survey> The Tab

most frequently used drug followed by ecstasy, whereas amongst 16 to 24 year olds in the CSEW, cocaine is the second most commonly used drug. Other drugs reportedly used by the surveys' respondents included ketamine, mephedrone, nitrous oxide, Salvia, synthetic cannabinoids and 2C-B. Some respondents reported using an unknown legal high. The majority of those reporting use had used drugs prior to going to university

### 2.5.3 Ethnic groups

As in previous years, drug use was higher amongst Mixed (16.9%) and White (8.6%) adults in the 2012/13 CSEW than amongst Asian (3.8%) and Black (6.2%) adults (Home Office 2013b) but these data have not been adjusted to take account of the different age structures within these groups.

### 2.5.4 Other studies amongst specific groups

Chatwin and Porteus (2013) explored the experiences and perspectives of long-term, regular cannabis users.<sup>47</sup> They found that more regular use was characterised by a move from social smoking to smoking while alone. Despite the long-term nature of their cannabis use, most reported that they'd either stopped use or reduced use at various times in their life. Frequency of use amongst participants differed with half reporting daily use and great variation even amongst the daily smokers. A diverse and sometimes contradicting set of motivations for regular smoking were given by participants but many mentioned the calming effects of the drug and ways it improved their health and well-being. When asked about the impact their cannabis use had on their life, most did not feel it impacted on personal relationships although participants differed in their view of concealing their cannabis use from their children. Most of the participants were employed and did not feel their cannabis use had impacted on their employment. In terms of negative health effects, most of the problems cited were felt to be due to mixing cannabis with tobacco. Over one-third of the sample had been in contact with the criminal justice system due to their use of cannabis and rather than acting as a deterrent, this contact had no effect on use and created resentment and alienation.

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

### 2.6.1 Truants and those excluded from school

Data from the 2012 survey of *Smoking, drinking and drug use in England* (Fuller 2013; see section 2.4.1) show that pupils who had ever truanted or had been excluded from school were more likely to have used Class A drugs in the last year than those who had not; nine per cent compared to one per cent. Although this pattern is similar to previous years, there has been an overall downward trend in the prevalence of drug use amongst truants/excludees since 2003 when it was 14%. Truants/excludees were also more likely to report using drugs at least once a month (10% compared to 1%) although this has decreased from 21% in 2003.

### 2.6.2 Ethnic groups

Data from the school survey in England (Fuller 2013) show that, compared with White pupils, pupils of Asian (OR=2.36), Black (OR=1.97) or Mixed (OR=1.80) ethnicity were more likely to have used drugs in the last year. This contrasts with the CSEW where Mixed and White

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surveyed 5,126 students at 21 UK universities in the second term of the 2012/13 academic year. See: <http://leeds.tab.co.uk/2013/05/20/revealed-who-does-the-most-drugs/62> students responded to the survey carried out by Felix, the student website of Imperial College, London. See: <http://felixonline.co.uk/news/3588/felix-drugs-survey/>

<sup>47</sup> Individuals who were over the age of 35 years, had been using cannabis for 15 years or more and who were still using at least once a week were recruited via the study interviewer's social network and via a request at the end of a newspaper article. Altogether, 23 individuals were interviewed; 13 via face-to-face interviews and 10 via the Internet. The same semi-structured interview/questionnaire schedule was used for both methods.

respondents were more likely to report drug use than Asian or Black respondents (see section 2.5.3).

### **2.7 Attitudes to drug use**

The Crime Survey for England and Wales (CSEW) asked questions on the acceptability of drug use and how safe respondents thought drug use was (Home Office 2013b). Just under one-third (32%) of adults aged 16 to 59 thought that it was acceptable for someone of their age to occasionally use cannabis, a much higher percentage than thought occasional use of ecstasy (8%), cocaine (7%) or heroin (1%) was acceptable. This compares to around three-quarters (74%) who thought it was acceptable for someone of their age to get drunk. The oldest age group (55-59 years old) was least likely to think occasional drug use and getting drunk was acceptable.

When looking at personal and lifestyle characteristics, the only groups where a majority thought cannabis use was acceptable were those reporting nine or more visits to pubs/bars (56%), four or more visits to clubs (60%), or drinking alcohol three or more days a week (52%) in the last month. When looking at household and area characteristics, those finding cannabis use acceptable were in the minority in each group. Those categorised as city living (47%), urban prosperity (44%), and those earning over £50,000 (42%) were most likely to believe that cannabis use was acceptable.

Respondents were less likely to believe that cannabis and other drugs were safe than they were to believe that use was acceptable. This was also the case with alcohol, with only one-quarter of adults believing that getting drunk was safe. The vast majority of respondents thought that cocaine (97%), ecstasy (97%), and heroin (100%) were unsafe with 79% believing that cannabis was unsafe.

## 3. Prevention

### 3.1 Introduction

Prevention of young people's drug use is a key element of drug strategies in the United Kingdom. Establishing a whole-life approach to drug prevention covering early years, family support, drug education and targeted, specialist support for young people is a key aim of the UK Drug Strategy (HM Government 2010).

Policies have been embedded in, or complemented by, a much wider framework of social action to create the capacity of both individuals and communities to resist drugs, including policies for children and young people aimed at enabling them to reach their full potential. In England, the *Children's Plan* aims to facilitate this (DCSF 2007). The devolved administrations take a similar approach, in Wales through Rights of Children and Young Persons (Wales) Measure 2011 (Welsh Government 2011a). The GIRFEC (Getting It Right For Every Child) programme<sup>48</sup> provides the methodology for delivering the Scottish Government's three social policy frameworks: the *Early Years Framework*; *Achieving our Potential*; and *Equally Well* (Scottish Government 2008b;c;d), which aim to develop the prevention and early intervention agenda. In Northern Ireland, *Our Children and Young People – Our Pledge: A 10 year strategy for children and young people in Northern Ireland, 2006-2016* (OFMDFMNI 2006) sets a framework for addressing the needs of young people. Improved education and early interventions for young people and families (especially those most at risk) and improved public information about drugs are priority areas.

Universal drug prevention initiatives are an important area of policy. Communication programmes, such as 'Talk to FRANK'<sup>49</sup> in England and 'Know the Score'<sup>50</sup> in Scotland, provide factual information and advice to young people and their families. In Northern Ireland, the Public Health Agency<sup>51</sup> develops public information campaigns for various target groups and settings, and in Wales a bilingual (Welsh and English) helpline, 'Dan 24/7'<sup>52</sup> is available. School-based drug education forms a central part of the United Kingdom's approach to universal drug prevention. Throughout most of the United Kingdom, the effects of substances on the body are part of the national curriculum, and schools are encouraged to supplement this through non-statutory personal, social, health and economic education (PSHE). The majority of schools have a drug education policy and guidelines for dealing with drug incidents. Guidance on drug education recommends an approach that incorporates all psychoactive substances, including alcohol and tobacco, and places drug education within the wider health and social education agenda. A consultation on PSHE in England was launched in 2011 (DfE 2011), and led to increased flexibility for schools to decide what and how they teach PSHE content (DfE 2013a).

In England and Wales, all local areas are expected to produce *Children and Young People's Plans* for all services for children and young people, including prevention and treatment. The *Common Assessment Framework (CAF)*<sup>53</sup> in England aims to facilitate early identification of problems and secure a network of required support services, linking into more targeted arrangements. The priorities within targeted prevention are to ensure young people have access to a range of core services to help keep them engaged in education, in stable housing and with a supportive family or care placement. Similarly, in Scotland, the *Integrated Children's Services Planning Framework* requires a single plan agreed with all relevant agencies to deliver integrated services for children and young people.

<sup>48</sup> See: <http://www.scotland.gov.uk/Topics/People/Young-People/childrenservices/girfec>.

<sup>49</sup> See: <http://www.talktofrank.com/>

<sup>50</sup> See: <http://knowthescore.info/>

<sup>51</sup> See: <http://www.publichealth.hscni.net/>

<sup>52</sup> See: <http://www.dan247.org.uk>

<sup>53</sup> See: <http://www.cwdcouncil.org.uk/caf>

Communities are provided with assistance to build the capacity to resist drugs through a range of initiatives which are delivered by local partnerships. There are specific interventions targeting young people in deprived communities such as Positive Futures<sup>54</sup> in England and the Integrated Families Support Service (IFSS) in Wales. In Scotland, a number of projects receive time-limited funding from the Scottish Government in partnership with Lloyds TSB Partnership Drugs Initiative (PDI)<sup>55</sup>, targeting children with, or at risk of, substance misuse as well as those affected by familial substance misuse. Increasingly, family interventions are being set up, more specifically for problem drug and alcohol users, to help support parenting, and therefore reduce the risk of substance misuse amongst their children but also with wider objectives.

There have been concerns, however, that austerity and the move to localism could have a detrimental effect on wider services for children and young people (UKDPC 2012b).

### **3.2 Environmental prevention**

Environmental prevention strategies aim to alter the immediate cultural, social, physical and economic environments in which people make their choices about drug use.

#### **3.2.1 Illicit drugs, alcohol and tobacco policies in the UK**

Across the United Kingdom there are a range of policies and strategy documents concerned with licit substances such as tobacco and alcohol. In some UK countries, such as Wales and Northern Ireland, there are global strategies covering both illicit and licit substances. A summary of the situation across the UK was provided in the UK Focal Point Report 2012.

Tackling the wider determinants of health is one of the four domains identified as important in the Public Health Outcomes Framework (DH 2012a) for delivering the two main outcomes: increasing healthy life expectancy and reducing inequalities in life and healthy life expectancy. This recognises the role of social and environmental factors in determining health and complements the increasing policy focus on early intervention as a means to prevent future problems.

### **3.3 Universal prevention**

Universal prevention targets the entire population, regardless of individual levels of risk, with programmes, initiatives and messages aimed at preventing or delaying the onset of illicit drug use.

#### **3.3.1 Schools**

##### **England**

In schools, the effect of substances on the body is a statutory part of the national science curriculum, as set out in *The National Curriculum in England Framework Document* published in September 2013 (DfE 2013b). However, the Government also advises schools to use the non-statutory Personal Social and Health Education (PSHE) curriculum to cover drug education. A consultation on PSHE ran in 2012 and a summary report of consultation responses was published in 2013 (DfE 2013a). Of the 492 respondents to the consultation question on which elements of PSHE should be made statutory, 21% stated that drugs and alcohol education should be made statutory.

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<sup>54</sup> See: <http://www.posfutures.org.uk/index.asp?m=793&t=Home>

<sup>55</sup> See: <http://www.ltsbfoundationforscotland.org.uk/index.asp?tm=16>

Ofsted (2013) published a report evaluating the strengths and weaknesses of PSHE in primary and secondary schools in England.<sup>56</sup> It found that most pupils understood the dangers to health of tobacco and illegal drugs but they were less aware of the physical and social damage associated with alcohol misuse, including personal safety. Eighteen per cent of panellists said that they had not learnt about drugs, alcohol and tobacco until aged 14, although 95% reported having done so by the time they left school.

The Substance Misuse Team in the Department for Education was disbanded in 2013 so Department for Education no longer lead on the Reducing Demand strand of the Drug Strategy. The Home Office have temporarily taken over responsibility for this strand. On 1<sup>st</sup> April 2013, Public Health England came into existence and the Alcohol and Drugs section of PHE will take an increasing role in substance misuse prevention.

#### *Alcohol and Drug Education and Prevention Information Service*

An Alcohol and Drug Education and Prevention Information Service (ADEPIS)<sup>57</sup> was launched in 2013, funded by DfE and run by the drug prevention charity Mentor, in partnership with DrugScope and Adfam. The new service provides practical advice and tools based on the best international evidence. DfE has also provided funding to the Centre for the Analysis of Youth Transitions (CAYT) to develop a database of evaluations of programmes aimed at improving outcomes for young people.

#### *Quality standards for drug education*

In September 2013, ADEPIS launched a consultation on new quality standards for drug and alcohol education.<sup>58</sup> The standards cover three areas: delivering effective drug education in the classroom; school context for effective drug education; and staff policies and safeguarding. The consultation will run until November 2013.

#### *Mapping drug and alcohol education*

Findings from an online survey of drug and alcohol education in schools were published in September 2013 (Boddington et al. 2013).<sup>59</sup> Key findings indicated that drug and alcohol education provision remains inconsistent across schools and that the majority of respondents reported that they would like more classroom resources for drug and alcohol education. Many respondents also felt that there was a lack of time in the curriculum to build on learning around drugs and alcohol and that a lack of finances restricted the availability of resources and training opportunities.

#### *Reviewing your drug and alcohol policy: a toolkit for schools*

Mentor (2012) produced *Reviewing your drug and alcohol policy: a toolkit for schools*<sup>60</sup>. The toolkit uses as its base, the guidance produced in 2012 by the Department for Education and Association of Chief Police Officers (ACPO) which focused on dealing with drugs and drug-related issues, not on drug education (DfE and ACPO 2012). The toolkit attempts to address this gap by creating a working document designed to assist schools in examining and

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<sup>56</sup> Based upon evidence from inspections of PSHE education carried out between January 2012 and July 2012 in 50 maintained schools and on evidence from an online survey of 178 young people conducted on behalf of Ofsted between October and November 2012

<sup>57</sup> See: <http://mentor-adepis.org/>

<sup>58</sup> See: <http://mentor-adepis.org/quality-standards-for-drug-education-consultation-and-survey-findings/>

<sup>59</sup> The online survey was completed by 288 participants between the 3rd June and the 24th June 2013 recruited through the PSHE Association's mailing list and other means. This was a non-random, self-selecting sample covering staff in primary, secondary and special educational establishments. Fifty-five per cent of respondents were from secondary schools. The report also draws upon 20 follow-up telephone interviews undertaken with respondents from a wide range of different school types.

<sup>60</sup> See: <http://www.mentoruk.org.uk/wp-content/uploads/downloads/2012/12/Toolkit.pdf>

implementing drug and alcohol programmes and policies within schools. It takes a broad approach with consultation a dominant theme and sections dedicated to methods of consultation with teachers, parents, pupils and on ways to engage with local agencies such as drug and alcohol services, police and the local authority. It also provides a series of tools that can be used in developing school policies including examples of teacher surveys and a checklist for reviewing existing drug education provision.

*The All-Party Parliamentary Group for Drug Policy Reform (APPGDPR) Inquiry*

The APPGDPR (2012) reviewed current drug prevention and education activities for addressing new psychoactive substances and found very little evidence of specific programmes. After looking at the evidence for different types of prevention, the report recommendations were that:

- Preventive programmes with a strong evidence base should be promoted much more widely within schools and the community.
- Resources should be made available for robust evaluation in the UK of preventive programmes to assess their effectiveness in reducing the harms of NPS, delaying first use and to minimizing problematic use.

Scotland

*Choices for Life*<sup>61</sup>

Police Scotland's *Choices for Life* programme continues to be supported by the Scottish Government in 2013/14. In September 2012, a new website for young people, their parents and carers and teachers was launched.<sup>62</sup> This website was designed in partnership with Young Scot, and young people were involved in the design.

Wales

*Guidance for substance misuse education*

Following a consultation on draft guidance for substance misuse education in Wales in late 2012, the Welsh Government has now published *Guidance for Substance Misuse Education (SME)* (Welsh Government 2013d), which will support the delivery of appropriate SME. The guidance is aimed at all organisations in the statutory, voluntary and independent sectors that offer educational opportunities to children and young people under the age of 19 and provides guidance on dealing with substance misuse incidents and developing an effective substance misuse policy in addition to good practice in substance misuse education.

*All Wales School Liaison Core Programme (AWSLCP)*<sup>63</sup>

The Welsh Government's *Substance Misuse Delivery Plan 2013-15* (Welsh Government 2013a; see section 1.3.1) includes a key action: to ensure appropriate educational programmes are available across Wales. The AWSLCP is jointly funded by the Welsh Government and the four Welsh police forces. For the academic year 2012-2013 it was delivered by police officers in 98.5% of the primary and secondary schools in Wales, an increase of 7.5% on 2011-12 figures. The programme also delivers wider community safety

<sup>61</sup> Choices for Life is an interactive substance use education programme (covering drugs, alcohol and tobacco), project managed by Police Scotland and funded by the Scottish Government. It was previously delivered as large-scale concert style events for 10 and 11 year old children across Scotland, combining health education with music, drama and quizzes. In order to widen access to the programme to young people aged up to 18 years old, the programme was re-launched online in late 2011 and delivered using GLOW, the schools intranet system in Scotland, with accompanying resources for teachers. Education Scotland are involved in the development of Choices and materials are aligned with the Curriculum for Excellence.

<sup>62</sup> See: [www.choicesforlifeonline.org](http://www.choicesforlifeonline.org)

<sup>63</sup> The AWSLCP is a substance use education programme running in Wales since 2004. It is delivered across the majority of primary and secondary schools in Wales by a partnership between specialist police liaison officers and teachers. In addition to substance use, it aims to reduce anti-social behaviour and problems associated with personal safety. See: UK Focal Point Reports 2008 to 2011.

messages about domestic violence, internet safety and healthy relationships. The content of the programme is kept under constant review and lessons on new psychoactive substances and image enhancing drugs such as steroids and self-tanning drugs have recently been added.

### 3.3.2 Family

#### Strengthening Families Programme 10-14

Coombes et al. (2012) carried out an exploratory pilot study of the Strengthening Families Programme 10-14 in three locations in the UK.<sup>64</sup> Participants reported improvements in parenting behaviour and family life, and found sessions addressing these skills as more beneficial than specific substance sessions. The study was hampered by slow recruitment and participants' desire not to be randomised into an intervention group. The authors conclude that a larger evaluation of the programme's efficacy and effectiveness would be worthwhile but the issues with recruitment would need addressing.

### 3.3.3 Community

#### England

##### *Positive Futures*<sup>65</sup>

The Home Office provided funding of £5 million in 2012/13 for the Positive Futures prevention and diversionary programme. The national programme has now been closed down following the transition to local commissioning for crime prevention and community safety services, including through Police and Crime Commissioners (see section 9.3.1). The programme targeted vulnerable 10-19 year olds at risk of crime, substance misuse and serious youth violence and engaged them in sports, arts based and developmental activities.

Positive Futures was run by 91 projects in some of the most deprived areas of England and Wales and helped around 49,000 young people annually. With the closure of the programme, former Positive Futures projects have developed their own local identities and brands. Approximately 54 of the 91 projects have received some funding from their local Police and Crime Commissioner in 2013/14 to continue to deliver their prevention and crime reduction activities.

#### Scotland

##### *CashBack for Communities*

CashBack for Communities reinvests money recovered through the *Proceeds of Crime Act 2002* and invests them into community programmes, facilities and activities largely, but not exclusively, for young people at risk of turning to crime and anti-social behaviour as a way of life. Individual CashBack projects and the overall programme are now subject to an evaluation of their impact and outcomes. This work puts arrangements in place to allow a qualitative approach of measuring short, medium and longer-term outcomes. The CashBack evaluation plan is published on the website<sup>66</sup> and evaluations of projects funded by the

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<sup>64</sup> Originally designed as a RCT, slow recruitment and a desire to only participate if receiving the SFP 10-14 intervention changed this to a quasi-experimental design. Across the three sites, 37 families were recruited (53 parents and 64 young people) with 26 parents/carers and 34 young people receiving the intervention and 27 parents/carers and 35 young people acting as controls.

<sup>65</sup> Positive Futures was a community based prevention programme targeting and supporting 10 to 19 year olds on the cusp of, or who have desisted from, offending. The programme began in 2001 and provided sports and arts based activities through 91 projects in deprived communities across England and Wales. It was managed by a young people's charity, Catch22. See: <http://www.catch-22.org.uk/>

<sup>66</sup> See: <http://www.scotland.gov.uk/Resource/0043/00434954.pdf>

CashBack programme carried out so far are published on the Scottish Government's website.<sup>67</sup>

#### *Social norms approach*

Bewick et al. (2013) used three projects to illustrate the practical implementation of a public health programme using a social norms approach.

#### 3.3.4 Workplace

The Welsh Government continues to develop its work and health programme, 'Healthy Working Wales' (HWW)<sup>68</sup>, which includes the Corporate Health Standard and the Small Workplace Health Award, with the aim to provide free support and advice to employers in developing health and well-being policies and initiatives in the workplace. Both programmes have a substance misuse element and the Corporate Health Standard includes criteria on substance misuse at bronze and gold levels. Seventy-nine employers have achieved the Corporate Health Standard and 194 smaller businesses/organisations have achieved the Small Workplace Health Award. The Substance Misuse Delivery Plan 2013-15 (Welsh Government 2013a; see section 1.3.1) has raising awareness of substance misuse issues in the workplace as a key action.

#### 3.3.5 Sources of information on drugs

##### England

The Smoking, Drinking and Drug Use Survey 2012 (Fuller 2013) asked pupils a question about sources of helpful information on drug use. Pupils were most likely to cite teachers as a source of helpful information on drugs (66%) with parents (63%), television (60%), and the Internet (52%) the next most common sources. Around two-fifths of pupils found newspapers and magazines (42%), other relatives (41%), friends (37%) and other adults at school (37%) sources of useful information.

The FRANK campaign was mentioned by just over one-fifth (22%) of pupils, a decrease from 27% the previous year, 31% in 2010 and 36% in 2009. Older pupils were more likely to mention the FRANK campaign than younger pupils (38% of 15 year olds compared to 8% of 11 year olds).

Similar to previous years, of the options provided, telephone helplines were the least likely source of information to be mentioned by participants (16%).

#### *Breaking the cycle: Home Affairs Committee report*

The Home Affairs Committee report (HAC 2012) expressed concern about the reduction in funding for drug education and preventative work. Recommendations contained within the report include that the next version of the Drugs Strategy contains a clear commitment to an effective drugs education and prevention programme, including behaviour-based interventions and that Public Health England commit centralised funding for preventative interventions when pilots are proven to be effective.

#### *YouTube, drug videos and drug education*

Manning (2013) carried out a content analysis of drug videos posted on YouTube<sup>69</sup> classifying them by drug discourse. Out of the sample, documentaries (16%), celebratory

<sup>67</sup> See: <http://www.scotland.gov.uk/Topics/Justice/public-safety/17141/cashback>

<sup>68</sup> See: [http://www.healthyworkingwales.com/splash\\_wales/en.html](http://www.healthyworkingwales.com/splash_wales/en.html)

<sup>69</sup> A sample of 750 drug videos were extracted from YouTube using webometric software. Coding categories were based on a previous pilot study and included: cautionary; DIY; legal high ads; news; documentary; celebratory; satirical; reflective; traditional drug education; new drug education; and other. Videos were placed into one category only.

(16%), news (15%) and cautionary (13%) were the most common type. Drug education videos (both 'traditional' and 'new') made up around 12% of the sample. When looking at the number of views, however, drug education videos were watched relatively infrequently. Analysis by drug showed that there were no celebratory videos for cocaine powder, crystal meth or heroin. Crack cocaine and crystal meth videos were most likely to be cautionary while there were no cautionary cannabis videos in the sample. The author concludes that drug education strategies based on old media are likely to be unsuccessful as they are competing with many alternative discourses that offer different forms of drug education.

### 3.4 Selective prevention in at-risk groups and settings

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

#### 3.4.1 At-risk groups

##### England and Wales

###### *Choices targeted prevention and early intervention programme*

Choices was a £4 million programme for 2011-12 funded by the Home Office.<sup>70</sup> It was aimed at the voluntary and community sector to help them prevent and reduce substance misuse and related offending by vulnerable groups of young people aged from 10 to 19 years. Delivery of programmes funded through the Choices programme has been completed. Projects have been encouraged to develop their local evaluations of the various approaches funded under Choices to ensure that the learning helps to add to the evidence base on prevention and early intervention.

Barnardo's (2013) has published its evaluation of the Choices project in Keighley, which worked with vulnerable young people and their families who did not qualify for statutory intervention in relation to their substance misuse and related offending behaviour. The evaluation found that positive outcomes were achieved by 15 out of 19 young people on the factors known to correlate with offending and substance misuse. Some of these characteristics included improved family relations and enhanced self-esteem. The evaluation provides seven broad recommendations for future programmes.

##### Scotland

###### *Inspiring Scotland*

The Inspiring Scotland 14 to 19 fund has been running since 2008. The Scottish Government invested £9.4m between 2009 and 2012 and a further £4m in both 2012/13 and in 2013/14. Government is one of many investors from the public and private sectors, alongside high net worth individuals and other trust funding. In 2012, a total of 6,067 vulnerable young people, including those with issues around drug use, were assisted across 22 ventures which helping them into education, training or employment. Since 2008, 19,043 vulnerable young people engaged with the programme, of which 8,925 individuals are reported to have achieved 'positive destinations'.

##### Research

Stevens et al. (2013) evaluated the RiskKit programme, which involved screening school pupils aged 14 to 16 years in order to identify those at risk of alcohol and drug use and inviting them to participate in a multi-component programme.<sup>71</sup> The qualitative process

<sup>70</sup> See: <https://www.gov.uk/integrated-offender-management-iom#choices>

<sup>71</sup> All pupils aged 14 to 16 in participating schools were invited to complete the adolescent risk-behaviour screen. Those identified at risk were invited to attend two drug and alcohol awareness

evaluation found that the programme was feasible, acceptable and positively viewed. The quantitative outcomes evaluation found significant reductions in alcohol use (measured by percentage of days abstinent and mean number of drinks per drinking day). There were no statistically significant changes in drug use.

### 3.4.2 At-risk families

#### England

A guide to the evidence and best practice around working with troubled families was published by the Department for Communities and Local Government (DCLG 2012a). It contains findings from the Troubled Families Programme, which has been running since 2011 and shows evidence of a reduction in drug misuse problems after receiving a family intervention (see section 8.3.3).

#### Wales

##### *Integrated Family Support Service (IFSS)*

The Integrated Family Support Service provides intensive support for families that have been identified as having parental substance misuse issues and helps co-ordinate action from relevant services. The IFSS has been rolled out across the majority of Wales, with implementation in the last two areas due in 2014 (Welsh Government 2013e).

##### *Drug Education Forum<sup>72</sup>*

The Drug Education Forum (DEF) hosted by Mentor UK, was a representative body of national organisations seeking to influence policy and increase the profile of drug education within the UK. In March 2012 the Drug Education Forum, produced a series of six briefing papers relating to drug education and best practice. The papers cover the following topics: the principles of good education<sup>73</sup>; the principles of supporting school drug education<sup>74</sup>; beyond the lesson plan;<sup>75</sup> engaging parents in drug education<sup>76</sup>; learning from life skills programmes<sup>77</sup> and; legal highs<sup>78</sup>. Funding for DEF ended in March 2012.

## 3.5 National and local media campaigns

### 3.5.1 England: Talk to FRANK<sup>79</sup>

Three adverts were launched in January 2013 to mark the 10<sup>th</sup> anniversary of Talk to FRANK and ran on TV, radio and online. On average there was a 56% increase in visits to the website during campaign time when compared to standard web visits outside of campaign time (Home Office, personal communication). The website was extended to include a live chat facility with a trained adviser between 2pm and 6pm each day. A targeted

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sessions with those deemed to need further assistance attending eight targeted life skills training sessions and a one-to-one motivational interview. The evaluation used qualitative methods and a quantitative questionnaire on drug and alcohol use at entry, exit and six-month follow-up of the 226 programme participants (180 participants (80%) had at least one follow-up).

<sup>72</sup> See: <http://www.drugeducationforum.com/>

<sup>73</sup> See: [http://www.drugeducationforum.com/images/dynamicimages/documents/documents\\_12644\\_498064.pdf](http://www.drugeducationforum.com/images/dynamicimages/documents/documents_12644_498064.pdf)

<sup>74</sup> See: [http://www.drugeducationforum.com/images/dynamicimages/documents/documents\\_12645\\_264217.pdf](http://www.drugeducationforum.com/images/dynamicimages/documents/documents_12645_264217.pdf)

<sup>75</sup> See: [http://www.drugeducationforum.com/images/dynamicimages/documents/documents\\_12646\\_760305.pdf](http://www.drugeducationforum.com/images/dynamicimages/documents/documents_12646_760305.pdf)

<sup>76</sup> See: [http://www.drugeducationforum.com/images/dynamicimages/documents/documents\\_12647\\_383840.pdf](http://www.drugeducationforum.com/images/dynamicimages/documents/documents_12647_383840.pdf)

<sup>77</sup> See: [http://www.drugeducationforum.com/images/dynamicimages/documents/documents\\_12648\\_968284.pdf](http://www.drugeducationforum.com/images/dynamicimages/documents/documents_12648_968284.pdf)

<sup>78</sup> See: [http://www.drugeducationforum.com/images/dynamicimages/documents/documents\\_12649\\_653453.pdf](http://www.drugeducationforum.com/images/dynamicimages/documents/documents_12649_653453.pdf)

<sup>79</sup> The Talk to FRANK drugs internet information and advice service funded by the Department of Health, the Home Office and the Department for Education has been running in England for nine years. See: <http://www.talktofrank.com> and <http://www.homeoffice.gov.uk/media-centre/news/frank-campaign>.

campaign to encourage about legal highs started in June 2013 using online and radio channels. In 2012-13, £0.9 million was spent on the FRANK service.

### 3.5.2 Know the Score campaign: Scotland

Know the Score<sup>80</sup>, continues to offer credible and non-judgmental information and advice on drugs and their risks, via a free telephone helpline and website. In 2012/13 new articles were added to the website including on drug use in sport, new psychoactive substances and staying safe during the festive season and at summer music festivals. Facebook adverts were used at intervals throughout the year to raise awareness of the Know the Score campaign and direct young people to the website.

### 3.5.3 The Welsh Drug and Alcohol Helpline DAN 24/7<sup>81</sup>

DAN 24/7, the Welsh Government's 24 hour/7 days a week bilingual substance misuse helpline continues to reach out to more individuals year on year. In 2012/13 the helpline responded to 4,321 contacts (calls and text messages) compared to 3,162 in 2011/12, a rise of 37%. The interactive web page which in 2011/12 had 22,700 hits has seen an increase of 75% in 2012/13 to 39,836.

This increase is largely due to the successful mephedrone awareness campaign that ran from January to March 2013. The campaign "Know The Score" consisted of a Ministerial launch, radio advertisements and announcements on Real Radio Wales, press advertisements, social media and a tie into the Six Nations Rugby tournament with display boards at two of the games. Beer mats using the strapline were also distributed in one chain of pubs throughout Wales during the course of the campaign.<sup>82</sup> Findings from the campaign showed that visits to the DAN 24/7 helpline website increased by 82% (using the comparative 3 month period last year), calls to the helpline increased by 45% and there was a vast increase in social media activity.

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<sup>80</sup> See: <http://knowthescore.info/>

<sup>81</sup> Drug and Alcohol Helpline, 'DAN 24/7' is a bilingual (Welsh and English) telephone help line funded by the Welsh Assembly Government and operated by Betsi Cadwaladr University Health Board. It provides a 24 hour gateway service, designed to provide substance use information, guidance, advice and sign post callers to local relevant services.

<sup>82</sup> See: <http://wales.gov.uk/newsroom/healthandsocialcare/2013/130112mm/;jsessionid=D793CD21F04209EA2032692AEA24BE77?lang=en>

## 4. Problem drug use

### 4.1 Introduction

The EMCDDA's definition of problem drug use is 'injecting drug use or long-duration/regular use of opioids, cocaine and/or amphetamines'. In England, estimates are produced for opiate and/or crack cocaine users (OCUs) and injecting drug use.<sup>83</sup> In Scotland, problem drug use refers to the problematic use of opiate<sup>84</sup> and/or the illicit use of benzodiazepines and drug injecting; in Wales it is long duration or regular use of opioids, cocaine powder and/or crack cocaine; and in Northern Ireland problem opiate and/or problem cocaine powder use. For the purpose of this chapter the term problem drug use (PDU) will be used to encompass all of these definitions from across the UK and to allow for comparisons across Europe to be made by the EMCDDA.

Estimates of problem drug use (PDU) in the United Kingdom are derived using two indirect measurement techniques: the capture-recapture (CRC) method; and the multiple indicator (MIM) method. Since 2006, all four United Kingdom administrations have published prevalence estimates to meet their policy requirements. The drugs and data covered by these estimates differ across the United Kingdom.

Latest national and regional estimates for England are for 2010/11 for opiate and/or crack cocaine use, with separate estimates available for opiate use, crack cocaine use, and injecting drug use. In Scotland, the latest national and regional estimates for problematic opiate and/or benzodiazepine use are for 2009/10 and were published in 2011. Work is currently underway by the Information Services Division of NHS National Services Scotland to update the estimates for 2012/13 (due to report in 2014). Drug injecting estimates for Scotland are available for 2006. In Wales, local and national estimates for 2009/10 for long duration or regular use of heroin, other opioids, crack cocaine and/or cocaine powder were published in 2011. Estimates for Northern Ireland for 2004 were published in 2006 and cover problem opiate and/or problem cocaine powder use.

Based on these, it is estimated that there are a total of 376,136 problem drug users in the United Kingdom, and 133,112 people who inject drugs (PWID) (primarily opiates or crack cocaine).

### 4.2 Prevalence estimates of problem drug use

#### 4.2.1 Estimates of problem drug use in England

In England, new national and local estimates of the prevalence of opiate and/or crack cocaine use (OCU)<sup>85</sup> for 2010/11 were published, with separate estimates available for opiate use, crack cocaine use and injecting drug use (Hay et al. 2013).

There were an estimated 298,752 opiate and/or crack cocaine users in England in 2010/11, a rate of 8.67 per thousand population aged 15 to 64; an estimated 261,792 opiate users, a rate of 7.59 per thousand population; an estimated 170,627 crack cocaine users, a rate of 4.95 per thousand population; and an estimated 93,401 injectors who use opiates and/or crack cocaine, a rate of 2.71 per thousand population (Table 4.1).

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<sup>83</sup> Injecting drug use refers to estimates of the numbers injecting out of those that are opiate and / or crack cocaine users. It does not include estimates of injectors of amphetamines, performance and image enhancing drugs or other drugs.

<sup>84</sup> Including illicit and prescribed methadone.

<sup>85</sup> Problem drug users according to the EMCDDA definition.

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**Table 4.1** Estimated number of OCUs, opiate users, crack cocaine users and drug injectors and rates per 1,000 population aged 15 to 64 in England, 2010/11

	Estimate	95% CI	Rate	95% CI
Opiate and/or crack cocaine users (OCUs)	298,752	294,858 - 307,225	8.67	8.55 - 8.91
Opiate users	261,792	259,260 - 269,025	7.59	7.52 - 7.80
Crack cocaine users	170,627	165,877 - 176,692	4.95	4.81 - 5.12
Injectors of opiates and/or crack cocaine	93,401	90,974 - 96,757	2.71	2.64 - 2.81

Source: Hay et al. 2013

There was a significant decrease in the estimated number of opiate and/or crack cocaine users in England between 2005/06 and 2010/11 (Table 4.2). A significant decrease in the number of crack cocaine users and the number of injectors of opiates and/or crack cocaine is also evident over this period. Between 2009/10 and 2010/11 there was a significant decrease in the number of crack cocaine users and the number of injectors of opiates and/or crack cocaine.

**Table 4.2** Estimated number of OCUs, opiate users, crack cocaine users and drug injectors aged 15 to 64 in England, 2004/05, 2005/06, 2006/07, 2008/09, 2009/10 and 2010/11

	2004/05	2005/06	2006/07	2008/09	2009/10	2010/11
Opiate and/or crack cocaine users	327,466	332,090	328,767	321,229	306,150	298,752
<i>Lower bound</i>	325,945	324,546	322,128	316,684	299,094	294,858
<i>Upper bound</i>	343,424	346,345	340,196	329,025	316,916	307,225
Opiate users	281,320	286,566	273,123	262,428	264,072	261,792
<i>Lower bound</i>	279,753	281,668	268,530	258,782	260,023	259,260
<i>Upper bound</i>	292,941	299,394	283,560	268,517	271,048	269,025
Crack cocaine users	192,999	197,568	180,618	188,697	184,247	170,627
<i>Lower bound</i>	188,138	190,786	175,823	182,894	177,534	165,877
<i>Upper bound</i>	210,763	208,322	189,442	196,506	195,526	176,692
Injectors of opiates and/or crack cocaine	137,141	129,977	116,809	n/a	103,185	93,401
<i>Lower bound</i>	133,118	125,786	114,637		100,085	90,974
<i>Upper bound</i>	149,144	137,034	121,279		107,544	96,757

Source: Hay et al. 2008; 2010a; 2011; 2013

### Regional differences

Similar to previous years, estimates show marked variation in prevalence rates for opiate and/or crack cocaine use across English Regions. The North West (10.83 per 1,000)<sup>86</sup> and North East (10.57 per 1,000)<sup>87</sup> had the highest rate of opiate and/or crack cocaine users per 1,000 population with the lowest rate in the South East and East of England (5.98<sup>88</sup> and 6.30<sup>89</sup> per 1,000 respectively).

While the North East had one of the highest rates of opiate use, it had the lowest rate of crack cocaine use (3.22 per 1,000 population)<sup>90</sup>, which is less than half the rate of the region with the highest prevalence, London (7.30 per 1,000 population)<sup>91</sup>.

<sup>86</sup> Confidence Interval (CI) 95% : 10.40 - 11.41 per thousand population

<sup>87</sup> Confidence Interval (CI) 95% : 10.25 - 11.38 per thousand population

<sup>88</sup> Confidence Interval (CI) 95% : 5.58 - 6.48 per thousand population

<sup>89</sup> Confidence Interval (CI) 95% : 5.62 - 7.07 per thousand population

<sup>90</sup> Confidence Interval (CI) 95% : 2.68 - 3.84 per thousand population

## Age

Since 2006/07 there has been a decrease in the estimated number of OCUs aged 15 to 24 years old and 25 to 34 years old between each of the sweeps (Table 4.3). Between 2009/10 and 2010/11 there were decreases in the estimated number of 15 to 24 year old OCUs in two out of the nine Government Regions (Hay et al. 2011; 2013). There has been an increase in the estimated number of OCUs aged over 35 years old since 2006/07. Treatment data show a similar pattern with a large increase in the number of opiate and crack cocaine users aged over 35 in treatment in England (from 63,705 in 2006/07 to 89,575 in 2010/11 representing 52%<sup>92</sup> of all OCUs in treatment in 2010/11 compared to 39% in 2006/07) (NTA 2011). This supports the suggestion that there is an ageing population of heroin users (NTA 2012a).

**Table 4.3** Estimated number of opiate and/or crack cocaine users by age group in England, 2006/07, 2008/09, 2009/10 and 2010/11

Year	15 to 24 years		25 to 34 years		35 to 64 years	
	Estimate	95% CI	Estimate	95% CI	Estimate	95% CI
2006/07	60,672	59,245-63,598	139,284	136,139-144,344	128,810	125,982-133,641
2008/09	55,145	55,104-58,618	129,141	126,101-131,926	136,943	134,091-140,083
2009/10	47,173	46,944-50,798	121,636	117,920-125,442	137,341	133,424-141,512
2010/11	41,508	39,859- 43,141	113,466	110,867 -116,238	143,778	140,952- 147,331

Source: Hay et al. 2010a; b; 2011; 2013

Despite increases in the estimated numbers of opiate and crack cocaine users aged over 35 years old, the highest prevalence rate continues to be amongst those in the 25 to 34 age group (Table 4.4).

**Table 4.4** Prevalence rate per 1,000 population of opiate and/or crack cocaine users by age group in England, 2010/11

Rate	15 to 24 years		25 to 34 years			35 to 64 years		
	95% CI		Rate	95% CI		Rate	95% CI	
6.04	5.80	6.28	16.46	16.08	16.86	6.94	6.81	7.11

Source: Hay et al. 2013

## Estimate using Bayesian methods

King et al. (2013a) estimated the number of current injectors of opiates and/or crack cocaine in England in 2005/06 using Bayesian capture-recapture methods. The authors estimate that there were 195,940 injecting drug users in 2005/06 (95% CI: 181,700-210,480). The authors note that this estimate is significantly higher than a previous estimate obtained by Hay et al. (2009) using the same data of 129,980 (95% CI: 125,790-137,030) and this discrepancy is also observed in eight of the nine regions in England. Several differences between the two analyses were noted, including that Hay et al. did not include covariate information, but the authors ultimately ascribe the previous decreased estimates to the limit of two source x

<sup>91</sup> Confidence Interval (CI) 95% : 7.01 – 7.63 per thousand population

<sup>92</sup> Of adults aged 18 years old and over

source interactions<sup>93</sup>, noting that in the new analysis the number of source x source interactions typically lay between four and six per region. In the South East, where only two source x source interactions were observed by King et al., the estimate of 15,930 (95% CI: 12,550-23,720) was noted to be similar to the 13,270 observed by Hay et al. (95% CI: 10,290-16,380) with both point estimates falling within the confidence interval for the alternative analysis.

#### 4.2.2 Estimates of problem drug use in Scotland

National and local estimates of the prevalence of problem drug use in Scotland for 2009/10 were published in autumn 2011 covering the use of opiates and/or the illicit use of benzodiazepines (ISD Scotland 2011; see UK Focal Point Report 2012). No injecting estimates were published. Updated estimates for 2012/13 (including injecting estimates) are due to be published in autumn 2014.

King et al. (2013b) estimated the number of current drug injectors in Scotland during 2006 using Bayesian capture-recapture methods.<sup>94</sup> The authors estimate that there were 31,700 injecting drug users in 2006 (95% CI: 24,900-38,700), an increase since the 2000 and 2003 estimates. However, when excluding the HCV testing data source (due to concerns about the inclusion of former injectors rather than only current injectors), the estimated number of injecting drug users decreased to 24,300 (95% CI: 20,700-35,000). The impact of the exclusion of HCV testing data source was predominantly amongst those aged over 35 years of age; a difference between 12,400 and 6,300 in 2006. This affected the interpretation of trends with a stabilisation in numbers between 2003 (n=7,500) and 2006 if excluding the HCV data source after an increase from 4,100 in 2000. Amongst those aged 15 to 34 years, the numbers were broadly similar regardless of the inclusion of HCV testing data; 22,300 in 2000; 19,900 in 2003; and 19,300/18,700 in 2006. The authors conclude that attention needs to be paid to how current IDUs are identified in cross-linked CRC data-sources; not just in relation to capturing them in the data sources but to ensuring that current injecting status is not misattributed to former injectors.

The estimates in King et al. (2013b) are slightly higher than the injecting estimates provided in the study commissioned by the Scottish Government (23,933, 95% CI: 21,655-27,143) to provide problem drug use estimates for 2006 (Hay et al. 2009). Work is still underway amongst academics to refine the methodology and definition for estimating drug injecting estimates in Scotland.

#### 4.2.3 Estimates of problem drug use in Wales

National PDU estimates for Wales for the period 2009/10 were published by the Welsh Government in October 2011 covering 'long duration or regular use of opioids, cocaine powder and/or crack cocaine' (Welsh Government 2011b; see UK Focal Point Report 2011). Work is ongoing, utilising the 2009/10 problematic drug use data for Wales, to establish and agree robust methods for estimating the prevalence of both problematic and injecting drug use in future years.

<sup>93</sup> A source x source interaction is implied where being observed by one source increases or decreases the probability of being observed by another source. In this analysis there were four sources and therefore up to six two-way interactions between them. The possibility of higher order (e.g. three-way) interactions are noted but both analyses only consider two-way interactions.

<sup>94</sup> Based on the cross-counts of 5,670 IDUs listed on four data-sources used for the national problem drug use estimates in Scotland 2006 (Hay et al. 2009): social enquiry reports (901 IDUs listed), hospital records (953), drug treatment agencies (3,504), and recent hepatitis C virus (HCV) diagnoses (827 listed as IDU-risk).

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

Combining the 2010/11 estimate for England (Hay et al. 2013), the 2009/10 estimates for Scotland and Wales (ISD Scotland 2011; Welsh Government 2011b) and the most recent estimate for Northern Ireland for 2004 (Centre for Drug Misuse Research 2006), it is possible to derive an estimate for the United Kingdom of 376,136 problem drug users, a rate of 9.15 per 1,000 population aged 15 to 64 (Table 4.5).

**Table 4.5** Estimates of the numbers of problem drug users in the United Kingdom: number and rate per 1,000 population aged 15 to 64, by country

Country	Estimate	95% Confidence Interval		Rate*	95% Confidence Interval	
England	298,752	294,858	307,225	8.65	8.54	8.89
Northern Ireland	1,395	1,316	1,910	1.25	1.18	1.71
Scotland	59,600	58,300	61,000	17.15	16.78	17.55
Wales	16,389	13,850	23,580	8.31	7.02	11.95
United Kingdom	376,136	368,324	393,715	9.15	8.96	9.58

\*Rate has been based on updated population estimates from the 2011 census so may differ from previously published rates.

Source: Centre for Drug Misuse Research 2006; Hay et al. 2013; ISD Scotland 2011; Welsh Government 2011b

#### Opiate use estimate

Estimates of opiate use for the United Kingdom have not been published previously since only England and Northern Ireland publish separate opiate estimates. However, the number of opiate users in Wales for 2009/10, derived from the capture–recapture estimate, has been provided to the UK Focal Point by Public Health Wales (PHW, personal communication). It is also possible to estimate the number of opiate users in Scotland for 2009/10 using the assumption that 90% of all problem opiate/benzodiazepine users in Scotland are opiate users.<sup>95</sup>

**Table 4.6** Estimates of the numbers of opiate users in the United Kingdom: number and rate per 1,000 population aged 15 to 64, by country

Country	Number	Pop (15-64)	lower	upper	Rate*	Lower	Upper
England	264,072	34,543,700	260,023	271,048	7.64	7.53	7.85
Northern Ireland	1,395	1,119,956	1,316	1,910	1.25	1.18	1.71
Scotland	53,640	3,475,011	52,470	54,900	15.44	15.10	15.80
Wales	13,618	1,973,100	11,002	16,734	6.90	5.58	8.48
United Kingdom	332,725	41,111,767	324,811	344,592	8.09	7.90	8.38

Source: Centre for Drug Misuse Research 2006; Hay et al. 2013; Public Health Wales 2013.

Using the most recently published data, it is estimated that there are 332,725 opiate users in the United Kingdom, a rate of 8.09 per 1,000 population aged 15 to 64 years (Table 4.6).

<sup>95</sup> This assumption has been derived from the Drug Outcomes Research in Scotland (DORIS) study, in which 906 of 1,001 problem drug users (opiate/benzodiazepine users) reported using heroin, as reported by Casey et al. 2009.

Trends in the prevalence of problem drug use in the United Kingdom

Table 4.7 shows estimates provided over time by the UK Focal Point; the dates refer to the year the estimate was produced for the UK Focal Point on Drugs rather than the year the estimate is for. Please see footnotes for the year that the estimates are for.<sup>96</sup>

**Table 4.7** Estimates of the number of problem drug users: number and rate per 1,000 population, aged 15 to 64 in the United Kingdom, by year of estimate\*

Year of estimate	Estimate	95% confidence interval		Rate	95% confidence interval	
2007 <sup>97</sup>	398,845	397,033	421,012	10.15	10.11	10.72
2008 <sup>98</sup>	403,547	395,378	423,907	10.19	9.98	10.70
2009 <sup>99</sup>	404,884	396,267	431,120	10.10	9.88	10.75
2010 <sup>100</sup>	397,346	387,536	419,949	9.79	9.55	10.35
2011 <sup>101</sup>	379,262	368,711	402,640	9.31	9.05	9.88
2012 <sup>102</sup>	383,534	372,560	406,406	9.38	9.11	9.94
2013 <sup>103</sup>	376,136	368,324	393,715	9.15	8.96	9.58

\*year of estimate refers to year in which the estimate was produced for the UK Focal Point rather than the year the estimate was for.

Source: Centre for Drug Misuse Research 2006; Hay et al. 2004; 2006; 2007; 2008; 2009; 2010a; 2011; 2013; ISD Scotland 2011; WAG 2009; Welsh Government 2011b

There has been a decrease in the number of problem drug users from 398,845 in the 2007 estimate to 376,136 in the 2013 estimate. This also represents a reduction in the rate per 1,000 population from 10.15 in the 2007 estimate to 9.15 in the 2013 estimate.

<sup>96</sup> For more information on these estimates see previous UK Focal Point Reports.

<sup>97</sup> 2007 estimate is based on estimates of opiates and/or crack cocaine use in England for 2004/05 (Hay et al. 2006), opiate use in Northern Ireland for 2004 (The Centre for Drug Misuse Research 2006), and problem drug use in Scotland, 2003 (Hay et al. 2004). Estimates for Wales are extrapolated from the estimates for England.

<sup>98</sup> 2008 estimate is as 2007 above except for England for 2005/06 (Hay et al. 2007).

<sup>99</sup> 2009 estimate is based on estimates of opiates and/or crack cocaine use in England for 2006/07 (Hay et al. 2008), opiate use in Northern Ireland for 2004 (The Centre for Drug Misuse Research 2006), opiate and/or benzodiazepine use in Scotland for 2006 (Hay et al. 2009) and long duration or regular use of opioids, powder cocaine and/or crack cocaine in Wales for 2006/07 (WAG 2009).

<sup>100</sup> 2010 estimate is based on estimates of opiates and/or crack cocaine use in England for 2008/09 (Hay et al. 2010a;b), opiate use in Northern Ireland for 2004 (The Centre for Drug Misuse Research 2006), opiate and/or benzodiazepine use in Scotland for 2006 (Hay et al. 2009), and long duration or regular use of opiates and/or cocaine in Wales for 2006/07 (WAG 2009).

<sup>101</sup> 2011 estimate is based on estimates of opiate and/or crack cocaine use in England for 2009/10 (Hay et al. 2011), opiate use in Northern Ireland for 2004 (Centre for Drug Misuse Research 2006); opiate and/or benzodiazepines use in Scotland for 2006 (Hay et al. 2009), and long duration or regular use of opiates and/or crack cocaine/ cocaine powder in Wales for 2009/10 (Welsh Government 2011).

<sup>102</sup> 2012 estimate is based on estimates of opiate and/or crack cocaine use in England for 2009/10 (Hay et al. 2011), opiate use in Northern Ireland for 2004 (Centre for Drug Misuse Research 2006), opiate and/or benzodiazepine misuse in Scotland for 2009/10 (ISD Scotland 2011), and long duration or regular use of opioids and/or crack cocaine/ cocaine powder in Wales for 2009/10 (Welsh Government 2011).

<sup>103</sup> 2013 estimate is based on estimates of opiate and/or crack cocaine use in England for 2010/11 (Hay et al. 2013), opiate use in Northern Ireland for 2004 (Centre for Drug Misuse Research 2006), opiate and/or benzodiazepine misuse in Scotland for 2009/10 (ISD Scotland 2011), and long duration or regular use of opioids and/or crack cocaine/ cocaine powder in Wales for 2009/10 (Welsh Government 2011).

### 4.3 Data on PDUs from non-treatment sources

#### Data from needle and syringe programmes in Wales

There are concerns in Wales about the growing number of people who inject steroids. Data collected through the Harm Reduction Database (see section 7.3.1) from needle and syringe exchange programmes show that around one-third of attendees were steroid injectors (Public Health Wales 2013).

#### Statistics from the Northern Ireland Addicts Index 2012

The Northern Ireland Addicts Index provides information about individuals reported to be addicted to one or more of 14 specific drugs<sup>104</sup> classified under the *Misuse of Drugs Act 1971* (PHIRB 2013). As at December 31<sup>st</sup> 2012, there were 226 individuals registered on the Addicts Index, a decrease of 17% from 2011 (n=272) following on from a 14% decrease between 2010 (n=315) and 2011. The majority of those registered were notified to the index for heroin use (83%) with 19% registering methadone use and seven per cent cocaine use. Of the 15 people registered for cocaine use, nine used heroin and cocaine.

While decreases occurred across all age groups, they were more pronounced amongst the younger age groups (aged under 29 and aged 30 to 34 years old). Similar to elsewhere in the UK, there have been increases in the percentage of problem drug users (mainly opiate users) aged over 35 years old; in 2012, people aged 35 years and over accounted for 55% of all those registered on the index compared to 25% in 1999.

Data show that 19% of all those registered on the index had been on the index for more than 10 years with 22% on the index for six to nine years. The number and percentage reporting injecting has been elevated since 2008 compared to between 2004 and 2007 and stood at 57% in 2012. Of the 56 individuals removed from the index in 2012, 23 had 'addiction ceased' as a reason while the whereabouts of the remainder were unknown.

### 4.4 Intensive, frequent, long-term and other problematic forms of use

#### 4.4.1 Problematic use amongst specific groups

##### Looked after children

Since 2006, the Department for Education<sup>105</sup> has collected information on the number of looked after children in England identified as having a substance use problem. In the year ending 31 March 2012, 4.1% of looked after children (n= 1,900) were identified as having a substance misuse (drugs or alcohol) problem compared to 4.3% in 2011 (Department for Education 2012). Substance misuse was more common amongst older children with 11.3% of looked after children aged 16 to 17 (n=1,240) who had been looked after continuously for 12 months, identified as having a substance misuse problem. In this age group, boys (12.5%) were more likely than girls (9.7%) to have a substance misuse problem.

Fifty-five per cent (n=1,040) of children identified as having a substance misuse problem received an intervention with 31% refusing an intervention. Data from the National Drug

<sup>104</sup> People are registered on the Index if they are known to be, or a medical practitioner considers them to be, addicted to one or more of 14 controlled drugs. *The Misuse of Drugs (Notification of and Supply to Addicts) (Northern Ireland) Regulations 1973* require any doctor to notify the Chief Medical Officer (CMO) of the Department of Health, Social Services and Public Safety in writing within seven days, if they attend a patient who is considered to be, or they have reasonable grounds to suspect is, addicted to any of the following controlled drugs: cocaine, methadone (physeptone), dextromoramide (palfium), morphine, diamorphine (heroin), opium, dipipanone (constituent of diconal), oxycodone, hydrocodone, pethidine, hydromorphone, phenazocine, levorphanol, piritramide.

<sup>105</sup> Previously known as the Department for Children, Schools and Families (DCSF).

Treatment Monitoring System (NDTMS) in England show that in 2011/12, 1,177 young people aged under 18 in specialist substance misuse services were recorded as being looked after, representing six per cent of all young people in treatment (NTA 2012b).

#### Injecting use of mephedrone amongst gay men

There have been reports of high-risk use, including injecting of methamphetamine and mephedrone amongst some sections of London's gay scene (Kirby and Thornber-Dunwell 2013) (see section 6.2.5).

### 4.4.2 Research

#### Factors associated with drug dependence

Macleod et al (2013) investigated the factors in early life that were associated with later injecting drug use.<sup>106</sup> All interviewees were asked the same questions about their early life to find out if they had been exposed to events, circumstances and experiences believed to influence later development of substance misuse. Many of the events and circumstances had occurred in the early lives of the PWID to a greater extent than in the early lives of the control group. Multivariate analysis showed the strongest risk factors for later drug injecting were childhood criminality and particularly having been in a young offender institution, being excluded from school, physical violence from a carer, having lived with a relative or family friend rather than a parent and having lived in care or been adopted. Sexual abuse was associated with later injecting drug use but there was a weaker association than for physical abuse. More than 70% of the risk of injecting was accounted for by the factors described and many of the circumstances described would bring the children involved to the attention of social services, making them an identifiable group of children. The authors conclude that it would be worthwhile to target prevention interventions at children in these risk categories to try to reduce the risk of both conduct problems and other adverse outcomes such as injecting drug use.

#### Use of non-prescribed methadone

Duffy and Mackridge (2013) reported on the use of non-prescribed methadone and other substances by past year methadone users and on reasons given for providing their prescribed methadone to other individuals. Sixty per cent (531) of participants reported using diverted methadone in the past year. Half said they had done so because they failed to pick up their prescription from the pharmacist, 28% because they missed an appointment with an agency or doctor, 27% to top up their prescribed dose, and 12% to self-medicate when they were not in treatment. In the four weeks prior to the interview, 92% of the participants reported using other substances (including alcohol), 85% reported using substances other than alcohol. Specifically, 66% used heroin, 58% alcohol, 47% crack cocaine, 40% cannabis, and 34% used benzodiazepines. Seventy-seven per cent of the overall sample said they had engaged in simultaneous polysubstance use in the past year, reporting use of up to nine substances at the same time. The authors highlight the risks associated with the widespread use of additional substances.

Fourteen per cent (n=123) of participants said they had provided their prescribed methadone to others in the past year. Of these, 80% said they did so to help another substance user, 25% sold it to get money to buy other substances, 13% traded the methadone for other substances (25% gave more than one reason) . A quarter of these participants said they had regularly provided their methadone to another individual.

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<sup>106</sup> They interviewed 432 people who inject drugs (PWID) and 432 controls (who did not have a history of injection drug use), matched for sex and age, recruited from the same large primary care facility in Edinburgh.

## 5. Drug-related treatment: treatment demand and treatment availability

### 5.1 Introduction

United Kingdom (UK) drug strategies identify treatment as being effective in tackling problem drug use and, therefore, seek to improve its quality and effectiveness. *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (DH and the devolved administrations 2007) continues to provide guidance for clinicians delivering drug treatment in the UK. With an increasing focus on recovery oriented treatment, UK countries have developed further guidance to support treatment delivery, including, in England, *Medications in Recovery* (NTA 2012c).

There are many types of drug misuse treatment available in the UK including community (and primary-care) based prescribing, community one-to-one and group-based psychosocial interventions to support recovery, inpatient treatment, day programmes, and quasi- and fully residential drug treatment and rehabilitation support. Prescribing for drug dependence is provided for stabilisation, detoxification, maintenance and for relapse prevention. (SQ27, part 1). The National Institute for Health and Care Excellence (NICE) also provides guidance on a number of topics.<sup>107</sup> Treatment interventions in any given area are expected to include advice and information, care planning, psychosocial interventions, community prescribing, inpatient drug treatment and residential rehabilitation. In addition, drug misusers should be offered relapse-prevention and aftercare programmes; hepatitis B vaccinations; testing for hepatitis B and C and HIV; access to hepatitis and HIV treatment; and needle exchange. Oral opiate substitution treatment with methadone is the most common pharmacological treatment used in treating heroin addiction; buprenorphine is also prescribed while injectable opiates, such as injectable methadone and injectable diamorphine, are also available but are not commonly used. Naltrexone<sup>108</sup> is recommended as a treatment option to prevent relapse in detoxified formerly opioid-dependent people who are highly motivated to remain in an abstinence programme.

Co-ordination and integration between a range of providers is seen as key in helping problem drug users reintegrate into society and all recent drug strategies in the United Kingdom focus on this area. While providing treatment remains a priority, housing, employment, education and training have also been identified as important, with new drug strategies having a much stronger focus on recovery and reintegration.

With access to effective treatment being a priority of recent UK drug strategies, treatment capacity increased substantially over the last 10 years. This has been accompanied by significant financial investment. There are initiatives to increase capacity and improve effectiveness, for example: nurse prescribing; guidance for pharmacists working with drug users; and continued encouragement to expand the role of General Practitioners (GPs) in the treatment and care of drug misusers. Increased attention is being given to measuring the health and social outcomes associated with treatments. Recently there has been an increased focus on the recovery of drug users with attempts to rebalance treatment services to support this aim.

Treatment Demand Indicator (TDI) data on numbers presenting to treatment are from four separate systems: the National Drug Treatment Monitoring System (NDTMS) in England, the Scottish Drug Misuse Database (SDMD); the Welsh National Database for Substance Misuse (WNDSM); and the Northern Ireland Drug Misuse Database. Data from the four systems are combined into United Kingdom totals for reporting to the EMCDDA. Continuous

<sup>107</sup> See: UK Focal Point Report 2010.

<sup>108</sup> A drug that blocks the effects of opioids and alcohol.

national data are available from 2003/04. From 2003/04 to 2005/06, presentations to treatment increased substantially, levelling off in 2006/07 before rising in 2007/08 and 2008/09 and decreasing since then. The majority of presentations continue to be for opiate use, although the number has decreased particularly amongst first ever presentations. This reflects, in part, the retention of opiate users in treatment, which contributes to the high penetration rate of treatment amongst this group (estimated at 64% in England during 2010/11). Cocaine powder presentations increased substantially between 2003/04 and 2008/09 before decreasing in 2009/10 and 2010/11. In 2011/12 the number of primary cocaine powder presentations increased. Cannabis presentations have increased since 2003/04, now accounting for over one-fifth of all treatment presentations and the most common primary drug amongst first ever treatment presentations.

It is estimated that, in 2011/12, TDI data on those presenting to treatment represented less than half of all those receiving drug treatment in the UK during that year.

## 5.2 Strategy and policy

### 5.2.1 Advisory Council on the Misuse of Drugs (ACMD) Recovery Committee

The Recovery Committee of the ACMD was formed in response to an invitation from the Inter Ministerial Group on Drugs (IMG). It has been created as a standing committee of the ACMD with membership drawn from the Council plus co-opted external expertise. The first report from the Committee was published in January 2013, providing an overview of the evidence on factors that contribute to recovery from drug addiction (ACMD 2013d). The purpose of the report was to 'map the terrain'. More detailed, thematic reports on the evidence will be produced in the future. The report found that recovery is complex and not a linear process and that an individual's recovery potential is influenced by a number of factors. It also found evidence that initial recovery can be helped by good quality drug treatment and mutual aid but that there was less evidence of the factors contributing to sustained recovery. The report concludes that "the evidence offers reasonable grounds for optimism that rates of recovery can be further improved, whilst also recognising that this might not be achievable for everyone".

### 5.2.2 England

#### Public Health England

On 1<sup>st</sup> April, the National Treatment Agency for Substance Misuse (NTA)'s functions transferred to a new organisation, Public Health England, an executive agency of the Department of Health. Public Health England (PHE) was established to bring together public health specialists from more than 70 organisations into a single public health service. Its role is to be an expert national body that supports local government led public health systems. Working in conjunction with local areas, it will support and enable improvements in health and well-being in the areas set out in the Public Health Outcomes Framework (DH, 2012a) and design and maintain systems to protect the population against existing and future threats to health. The alcohol and drugs section sits within the Health and Wellbeing Directorate with recovery from drug dependence as one of the directorate's priorities.

PHE has a regional structure made up of 4 regions, with 15 local Centre Teams distributed across them. The functions of the former NTA's regional teams, which supported local areas to deliver effective treatment, have transferred to these Centre Teams.

#### Public Health Outcomes Framework

The Public Health Outcomes Framework sets out the Secretary of State's strategic direction in meeting two high level objectives:

- Increased healthy life expectancy; and

- Reduced differences in life expectancy and healthy life expectancy between communities.

The indicators used are grouped under four domains: improving the wider determinants of health; health improvement; health protection; and healthcare public health and preventing premature mortality. Under the health improvement domain there are two indicators explicitly related to drugs: successful completion of drug treatment<sup>109</sup>; and people entering prison with substance dependence issues who are previously not known to community treatment. In addition, the healthcare public health and preventing premature mortality domain has an indicator on mortality from preventable causes including mortality due to drug misuse.

The indicator for successful completion of drug treatment now distinguishes between opiate and non-opiate users. Data for available indicators at England and upper tier local authority levels are available using the online Public Health England Outcomes Framework Data Tool.<sup>110</sup>

### Funding

On 1<sup>st</sup> April 2013, local authorities became responsible for commissioning public health services supported by a ring-fenced public health grant of £2.7 billion in 2013/14 and £2.8 billion in 2014/15 (see section 1.4.1). Local authorities are free to use the public health grant as they see fit with no requirement to spend allocations on substance misuse services but the allocation formula incentivises continued investment. There is a requirement that local authorities report on grant expenditure and adult and young people's drug services.

### Drugs recovery adviser

PHE appointed an international expert, Dr Thomas McLellan, to act as drugs recovery adviser and provide independent advice to PHE. Specifically the role is expected to:

- Review progress made by the English drug treatment system in relation to its orientation towards recovery as its principle aim, and make recommendations on how to maintain and accelerate progress.
- Offer independent advice to PHE on evidence-based drug treatment and prevention.
- Provide advice on current PHE work programmes including research programmes, workforce development, data collection and analysis and clinical or practice guidance.
- Assess and provide independent advice on the key risks, challenges and opportunities facing the English drug treatment system and how PHE can most effectively respond to these.

## 5.2.3 Scotland

### Review of opioid replacement therapies in Scotland

An independent expert group was commissioned by the Scottish Government to gather evidence on opiate replacement therapies and residential and community rehabilitation in Scotland.<sup>111</sup> The expert group led by the Chief Medical Officer in collaboration with the Scottish Drugs Strategy Delivery Commission was convened in October 2012 to:

- Consider evidence on opioid replacement therapies for people with drug addiction and make recommendations to the Minister for Community Safety and Legal Affairs to ensure that these interventions are being used appropriately and in line with the international evidence base as part of a person-centred, recovery-focused approach;

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<sup>109</sup> Defined as the number of drug users that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within six months.

<sup>110</sup> See: <http://www.phoutcomes.info/>

<sup>111</sup> See: <http://www.scotland.gov.uk/News/Releases/2012/10/treatment05102012>

- Examine the quality of delivery of substance misuse care, treatment and recovery services including opioid replacement therapies and community and residential rehabilitation;
- Address the impact methadone and other opioid replacement therapies are having on national progress towards delivering the recovery-orientated outcomes defined within the 'Road to Recovery' strategy;
- Re-consider the value of opioid replacement therapies and provide advice on how best to maximise outcomes achieved from all treatments;
- Articulate how positive progress is understood, identified and measured for people receiving opioid replacement therapy, including methadone; and
- Consider where further improvement or gains may be made to contribute to the quality emphasis of Phase Three of the 'Road to Recovery' Strategy.

The final report of the Expert Group was published in August 2013 (SDSDC 2013) and contained findings from a literature review of international evidence, a review of relevant guidance and standards, a survey of all Alcohol and Drug Partnerships in Scotland and evidence from a wide range of stakeholders, including users and their families. The report set out the international evidence for the provision of opioid replacement therapies and stressed the need to provide opioid replacement therapies within a flexible and mixed treatment system that provides quality of care. To achieve this, the report contained 12 recommendations under six themes: social exclusion and health inequalities; opioid replacement therapies in Scotland; progressing recovery in Scotland; governance and accountability of the delivery system; information, research and evaluation; and mechanism for change. The Scottish Government intend to prepare a response to this report by the end of 2013.

#### Waiting times target

Scotland's HEAT<sup>112</sup> target, that by March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery<sup>113</sup>, was exceeded early in the latter two quarters of 2012. National performance against the final March 2013 target was reported at 94.6%.<sup>114</sup> For 2013/14, the target has evolved to become a HEAT standard to support sustained performance. Quarterly data reports will continue to be published to assess performance and progress in 2013/14. Data from April-June 2013 shows that performance has been maintained and exceeded at a national level, with 96% of people starting treatment for drug and alcohol use within 3 weeks of their referral.

#### 5.2.4 Wales

In response to the recently published evaluation of the first three years of the strategy, the delivery arrangements within substance misuse have been reviewed and a new governance framework is in place to monitor progress in the implementation of the substance misuse strategy and associated Delivery Plan (see section 1.3.1).

An internal Substance Misuse Programme Board has been established which will provide a forum for cross-departmental scrutiny and will collectively provide assurance to the external

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<sup>112</sup> HEAT stands for Health Improvement, Efficiency, Access to Services and Treatment. It is an internal NHS performance management system that includes targets that support National Outcomes. NHS Boards are accountable to the Scottish Government for achieving HEAT targets. See: <http://www.scotland.gov.uk/Topics/Justice/law/Drugs-Strategy/recovery/HEAT>

<sup>113</sup> See:

<http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/HEATstandards/drugandalcoholtreatmentwaitingtimesstandard>

<sup>114</sup> <http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/>

Substance Misuse National Partnership Board (SMNPB) whose primary role is to ensure the strategy is implemented appropriately.

The Advisory Panel on Substance Misuse (APoSM), which was established in 2000 in order to provide expert advice to the Welsh Government on issues relating to substance misuse including alcohol has also been reviewed. As part of this process, the role, remit and current membership of the board has been strengthened and an agreed work programme will be published in October 2013.

### 5.2.5 Northern Ireland

A consultation on an Alcohol and Drug Commissioning Framework for Northern Ireland 2013-16 ran between March and April 2013.<sup>115</sup> This is currently being finalised and it is anticipated that the final document will be published later in 2013.

## 5.3 Treatment systems

### 5.3.1 Organisation

#### Payment by results (PbR) in England

The 2010 Drug Strategy published by the coalition Government (HM Government 2010) contained proposals for a trial payment by results scheme for drug and alcohol treatment in England. Payment by Results (PbR) sees providers receive financial rewards for outcomes related to a client's recovery from drug and alcohol dependence. In April 2011, it was announced that eight areas had been selected to run the pilots. A co-design group consisting of representatives from central government departments and local pilot sites was convened to develop a draft set of proposals to measure national outcomes and set eligibility criteria. A document detailing lessons learnt from the co-design stage was published in 2012, setting out reasons for adopting payment by results, the basic model for the pilots (see Figure 5.1), design details for the national outcomes, decisions on pricing and weighting and resource and support (Home Office, 2012a). The pilots 'went live' in April 2012. A report on the performance of PbR pilot sites using 11 months' treatment data concluded that, while it is too early to judge the performance of the pilots, the performance to date is mixed.<sup>116</sup> There have been improvements in rates of abstinence from presenting drug but a decrease in successful treatment completions. Other outcome domains such as improved housing situation, stopping injecting and quality of life show varied results across the different client groups<sup>117</sup>.

An evaluation of the PbR pilot schemes has been commissioned and a scoping and feasibility report was published by the commissioned team in December 2012 (University of Manchester 2012). The report covers the policy background and reviews the use of payment by results in other fields concluding that there is limited empirical evidence on which to draw when designing the research questions and hypotheses. It also critically reviews the

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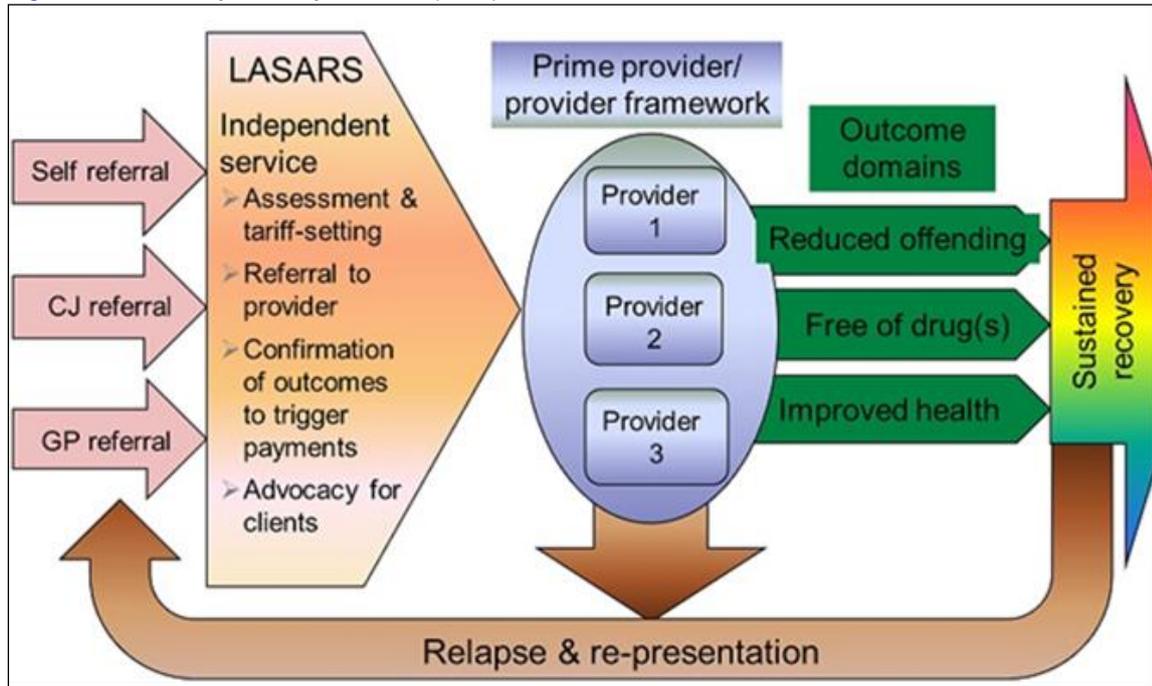
<sup>115</sup> See: <http://www.publichealth.hscni.net/alcohol-and-drug-commissioning-framework-northern-ireland-2013-16>

<sup>116</sup> See: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/194007/Agenda\\_item\\_3.2\\_-\\_Pilot\\_data\\_for\\_publication\\_on\\_the\\_web.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/194007/Agenda_item_3.2_-_Pilot_data_for_publication_on_the_web.pdf)

<sup>117</sup> There are five complexity levels for drug clients, which reflect the characteristics that impact on the likelihood of clients achieving the PbR outcomes. These factors were determined by using historical treatment data from NDTMS and the Treatment Outcomes Profile. Local Area Single assessment and Referral Systems (LASARS) are responsible for determining the complexity level of a client and setting tariffs. The factors determining complexity are gender, whether the client is pregnant, type and frequency of drug use, injecting status, education, employment, housing situation, previous unplanned exits, referral route, and well-being. The factors used to assess complexity are dependent on the items contained within assessment tools.

literature on outcome measures for those in drug and alcohol treatment including abstinence and drug-free measures. As part of the scoping and feasibility stage of the evaluation, a number of interviews with key informants were carried out.<sup>118</sup> Findings from the interviews were grouped into themes in the report, focussing on considerations when applying for the PbR pilots, experiences of the co-design process, developing and implementing the Local Area Single Assessment and Referral System (LASAR), and opportunities and challenges posed by the transition to a PbR model.

Figure 5.1 The Payment by Results (PbR) Basic Model



Source: Public Health England

The issues identified within the scoping and feasibility stage of the research have informed the refinement of the research questions for future stages of the evaluation. The research questions are grouped into three main areas in the report: service provision and the impact of recovery based outcomes; unintended impacts attributable to the adoption of PbR; and pilot schemes, funding models and costs to run.

The report concludes that the evaluation is progressing as originally planned and the research remains feasible and within the original scope of the evaluation. One change to the evaluation design has been the adoption of a different methodology for comparing pilot sites with non-pilot sites to take into account the general move towards a recovery model in England.

#### Impact of changes to the commissioning environment

The Royal College of General Practitioners (RCGP) and the Substance Misuse Management in General Practice (SMMGP) published a joint paper on the impact of the changing commissioning environment on primary care drug and alcohol treatment (RCGP and SMMGP 2012). It sets out the key themes of recovery orientated treatment and provides a self-audit check list for each of these themes.

<sup>118</sup> Interviews with 31 key informants were carried out between 15<sup>th</sup> March and 9<sup>th</sup> August 2012 comprising of at least one co-ordinator/commissioner in each pilot site and policy officials from central government.

### 5.3.2 Guidance

#### Quality standards for drug use disorders

A quality standard<sup>119</sup> for drug use disorders was issued by NICE in November 2012.<sup>120</sup> It sets out 10 quality statements across the following areas: needle and syringe programmes; assessment; families and carers; blood-borne viruses; information and advice; keyworking – psychological interventions; recovery and reintegration; formal psychosocial interventions and psychological treatments; continued treatment and support when abstinent; and residential rehabilitative treatment. Each statement includes the rationale for the statement, the quality measure, data source, what the quality measure means for each audience and definitions used in the statement. The quality standard for drug use disorders recommends that services should be commissioned from, and co-ordinated across, all relevant agencies encompassing the whole drug use disorder care pathway.

#### Consultation on improving access to substance misuse treatment for veterans in Wales

The Welsh Government issued a consultation document in May 2013 (closing August, 2013) asking for views on its proposals for improving access to substance misuse treatment for veterans as part of the Substance Misuse Treatment Framework. The document, produced by Public Health Wales for the Welsh Government, provides some background information on substance misuse in veterans and outlines actions that could be taken to improve their access to substance misuse treatment. The proposals put forward for consultation are in recognition of the high levels of mental illness, (particularly, depression, anxiety and post traumatic stress disorder) and co-occurring substance misuse, experienced by ex-service personnel (Welsh Government 2013f).

#### Joint Commissioning Panel for Mental Health

The Joint Commissioning Panel for Mental Health published guidance for commissioners of drug and alcohol services (JCP-MH 2013). The guide is structured into five chapters covering: what drug and alcohol services are; why drug and alcohol services are important to commissioners; what is known about current drug and alcohol services; and what a good drug and alcohol service looks like. The final chapter covers how the commissioning of effective drug and alcohol services can support the delivery of the Department of Health's 2011 Mental Health Strategy (DH 2011).

### 5.3.3 Recovery

#### Routes to recovery

Public Health England (2013a) published a new mapping manual called 'Routes to Recovery via the community'. The manual is a client-focused tool, designed for busy community service-based key workers who are responsible for large caseloads of people. It includes elements of effective interventions such as Motivational Interviewing and cognitive behavioural approaches. Node-Link Mapping is used as a unifying element, presenting clinical tools in a map format. It is designed to be a practical tool to support effective recovery focused interventions.

A Recovery Diagnostic Tool<sup>121</sup> has also been released by Public Health England to help partnerships understand who they have in treatment, how they are progressing and how they can optimise treatment to best support recovery. It draws on the latest NDTMS

<sup>119</sup> NICE quality standards are a concise set of statements designed to drive and measure priority quality improvements within a particular area of care. See: <http://www.nice.org.uk/aboutnice/qualitystandards/qualitystandards.jsp>

<sup>120</sup> See: <http://publications.nice.org.uk/quality-standard-for-drug-use-disorders-qs23/introduction-and-overview>

<sup>121</sup> See: <http://www.nta.nhs.uk/uploads/anoverviewoftherdt.pdf>

research and analysis to reveal the client characteristics that predict success and to expose the common barriers to recovery. It also offers clinical prompts to help partnerships to respond effectively to clients' needs based on the best available evidence, by suggesting which interventions will give people the greatest chance of overcoming dependence. A series of events were held during 2013 to demonstrate to partnerships how the tool works and how it can assist them in supporting their clients' progress.

### Wales

Last year it was reported that a specialist sub group of the Advisory Panel on Substance Misuse (APoSM) was developing a framework of recovery-oriented, integrated systems of care along with audit tools for commissioners. This guidance entitled 'Recovery Oriented Integrated Systems of Care' (ROISC) was published in October 2013 and forms part of the Welsh Government's Substance Misuse Treatment Framework.

The document is intended to provide guidance for Area Planning Boards (APB) commissioners, planners, service providers and service users on establishing integrated systems of recovery oriented service provision which will inform practice and improve outcomes for service users by:

- Setting out a clear definition of recovery to be adopted across Wales;
- Providing a clear vision of 'ROISC';
- Setting out a framework that will embed recovery in the culture of treatment provision across Wales;
- Explaining what a workforce development initiative entails and what support will be required to deliver ROISC;
- Offering a guide to tools and interventions compatible with ROISC; and
- Explaining systems of monitoring and measuring effectiveness and quality of ROISC

Recovery focused training (which was piloted last year) will now be rolled out to commissioners and providers to ensure that recovery-based approaches are integrated into core substance misuse treatment services across Wales.

### Research on recovery

Neale et al. (2013) set out to explore whether recovery-oriented treatment might be encouraging heroin users to go into detoxification and abstinence programmes before they are ready. They examined existing data from semi-structured interviews with 30 heroin users (15 men and 15 women) and analysed the findings with reference to the approach of the French social theorist, Michel Foucault. They found that some heroin users were impatient with the detoxification process and tried to reduce their dose of substitute medication faster than prescribed, resulting in relapse or addiction to other substances. Those who experienced an unsuccessful rapid detox tended to approach the next attempt more slowly. Participants all wanted to be free of heroin and substitute drugs and they seemed to learn from their own experiences and those of others, as well as through residential rehabilitation, that successful detoxification took time and effort.

In a review of evidence on recovery from addiction, Wisely (2013) argues that there is no contradiction between harm-reduction approaches to injecting drug use and recovery, but that they are complementary approaches within a framework aiming to help service users stop injecting and achieve abstinence. He suggests that injecting drug users' contact with needle and syringe services can be an opportunity for workers to build rapport and use their skills (such as motivational interviewing skills) to discourage injecting and encourage recovery even if the service user does not enter treatment. He emphasises the importance of workers developing the necessary skills to facilitate change and recovery within harm

reduction settings as well as in more formal treatment settings and argues for a national framework for recovery oriented competencies.

Duffy and Baldwin, (2013) conducted qualitative semi-structured interviews, to identify factors that played a role in recovery following drug treatment.<sup>122</sup> Most participants engaged in aftercare and a wide variety of types of aftercare were felt to be beneficial, including those offering outdoor or creative activities as well as therapeutic groups such as the 12-step programmes. Social support was identified as important and this most often came from others in recovery. Family support was mentioned less frequently but participants mentioned their desire to rebuild relationships with family, particularly with their children, as a key motivator for maintaining their recovery. Suitable accommodation was seen as vital for maintaining recovery and for many this was supported housing where they valued the availability of peer support and abstinence checks. Paid employment was a goal for many (particularly employment in drug treatment services) but there were concerns about doing this 'too soon' and provoking relapse, and also concerns about losing benefits and supported housing. The main factors perceived to be risks to continued recovery included, social situations, doing too much too soon, having too much unoccupied time, points of high emotion or stress, and practical barriers due to finances and criminal records. The researchers identified a need for those in recovery to be offered a wide range of opportunities to build a life away from substance use at a pace that is appropriate for each individual.

#### 5.3.4 Opioid substitution treatment

Data on opioid substitution treatment are in section 5.5.2 and information about the review of opioid replacement therapy treatment in Scotland can be found in section 5.2.3

#### Research

McKeganey et al. (2013) compared the efficacy of oral methadone and suboxone for reducing heroin users' days of heroin use and preventing short term abstainers from relapsing.<sup>123</sup> At study intake, Suboxone clients were more likely to be abstinent (71%) than methadone clients (38%). Amongst those still using heroin, the number of days of use did not differ significantly between the two medications. Mean number of heroin use days amongst Suboxone clients reduced from 38.6 at intake to 8.5 at follow-up while methadone clients also reduced the number of days of heroin use from 37.4 to 24.2. Suboxone clients were significantly more likely than methadone clients to cease heroin use. When controlling for other possible explanatory variables, both medications significantly reduced the number of days of heroin use. The authors conclude that the data provide evidence for prescribing services to make greater use of Suboxone although it is acknowledged that the lack of randomisation and data on baseline treatment characteristics are study limitations.

Holland et al. (2012) carried out a pilot randomised controlled trial (RCT) of various levels of supervised consumption for methadone maintenance clients<sup>124</sup>. The research demonstrated

<sup>122</sup> Data were gathered from 45 participants who had successfully completed treatment, in a variety of substance misuse treatment settings including residential rehabilitation and community treatment settings. Most (n=40) of the participants had been treated for poly-substance use and 5 had been treated for alcohol use only.

<sup>123</sup> A total of 109 opiate dependent adults were randomly selected from lists of individuals who had been prescribed methadone or suboxone for maintenance for 6 months in Glasgow and Fife in Scotland. All participants were invited to attend an interview at study intake (after 6 months of maintenance treatment) and 8 months after intake. Data were collected on demographics and drug use history with treatment motivation and self-rated physical and mental health (SF-36) also recorded using established assessment tools. Participants were split into two sub-samples: current heroin users and short-term abstainers based upon reported heroin use in the 90 days prior to study intake.

<sup>124</sup> 102 patients were identified through community pharmacists in two Scottish areas with 60 entering the study and 46 followed up after 3 months. All clients had been receiving methadone maintenance

that it is possible to carry out such a study with pharmacists willing to participate. Results suggested that increased supervision may lead to less heroin use but increase attrition. However, the pilot was not sufficiently powered to provide statistically significant results and the authors conclude that these initial findings should be tested in a large-scale multisite randomised controlled trial.

### Methadone diversion

In a study of drug treatment practitioners' perceptions of methadone diversion<sup>125</sup> and their response to it<sup>126</sup>, Baldwin and Duffy (2013) found that there was a lack of knowledge about the extent of diversion. Study participants believed that the primary reason for methadone diversion was for financial gain with doctors more likely than other practitioners to believe that clients divert methadone to drug dealers. Other possible motives included to prevent withdrawal symptoms or to top up their dose. The general opinion was that supervised consumption was the most effective way of preventing diversion with some practitioners also feeling that it protects children and vulnerable clients. However, the limitations of supervised consumption, particularly with regards to treatment engagement were also acknowledged.

Harris and Rhodes (2012) report from qualitative interviews with 37 people who inject drugs<sup>127</sup> on the ways in which participants managed their methadone use, when they were allowed to take it away rather than consume it immediately. The authors argue that their data suggest the diversion of prescribed methadone to other drug users and the use of methadone in self-regulated doses rather than the prescribed doses could have benefits for drug users. They give examples of participants trying to gradually reduce their own methadone use when they are able to take it in their own time. The authors also argue that, by hoarding methadone for times when they have withdrawal symptoms and giving methadone to other drug users who have withdrawal symptoms, participants avoided being driven to use street heroin or to share equipment.

### 5.3.5 Injectable opioid treatment

A three-year pilot programme was set up in 2012 with pilot sites in Brighton, Durham and London to explore the appropriate referral pathways into and out of injectable opioid treatment and its cost-effectiveness, with a view to informing and securing future commissioning arrangements. The pilot started in August 2012 and will end in March 2015. Outcomes to be monitored and reported are:

- Cessation or significant reduction of street heroin use.
- Reduction of offending behaviour
- Reduction of housing problems
- Achievement of quality of life score on the Treatment Outcomes Profile (TOP, see section 5.5.4) equal to or in excess of 14. Achievement of normal quality of life.
- Cessation of injecting other than the supervised injecting taking place within the programme
- Completion of a course of hepatitis B immunization, where required (or evidence of a full course within the last 5 years).
- Hepatitis C and HIV testing and, where appropriate, referral to treatment.

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for 3 months prior to study entry and were assigned to 3 groups: no supervision; twice weekly supervision; and daily supervision. All groups attended the pharmacist daily. The two primary outcome measures were retention in treatment and illicit heroin use.

<sup>125</sup> Prescribed methadone being used by someone other than the person it was prescribed for.

<sup>126</sup> Semi-structured interviews were conducted with 120 practitioners including 19 doctors, 76 key workers and 25 community pharmacists between June 2009 and August 2010 in Merseyside.

<sup>127</sup> The sample contained 37 people who inject drugs, 22 hepatitis C antibody negative and 15 antibody positive, recruited through community drug and alcohol services and drug user networks in South East and North London. Each participant was interviewed one to three times with analysis undertaken using NVivo qualitative software.

The first six outcomes are in line with the outcomes used in the Drug & Alcohol Recovery Payment by Results pilot programme. Patients failing to reduce street heroin use within 8 weeks or failing to benefit on the other parameters within the first 6-12 months may be returned to alternative treatments.

Bond et al. (2012) explored whether slow-release oral morphine (SROM) is an alternative option to oral methadone in patients being treated with injectable diamorphine who are intolerant to supplementary methadone.<sup>128</sup> The authors illustrate some of the themes related to clients' dissatisfaction with methadone, which despite being seen as working to some extent, was deemed to be insufficient, to have a different effect to heroin, to be difficult to come off and to lead to dependence on two drugs rather than one. Common themes emerging from interviews with clients after treatment with SROM were; it felt better, it improved sleep, reduced craving and was better than methadone. Some patients also believed it would be easier to detoxify using SROM. Five out of the 12 patients had more than a 20% reduction in diamorphine dose after 10 weeks using SROM, two reduced the number of days they received injectable diamorphine and one chose to use SROM only rather than go back to injectable diamorphine after a hospital stay. The average daily dose of injectable diamorphine decreased from 382.08mg to 314.75mg. The authors conclude that SROM is a valuable alternative that may provide a route to stopping injection.

#### 5.3.6 Inpatient and residential treatment

Drug-free residential rehabilitation (RR) treatment is recognised as an important element in the suite of treatment services available for those with a substance use disorder. However, the effectiveness of RR is under-researched in the UK. The Tracking Residential Addiction Clients for Effectiveness Research (TRACER) study aims to fill this knowledge gap and will be the first national prospective cohort study of RR in England open to all operational RR services. It is a five-year research study organised and funded by Public Health England and sponsored by King's College London (Addictions Department, Institute of Psychiatry).

The study plans to recruit a sample of 1,500 adults with an opioid, cocaine or alcohol use disorder at admission and will use national database registry linkage methods to evaluate health, social and crime treatment outcomes over 24 months. It aims to link positive and negative change to therapeutic characteristics and processes amongst treatment sub-populations. The clinical severity, complexity and recovery capital of participants will be recorded at intake using the Treatment Outcomes Profile (TOP) and Addiction Dimensions for Assessment and Personalised Treatment (ADAPT) tools. TOP and ADAPT data will then be linked to post-discharge addiction treatment, hospital admissions, criminal convictions and mortality data.

The Welsh Government is currently reviewing referral and assessment procedures for inpatient detoxification and residential rehabilitation services in Wales. Phase 1 of the review is now complete and a report making a number of recommendations was published in August 2013. A National Working Group has been established to support the implementations of the recommendations and to consider what the priorities should be for phase 2 of the review.

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<sup>128</sup> All 12 participants had been part of the Randomised Injectable Opioid Treatment Trial (RIOTT) (see: UK Focal Point Report 2010) and had responded to injectable diamorphine treatment and were no longer taking illicit heroin. Those receiving injectable diamorphine had also been taking oral methadone to ensure stability overnight. Participants had chosen to transfer from methadone to SROM. A case note review of interviews and medication details before and after a switch in medication from supplementary oral methadone to SROM was undertaken with post-changes recorded after a mean of 10 weeks of SROM treatment.

## Research

Millar et al. (2013) explored factors associated with the receipt of residential rehabilitation (RR) by opiate users using data from the Drug Outcomes Research Study (DTORS) in England.<sup>129</sup> Compared to those receiving community substitute prescribing (CSP), those receiving RR were more likely to have problematic use of other opiates or alcohol at baseline, been involved in acquisitive offending in the previous 12 months and less likely to be of white origin. RR clients were more likely to have a treatment goal of improving education and have a higher motivation score. The authors suggest that the higher motivation scores observed within the RR group may account for the effectiveness of RR compared to other modalities and that this needs to be considered when assessing the suitability of this treatment for the wider treatment population.

### 5.3.7 User involvement

The current Service User Involvement Treatment Framework in Wales is being refreshed. Changes to the document will be consulted upon in November 2013 and will support the seven Area Planning Boards (aligned to the Health Board Areas) across Wales to further embed service user involvement in the planning and delivery of substance misuse services.

In Northern Ireland, a Regional Service User Network group was established in 2012/13 to bring together service users in Northern Ireland. Service User representatives are now members of all relevant policy advisory and operational steering groups, and are supporting the development of policy and practice.

### 5.3.8 Substance misuse workforce

Skills for Justice<sup>130</sup> is in the final stages of development for a new competence assessment framework for the drug and alcohol workforce. It will provide information about the range of skills and knowledge that are required to work in the sector.

Skills for Health<sup>131</sup> is undertaking a review of the Drug and Alcohol National Occupational Standards (DANOS). The standards are being reviewed by a Working Group consisting of service user organisations and stakeholders who work in substance misuse services.

## Wales

As part of the commitment within the Substance Misuse Delivery Plan 2013-15 (see section 1.3.1), the Welsh Government will be revising its Substance Misuse Workforce Development Plan which is due to expire in March 2014.

## Guidance

The British Psychological Society published a guide for commissioners and service managers on the contribution that clinical psychologists can make to recovery orientated substance misuse services (British Psychological Society 2013). The guide sets out the role that clinical psychologists can play under three headings: leadership competences; practitioner competences; and effectiveness competences.

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<sup>129</sup> Opiate users who received either residential rehabilitation or community substitute prescribing (CSP) were sampled from DTORS, a cohort study with recruitment between February 2006 and March 2007 (see: <http://www.dtors.org.uk/DTORSHome.aspx>). Eligibility criteria were opiate users aged 18 to 65 years seeking drug treatment who had not yet received any treatment during the current treatment episode. The sample comprised of 406 individuals, 34 of whom received residential rehabilitation by first follow-up and 372 who received community substitute prescribing.

<sup>130</sup> Skills for Justice is the Sector Skills Council (SSC) for justice and is licensed by Government. See: <http://www.sfjuk.com/>

<sup>131</sup> Skills for Health is the Sector Skills Council (SSC) for justice and is licensed by Government See: <http://www.skillsforhealth.org.uk/>

Similar guidance on the role of doctors was published in 2012 setting out roles and responsibilities, levels of competency, and training and qualifications (Royal College of Psychiatrists 2012).

### 5.3.9 Cost-effectiveness of drug treatment

A Cost-Effectiveness Tool<sup>132</sup> has been released by Public Health England to assist partnerships to improve the cost effectiveness of their local treatment system by identifying how to use existing resources more efficiently. The tool provides local and benchmark information on the cost of treating adult drug users and supporting them during their recovery. It builds on the local value for money tool, which shows that crime falls and health improves when people are in drug treatment, complete treatment successfully, and do not return to treatment.

### 5.3.10 Addiction to Medicines

A consensus statement on addiction to medicines was published by medical bodies in January 2013 setting out the actions needed to tackle the problem.<sup>133</sup>

A national conference on addictions to medicine was held in February 2013 to consider future commissioning and provision of services for dependence on prescription and over-the-counter medicines, particularly benzodiazepines. Presentations from the conference are available online.<sup>134</sup>

In June 2013, Public Health England published a guide for NHS and local authority commissioners on commissioning treatment for dependence on prescription and over-the-counter medicines.<sup>135</sup>

### 5.3.11 Other research and commentary

Bacon and Seddon (2013) present an analysis of the use of contract-like written agreements between drug services and service users. They report widespread use<sup>136</sup> of contractual governance of drug users in treatment, (in at least 85% of local authority areas that responded to a survey) even though it is not part of the national drug policy framework. The agreements typically set out what is expected of the service user and what the service will provide in exchange but there were a wide variety of contracts used, for a variety of purposes and at different stages of treatment. Many service users were subject to a number of different agreements or contracts at the same time. The authors conclude more research is needed in order to understand *how* contracts are used in treatment services, the potential contracts may have for engaging drug users in treatment and also to understand the issues of justice and human rights associated with contractual governance with this group of individuals.

Drawing on previous research suggesting support from family and friends can improve drug treatment outcomes, Day et al. (2013) assessed the social support available to 118 patients engaged in opiate substitution treatment in four community drug teams in Birmingham. Using a cross-sectional survey of patients, selected randomly from each drug treatment service,

<sup>132</sup> See: <http://www.nta.nhs.uk/uploads/cetexternalfacingnotev1.0.pdf>

<sup>133</sup> See: <http://www.rcgp.org.uk/news/2013/january/~media/Files/News/RCGP-Addiction-to-Medicine-consensus-statement.ashx>

<sup>134</sup> See: <http://www.nta.nhs.uk/news-2013-atmconf.aspx>

<sup>135</sup> See: <http://www.nta.nhs.uk/uploads/pheatmcommissioningguide.pdf>

<sup>136</sup> The authors mapped the extent of the use of contractual agreements with drug treatment service users through a national survey of Drug and Alcohol Action Team commissioning and co-ordinating managers in England. The survey had a 62% response rate. Initial survey questions asked whether any services within the area used contract-like agreements with service users and if so, how widespread the practice was and which services used them. There were then follow-up calls and emails to add clarification and detail and some more qualitative information.

the authors explored the relationship between the level and type of patients' social support and their continued use of heroin. Most patients said they had social networks that were supportive and positive about treatment but more than half had used heroin in the past month. A multivariate analysis showed that those patients who were still using heroin, were more likely to have people in their social network who were using substances. While the study could not determine whether the association between continued heroin use and contact with other drug users was causal, it highlights the need for a better understanding of the potential role of social networks in substance misuse treatment.

Orr et al. (2012) conducted qualitative research (using interviews and focus groups) with policy makers, service providers and carers looking after drug service users. They explored the experiences and attitudes of the different groups regarding the level of involvement carers had in the treatment of their relative. Policy-makers tended to believe carers were more actively involved than either treatment providers or carers themselves felt they were. The researchers called for greater clarity and shared understanding (between policy-makers, treatment providers and carers) about the purpose and scope of carer involvement so that carers could have realistic expectations about the level of involvement treatment services could enable them to have.

Watson et al. 2013 carried out a systematic review to identify interventions for alcohol and drug use problems that had been evaluated for hospital outpatient populations (those attending hospital for problems other than substance misuse). The authors found reports of just seven studies that met their criteria, five related to interventions for alcohol problems, one for drug problems and one for both alcohol and drug problems. The lack of research in this area meant that no conclusions could be drawn regarding the effectiveness of interventions in outpatient settings for the treatment of drug misuse or combined drug and alcohol misuse.

#### **5.4 Characteristics of treated clients (Data from the Treatment Demand Indicator (TDI))**

The Treatment Demand Indicator (TDI) records the number of clients presenting to a treatment centre in a particular year but does not provide information on clients who remain in treatment without starting a new treatment episode.<sup>137</sup> Data presented are from the National Drug Treatment Monitoring System (NDTMS) in England, the Scottish Drug Misuse Database (SDMD), the Welsh National Database for Substance Misuse<sup>138</sup> (WNDSM), and the Northern Ireland Drug Misuse Database. Data are presented for the UK as a whole unless otherwise stated.<sup>139</sup> Continuous national data are available from 2003/04.

##### **5.4.1 Treatment centres**

A total of 1,705 treatment centres reported through national treatment monitoring systems in the UK during 2011/12. Of these, 83% provided outpatient services (n=1,418), nine per cent were general practitioner (GP) services (n=148) and eight per cent provided inpatient services (n=139).

Table 5.1 shows that 94% of all clients presenting to drug treatment in the United Kingdom during 2011/12 were treated in outpatient centres, similar to previous years. While the coverage of outpatient and inpatient centres within the TDI is high, the level of GP reporting is uncertain. Opiate users make up a larger proportion of clients within inpatient and GP services than within outpatient services.

<sup>137</sup> For further information about the TDI, please see the TDI Protocol document available at: <http://www.emcdda.europa.eu/html.cfm/index65315EN.html>

<sup>138</sup> Data from Wales include less structured treatments.

<sup>139</sup> Percentages quoted are valid percentages. Where missing data are substantial, this has been stated in the text.

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**Table 5.1 Primary drug by centre type in the United Kingdom, 2011/12**

Drug	Outpatients		Inpatients		GP*		Total	
	n	%	n	%	n	%	n	%
Amphetamines	2,979	2.9	59	1.8	46	1.9	3,084	2.8
Benzodiazepines	2,615	2.6	68	2.1	9	0.2	2,692	2.5
Cannabis	24,248	23.7	88	2.7	162	4.3	24,498	22.4
Cocaine powder	8,554	8.3	136	4.1	42	1.1	8,732	8.0
Crack cocaine	4,699	4.6	273	8.2	83	2.2	5,055	4.6
Opiates	55,727	54.4	2,636	79.6	3,374	90.4	61,737	56.4
Other	3,656	3.6	53	1.6	18	0.5	3,727	3.4
<i>Sub Total</i>	<i>102,478</i>	<i>100.0</i>	<i>3,313</i>	<i>100</i>	<i>3,734</i>	<i>100</i>	<i>109,525</i>	<i>100</i>
Not Known	4,260		26		3		4,289	
Total	106,738	93.8	3,339	2.9	3,737	3.3	113,814	100

\*data are for England only

Source: Standard Table 34

### 5.4.2 Characteristics of treated clients (TDI)

#### Source of referral

As in previous years, the most common source of referral amongst clients starting a new episode of treatment in 2011/12 was self-referral (30%) with referral from the criminal justice system the next most common referral source (28%). The pattern of referral was similar for all presentations and first ever presentations, although those presenting to treatment for the first time were more likely to have been referred by a GP than those who had been previously treated (10.7% compared to 7.6%).

The source of referral differs between males and females with males (31.7%) almost twice as likely to be referred from the criminal justice system as females (16.7%). The criminal justice system was the most common source of referral amongst all males but slightly lower than self-referral amongst first ever male treatment presentations. For first ever female presentations, the criminal justice system (12.2%) ranked after self-referral (32.9%), other (14.9%) and general practitioner (13.9%) as a referral source. For both all treatments and first ever treatments, females were more than twice as likely to be referred from social services as males.

#### Drugs used

In 2011/12, over half of treatment presentations in the United Kingdom were for primary opiate use, with just over one-fifth for primary cannabis use. However, the pattern is markedly different between those who report that they have been previously treated and those who do not, with cannabis now the most frequently reported primary drug amongst first ever presentations (37% compared to 11% of those reporting previous treatment). One-third of first ever treatment clients (33%) reported primary opiate use compared to around three-quarters of previously treated clients (73%). First ever treatment clients were also more likely to be primary cocaine powder users (13%) than clients who had been previously treated (5%).

Primary users of 'other stimulants' (28%) and cannabis (31%) were least likely to report being previously treated in 2011/12, while the vast majority of opiate users (77%) reported previous treatment.

In England, Scotland and Wales the percentage of treatment presentations that were primary opiate users was similar but clients presenting to treatment in Scotland were more likely to report primary benzodiazepine use (12.5% compared to 2.5% in the UK as a whole) and clients in Wales were twice as likely to report primary amphetamine use than the UK as a whole (6.3% compared to 2.8% respectively) (Table 5.2). The drug use profile of clients

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presenting to treatment in Northern Ireland was markedly different to elsewhere in the UK with cannabis the dominant drug (40.6%) followed by benzodiazepines (26.5%). Primary opiate presentations, in contrast, accounted for only 11.2% of all those presenting to treatment in Northern Ireland during 2011/12.

**Table 5.2** Number and percentage of drug treatment presentations by primary drug of use and country in the United Kingdom, 2011/12

Drug	England		Northern Ireland		Scotland <sup>140</sup>		Wales*		UK	
	n	%	n	%	n	%	n	%	n	%
Amphetamines	2,241	2.5	5	0.2	161	2.3	677	6.3	3,084	2.8
Benzodiazepines	904	1.0	624	26.5	891	12.5	273	2.5	2,692	2.5
Cannabis	20,404	22.8	957	40.6	1,397	19.5	1,740	16.2	24,498	22.4
Cocaine powder	7,449	8.3	124	5.3	321	4.5	838	7.8	8,732	8.0
Crack cocaine	4,891	5.5	2	0.1	61	0.9	101	0.9	5,055	4.6
Opiates	51,184	57.3	264	11.2	4,156	58.1	6,133	57.3	61,737	56.4
Other	2,232	2.5	379	16.1					3,727	3.4
<i>Sub Total</i>	<i>89,305</i>	<i>100</i>	<i>2,355</i>	<i>100</i>	<i>7,154</i>	<i>100</i>	<i>10,711</i>	<i>100</i>	<i>109,525</i>	<i>100</i>
Not Known	187		4		2,625		1,473		4,289	
<b>Total</b>	<b>89,492</b>	<b>78.6</b>	<b>2,359</b>	<b>2.1</b>	<b>9,779</b>	<b>8.6</b>	<b>12,184</b>	<b>10.7</b>	<b>113,814</b>	<b>100</b>

\*Data from Wales includes structured and less structured treatment

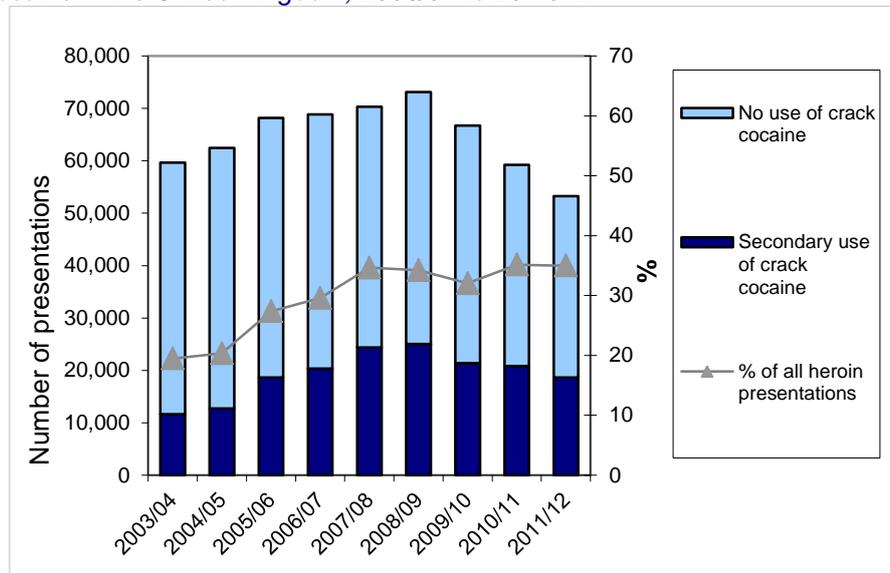
Source: Standard Table 34

### Secondary drugs

#### Crack cocaine

While there has been a decrease in the number of primary heroin presentations to treatment since 2008/09, the number of primary heroin users reporting secondary use of crack cocaine has decreased less sharply (Figure 5.2), resulting in a relatively stable trend in the percentage of all primary clients reporting secondary problems with crack cocaine (35% in 2011/12).

**Figure 5.2** Number and percentage of primary heroin presentations reporting secondary problems with crack cocaine in the United Kingdom, 2003/04 to 2011/12



Source: Standard Table 34

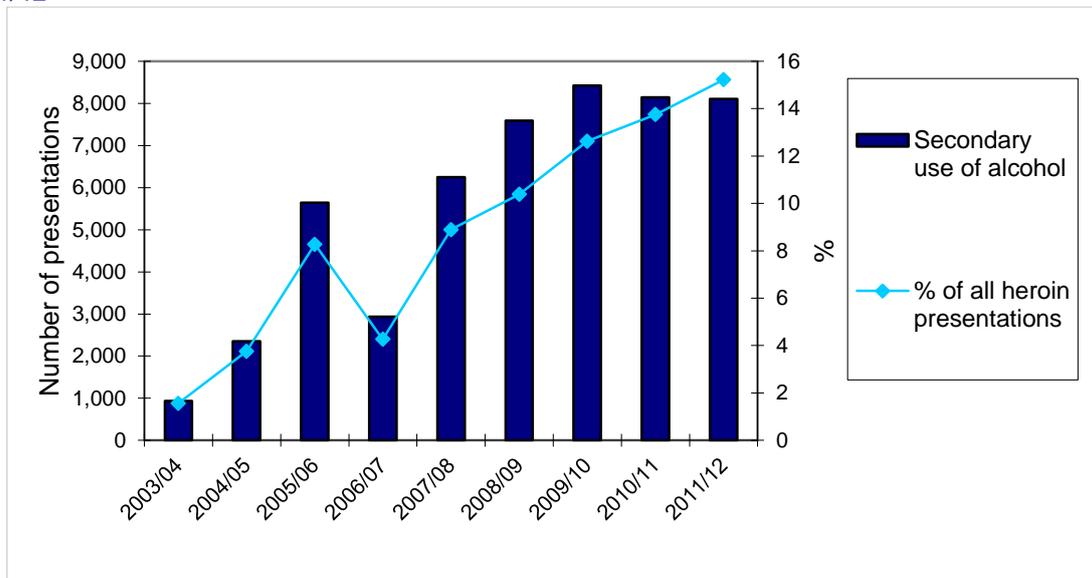
<sup>140</sup> Data presented here are from TDI data supplied to the UK Focal Point and include only presentations where the type of treatment centre could be determined. Data will therefore differ from the published SDMD data.

**Alcohol**

Primary cocaine powder clients were most likely to report secondary alcohol problems (38.2%) followed by users of other stimulants (37.5%), MDMA (37.4%) and cannabis (36.2%). This supports evidence from general population surveys suggesting a link between alcohol and drug use (Home Office 2013b; see section 2.2.1). Overall, 22% of clients presenting to drug treatment in 2011/12 reported a secondary alcohol problem with those reporting primary opiate use less likely to report secondary alcohol problems than other treatment clients.

Figure 5.3 shows an increase in the percentage of primary heroin presentations reporting a problem with alcohol (from 8.9% in 2007/08 to 15.2% in 2011/12). It is uncertain whether this reflects an increase in prevalence of alcohol problems amongst this group or whether it is due to an increased awareness of the importance of alcohol issues amongst treatment providers and a change in recording practices (see UK Focal Point Report 2011). Given the prevalence of secondary alcohol problems amongst the general treatment population and the research evidence suggests higher levels of alcohol problems amongst methadone users than the treatment data suggest (33% - Senbanjo et al. 2007), alcohol problems may be under-reported amongst this group.

**Figure 5.3** Number of reports of secondary alcohol use amongst primary heroin users and percentage of all heroin clients reporting secondary alcohol use in the United Kingdom, 2003/04 to 2011/12



Source: Standard Table 34

**Benzodiazepines**

While there has been a 22% decrease in the number of primary heroin users reporting secondary use of benzodiazepines between 2009/10 (n=7,618) and 2011/12 (n=5,937), the percentage of primary heroin users that this represents has remained stable at around 11 per cent.

The number of presentations to treatment in the UK in 2011/12 reporting a secondary benzodiazepine problem (n=8,375) was over three times as high as the number of presentations reporting a primary benzodiazepine problem (n=2,692). A large percentage of primary benzodiazepine users also reported secondary problems with other drugs; alcohol being the most frequently reported secondary drug (20.1% of primary benzodiazepine users, n=541). Amongst clients receiving drug treatment in England during 2011/12 who reported a benzodiazepine problem, only five per cent reported no other illicit drug problem (NDTMS). This mirrors the data on drug-related deaths in England and Wales for 2012, where only five

per cent of deaths mentioning benzodiazepines (13 out of 284 deaths) mentioned no other drug (ONS 2013a; see section 6.4.2).

The total number of clients reporting either primary or secondary use of benzodiazepines decreased by 10% in the past two years from 12,360 in 2009/10 to 11,067 in 2011/12. However, there was an eight per cent increase in the number of non-primary heroin clients reporting secondary use of benzodiazepines over this period (from 4,742 to 5,130).

### Age

The mean age of treatment presentations was 31.9 years in 2011/12 with first ever treatments younger (28.9 years). As in previous years (see UK Focal Point Report 2012), the age profile of cannabis users was younger with just over half (52%) of treatment presentations for primary cannabis use aged 19 years or younger.

### Age of first use

For each individual primary drug, apart from volatile inhalants and cannabis (where age of first use was lower), the mode age of first use was between 15 and 19 years old.

### Injecting status

The majority (58%) of clients presenting to treatment reported that they had never injected drugs with 14% reporting current injecting<sup>141</sup> (Table 5.3). Primary opiate users accounted for 92% of current injectors with amphetamine users accounting for three per cent. It is not possible to comment on trends in injecting status since previous data had a large number of not known/missing and it is likely that there would be a bias towards non-injectors in this group.

**Table 5.3** *Injecting status amongst all clients entering treatment in the United Kingdom, 2011/12 by gender*

Injecting status	Male		Female		Total	
	n	%	n	%	n	%
Ever injected, but not currently	22,387	28.4	7,644	28.2	30,031	28.3
Currently injecting (in last month)	11,260	14.3	3,403	12.6	14,663	13.8
Never injected	45,319	57.4	16,066	59.3	61,385	57.9
<i>Sub Total</i>	<i>78,966</i>	<i>100</i>	<i>27,113</i>	<i>100</i>	<i>106,079</i>	<i>100</i>
Not known/missing	5,624		2,111		7,735	
Total	84,590		29,224		113,814	

Source: Standard Table 34

### Living and labour status

Treatment data on living and labour status are contained in section 8.2.

### 5.4.3 TDI trends

The percentage of treatment presentations for each centre type has been relatively stable across the reported years (Table 5.4). Between 2010/11 and 2011/12 there were decreases in the number of presentations for each centre type.

<sup>141</sup> Data on current injecting are not available for Wales as the item asks for ever injected (which has been mapped to ever but not currently) and never injected.

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**Table 5.4 Presentations by centre type in the United Kingdom, 2004/05 to 2011/12**

Centre type		2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Outpatient	n	111,434	121,202	120,226	123,850	131,532	119,065	112,108	106,738
	%	94.6	94.4	93.8	93.8	94.4	93.1	93.7	93.8
GP*	n	3,402	3,833	4,303	3,833	4,151	4,988	3,810	3,737
	%	2.9	3.0	3.6	2.7	3.0	3.9	3.2	3.3
Inpatient	n	2,945	3,411	3,679	4,320	3,707	3,840	3,734	3,339
	%	2.5	2.7	2.8	3.3	2.7	3.0	3.1	2.9
Total	n	117,781	128,446	128,208	132,003	139,390	127,893	119,652	113,814
	%	100	100	100	100	100	100	100	100

\*Data for 2008/09, 2010/11 and 2011/12 are for England only; data for other years include Scotland  
Source: Standard Table 34

The number of presentations to drug treatment in the United Kingdom continues to decrease with a five per cent decrease between 2010/11 and 2011/12 (Table 5.5). This is mostly driven by a decrease in primary opiate presentations as more opiate users are retained in treatment (see section 5.5.1). The number of primary opiate users in the younger age groups (aged under 19 years old) has decreased substantially from 2,112 in 2007/08 to 690 in 2011/12, a decrease of 67% (ST34).

In contrast, after decreasing in 2010/11 following continuous increases since 2003/04, the number of primary cannabis presentations to treatment again increased in 2011/12, by five per cent. The number of primary cocaine powder presentations also increased (+3%) after decreasing in the preceding two years, following year-on-year increases between 2003/04 and 2009/10. Nevertheless, the number of primary cocaine presentations remained lower than in 2007/08.

**Table 5.5 Number and percentage of all drug treatment presentations by primary drug in the United Kingdom, 2003/04 to 2011/12**

Drug		2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Amphetamines	n	3,474	3,731	4,134	4,622	4,416	4,315	3,701	3,486	3,084
	%	3.7	3.6	3.5	3.8	3.5	3.2	3.2	3.0	2.8
Benzodiazepines	n	1,929	2,503	2,297	2,226	2,512	2,480	2,453	2,417	2,692
	%	2.1	2.4	1.9	1.8	2.0	1.9	2.0	2.1	2.5
Cannabis	n	9,849	14,801	18,793	19,108	20,938	22,884	24,112	23,378	24,498
	%	10.7	14.1	15.8	15.6	16.4	17.1	19.6	20.3	22.4
Cocaine powder	n	3,739	5,093	6,890	8,372	10,215	11,446	9,362	8,515	8,732
	%	4.0	4.9	5.8	6.9	8	8.5	7.6	7.4	8.0
Crack cocaine	n	4,980	5,842	6,857	7,096	7,453	7,985	5,517	5,562	5,055
	%	5.4	5.6	5.8	5.8	5.9	6.0	4.5	4.8	4.6
Opiates	n	66,012	70,179	77,580	77,849	78,803	82,016	74,815	68,112	61,737
	%	71.4	67.0	65.1	63.7	61.9	61.2	60.8	59.3	56.4
Other	n	2,494	2,662	2,540	2,890	3,011	2,834	3,152	3,434	3,727
	%	2.7	2.5	2.1	2.4	2.4	2.1	2.6	3.0	3.4
Sub Total	n	92,477	104,811	119,091	122,163	127,348	133,960	123,212	114,904	109,525
	%	100	100	100	100	100	100	100	100	100
Not Known	n	7,186	12,970	9,355	6,045	4,655	5,430	4,781	4,748	4,289
Total	n	99,763	117,781	128,446	128,208	132,003	139,390	127,993	119,652	113,814

Source: Standard Table 34

The decrease in primary opiate presentations to treatment is more pronounced amongst first ever treatments than all treatments with a 25% decrease between 2010/11 and 2011/12 (Table 5.6). For the first time, in 2011/12 primary cannabis presentations accounted for the highest percentage of first ever treatment presentations (37.1%). The number of first ever cannabis presentations (n=15,107) was also higher than it has been in previous years. Other

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trends worth noting are the increase in both the number of primary benzodiazepine presentations and the proportion of the overall number of first presentations they accounted for and the decrease in primary crack cocaine presentations. The trends suggest that the treatment system in the UK is expanding beyond its initial focus on opiate and crack cocaine users and attracting users of other substances. This may also be a consequence of changing patterns of drug use and the success of the treatment system in retaining opiate users in treatment and supporting their recovery.

**Table 5.6** Number and percentage of first drug treatment presentations by primary drug in the United Kingdom, 2003/04 to 2011/12

Drug		2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Amphetamines	n	1,455	1,619	1,812	2,045	1,976	1,640	1,415	1,615	1,329
	%	5.1	4.1	3.9	4.3	4.4	3.8	3.3	3.6	3.3
Benzodiazepines	n	675	1,226	1,153	916	1,285	1,074	1,270	1,406	1,586
	%	2.3	3.1	2.5	1.9	2.9	2.5	3.0	3.1	3.9
Cannabis	n	5,289	8,653	11,506	11,325	12,251	12,214	13,969	14,559	15,107
	%	18.6	22.1	24.8	24	27.2	28	32.5	32.4	37.1
Cocaine powder	n	1,683	3,016	4,197	4,951	5,980	6,581	5,345	5,107	5,268
	%	5.8	7.7	9.1	10.5	13.3	15.1	12.4	11.4	12.9
Crack cocaine	n	1,722	2,589	3,116	2,900	2,822	2,922	1,998	2,078	1,619
	%	6.0	6.6	6.7	6.1	6.3	6.7	4.6	4.6	4.0
Opiates	n	16,656	20,464	23,021	21,561	19,126	17,892	17,377	18,005	13,586
	%	57.8	52.3	50.0	45.7	42.5	41.0	40.4	40.0	33.4
Other	n	1,329	1,525	1,528	1,468	1,573	1,360	1,617	2,214	2,196
	%	4.6	3.9	3.3	3.1	3.5	3.1	3.8	4.9	5.4
Sub Total	n	28,809	39,092	46,333	45,166	45,013	43,683	42,991	44,984	40,691
	%	100	100	100	100	100	100	100	100	100
Not Known	n	1,056	3,405	3,292	1,999	1,588	1,365	1,933	2,582	2,419
	%									
Total	n	29,865	42,497	49,625	47,165	46,601	45,048	44,924	47,566	43,110
	%									

Source: Standard Table 34

### 5.5 Clients in treatment

Data on clients in treatment are currently only available from England and Wales. Scotland has started collecting data on individuals in treatment through the Scottish Drug Misuse Database (SMR25b form) but no data on total numbers receiving treatment have been published. In Northern Ireland, a census of those in treatment on a certain day is carried out every two years with the most recent carried out in 2012 (NISRA 2012; see UK Focal Point Report 2012).

It is estimated that, in 2011/12, TDI data on those presenting to treatment represented around half of all those receiving drug treatment in the UK during that year.

#### 5.5.1 Treatment prevalence

In 2011/12 there were 197,110 individuals aged over 18 years in drug treatment in England (NTA 2012d), a four per cent decrease from the previous year (n=204,473) and a seven per cent decrease since a peak of 210,815 in 2008/09. The number in treatment was 12% higher than in 2005/06 (n=175,869). The treatment system remains dominated by opiate and crack cocaine users; 49% of clients in treatment during 2010/11 were opiate only users, 32% opiate/crack cocaine users, and three per cent crack cocaine only users.<sup>142</sup> Primary

<sup>142</sup> The NDTMS collects up to three substances recorded as problematic for the client by the clinician at the point of triage. Clients citing opiates or crack at the start of any episode of treatment within their treatment journey are classed as opiate and/or crack cocaine users. These are then divided by whether they cite opiates only (i.e. without crack cocaine), crack cocaine only (without opiates) or both

cannabis users accounted for eight per cent of all treatment clients, although this rises to 32% amongst those aged 18 to 24 years. The number of primary cannabis users in treatment continued to increase, by four per cent between 2010/11 (n=14,547) and 2011/12 (n=15,194). Clients aged 18 to 24 accounted for 45% of all primary cannabis users with the number in treatment stable between 2010/11 (n=6,852) and 2011/12 (n=6,884). The largest increase was amongst those aged 30 to 34 years old, up by 11% from 1,751 in 2010/11 to 1,948 in 2011/12.

The number of over 40s in treatment increased by 90% between 2005/06 and 2011/12 and in 2011/12, 31% of all treatment clients were aged over 40 years old, 90% of whom were opiate and/or crack cocaine users. This compares to 18% and 83% respectively in 2005/06. The number of 18 to 24 year olds in treatment decreased by 59% over this period with a 46% decrease in the number of opiate and/or crack cocaine users of this age.

In 2011/12, the most common treatment pathway for treatment clients was prescribing only, which also includes basic psychosocial support through keyworking. Around one-half of clients in treatment (n=96,070) received this intervention. The next most common pathway was prescribing and psychosocial, received by 16% of clients.

Of those exiting treatment in 2011/12 (n=63,020), just under half (47%) were recorded as completing treatment free of dependency<sup>143</sup>. The percentage recorded as incomplete decreased to 28% compared to 69% in 2005/06. Eleven per cent of those exiting treatment were transferred into custody with the remainder exiting for other reasons.

#### Young people in treatment in England

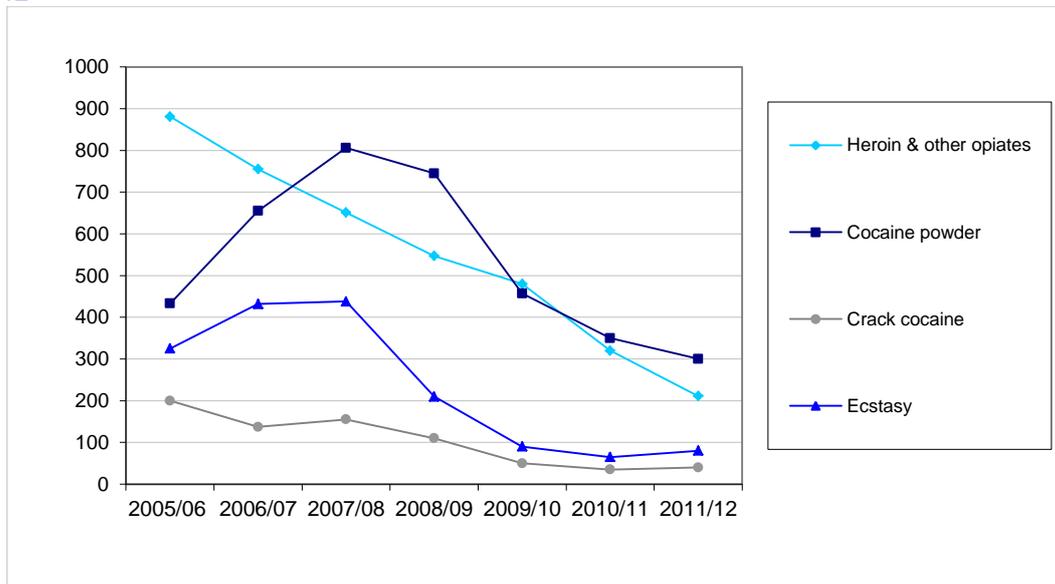
NDTMS data show that 20,688 young people under the age of 18 were in treatment in England during 2011/12 (NTA 2012b), a six per cent decrease from 2010/11 (n=21,955). Similar to the adult population, the number in treatment peaked in 2008/09 and has fallen since. Cannabis continues to be the drug for which treatment is most commonly sought amongst under 18s; 64% of those in treatment were primary cannabis users in 2011/11, an increase from 58% in 2010/11. Following a decrease in the number of primary cannabis users in 2010/11 for the first time after continued increases, the number of primary cannabis users again increased to 13,200, which was higher than before the previous year's decrease. The number of under-18s receiving treatment for primary heroin or crack cocaine use has fallen each year for the last seven years and is now one-quarter of its 2005/06 level (Figure 5.4). After a large increase between 2005/06 and 2007/08, the number of under-18s seeking treatment for cocaine powder use decreased to below 2005/06 levels.

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opiates and crack cocaine. If neither opiates nor crack cocaine are recorded within the client's treatment journey, then the first substance in the three NDTMS data items at presentation is reported in the report as the primary drug.

<sup>143</sup> Defined in NDTMS as: the client no longer requires structured drug treatment interventions and is judged by the clinician not to be using heroin (or any other opioids) or crack cocaine or any other illicit drug

**Figure 5.4** Numbers of under-18s in treatment for individual Class A drugs in England, 2005/06 to 2011/12



Source: NTA 2012b

### Club drugs

A report on club drugs<sup>144</sup> and emerging trends using treatment data from England (NTA 2012e) found that there were a total of 6,486<sup>145</sup> people receiving treatment for these drugs in 2011/12, a 39% increase since 2005/06 (n=4,656). Just under one-third of all those in treatment for club drugs were aged under 18.

Amongst those aged over 18, the analysis showed that ecstasy was the most commonly treated club drug although the number halved from 2,138 in 2006/07 to 1,018 in 2011/12. Ketamine and mephedrone numbers have risen with 751 ketamine users in treatment in 2011/12 and 900 mephedrone users. There were a further 387 ketamine users and just over 1,000 mephedrone users in treatment in 2011/12 who were under the age of 18. Between 2007/08 and 2011/12, the number of under 18s in treatment for ecstasy use decreased by 68% from 2,281 to 732.

### Data from the Welsh National Database on Substance Misuse

Data show that in 2011/12 there were 8,680 individuals receiving treatment for drug problems in Wales, an eight per cent decrease from the previous year (n=9,443). Of these, 6,902 were problem drug users with 4,979 opioid users, compared to 6,775 and 5,508 respectively in 2010/11 (ST24). Data cannot be compared to TDI data as TDI data also include individuals receiving less structured treatment.

### 5.5.2 Opioid substitution treatment

#### Data from the National Drug Treatment Monitoring System (NDTMS) in England

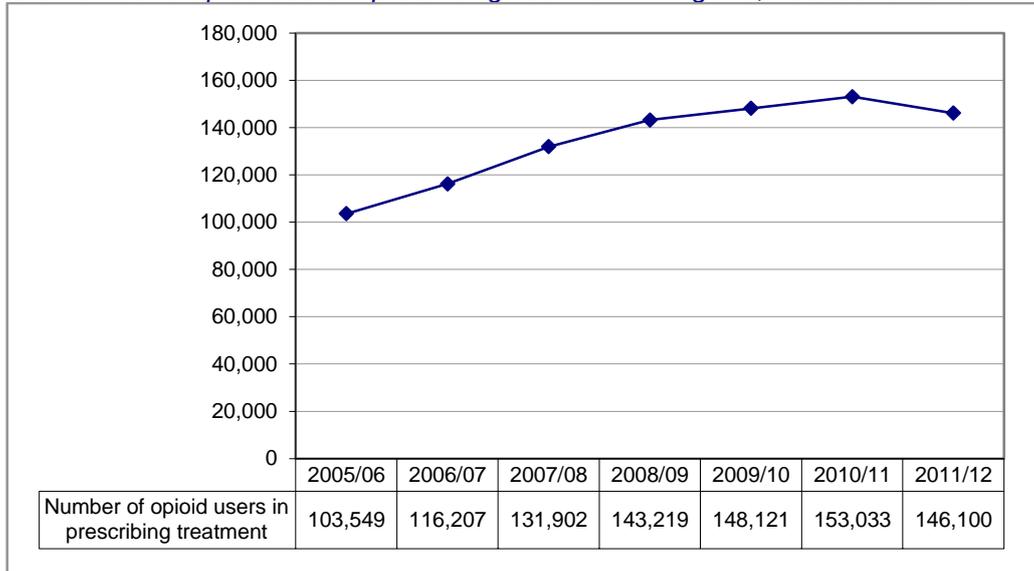
Data show that the number of opioid users in prescribing treatment in 2011/12 was 146,100, representing 92% of all opioid users in drug treatment during the year (ST24). This is a five per cent decrease from the previous year (Figure 5.5). Around two-thirds of primary opioid

<sup>144</sup> For the purposes of the report, club drugs were defined as ecstasy, GHB, ketamine, methamphetamine and mephedrone.

<sup>145</sup> Data in this publication include primary and adjunctive drugs so cannot be compared to the data based on primary drug above.

users in prescribing treatment during 2011/12 had been receiving it for more than 12 months.

**Figure 5.5** Number of opioid users in prescribing treatment in England, 2005/06 to 2011/12



Source: Standard Table 24

**Data from the Welsh National Database for Substance Misuse**

In Wales during 2011/12 there were 2,151 clients in opioid substitution treatment (OST), a similar number to the previous year (n=2,129).<sup>146</sup> Data show that 78% of those in OST received methadone and 22% received buprenorphine, a similar split to previous years (ST24).

**Research**

Badrakalimunthu et al. (2013) published results from a retrospective cross-sectional study exploring characteristics of people aged over 50 who were in an opiate maintenance programme and compared them with the characteristics of those aged under 50 from an earlier study who were part of the same programme.<sup>147</sup> The average age of first use of opiates amongst the over 50s was 28.5 years old with 11% first using opiates after the age of 50. Data showed that there were high levels of co-morbidity in the over 50s group with 62% recorded as having psychiatric problems and 64% as having physical problems. This compares with 43% and 26% respectively in the under 50 study. The prevalence of blood-borne viruses was also higher amongst the older group; 43% compared to 26% in the under 50s. The authors conclude that despite the limitations of the study design, the study has shown that there are a considerable number of patients aged over 50 and they have a distinct characteristic profile compared to the younger age group.

**5.5.3 Treatment coverage**

**England**

Using data on the number of opiate and crack cocaine users (OCU) in treatment during 2010/11 and estimates of the total number of opiate and crack cocaine users derived from

<sup>146</sup> As 2009 was the first year that opioid substitution treatment data started being collected, in some cases the data collection has not been complete. Therefore, it is not possible to calculate the proportion of opiate users in opiate substitution treatment.

<sup>147</sup> A total of 92 clients aged over 50 were admitted to the community-based maintenance treatment programme in one area in the East of England over a period of 12 months. Data were retrieved from assessment records and compared with 194 clients aged under 50 from a previous study who were in the same programme.

indirect estimation methods (see section 4.2), it is possible to estimate the coverage of drug treatment amongst the population in need. It is estimated that 58% of opiate and crack cocaine users were in treatment in 2010/11 with opiate users (63.5%) more likely to be in treatment than crack cocaine users (42.0%) (Table 5.7). There has been a slight increase in the percentage of crack cocaine users in treatment since 2009/10 and across all groups, treatment coverage has increased substantially since 2005/06 (see UK Focal Point Report 2011). Older OCUs were more likely to be in treatment than younger OCU; 62.3% of those aged over 35 were in treatment compared to 55.6% of those aged 25 to 34 years old and 32.0% of those aged 15 to 24 years old.

**Table 5.7** Opiate and crack cocaine users in drug treatment in England in 2010/11

	Estimated number of users	Number in treatment	Coverage
Opiate and/or crack cocaine users	298,752	172,139	57.6%
Opiate users	261,792	166,221	63.5%
Crack cocaine users	170,627	71,706	42.0%

Source: Hay et al. 2013; NTA 2012a

#### 5.5.4 Treatment outcomes

The Treatment Outcomes Profile (TOP) is a clinical tool that enables clinicians and drug workers to keep track of the progress of individuals through their treatment journey.<sup>148</sup> It measures drug use and gives an early indication about clients' progress in overcoming problems with work, education or housing through a set of 20 questions<sup>149</sup>. TOP was introduced in England in 2007 and has also been used in Wales since 2009. From 2008 an enhanced, web-based Scottish Drug Misuse Database (SDMD) Follow-up Reporting System was introduced in Scotland to collect information on individuals throughout their treatment not just at initial assessment. This includes details on their substance misuse and wider social circumstances and should be updated every three months.

#### England

Analysis of TOP data for clients who received a review in 2011/12 and had TOP data completed at treatment start (n=50,954), showed that 51% of opiate only users were abstinent from illicit opiates at review, 23% had improved<sup>150</sup>, 24% were unchanged and three per cent had deteriorated (NTA 2012d). Users of both opiates and crack cocaine were less likely to be abstinent (41%) and they reduced their days of illicit opiate use by less than opiate only users (mean of 12.2 days reduction compared to 15.2 days). Crack cocaine only users and cocaine powder users were most likely to be abstinent (63%) with cannabis users least likely to be so (33%).

Data also showed some improvement in employment (increase from 18% employed at treatment start to 21% at review) and housing situation (19% had a housing problem at treatment start compared to 13% at review).

#### Wales

TOP data published for Wales looks at the difference in drug use recorded in the initial TOP assessment and at exit TOP<sup>151</sup> (NWIS 2012). Of the 1,031 clients exiting treatment with primary use of heroin, 34% were abstinent from opiates and the average number of days using had decreased by 29%. One-quarter of primary cannabis users exiting treatment

<sup>148</sup> A TOP assessment is completed at treatment entry and then should be completed every three months and on treatment exit.

<sup>149</sup> See: <http://www.dtmu.org.uk/sph-files/top/TOP-form-v1.1-Aug%202008.pdf>

<sup>150</sup> The degree of change is assessed using the Reliable Change Index as described in Marsden et al. 2011 (see: UK Focal Point Report 2011).

<sup>151</sup> Clients who started and exited treatment between April 2009 and March 2012 are included in the analysis.

(n=568) were abstinent with a 34% decrease in the number of days of use. As in England, primary cocaine users (n=107) were most likely to be abstinent (56%) at treatment exit. Data also show that self-rated physical and psychological health improved as did quality of life. Across treatment modalities, all three measures improved more amongst clients undergoing inpatient detoxification or residential rehabilitation than community based treatment.

### Scotland

The first report using data from the SDMD Follow-up Reporting System was published in 2012 (ISD Scotland 2012). Due to low levels of data completeness, the results presented may not tell us about all those engaging with drug treatment services in Scotland. However, they do give a useful first picture of outcomes for those individuals for whom follow-up information is available.

For individuals who self-reported as having used illicit drugs 'in the past month' at initial assessment and who had 3 month follow-up data (1,856 in 2011/12, 1,664 in 2010/11), almost one third of these self-reported as not having used illicit drugs 'in the past month' by 3 month follow-up (32% of the 2011/12 cohort and 31% of the 2010/11 cohort). For such individuals, where there was 12 month follow-up data, 46% said that they had not used illicit drugs in the past month.

In 2011/12, at least 28% of all individuals who reported that they were homeless at initial assessment had moved into 'owner/rented accommodation', 'supported accommodation/residential rehab' or 'other accommodation' by three month follow-up. By 12 month follow-up, at least 45% of those who had been homeless had moved into accommodation (2010/11 cohort) (most conservative estimates). From 31<sup>st</sup> December 2012, all those assessed as unintentionally homeless by local authorities in Scotland became legally entitled to settled accommodation and a new housing support duty in relation to these households was introduced from June 2013.

In 2011/12, at least 4% of individuals who reported that they were unemployed at initial assessment had moved into employment by three month follow-up. In 2010/11, at least 6% had moved into employment by 12 month follow-up (most conservative estimates).

## 6. Health correlates and consequences

### 6.1 Introduction

The number of new HIV diagnoses in the UK associated with injecting drug use has been low in recent years, with 111 diagnoses reported for 2011. The overall prevalence of HIV seen amongst people who inject drugs (PWID) in 2012 was similar to that seen in recent years, and remains higher than that found in the late 1990s. The prevalence of HIV amongst the current and former PWID taking part in the Unlinked Anonymous Monitoring (UAM) survey<sup>152</sup> across England, Wales and Northern Ireland during 2012 was 1.3%. A HIV prevalence of 0.4% was found amongst PWID undergoing testing in Scotland during 2010<sup>153</sup>. This compares with a prevalence of 1.4% to 3.2% in the early to mid-1990s and 0.3% to 0.9% during the period 1998 to 2009 (PHE et al. 2013a; ST09).

The prevalence of hepatitis C infection amongst PWID remains relatively high (PHE et al. 2013a). In the UAM Survey in 2012 the hepatitis C prevalence amongst the participants in England was 49%; in Wales 33% and in Northern Ireland it was 34% (PHE 2013b). In Scotland, the estimated prevalence of antibodies to hepatitis C was 53% amongst current and former PWID surveyed at needle exchanges across the country as part of the Needle Exchange Surveillance Initiative (NESI) in 2011-12 (ST09; PHE et al. 2013b).

Prevalence and attribution of dual diagnosis remain difficult to estimate. Depression, anxiety disorders, personality and psychotic disorders are commonly reported amongst drug users, although prevalence varies with setting and specific sub-populations. Two recent studies of populations of substance misusers found around 70% had psychiatric co-morbidity (Shahriyarmolki and Meynen 2013; Delgadillo et al. 2013). It has been suggested that from 1993 to 1998 there were at least 195,000 co-morbid patients and 3.5 million general practitioner (GP) consultations involving such patients in England and Wales.

The impact of drug use on health services is difficult to measure. Hospital inpatient data are available across the UK using ICD-10 coding but no similar data exist for general practitioners or hospital emergency departments.

The impact of maternal drug use on unborn children can be wide ranging and babies can be affected by withdrawal from maternal drug use. In the United Kingdom, there is little evidence of HIV transmission to babies through maternal infection associated with drugs. However, there is a risk of hepatitis transmission, particularly of HCV, where the risk of transmission amongst babies whose mothers test positive is usually between three to five per cent although higher for women with very high HCV viral loads and also for women who are infected with HIV as well as HCV (Thorne 2011).

<sup>152</sup> The survey aims to measure the changing prevalence of HIV, hepatitis B and hepatitis C in PWID who are in contact with specialist drug agencies (e.g. needle exchange services and treatment centres). The programme also monitors levels of risk and protective behaviours amongst PWID. The data are used to assess and develop appropriate preventative and health education campaigns, evaluate the impact of such interventions, and to assist in the provision of services for PWID in the United Kingdom. Survey data have been collected annually since 1990. Each participant is asked to complete a short questionnaire and to provide a dried blood spot sample. Samples are tested for the presence of antibodies to HIV (signalling current infection), and antibodies to the hepatitis C and hepatitis B viruses (which can indicate current or previous infection). Participants are asked to provide information regarding their HIV diagnosis status (if known), their patterns of drug use (including treatment for drug addiction and participation in needle exchange services) and their sexual behaviour. This information is used to assess the association between risky activities (such as needle sharing) and the prevalence of HIV and hepatitis C amongst PWID.

<sup>153</sup> In Scotland, the prevalence of HIV amongst PWID has been monitored through the surveillance of people undergoing voluntary confidential HIV testing.

Data on drug-related deaths (DRDs) submitted to the EMCDDA by the United Kingdom are based on three different definitions. The EMCDDA definition refers to deaths caused directly by the consumption of at least one illegal drug.<sup>154</sup> The UK Drug Misuse Definition (DMD)<sup>155</sup> is where the underlying cause is drug abuse, drug dependence, or poisonings where any of the substances scheduled under the *Misuse of Drugs Act 1971* are involved. The definition used by the Office for National Statistics (ONS) is much wider and includes legal drugs.<sup>156</sup>

The UK Drug Misuse Definition has been adopted by the General Mortality Registers (GMRs) across the UK and is a subset of the ONS definition. Historical information on deaths is also available from a Special Mortality Register (SMR).<sup>157</sup> In the United Kingdom, based on the EMCDDA definition, DRDs rose steadily from 1996, when 1,152 deaths were registered. Following a period of decline between 2001 and 2003, deaths increased again between 2004 and 2008 when they reached their highest level (2,231). There has been a year-on-year decrease since 2008 and latest figures for 2012 were 1,666 deaths (compared to 1,785 in 2011).

## 6.2 Drug-related infectious diseases

Information on infectious disease is principally based on that presented in *Shooting Up: Infections amongst people who inject drugs in the United Kingdom 2013* (PHE et al, 2013a) and provided to EMCDDA in standard table 09.

### 6.2.1 HIV and viral hepatitis

#### HIV

The overall prevalence of HIV seen amongst PWID in 2012 was similar to that seen in recent years, and remains higher than that found in the late 1990s. The prevalence of HIV amongst the current and former PWID taking part in the Unlinked Anonymous Monitoring (UAM) Survey across England, Wales and Northern Ireland during 2012 was 1.3% (95% CI, 0.94%-1.7%). Between 2002 and 2012, prevalence varied between 0.93% and 1.6% (PHE 2013b; 2013c; Figure 6.1). No HIV was detected in the survey participants in Wales (95% CI, 0%-1.6%) and Northern Ireland (95% CI, 0%-2.1%) during 2012. In England, the HIV prevalence was 1.4% (95% CI, 1.1%-1.9%) in 2012, which was not significantly higher than in 2002 when prevalence was 1.0% (95% CI, 0.70%-1.5%) (PHE 2013c).

The UAM Survey indicated an overall HIV prevalence in England and Wales of 1.3% in 2012 (ST09); amongst men it was 1.4% and amongst women, 1.2%. Prevalence increased with age from 0.73% amongst those aged under 25 years to 1.7% amongst those aged 35 years and over (ST09).

There is also evidence of ongoing HIV transmission amongst PWID within the UK, and evidence that this might be higher than a decade ago. HIV prevalence amongst “recent initiates” to injecting drug use (those who first injected during the preceding three years) is an indicator of recent HIV transmission. The prevalence amongst the recent initiates

<sup>154</sup> These deaths are known as ‘overdoses’, ‘poisonings’ or ‘drug-induced deaths’. See: <http://www.emcdda.europa.eu/themes/key-indicators/drd>

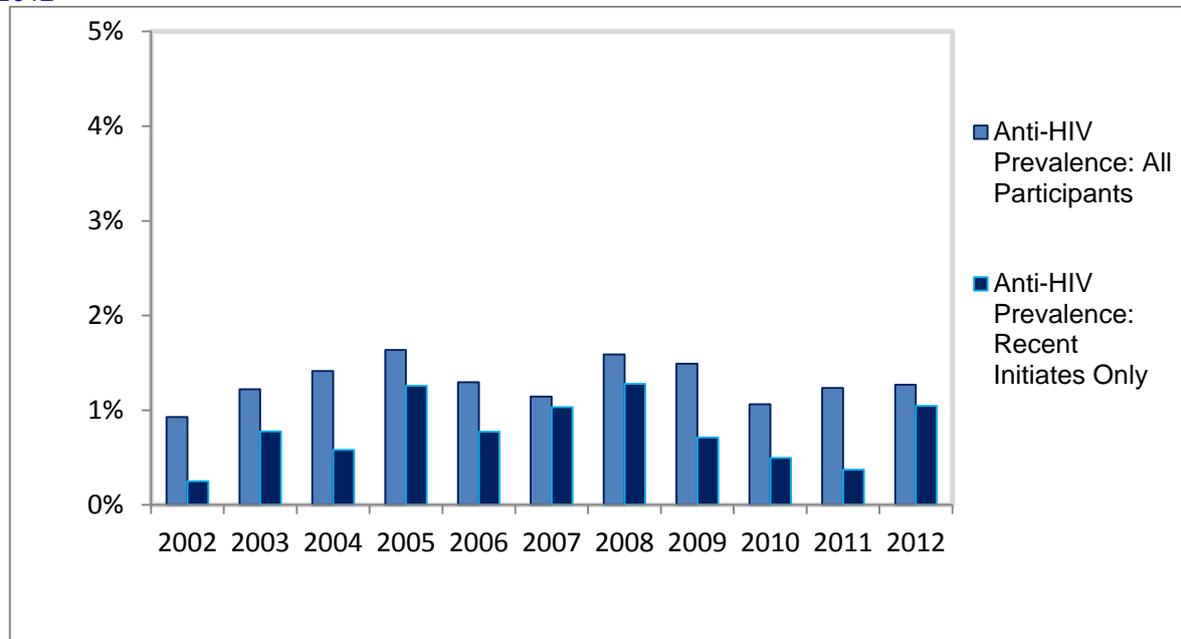
<sup>155</sup> Formerly known as the Drug Strategy Definition (DSD) and originally adopted to measure progress against an aim in a former UK Drug Strategy (HM Government 2002; UK Focal Point on Drugs Reports 2003-2011)

<sup>156</sup> For ONS definitions See: ONS (2013) <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-314585>

<sup>157</sup> The National Programme on Substance Misuse Deaths (np-SAD) published data until 2011 from inquests into drug-related deaths reported by coroners in England, Wales, Northern Ireland, Guernsey, Jersey and the Isle of Man; Procurators Fiscal in Scotland and the Scottish Crime and Drug Enforcement Agency.

participating in the UAM Survey across England, Wales and Northern Ireland was 1.0% (95% CI, 0.29%-2.7%) in 2012. This is similar to that found in recent years, but higher than in the late 1990s. This finding indicates that HIV transmission is continuing to occur amongst PWID (PHE 2013b; 2013c; Figure 6.1).

**Figure 6.1** Prevalence of antibodies to HIV amongst all participants and recent initiates\* in the Unlinked Anonymous Monitoring Survey of PWID: England, Wales and Northern Ireland, 2002 to 2012



\*A recent initiate is someone who first injected during the preceding three years  
Source PHE 2013b

In Scotland, the prevalence of HIV amongst PWID has been monitored through the surveillance of people undergoing voluntary confidential HIV testing. An HIV prevalence of 0.4% was found amongst PWID undergoing testing in Scotland during 2010. This compares with a prevalence of 1.4% to 3.2% in the early to mid-1990s and 0.3% to 0.9% during the period 1998 to 2009 (PHE et al. 2013a; ST09).

The number of new HIV diagnoses in the UK associated with exposure through injecting drug use has been low in recent years, with an annual average of 162 reports between 2002 and 2011. Up to the end of June 2013, 111 new HIV diagnoses had been reported with this exposure for 2012 (39 in London, 14 in Scotland and 58 elsewhere in the UK (PHE et al. 2013a).

### Hepatitis C

The prevalence of hepatitis C infection amongst PWID remains relatively high (PHE et al. 2013b). The overall prevalence of antibodies to hepatitis C amongst the current and former PWID participating in the UAM Survey<sup>158</sup> across England, Wales and Northern Ireland in 2012 was 47% (95% CI, 46%-49%). This is higher than the anti-HCV prevalence of 42% (95% CI, 41%-44%) seen in 2002 (PHE 2013c; Figure 6.2). In England in 2012, the hepatitis C prevalence amongst the participants in the UAM Survey was 49% (95% CI, 47%-51%);

<sup>158</sup>Prior to 2009 this survey only collected oral fluid samples, however in 2009 and 2010 both oral fluid and dried blood spot (DBS) samples were collected from participants. From 2011, only DBS samples have been collected. The sensitivity of the test on DBS samples for antibodies to hepatitis C is almost 100%. However, the sensitivity of the oral fluid sample test for antibodies to hepatitis C is about 92%. Results presented are adjusted to allow for the poorer sensitivity of the tests on the oral fluids samples.

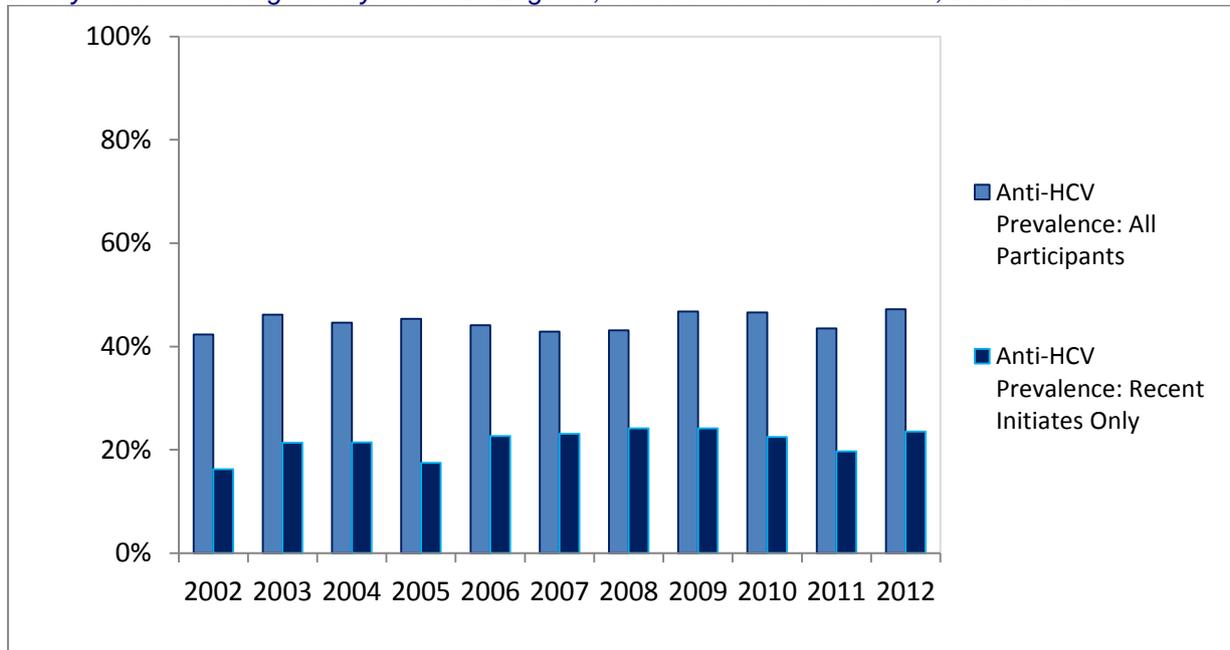
however, there were very marked regional variations from 33% in the North East region to 64% in the North West region (PHE 2013b). The prevalence in Wales and Northern Ireland was lower than in many of the English regions; in 2012, the hepatitis C prevalence amongst the UAM Survey participants in Wales was 33% (95% CI, 27%-39%) and in Northern Ireland it was 34% (95% CI, 27%-41%) (PHE 2013b).

In 2012, 48% of the PWID participating in the UAM Survey in England and Wales had antibodies to hepatitis C (ST09); 49% amongst men and 46% amongst women. Prevalence increased with age, from 23% amongst those aged under 25 years to 58% amongst those aged 35 years and over (ST09).

The prevalence of antibodies to hepatitis C amongst recent initiates in England, Wales and Northern Ireland (those injecting for less than three years) has been elevated in recent years. In 2012, amongst those in this group who participated in the UAM Survey from throughout England, Wales and Northern Ireland, the prevalence was 24% (95% CI, 20%-28%) and similar to that seen in recent years (PHE 2013c; Figure 6.2). However, the prevalence amongst this group is higher than in 2002 (16% (95% CI, 13%-20%) and earlier years (PHE 2013b; 2013c).

In Scotland, the estimated prevalence of antibodies to hepatitis C was 53% amongst current and former PWID surveyed at needle exchanges across the country as part of the Needle Exchange Surveillance Initiative (NESI) in 2011-12 (ST09; PHE et al. 2013b). Prevalence increased with age, from 26% amongst those aged under 25 years to 62% amongst those aged 35 years and over (ST09). The prevalence amongst the recent initiates (i.e. who had commenced injecting in the previous three years) was 20% (PHE et al. 2013b). These are similar to the levels found in the previous NESI survey in 2008/09 (PHE et al. 2013b).

**Figure 6.2** Prevalence of anti-HCV amongst all participants and recent initiates\* in the Unlinked Anonymous Monitoring Survey of PWID: England, Wales and Northern Ireland, 2002-2012



\*A recent initiate is someone who first injected during the preceding three years  
Source PHE 2013b

Newly diagnosed hepatitis C infections in the UK are principally monitored through laboratory reports rather than through the use of statutory notifications. Whilst data from both of these types of systems have limitations, laboratory reports are regarded as being more useful, however risk factor information is often missing or incomplete. There has been

a marked increase in the annual number of new diagnoses throughout the UK reflecting the increased availability and easier access to voluntary confidential testing (see section 7.3.3). In the UK, since reporting began, there have been over 150,000 reported laboratory diagnoses of hepatitis C infection; with around nine-tenths of these infections thought to be associated with injecting drug use. In 2012, there were 13,477 laboratory diagnoses of hepatitis C infection in the UK; 10,873 in England, 1,991 in Scotland, 480 in Wales, and 133 in Northern Ireland (PHE et al. 2013b; ST09).

In England, Wales and Northern Ireland, recent transmission of hepatitis C has been explored amongst the participants in the UAM Survey of PWID by looking for those who have recently developed antibodies to hepatitis C. This has been undertaken by testing the hepatitis C positive samples for antibody avidity. Preliminary work suggests that antibodies with weak avidity, in the presence of hepatitis C RNA, are likely to be from individuals who have a recent primary infection. The length of time that samples from recently infected individuals will have antibodies with weak avidity is unclear, but this state may last from two to six months. During 2011-12, 3.3% (95% CI, 2.6%-4.1%) of the participants in the UAM Survey that could have recently acquired hepatitis C<sup>159</sup> were found to have a probable recent primary infection (PHE et al. 2013b). These data are consistent with an incidence of hepatitis C infection amongst PWID in England, Wales and Northern Ireland of between 7 and 20 infections per 100 person years of exposure (PHE et al. 2013b).

In the very early stages of hepatitis C infection, individuals have high levels of viraemia prior to developing antibodies, often referred to as the viraemic pre-seroconversion window. During this relatively short period, individuals will test hepatitis C antibody negative but RNA positive. In Scotland, amongst PWID participating in the NESI survey at NSPs during 2011-12 who were hepatitis C antibody negative, 0.9% were found to be RNA positive; lower than the level amongst PWID surveyed in 2010 (1.5%) and 2008-2009 (2.1%) (PHE et al. 2013b). Assuming a viraemic pre-seroconversion window period of 51 days, the incidence of hepatitis C infection amongst PWID across Scotland is estimated at 6.1 per 100 person years during 2011-12 (PHE et al. 2013b).

### Hepatitis B

Overall about one in six PWID has ever had hepatitis B infection. In 2012, 17% (95% CI, 15%-18%) of the current and former PWID who took part in the UAM Survey in England, Wales and Northern Ireland had antibodies to hepatitis B core antigen (anti-HBc, a marker of previous or current hepatitis B infection)<sup>160</sup>; this is lower than in 2002 when prevalence was 29% (PHE 2013b; 2013c; Figure 6.3). The prevalence of anti-HBc varied by country; in 2012 the prevalence in England was 18% (95% CI, 16%-19%; down from 31% in 2002), in Wales it was 10% (95% CI, 6.6%-14%; it had been 12% in 2002), and in Northern Ireland it was 5.8% (95% CI, 3.2%-10%; it had been 3.1% in 2003/04) (PHE 2013b; 2013c). The overall decrease may reflect the impact of increased uptake of the hepatitis B vaccine amongst injecting drug users (PHE 2013b; see section 7.3.5).

The samples collected by the UAM Survey of PWID during 2012 that had anti-HBc detected were also tested for hepatitis B surface antigen (HBsAg), a marker of current infection. The

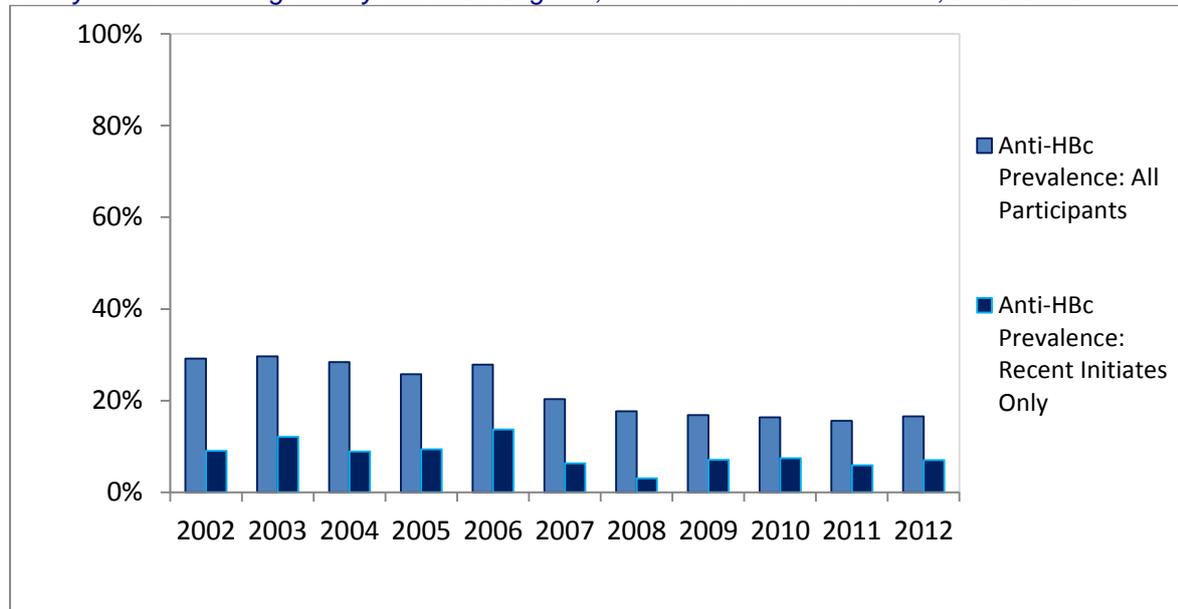
<sup>159</sup> That is those participants that were either hepatitis C antibody negative or antibody positive with weak avidity and hepatitis C RNA also present. Those taking part in 2012 who reported participating in 2011, and those anti-HIV positive, were excluded.

<sup>160</sup> Prior to 2009 this survey only collected oral fluid samples, however in 2009 and 2010 both oral fluid and dried blood spot (DBS) samples were collected from participants. From 2011, only DBS samples have been collected. The sensitivity of the test on DBS samples for antibodies to hepatitis C is almost 100%. However, the sensitivity of the Oral Fluid sample test for antibodies to hepatitis C is about 75%. Results presented are adjusted to allow for the poorer sensitivity of the tests on the Oral Fluids samples.

proportion of samples from the UAM Survey of PWID with HBsAg is an indicator of the prevalence of current hepatitis B infection amongst PWID. In 2012, of the samples with anti-HBc 5.7% (95% CI, 4.1%-7.9%) had HBsAg detected indicating current infection; this represents 0.94% (95% CI, 0.67%-1.3%) of all the PWID surveyed in England, Wales and Northern Ireland that year (PHE 2013c).

The number of diagnosed hepatitis B infections in the UK is principally monitored through laboratory reports rather than through the use of statutory notifications. In England, a total of 554 acute or probable acute hepatitis B cases were reported from health protection units and laboratories in 2012 (PHE 2013e). Of the cases that had associated exposure information (n=332), only five (1.5%) were associated with injecting drug use (PHE et al. 2013a; PHE 2013e). Overall, heterosexual exposure (58%) and homosexual exposure (17%) were the most commonly reported routes of infection (PHE 2013e). In 2002, 37% of the acute hepatitis B cases reported in England were associated with injecting drug use, though it should be noted that these data were from a different system (PHE et al. 2013a).

**Figure 6.3** Prevalence of anti-HBc amongst all participants and recent initiates\* in the Unlinked Anonymous Monitoring Survey of PWID: England, Wales and Northern Ireland, 2002-2012



\*A recent initiate is someone who first injected during the preceding three years  
Source PHE 2013b

In Scotland and Northern Ireland, reported hepatitis B diagnoses encompass both acute and chronic infections. In Scotland, there were 886 reports in 2012 compared to a total of 354 in 2002. The increase in reports over time probably reflects a rise in chronic cases being clinically recognised. The percentage of reports indicating injecting drug use as the main risk factor has declined over time from 11% in 2002 to 0.9% in 2012 (PHE et al. 2013a; ST09); however, as risk factor information is rarely provided, this decline needs to be interpreted cautiously. In Northern Ireland, a total of 111 infections were reported in 2012, of which 18 were known to be acute. Some of these infections will have been related to injecting drug use; however, risk factor information is not available (PHE et al. 2013a; ST09).

Together these data indicate that current hepatitis B infection amongst PWID in the UK is rare.

### Blood borne viral infections amongst male injectors of image and performance enhancing drugs

The injection of image and performance enhancing drugs (IPEDs), such as anabolic steroids, is not new, but may have become more common over the last decade (ACMD 2010a). A study in the 1990s indicated that the injecting risks associated with IPED use were much lower than those for psychoactive drug injection and that infections were rare (no HIV was found and 2.7% had ever been infected with hepatitis B) (Crampin et al. 1998). This possibly reflects that IPEDs, when compared to psychoactive drugs, are injected less frequently, injected subcutaneously or intramuscularly, and are generally easier to prepare for injection.

In response to the increasing number of IPED injectors using Needle and Syringe Programmes (NSPs) - IPED injectors are now the largest group of NSP users in some areas (ACMD 2010) - a voluntary unlinked-anonymous survey of male IPED injectors was undertaken during 2010-11. This survey recruited 395 participants through 19 NSPs in England and Wales (Hope et al. 2013). The most frequently injected IPEDs were reported to be anabolic steroids (86%) and growth hormone (32%); although the participants reported injecting a range of other drugs including melanotan (8.6%) and insulin (5.6%). The men surveyed also reported recent use of psychoactive drugs, with the non-injecting use of cocaine reported by 46% and amphetamine by 12% (Hope et al. 2013). One in 20 (5%) had ever injected a psychoactive drug (Hope et al. 2013).

Testing of the oral fluid sample collected in the survey indicated that overall 1.5% had HIV, nine per cent had been infected with hepatitis B, and five per cent had antibodies to hepatitis C (Hope et al 2013). After excluding those who reported a male sexual partner or who had ever injected psychoactive drugs, 0.8% had HIV, eight per cent had ever been infected with hepatitis B, and five per cent had antibodies to hepatitis C (Hope et al. 2013). These findings suggest that infection levels amongst IPED injectors in England and Wales may be higher than 15 years ago, and that the HIV prevalence is currently similar to that amongst injectors of psychoactive drugs.

The prevalence of blood-borne virus infections amongst IPED injectors in Scotland and Northern Ireland is currently not known.

### Research

#### *Under reporting of injecting risk*

Analyses of multiple data sources suggests that injecting drug use (IDU) may be under reported amongst individuals with diagnosed hepatitis C in Scotland (McDonald et al. 2013a). Using log-linear capture-recapture modelling with data on IDU risk from four linked data sources, the proportion of those individuals in Scotland (1991-2010) with diagnosed hepatitis C antibody-positive who had probably acquired their infection through injecting drug use was estimated. Existing data showed 14,836 (58%) of 25,521 hepatitis C diagnosed individuals had reported IDU risk, but the modelling estimated IDU risk in an additional 2,484 of the diagnosed individuals. Stratified analysis by birth showed that the estimated prevalence was 49% in those born before 1960, but as high as 90% for those born after 1960. The authors suggest this provides a more complete picture of the transmission route amongst Scotland's hepatitis C infected population and that this will help with targeting interventions.

#### *Risk of reinfection with hepatitis C amongst injecting drug users in Glasgow*

McDonald et al. (2012) used HCV test results covering the Greater Glasgow Health Board from 1993 to 2007 to compare the rate of HCV infection in injecting drug users (IDU) who had previously been infected with HCV, with the rate in those who had not previously been infected, in a large sample of 1,176 IDUs. A test result showing the presence of HCV

antibodies indicated previous HCV infection and a test showing HCV RNA indicated an acute infection. The study found a rate of reinfection of 7 in 100 person/ years (95% CI:5-9) in IDUs who were HCV antibody positive and RNA- negative at baseline and a rate of infection of 10 in 100 person/years (95% CI:9-12) in those who were HCV antibody negative at baseline. This difference in rates was not statistically significant, indicating no strong evidence for a difference in risk of infection between those who had previously had HCV infection and those who had not.

#### *Association between sharing injecting equipment and hepatitis C infection*

Palmateer et al. (2013a) aimed to summarise and identify possible explanations for the variation found amongst different studies in the strength of association between HCV infection prevalence/incidence and self-reported sharing of needles and syringes (N/S) amongst PWID. They carried out a review and meta-analysis of studies undertaken in Europe between 1990 and 2011 reporting HCV prevalence (or incidence) and N/S sharing behaviour. Amongst PWID who reported never or not recently sharing N/S, pooled HCV prevalence was 59% and incidence was 11%. This high level of infection was thought to be due to a combination of under reporting of N/S sharing and unmeasured risk factors such as: sharing of other injecting paraphernalia; needle stick injuries; sexual contact; and tattooing with dirty equipment. The random effects meta-analysis produced a pooled odds ratio of 3.3 (95% CI 2.4 - 4.6) comparing HCV infection in those who had shared N/S (ever or recently) with those who reported never or not recently sharing N/S. When the studies were stratified by recruitment setting (prison vs treatment service), recruitment by outreach vs non-outreach, sample HCV prevalence, and sample mean /median time since first injecting, this produced differences in pooled odds ratios. This suggests that such aspects of study population and design will influence the size and strength of association between HCV and N/S sharing.

#### *Alcohol use and hepatitis C infection amongst people who inject drugs (PWID) in Glasgow*

In a cross-sectional interview survey of PWID attending harm-reduction services in Glasgow, O'Leary et al. (2012) found an association between self-reported alcohol use and hepatitis C status. Respondents were asked about their HCV antibody status and 780 also had a saliva test carried out at the time of the survey; 65% tested positive for HCV salivary antibodies. A similar proportion of those who tested HCV antibody positive and those who tested negative, drank alcohol (65% compared to 61%) but 29% of those who tested HCV antibody positive drank to excess<sup>161</sup> compared with 18% of those who tested negative (  $p < 0.001$ ). Those who self-reported that they were HCV positive, were less likely to drink at all than those who self-reported as negative or unknown status but all groups were as likely to drink to excess. Other factors significantly associated with excessive drinking included incarceration, homelessness and having started injecting more than ten years before the interview. The authors highlighted that HCV infected PWID have a particular need for greater support to reduce their alcohol consumption.

### 6.2.2 Tuberculosis

In 2012, there were 8,751 cases of tuberculosis (TB) reported in the UK, an incidence of 13.9 cases per 100,000 population (PHE 2013d). Rates of TB have remained fairly stable in the UK since 2005 but the incidence of TB remains high compared to most other Western European countries. Two-fifths (39%) of the cases in the UK were in London, (as in previous years). Amongst the cases with known information on the four 'social risk factors' monitored, 2.8% (228/8,019) had a history of problem drug use, 3.2% (255/7,947) of alcohol misuse/abuse, 2.4% (194/8,088) of homelessness, and 2.8% (225/7,918) had a history of imprisonment. Overall, 7.7% of TB cases (637/8,321) had at least one of these social risk

<sup>161</sup> Respondents were categorised as drinking to excess if they exceeded the UK College of Physician's (2001) recommended weekly limits of 14 units per week for women and 21 units per week for men.

factors; with around one in three (195/637) having more than one risk factor (PHE 2013d). A higher proportion of UK-born TB cases had at least one social risk factor than non UK-born cases (13.4% versus 5.4%).

### 6.2.3 Infections due to spore-forming bacteria

Severe infections in PWID caused by spore-forming bacteria have been a problem in the UK and several other European countries over the last decade (Hope et al 2012).

Between June 2012 and the end of March 2013, 15 cases of anthrax were reported amongst PWID in Europe. Of these cases, five were in England, two in Scotland, and one in Wales; with six of the eight UK cases occurring in 2012. These cases are thought to be linked with exposure to heroin contaminated with anthrax spores. There were no cases of anthrax reported in heroin users in the UK during 2011. Prior to that, there had been an outbreak of anthrax amongst drug users in Europe during 2009-10, with a total of 52 confirmed cases (there were also a further 35 probable and 37 possible cases in Scotland) reported amongst heroin users in the UK (PHE et al. 2013a).

In 2012, there were two reported cases of wound botulism amongst PWID in the UK; this brings the total number of reported wound botulism cases since 2000 to 165 (PHE et al. 2013a). There were no reported cases of tetanus in PWID in 2012; a total of 35 cases of tetanus in PWID had been reported between 2000 and 2011 (PHE et al. 2013a).

### Research

The rates of infections caused by four spore-forming bacteria (botulism, tetanus, *Clostridium novyi* and anthrax) amongst PWID across England and Scotland from 2000 to 2009 have been estimated (Palmateer et al. 2013b). A total of 295 infections known to be caused by spore-forming bacteria (157 botulism, 33 tetanus, 92 *C. Novyi*, and 13 anthrax) were reported amongst PWID in this period, corresponding to an overall infection rate of 1.83 cases per 1,000 PWID. Two-thirds (199) were in England (a rate of 1.45 per 1,000 PWID), and one third were in Scotland (a rate of 4.01 per 1,000 PWID). The higher rate in Scotland was mainly due to *C. Novyi* and anthrax while rates of botulism and tetanus were similar in Scotland and England. Infection rates also varied in each of the countries. The number of reported cases for different infections varied over time, with the *C. Novyi* and anthrax infections clustered. The authors suggest the clustering of these cases into outbreaks could be due to possible contamination of specific heroin batches, whereas the more sporadic occurrence of tetanus and botulism suggests the spores are more commonly present in the drug supply or environment. The authors discuss the role of particular injecting practices such as injecting into skin or muscle, excessive use of citric acid, and the role of demographic factors in increasing vulnerability to these infections. They recommend that health care professionals should encourage PWID to seek treatment, should educate those who continue to inject on infection prevention and remain vigilant for signs of infection, reporting any occurrences promptly.

### 6.2.4 Other injection related bacterial infections

Cases of severe infections caused to both *Staphylococcus aureus* and Group A streptococci continue to occur amongst PWID in the UK (PHE et al. 2013a). For example, data from the mandatory enhanced surveillance of *Staphylococcus aureus* bacteraemia in England indicate that amongst those reports with risk factor information (which is optional), 8.6% of the meticillin sensitive *Staphylococcus aureus* and 3.1% of the meticillin resistant *Staphylococcus aureus* reported injecting drug use as a risk in 2012 (PHE et al. 2013a).

In May 2013, the Scottish Drugs Forum warned of two lethal cases of necrotising fasciitis and another possible case amongst injecting drug users in Lanarkshire. The report included prevention and treatment advice.<sup>162</sup>

In 2012, over one-quarter (29%) of PWID participating in the UAM Survey in England, Wales and Northern Ireland reported that they had experienced an abscess, sore or open wound, all possible symptoms of an injecting-site infection, during the preceding year (PHE et al. 2013a; PHE 2013b). In 2012, more women reported an injection-site symptom than men; 32% of women reported a symptom compared with 29% of men (PHE 2013b; 2013c).

### Research

A retrospective cohort study was undertaken at a central London Hospital to establish the clinical reasons for inpatient admissions amongst PWID and to estimate the financial implications of injecting drug use for the health service (Marks et al. 2013). Clinical, laboratory and financial data were extracted from hospital case notes and electronic records. The study found that between 2005 and 2009, 124 people who injected drugs had been admitted at least once; with a total of 191 admissions to the hospital. The most common reasons for admission were skin and soft tissue infections (58%) and pneumonia (18%). HIV (4%), hepatitis B (49%) and hepatitis C (84%) infections were very common amongst those admitted. The cost to the NHS of treating soft tissue infections in drug users was estimated at approximately £77 million per annum. The authors concluded that bacterial and viral infections are responsible for the substantive proportion of the mortality and morbidity amongst people who inject drugs presenting to hospitals.

### 6.2.5 Behavioural data: infection risks

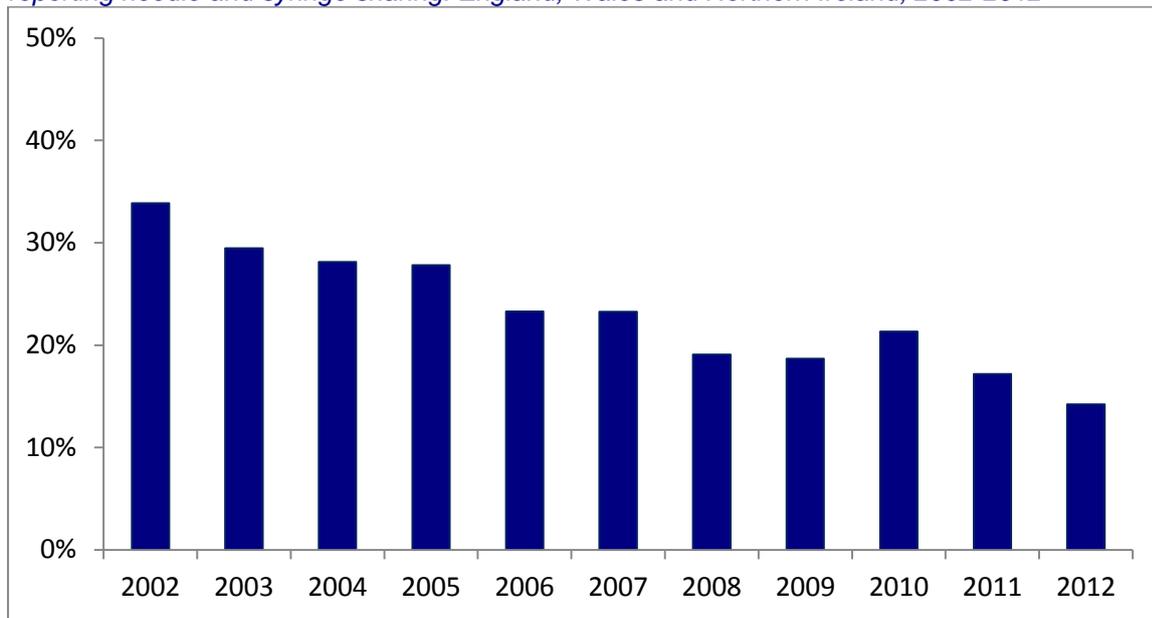
#### Sharing of injecting equipment: people who inject psychoactive drugs

The level of needle and syringe (direct) sharing reported by participants in the UAM Survey in England, Wales and Northern Ireland has declined from 34% (95% CI, 32%-36%) in 2002 to 14% (95% CI, 13%-16%) in 2012 (PHE et al. 2013a; PHE 2013b; 2013c; figure 6.4). Throughout the period 2002 to 2012, direct sharing levels were consistently higher amongst those aged under 25 years than amongst older participants; in 2012, 23% (95% CI, 17%-29%) of those aged under 25 years reported direct sharing compared with 14% (95% CI, 12%-17%) of those aged 25 to 34 years and 12% (95% CI, 9.5%-14%) of those aged 35 years and over (PHE 2013b; 2013c). Direct sharing was reported by 14% of the participants in England (regional range: 5.5% to 20%), 10% of those in Wales, and 19% of those in Northern Ireland in 2010 (PHE 2013b; 2013c).

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<sup>162</sup> See: <http://www.sdf.org.uk/news-and-media/general-news/warning-to-injecting-drug-users-after-two-die-in-lanarkshire-after-contracting-necrotising-fasciitis/>

**Figure 6.4** Percentage of current injectors\* in the Unlinked Anonymous Monitoring Survey of PWID reporting needle and syringe sharing: England, Wales and Northern Ireland, 2002-2012



\*Those reporting injecting in the four weeks preceding survey participation.  
Source PHE 2013b

Sharing of any of the injecting equipment asked about in the UAM Survey (i.e. needles, syringes, mixing containers, or filters; direct and indirect sharing) was reported by 34% of those participating in the survey in 2012. Sharing of any of this equipment was reported by 35% of the participants in England (regional range: 22% to 46%), by 25% in Wales, and by 35% in Northern Ireland in 2012 (PHE 2013b).

In Scotland, data from the Scottish Drug Misuse Database indicates that 17% of current injectors for whom information was available, reported needle and syringe sharing in the financial year 2011/12. This is a decline from 22% during 2006/07 (PHE et al. 2013a). Data from the Scottish Drug Misuse Database also indicates that in 2011/12 amongst those who had ever injected drugs and for whom information about sharing was available, 42% had ever shared needles or syringes. This is broadly similar to the 44% who reported doing so in 2006/07.

**Sharing of injecting equipment: people who inject image and performance enhancing drugs**

The voluntary unlinked-anonymous survey of male IPED injectors in England and Wales undertaken during 2010-11 found that almost one in 10 (9%) of the participants reported that they had ever shared injecting equipment (needle, syringe or vial of drugs) (Hope et al. 2013).

**Sexual behaviour: people who inject psychoactive drugs**

In 2012, nearly three-quarters (73%, 95%CI, 71%-75%) of the PWID participating in the UAM Survey across England, Wales and Northern Ireland reported having anal or vaginal sex during the preceding year, and this level has changed little over time. Of those who had sex in the last year, 44% (95% CI, 42%-46%) reported having had two or more sexual partners during that time in 2012. (PHE 2013b; 2013c).

**Sexual behaviour: people who inject image and performance enhancing drugs**

The voluntary unlinked-anonymous survey of male IPED injectors in England and Wales undertaken during 2010-11 found that the majority of men sampled (86%) reported sex during the preceding year. One in five (20%) of these reported multiple female partners, and three per cent a male partner.

### Risks amongst men who have sex with men

A recent research report raised concern about a possible increase in the use of methamphetamine and mephedrone, including injecting, amongst some sub-groups of gay men in London (Kirby and Thornber-Dunwell 2013). These drugs are typically being used during sex, with injecting equipment often shared and condoms not used. Whilst the scale of this remains unclear, specialist Lesbian Gay Bisexual and Transgender drug services in London have reported seeing an increase in the number of men who have sex with men who report injecting these drugs. The use and injection of these drugs has also been reported to be a factor in a recent Sexually Transmitted Infection outbreak (Gilbert et al. 2013).

### Research

#### *Peer injecting and infection risk amongst PWID in Northern Ireland*

McElrath and Harris (2013) conducted semi-structured interviews with 41 people (14 females and 27 males) in Northern Ireland who reported having received injections from other PWID. The study aimed to explore the context of receiving injections from others on initiation to injecting drugs and on later injecting occasions. Most participants reported that they asked others to give them their first injection, needing their expertise and knowledge, with only one suggesting that he had been persuaded into it. The majority of those interviewed had been given their first injection by a male PWID and 28 out of 41 reported being injected before the peer injector at initiation. Around half (8 out of 14) of the female initiates reported being injected first during initiation and those who were injected second tended to be those injected by their partner. After initiation, the majority of participants continued to sometimes be injected by others although most sometimes injected themselves. The main reasons given for subsequent peer injections were venous problems and withdrawal symptoms. The order of injection varied and participants reported some peer injectors who injected themselves first, struggling to inject them while under the influence of heroin. Peer injectors were often partners but most participants said they had several peers who they would sometimes ask, and some peer injectors would be given drugs in exchange for their help. The risk of transmitting blood borne infections was discussed in relation to the order of injecting and the context of the peer injecting.

## 6.3 Other drug-related health correlates and consequences

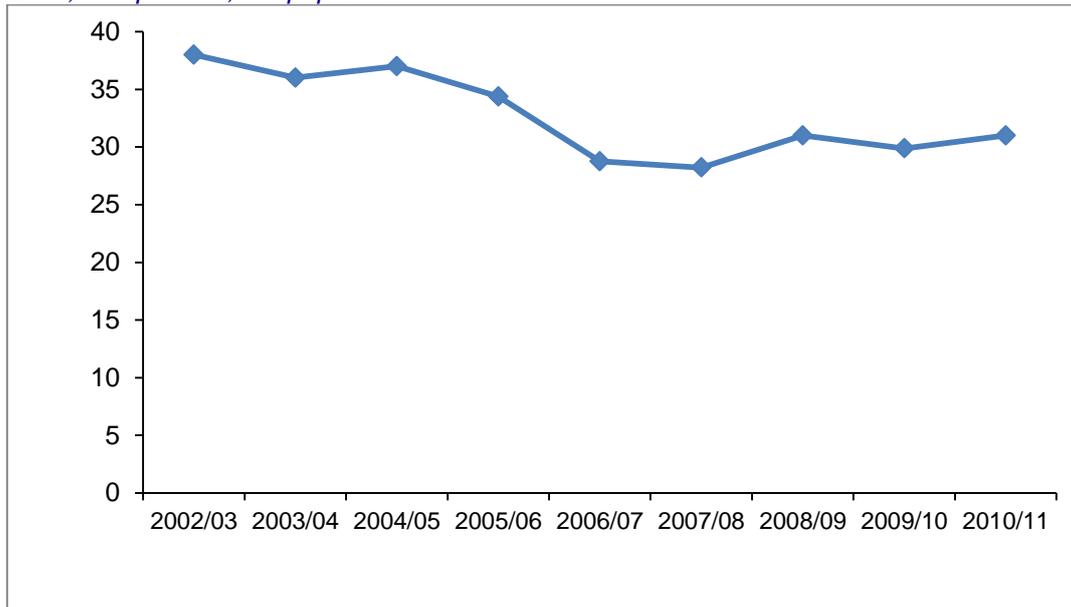
### 6.3.1 Psychiatric co-morbidity

#### Scotland

Inpatient hospital data from Scotland (ISD Scotland, 2013a) show that 7% (1,556) of psychiatric inpatient discharges in 2010/11 had a recorded diagnosis of drug misuse (as either a main or supplementary diagnosis). This equates to a rate of 31 discharges per 100,000 population, a rate similar to 2008/09 and 2009/10.<sup>163</sup> Previously, the rate had been higher, at between 38 and 36 per 100,000 population, from 2002/03 to 2004/05 before falling in 2005/06 and 2006/07, to reach a rate of 28 per 100,000 population in 2007/08 (Figure 6.5).

<sup>163</sup> Note that historical data have been amended since the publication of the UK Focal Point Report 2011 as provisional data for 2008/09 were used. Data for 2010/11 are also provisional and are subject to change in later editions.

**Figure 6.5** *Psychiatric inpatient discharges with a diagnosis of drug misuse in Scotland, 2002/03 to 2010/2011; rate per 100,000 population*



Source: ISD Scotland 2013a

In the older age groups, the rate increased between 2006/7 and 2010/11 (from 66 to 85 per 100,000 population amongst 35 to 39 year olds, and from 10 to 17 per 100,000 population amongst those aged 40 years and over). In the younger age groups there was an overall decrease during the same period.

Of the 1,556 psychiatric inpatient discharges with a diagnosis of drug misuse in 2010/11, 55% (851) recorded use of multiple drugs or other psychoactive substances. This was similar to 2009/10 when 54% recorded use of multiple drugs or other psychoactive substances. Of the single drug types recorded in psychiatric discharges with drug use, opioids were most frequently recorded, as in previous years. Opioids were recorded in 32% of discharges, cannabinoids in 6%, sedatives/hypnotics in 6% and other stimulants in 6% in 2010/11.

## Research

### *Needs assessment of dual diagnosis and unmet treatment need in London*

Shahriyarmolki and Meynen, (2013) screened routine data from the electronic records of a community drug and alcohol service in London to estimate the prevalence of dual diagnosis and unmet treatment need amongst its service users. They found that, of the 225 service-user records included in the sample, 72% (n=161) met their screening criteria for dual diagnosis<sup>164</sup> and of these, 53% (n=86) were not receiving current treatment for their mental health and 37% had *never* received treatment for their mental health. Women and those in treatment for alcohol dependence had higher rates of dual diagnosis than others. The cross-sectional survey was found to be a feasible method for assessing prevalence of dual diagnosis in services with limited resources for making such assessments. It revealed a high prevalence of dual diagnosis and unmet mental health needs amongst the users of the community drug and alcohol service surveyed in the study.

<sup>164</sup> For an individual to be classified as currently having dual diagnosis, at least one of the following had to be mentioned in their electronic record within the last 3 years, without any evidence to suggest the condition had remitted; contact with mental health services; receipt of drug treatment explicitly for a mental health problem; formal diagnosis; or reference to psychological distress which is enduring and/or functionally impairing.

*Association between common mental disorders and substance use in outpatients*

A study to examine the association between common mental disorders (CMD) such as depression and anxiety, and self-reported substance use was conducted in an outpatient addictions service in Yorkshire (Delgadillo et al. 2013).<sup>165</sup> Diagnostic interviews were carried out with 103 participants and approximately 70% met the criteria for CMD. There was a significant association only between weekly alcohol use and severity of mental illness. Other drug use was not directly associated with severity of psychiatric symptom scores, although there were some specific associations between particular drugs and particular symptoms. The study found similar levels of mental disorder in those who had recently abstained from drug use and more-long-term abstainers, emphasising the importance of detecting and treating mental illness in people with substance use problems.

*Psychological effects of ketamine*

A questionnaire study by Stirling et al. (2012) explored the frequency of occurrence of different experiences during ketamine use, as reported by participants who described themselves as either current or previous recreational users of ketamine. The 'Ketamine Experiences Questionnaire' was completed by 87 respondents, recruited by opportunity and snowball sampling. Participants indicated having a wide range of both appetitive and aversive experiences while using ketamine, affecting their thoughts, mood, perception, emotion and physical functions. Those who identified themselves as previous rather than current ketamine users tended to report fewer appetitive and more aversive effects than current users.

*Substance misuse in depression and bipolar disorder*

Richardson's (2013) review paper highlights the high levels of co-morbidity between mental illness and substance misuse. It describes both the high levels of substance misuse in people with depression and bipolar disorder, and the high levels of depression in those with substance misuse disorders. Those people with depression who also misuse drugs have more severe symptoms and half the likelihood of long-term recovery compared to those with depression only. Similarly, those with bipolar disorder and substance misuse have slower recovery, increased risk of relapse, severe mania and psychosis as well as poorer quality of life and increased suicide attempts. Careful screening for substance misuse in people presenting with mental illness and screening for mental illness in those known to have substance misuse problems, is recommended. Richardson advocates integrated treatment to address both problems but calls for more rigorous research to determine the most effective treatment approaches for this group of clients.

*Association between psychiatric co-morbidity and HCV infection*

Wang, Finch and Wolff (2013) carried out analysis of data from the National Drug Treatment Monitoring System (NDTMS) to identify whether psychiatric co-morbidity is associated with HCV infection<sup>166</sup>. Of the sample of 2,444 patients, 32% (n=783) were recorded in NDTMS as HCV positive and 68% as HCV negative. Logistic regression was carried out to identify variables predicting HCV positive status. HCV positive individuals were more likely than HCV negative individuals, to be male, of white ethnicity, to have urgent housing problems, to be unemployed, to have long term sickness, to have been younger when they first used drugs, to have injected in the last 28 days, to share injecting paraphernalia, to use cocaine and

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<sup>165</sup> Patients were recruited sequentially over one year, as they attended routine appointments. Their substance use was assessed using the Treatment Outcomes Profile (see Section 5.5.4) and psychiatric diagnosis was established using the Revised Clinical Interview Schedule (CIS-R). Psychological dependence was assessed using the severity of dependence scale (SDS).

<sup>166</sup> They included all adult patients attending drug treatment services within the South London and Maudsley NHS Foundation Trust between January 2007 and December 2010, whose records included hepatitis C and co-morbidity status.

crack cocaine and to drink alcohol at a harmful level. After controlling for age, sex, ethnicity and drug and alcohol use behaviours, the analysis showed patients with psychiatric co-morbidity were 1.33 times more likely to be HCV positive than patients without psychiatric co-morbidity.<sup>167</sup> This is a small effect but it shows that psychiatric co-morbidity is associated with HCV infection. The authors discussed the implications for clinical treatment of HCV in drug using populations.

### 6.3.2 Non-fatal overdoses and drug-related emergencies

Data on drug overdoses and drug-related emergencies are provided using hospital inpatient data and International Classification of diseases (ICD-10) codes. It is difficult to assess the full extent of non-fatal overdoses and drug-related emergencies due to the use of illegal drugs. This is because the ICD-10 coding system includes some legally available drugs such as codeine, which is available without prescription at pharmacies. Conversely, ICD-10 codes do not include new psychoactive substances. Also, data from hospitals are only available for those who are admitted to hospital and stay as an inpatient. Evidence shows that fewer than one-third of individuals attending hospital with acute recreational drug toxicity are admitted to hospital and even those admitted may not be assigned an appropriate ICD-10 code (Wood et al. 2011; see UK Focal Point Report 2011).

#### Hospital inpatient data

In 2011/12, hospital inpatient data showed there were 36,255 inpatient discharges recording poisoning by drugs in the UK, a seven per cent increase since 2010/11 (Table 6.1).<sup>168</sup> As in previous years, over half (61% or 22,102) were due to 'other opioids including morphine and codeine'. Discharges linked to other opioid poisonings have increased each year from 2007/08 when there were 16,452. Heroin poisoning accounted for 6.8% (2,453) of discharges, cocaine for 5.9% (2,139) and methadone for 5.1%. Almost all drug poisonings were emergencies (99%). The number of discharges recording heroin poisoning in 2011/12 was similar to the number in 2010/11, following a large decrease between 2009/10 (3,155) and 2010/11 (2,500). Cocaine and methadone poisoning discharges fell slightly compared to 2010/11 figures.

**Table 6.1** Inpatient discharges recording poisoning by drugs in the United Kingdom, 2007/8 to 2011/12

Drug	2007/08		2008/09		2009/10		2010/11		2011/12	
	n	%	n	%	n	%	n	%	n	%
Other opioids including morphine and codeine	16,452	50.6	17,902	57.2	19,266	62.9	21,509	63.5	22,102	61.0
Heroin	3,071	9.4	3,053	9.8	3,155	10.3	2,500	7.4	2,453	6.8
Cocaine	2,477	7.6	2,627	8.4	1,986	6.5	2,247	6.7	2,139	5.9
Methadone	1,365	4.2	1,493	4.8	1,533	5.0	1,954	5.8	1,833	5.1
<b>Total</b>	<b>32,511</b>	<b>100.0</b>	<b>31,319</b>	<b>100.0</b>	<b>30,618</b>	<b>100.0</b>	<b>33,889</b>	<b>100.0</b>	<b>36,255</b>	<b>100.0</b>
<b>% Emergencies</b>	<i>n/a</i>	<b>99.0</b>	<b>30,991</b>	<b>99.0</b>	<b>30,311</b>	<b>99.0</b>	<b>31,794</b>	<b>93.7</b>	<b>35,897</b>	<b>99.0</b>

Source: HSCIC, DHSSPSNI, ISD Scotland, Public Health Wales – personal communication

## Research

### Prevalence of non-fatal overdose amongst opiate users in Wales

The Welsh Government is funding a study to estimate the prevalence of non-fatal overdose amongst opiate users in Wales. A survey of all needle exchange schemes (excluding pharmacies) in Wales over a one-month period was carried out in February and March 2013.

<sup>167</sup>  $p < 0.05$  Confidence Interval 1.01-1.75

<sup>168</sup> Using ICD-10 diagnosis codes T40 and T43.6

It involved asking all opiate users to complete a short questionnaire about their history of non-fatal overdose and the characteristics of a recent event.

A secondary aim of the project is to find out more about the nature and characteristics of non-fatal overdose events. Qualitative interviews are being undertaken with opiate users who completed the survey and who expressed an interest in being interviewed about their experiences. The research is due to be completed later in 2013.

#### *Hospital episodes for drug treatment clients in Scotland*

Merrall et al. (2013a) examined the records of a national cohort of 69,457 drug treatment clients in Scotland during 1996 to 2006, to describe and characterise their hospital and psychiatric episodes. The records of individuals registered on the Scottish Drug Misuse Database (SDMD) were linked, using a probabilistic approach, to records on other national registers.<sup>169</sup> There were 107,723 hospital episodes linked to the cohort<sup>170</sup> and this represents a rate of hospital episodes more than double that of the general population. Rates of hospital episodes decreased between an earlier (1996/1997-2000/2001) and later (2001/2002 -2005-2006) era of recruitment. The most frequent main diagnoses at discharge were injury and other consequences of external causes, poisonings, non-drug-related mental disorders and diseases of the skin and subcutaneous tissue. Rates of mental disorders were 40 times higher than in the general population. Hospital episodes for skin conditions and conditions of the circulatory system appeared to be related to infection and damage from drug-injecting. The study authors warned of the need for effective treatment of individuals' substance misuse, particularly for those with dual diagnosis, if the high rate of hospital episodes experienced by this group is to be reduced.

#### *Management of drug misusers in Glasgow general hospitals*

McPherson and Benson (2013) conducted a brief literature review to find available evidence for the drug misusing guidelines used in Glasgow hospitals and surveyed junior medical staff for their views on the guidelines. They found a lack of other evidence and medical staff said they broadly welcomed the guidelines as a useful and accessible source of information for managing patients with substance misuse, although they wanted additional training or guidance on managing patients prescribed Suboxone.

#### *Use of emergency services due to recreational drug and alcohol toxicity*

In an online survey, linked to the dance music publication 'MixMag'<sup>171</sup>, Archer et al. (2013b) found a substantial proportion of participants reported using emergency medical services due to acute toxicity from recreational drugs and/or alcohol and very few of those participants said the experience had subsequently deterred them from taking drugs. Of 2,472 UK respondents, 461 (19%) reported needing emergency medical services after using recreational drugs or alcohol. Of these, 259 attended a hospital emergency department and 152 were then admitted to hospital.<sup>172</sup> Details of the substances used immediately prior to their most recent experience of emergency medical care for drug and/or alcohol toxicity were provided by 115 survey participants. Almost half (53 individuals or 46%) reported using at least one recreational drug plus alcohol, 36 (31%) consumed only alcohol and 26 (23%) used only one or more recreational drugs. The authors of the report identified a need to

<sup>169</sup> These were national registers held by Scotland's Information Services Division, the General Register Office for Scotland and Health Protection Scotland.

<sup>170</sup> The hospital episodes were experienced by 27,124 clients and over half of the cohort (61%) did not have a hospital episode.

<sup>171</sup> The population targeted by the survey has previously been reported to have a high prevalence of recreational drug use.

<sup>172</sup> Other emergency medical services used by participants were; ambulance services (196 individuals); first-aid facilities at a venue/club/festival (120 individuals); and NHS direct (65 individuals).

understand how health professionals can use these episodes of contact with emergency services to change patterns of drug and alcohol use.

*The effect of alcohol or drugs on casualty rates in accidental house fires*

The Department for Communities and Local Government (DCLG 2012b) examined Fire and Rescue Services records of accidental fires in dwellings in England in 2011 to 2012 to investigate the effect of alcohol or drugs on the casualty rates per fire. In eight per cent (n=2,483) of the fires it was suspected that impairment due to alcohol or drug use had been a contributory factor, resulting in 41 deaths and 1,208 injuries. Fires in which alcohol or drug use were a contributory factor, had an average rate at least three times higher for fatalities and four times higher for serious injuries compared to other accidental dwelling fires. Senior fire officers assessed the victims of the fires they suspected had involved impairment due to alcohol or drugs, recording whether they thought each casualty was under the influence of alcohol or drugs. These assessments suggested 56% of casualties were not under the influence of either alcohol or drugs, 37% were under the influence of alcohol and six per cent of the casualties were under the influence of drugs.

6.3.3 Pregnancies and children born to drug users

*Inpatient hospital data on effects of maternal use of drugs*

During 2011/12, in the United Kingdom, there were 291 hospital discharges with an ICD-10 code P04.4 related to the fetus or newborn baby being affected by maternal use of drugs of addiction and 1,213 discharges with an ICD-10 code P96.1 of neonatal withdrawal symptoms from maternal use of drugs of addiction.<sup>173</sup>

Scotland

Data on births in Scottish hospitals show that, in 2010/11, there were 1,202 and in 2011/12 there were 1,135 births for which drug misuse was recorded<sup>174</sup> (ISD Scotland 2013a)<sup>175</sup>. This equates to a rate of 20.7 per thousand births in 2010/11 and 19.6 per thousand births in 2011/12. This is double the rate in 2008/09 (10.4 per thousand) but the increase is reported to be mainly due to improvements in data recording rather than a large increase in drug use during pregnancy.

In 2011/12, in 79% (898 of 1,135) of the births in Scottish hospitals where drug misuse was recorded, the baby had a normal birth weight. This compares with a normal birth weight recorded for 93% of all births (53,910 of 57,911). In 13.5% of births with drug misuse recorded in 2011/12, the baby was born preterm compared to 7.4% of all births being preterm.

Research

*Illegal drug use and pregnancy outcomes*

Black et al. (2013) compared obstetric outcomes of women using illegal drugs and women smoking cigarettes who delivered between 1997 and 2007 in Aberdeen. The main outcome measures were preterm delivery, low birth weight and admissions to neonatal units. A total of 561 women comprised the illegal drug using group: 96% of whom also smoked cigarettes. A comparison sample of 4,463 women who smoked cigarettes but did not take illegal drugs were identified. The findings indicated that women using illegal drugs were more likely than

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<sup>173</sup> It should be noted that ICD-10 code P96.1 includes neonatal withdrawal symptoms from maternal use of any drug that the mother is addicted to- for example heroin or analgesics. Therefore, it is not possible to identify the specific drug the neonate is withdrawing from using ICD-10.

<sup>174</sup> Drug Misuse is defined using the following International Classification of Disease (10th Revision) codes : 035.5, F11, F12, F13, F14, F15, F16, F18 and F19.

<sup>175</sup> <http://www.isdscotland.org/Health-Topics/Maternity-and-Births/Publications/data-tables.asp?id=1136#1136>

women who smoked to have an antepartum haemorrhage, preterm delivery at any gestation, a low birthweight infant and to have a baby admitted to the neonatal unit and less likely to develop gestational hypertension. Although women using drugs were more likely to be underweight than those who smoked cigarettes, after adjusting for the effects of Body Mass index (BMI) in the smoking group, a significantly reduced risk of gestational hypertension in the illegal drug using group remained.

#### 6.3.4 Drug driving

In 2011, in Great Britain, impairment by drugs (including illicit and medicinal) was recorded as a contributory factor<sup>176</sup> in 49 (3%) of all reported<sup>177</sup> fatal road accidents and 176 (1%) of all reported serious road accidents. Pedestrians impaired by drugs were a contributory factor in 13 (1%) of all reported fatal road accidents and 58 (fewer than 1%) of all reported serious road accidents (DfT 2012a).

Data on self-reported drug driving from the Crime Survey for England and Wales (CSEW)<sup>178</sup> showed that, in 2010/11, an estimated 19% of adult drivers who had taken illegal drugs in the last year reported driving at least once or twice within the last 12 months whilst they thought they were affected by or under the influence of illegal drugs. This was similar to 2009/10, where an estimated 17% reported driving at least once or twice within the last 12 months whilst under the influence of illegal drugs (DfT 2012b).

### Research

#### *Analysis of blood samples for drugs in alleged drug-driving cases*

Burch et al. (2012) looked at the Forensic Science Service (FSS) data on blood concentrations of alcohol and drugs for alleged drug-driving cases from February 2010 until March 2011 in England and Wales. The FSS screened blood samples for all alleged drug-driving cases for amphetamines/methylamphetamines, benzodiazepines, cocaine, opiates and cannabinoids. Where results were positive for opiates, tests were then carried out for methadone. Alcohol levels were also obtained from laboratory blood samples and not from evidential breath tests. Alcohol was identified in 113 of the 376 cases (30%) and the median alcohol concentration was 120mg/% which exceeds the limit for driving in the UK (80mg/%). Eighty-one of the samples contained alcohol only, therefore breakdown of drugs of abuse were provided for 295 cases. Cocaine and/or its metabolite benzoylecgonine (BZE) were the most commonly quantified drug (92 cases), followed by diazepam (76 cases). Amphetamines were found in 39 cases, ketamine in 15, MDMA in eight cases and mephedrone in six cases. The authors note that drug concentrations may be complicated by a number of factors including; drug-drug interactions; delays between sampling and analysis; and a variation in the time between arrest and blood sampling.

#### 6.3.5 New psychoactive substances (NPS)

##### **Enquiries on NPS to the National Poisons Information Service**

In the year 2011/12, the National Poisons Information Service (NPIS) reported answering 1,217 telephone enquiries about drugs of abuse (2.6% of all their telephone enquiries) and 44,767 online sessions to access information on drugs of abuse on TOXBASE©<sup>179</sup> (4% of all

<sup>176</sup> The recording system allows up to 6 contributory factors

<sup>177</sup> Not all road accidents are reported.

<sup>178</sup> The CSEW was formerly known as the British Crime Survey (BCS). The BCS was renamed as the Crime Survey for England and Wales in March 2012. See: <http://www.ons.gov.uk/ons/guide-method/surveys/respondents/household/crime-survey-for-england---wales/index.html>

<sup>179</sup> TOXBASE© is a specialist online database of poisons and drug toxicity information for use by health care professionals in the UK. It is co-ordinated by the National Poisons Information Service. A

TOXBASE activity) (HPA, 2012). While these measures of activity do not directly represent numbers of episodes of toxicity or hospital episodes related to drugs of abuse, they are indicative of health care professionals encountering patients who say they have taken these drugs and then developed health problems. The top ten drugs of abuse featured in both telephone enquiries and TOXBASE sessions include cocaine, amphetamines, MDMA, heroin, cannabis, methadone, mephedrone, and ketamine. The newer psychoactive substances most frequently featured in telephone enquiries between March 2009 and March 2012 were mephedrone, 'legal highs', naphyrone, methcathinone, 6-APB, and 'Ivory Wave' products reported to contain desoxypipradol and methoxetamine. The NPIS data appears a useful source of surveillance of use of new psychoactive substances and is now listed by the EMCDDA as part of the UK early warning system national profile.

#### *Methoxetamine toxicity*

All user sessions and telephone enquiries to the National Poisons Information Service's (NPIS) website TOXBASE<sup>®</sup>, from 1<sup>st</sup> April 2010 to 1<sup>st</sup> August 2012, relating to methoxetamine, were studied in order to establish demographic and clinical characteristics of reported cases of methoxetamine toxicity (Hill et al., 2013). There were 47 telephone enquiries and 298 TOXBASE<sup>®</sup> sessions relating to methoxetamine. Contacts increased in late 2011/early 2012 and reduced after April 2012. In the three months prior to the Temporary Class Drug Order<sup>180</sup> (TCDO) there were 151 TOXBASE<sup>®</sup> sessions, compared to 32 sessions in the three months after the TCDO was introduced (a reduction of 79%). Thirty-five of the 47 phone enquiries to NPIS related to male patients with a median age of 24 years. The most commonly cited clinical features of methoxetamine toxicity (cited in 43% of the cases) were those related to acute mental health disturbance such as agitation, confusion, hallucinations, paranoia and hysteria. The authors point out that the data collected by NPIS do not directly measure numbers of people presenting to medical services with methoxetamine toxicity. However, interpreting the data within this limitation, structured NPIS data may reveal trends in the use and toxicity of drugs of abuse and a reduction in enquiries from clinicians suggests a reduction in clinical presentations with suspected methoxetamine toxicity.

#### *Mephedrone use and toxicity*

Wood and Dargan (2012) reviewed recent data to provide information on prevalence of mephedrone use and also its toxicity. Prevalence data included results from the 2010/11 British Crime Survey, two surveys of young people (in Scotland and Northern Ireland respectively) and a variety of surveys amongst subpopulations known to have higher than average levels of drug use. In the absence of formal human studies of mephedrone toxicity, this review combined information from sub-population user surveys, online discussion fora, reports to poisons information services and case reports and case series from hospital emergency departments. Despite the acknowledged limitations of self-report data<sup>181</sup> in the individual studies, the review found a fairly consistent pattern of acute toxicity similar to that of a combination of MDMA and amphetamine. Animal models suggested a similarity between the pharmacological actions of mephedrone and those of amphetamine together with MDMA .

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telephone enquiry service is also provided for health care professionals.  
<http://www.npis.org/toxbase.html>

<sup>180</sup> The first UK Temporary Class Drug Order (TCDO) was made on 5 April 2012 for methoxetamine. This implemented a temporary ban while further evidence of the effects of the drug could be examined by experts.

<sup>181</sup> For example, individuals may have believed they had taken mephedrone when they had actually taken another substance, and they may have used mephedrone together with other drugs so the effects reported may not have been specifically effects of mephedrone.

### Cardiovascular toxicity of New Psychoactive Substances (NPS)

Dawson and Moffatt (2012) argued a strong case for investigating the pharmacological effects of all NPS when they become available, in order to predict the likely cardiovascular risks associated with their use. They reviewed the pharmacological effects of more 'established' psychoactive drugs, highlighting the known cardiovascular damage associated with chronic use of drugs acting on three main neurotransmitter systems. NPS with affinity for a particular serotonin receptor (as in MDMA) and those which inhibit uptake or reverse transport of noradrenaline (as in cocaine and amphetamine) are predicted to be very likely to lead to cardiovascular complications.

### 6.3.6 Cannabis

#### Cannabis and schizophrenia

After considering the current evidence surrounding cannabis use and chronic psychotic disorders, Gage et al. (2013) argue that the role of cannabis in the aetiology of schizophrenia needs to be investigated further.

#### Cannabis and memory

Bhattacharyya (2013) reviewed the evidence of the acute and long-term effects of cannabis on memory. The author argues that the evidence regarding the acute effects of cannabis on memory function is generally robust, particularly for those using cannabis with a higher proportion of THC. However, it is unclear whether frequent cannabis users may develop a tolerance to the acute effects of THC. The author also argues for further investigation into the effects of cannabis use on neurodevelopmental processes as cannabis use initiation tends to start in teenage years.

#### Cannabis use and abstinence in first-episode psychosis

Research conducted by Seddon et al. (2012) investigated the factors that motivate or inhibit cannabis use in 30 people with first-episode psychosis in Birmingham and Solihull in England.<sup>182</sup> Participants who had used cannabis were interviewed to explore their cannabis dependency, subjective effects of cannabis and the effects on personal relationships. The context and patterns of cannabis use were also explored. For those who had not used cannabis, interview questions focused on identifying factors preventing the participants from using cannabis. Using grounded theory, data analysis revealed that for those with no history of cannabis use, abstinence from cannabis use was due to concerns of a negative impact on family and their own mental health and implications for religion and physical health. Cannabis initiation for those who had used cannabis was seen as a social activity, continuation occurred because cannabis use was enjoyable and increased cannabis use was generally unplanned. Subsequent to the onset of psychosis, participants' concerns about their mental health became more salient in both groups. Psychosis both further deterred non-users from initiation and motivated cessation of cannabis use in some users.

#### Comparison of synthetic cannabis and natural cannabis

Respondents to an anonymous online survey<sup>183</sup> provided information about their use of synthetic cannabis and natural cannabis and a comparison of the effects of both substances

<sup>182</sup> Participants were recruited from Birmingham and Solihull NHS Trust Early Intervention Service which manages cases of first-episode psychosis. Purposive sampling methods were used to recruit two groups of participants: current and ex-cannabis users (n=18) and people with no history of cannabis use (n=12). Two semi-structured interview schedules were used: one for each group.

<sup>183</sup> Data was collected through the online survey designed and conducted by Global Drug Survey ([www.globaldrugsurvey.com/mixmag2012](http://www.globaldrugsurvey.com/mixmag2012)). Of 14,966 survey participants who responded, 2513 (16.8%) reported ever using synthetic cannabis and 980 reported using it in the last 12 months. Half of the recent synthetic cannabis users (49.3%, n=471) were from the US and one-quarter were from the UK (26.6%, n=254). The authors acknowledge the limitations of the sampling and method

(Winstock and Barratt 2013). Of the 980 respondents who reported using synthetic cannabis in the last 12 months, 95% had also used some form of natural cannabis in the last 12 months. Natural cannabis tended to have been used more regularly and recently than synthetic cannabis, amongst this sample and 93% stated a preference for natural cannabis. Participants reported a similar speed of onset for both drugs but there was a shorter time before peak effect was reached and also a shorter duration of effect with synthetic cannabis. Natural cannabis was reported to have more pleasurable effects and milder negative effects, particularly paranoia and hangover effects compared to synthetic cannabis.

#### Reclassification of cannabis and hospital admissions for cannabis psychosis

Hamilton et al. (2013) examined the relationship between two changes to the legal classification of cannabis (from Class B to C in 2004 and from C to B in 2009) and numbers of hospital admissions for cannabis psychosis over the time period 1999 to 2010, using an interrupted time series analysis. They tested the assumption that classifying cannabis as Class B (with stricter penalties associated) might reduce admissions for cannabis psychosis and reclassifying it as Class C (with milder penalties) might increase admissions. There was no support for that assumption and the study found a statistical association in the opposite direction to that predicted. Admissions for cannabis psychosis increased significantly between 1999 and 2004, while cannabis was classified as a Class B drug. Between 2004, (when cannabis was reclassified as Class C) and 2009, admissions decreased, but after 2009 (when cannabis was reclassified as Class B), admissions increased again. The authors said the statistical association was unlikely to be due to changes in cannabis classification over the period and said the reasons for it were unclear. They suggested the most likely explanation might be changes in mental health care, towards community care rather than hospital admissions, although it was not clear how this would explain the timing of changes or the increase in admissions for cannabis psychosis after 2009.

#### 6.3.7 Other research

##### Health harms of khat use

In response to a government request, the Advisory Council on the Misuse of drugs (ACMD) carried out a review of the health and societal harms of khat use in the UK (see section 1.2.5). The medical harms reviewed included; dependence; effects on the cardiovascular system; respiratory system; the liver; on women during pregnancy; and psychiatric effects. The review concluded that, other than a small risk of significant liver disease associated with khat use, the research evidence surrounding the medical harms of khat use is generally weak and inconclusive. The effects of tobacco use as well as general poor health and genetic factors were highlighted as confounding factors (ACMD 2013a).

##### Cognitive impairments in poly-drug ketamine users

Liang et al. (2013) compared 32 current ketamine poly-drug users and 64 former users with 100 controls on a range of measures of cognitive function.<sup>184</sup> They found verbal and visual memory impairments in both current and former ketamine poly-drug users compared to controls. There were no differences in cognitive functioning between current and former ketamine poly-drug users, suggesting persistent effects.

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(including self-report, possible recall errors, lack of certainty about drugs used, polydrug use). Details of method are provided in Section 2 of the article.

<sup>184</sup> Depression, anxiety and severity of dependence were measured using the Beck Depression Inventory, the Hospital Anxiety Depression Scale and the Severity of Dependence Scale. Verbal memory was tested with the Weschler Memory scale 111: Logic Memory and Word List, visual memory with the Rey-Osterrieth Complex Figure, executive function with Stroop, Wisconsin Card sorting test, and Modified Verbal Fluency Test, working memory with Digit Span Backward and general intelligence with Information, arithmetic and digit-symbol coding tests.

### Tramadol

The ACMD reviewed the harms associated with tramadol misuse, advising that prescribing of tramadol has increased significantly in recent years and tramadol is currently widely available on prescription, as an analgesic drug, and on the internet without prescription (ACMD 2013b). It is a synthetic opioid which produces effects similar to those of codeine and it also inhibits re-uptake of noradrenaline and serotonin, producing effects on the monoamine system as well as on opioid receptors. Tramadol can cause a potentially fatal serotonin syndrome and, in the event of overdose, the administration of naloxone can only reverse the opioid effects of the drug. In this way, the dual-action pharmacological profile of tramadol increases the risk of harm from overdose in comparison to other equally potent opioids. This is considered to be a particular risk if tramadol is taken together with other monoamine-active drugs such as ecstasy.

The ACMD noted that deaths where tramadol was mentioned on the death certificate have increased steadily since over the last 20 years, recently rising more sharply. The majority of deaths involved tramadol obtained without prescription and more than 80% involved other drugs in addition to tramadol. As well as the risk of overdose, the ACMD considered evidence of people developing physical dependence to tramadol, resulting in a severe withdrawal syndrome sometimes involving seizures. The ACMD assessed the harms associated with tramadol to be commensurate with those of other Class C drugs and recommended it should be controlled as a Class C substance under the *Misuse of Drugs Act 1971* and be listed in Schedule III of the *Misuse of Drugs Regulations 2001*.

### Z-drugs

The ACMD considered the harms associated with three non-benzodiazepine hypnotic drugs: zaleplon, zolpidem and zopiclone, known as the Z-drugs (ACMD 2013c). Zolpidem is already controlled as a Class C drug, (as benzodiazepines are). The three drugs share a basic mechanism of action with benzodiazepines and they produce similar clinical effects although the Z-drugs are short-acting in comparison to benzodiazepines such as diazepam. All three Z-drugs are thought to be less likely than benzodiazepines to produce tolerance and withdrawal although some case reports suggested Z-drugs may have abuse potential. The health harms associated with excessive use of Z-drugs in combination with alcohol or other CNS depressants were reported to include coma, respiratory depression and death. Other effects reported to be associated with use of Z-Drugs were a risk of injury and loss of alertness and amnesia due to sedation as well as changes in mood and behaviour. There was evidence of Z-drugs playing a small role in drug-related deaths in the UK, mainly in combination with other CNS depressants and mainly in cases of intentional poisoning.

ACMD recommended all three Z-drugs should be controlled as Class C drugs on the basis of the similarities between all three Z-drugs and benzodiazepines.

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

### 6.4.1 Methodological issues in measuring drug-related deaths

#### Royal Statistical Society's statement on registration of deaths in England and Wales

The Royal Statistical Society (RSS) highlighted the problem of delayed registration of deaths in England and Wales which, they argue, poses a risk to public health by potentially undermining the evidence-base for public health monitoring, record-linkage research and policy development (RSS, 2013). Late registration of deaths in England and Wales occurs because registration of the fact of death is coupled with the registration of cause of death. In England and Wales, if a death is referred to the coroner and subject to an inquest, no registration of the fact of death need be made until the coroner's verdict is given. This may be months (or even years) later.

In fact, the registration delay is at least six months for around 10,000 deaths each year (2% of all deaths each year) in England and Wales, 4,000 of them at ages 5 to 44 years. Less than 50% of deaths, however, are referred to a coroner (MOJ 2012) and fewer will be subject to an inquest.

The RSS calls for the registration of deaths to be uncoupled from the registration of cause of death in England and Wales – as in Scotland and in a majority of 30 non-UK European countries surveyed on the RSS's behalf. They put forward 10 main arguments to support the need for uncoupling.

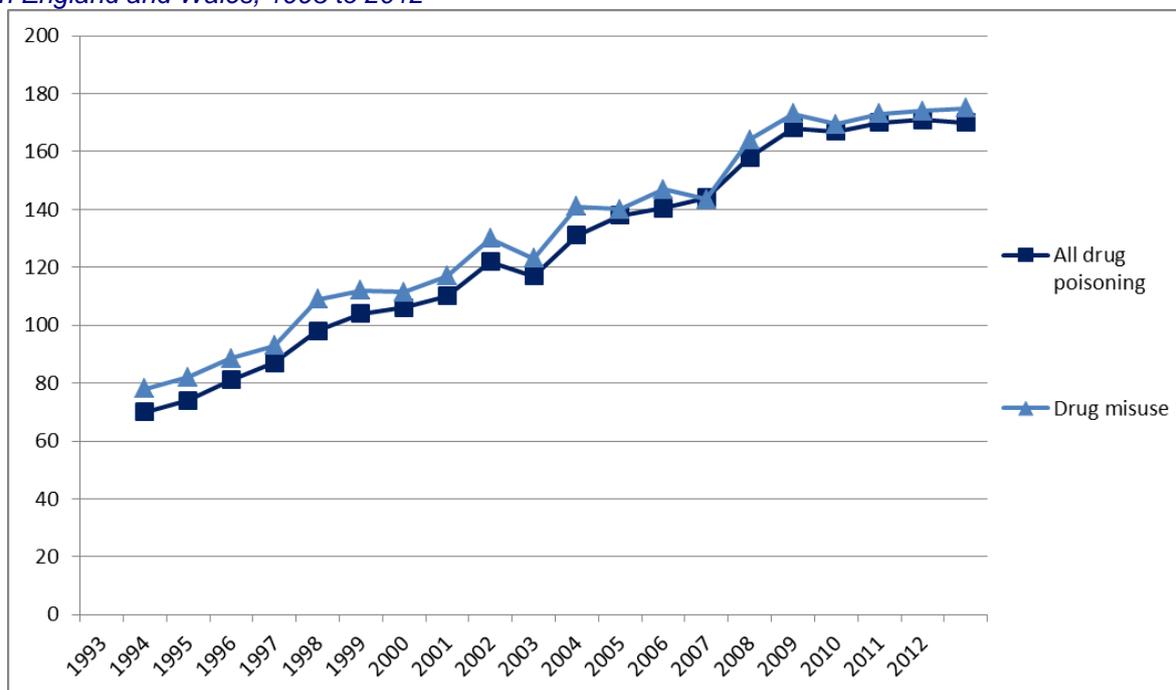
**Coroners' reforms**

On 25<sup>th</sup> July 2013, *The Coroners (Inquests) Rules 2013*<sup>185</sup> came in to force regulating the practice and procedure at, or in connection with, inquests which form part of an investigation into a death held under Part 1 of the *Coroners and Justice Act 2009*. Section 8 states that a coroner must complete an inquest within six months of the date on which the coroner is made aware of the death, or as soon as is reasonably practicable after that date. It is hoped that these national standards will lead to a more efficient system of investigations and inquests, which should reduce registration delays.

**Extent of registration delays on reporting of drug-related deaths in England and Wales**

The Office for National Statistics carried out further analysis to determine the extent of the delay between drug-related death and registration of death (ONS 2013a). Just over half (52%) of the drug-related deaths registered in 2012 took place in earlier years. Figure 6.5 shows that the average delay in days increased from 70 in 1993 to 170 in 2010 and has remained stable since (ONS 2013a).

**Figure 6.6** Average registration delay for all drug poisoning deaths and deaths related to drug misuse in England and Wales, 1993 to 2012



Source: ONS 2013a

**6.4.2 Direct overdoses and indirect drug-related deaths (DRD)**

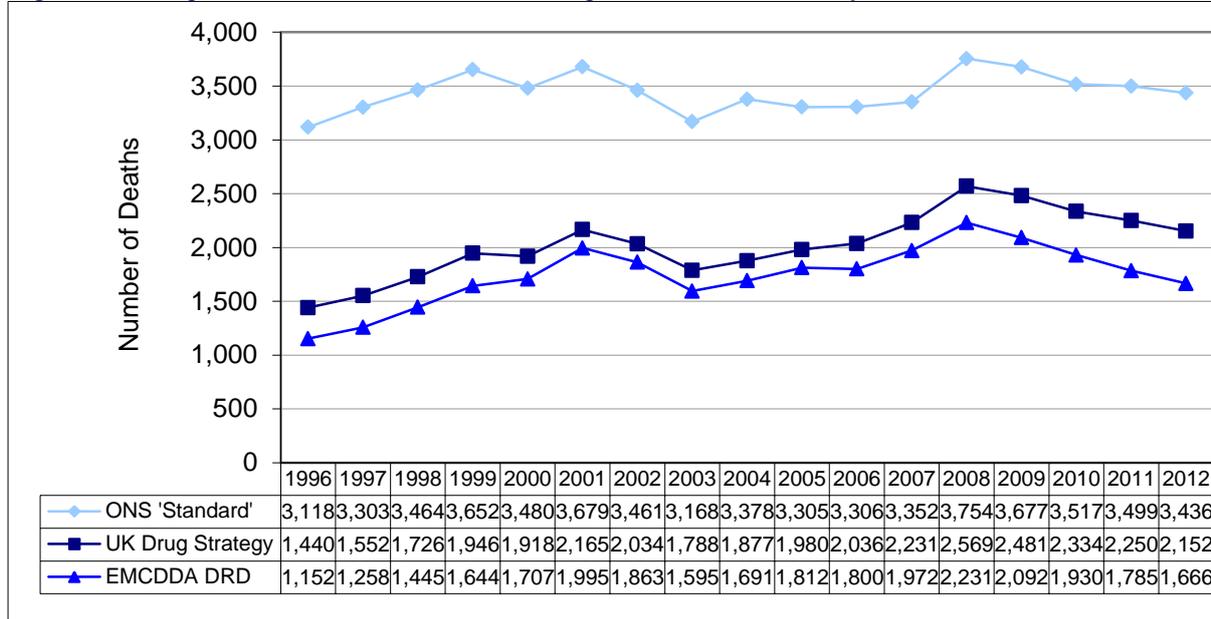
Using the EMCDDA definition, the total number of drug-related deaths registered in the UK during 2012 was 1,666, a decrease of 6.7% since 2011 (n=1,785). Using the slightly different definition of drug misuse, originally adopted to measure the impact of the former UK Drug

<sup>185</sup> See: <http://www.legislation.gov.uk/ukxi/2013/1616/contents/made>

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Strategy (Home Office 2002), there were 2,152 DRD in the UK in 2012 (down from 2,250 in 2011). Using the much wider ONS definition, there were 3,436 DRD in the UK in 2012 (down from 3,499 in 2011). Figure 6.6 shows the number of DRD in the UK from 1996 to 2012, using three definitions, for comparison.

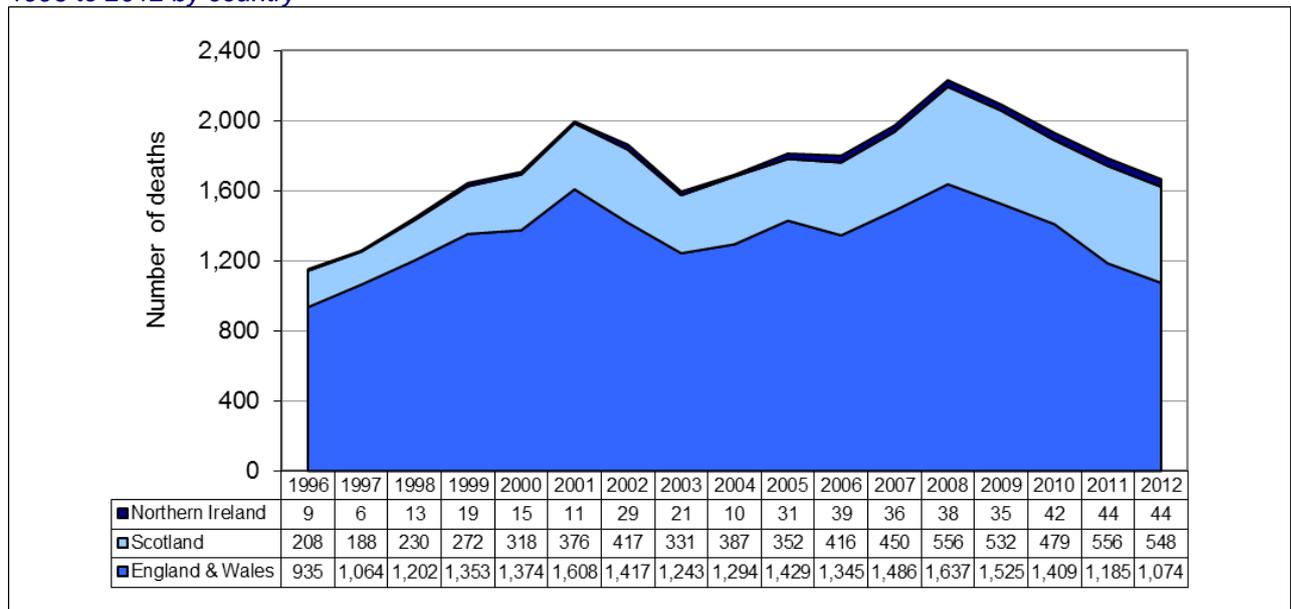
**Figure 6.7 Drug-related deaths in the United Kingdom, 1996 to 2012, by definition**



Source: Standard Table 06

From 1996, when there were 1,152 DRD (using the EMCDDA definition), the number of deaths rose each year to reach 1,995 in 2001. Numbers reduced in 2002 and 2003 to 1,595 in 2003, and then gradually increased over the following five years to reach 2,231 in 2008. Since 2008 DRD have gradually fallen each year to reach 1,666 in 2012. Overall since 1996, the annual rate of DRDs has increased by 45% (514 deaths). There were rises of 30% and 122% for males and females respectively over the period 1996 to 2012.

**Figure 6.8 Comparison of total number of deaths in the United Kingdom using EMCDDA definition, 1996 to 2012 by country**



Source: Standard Table 06

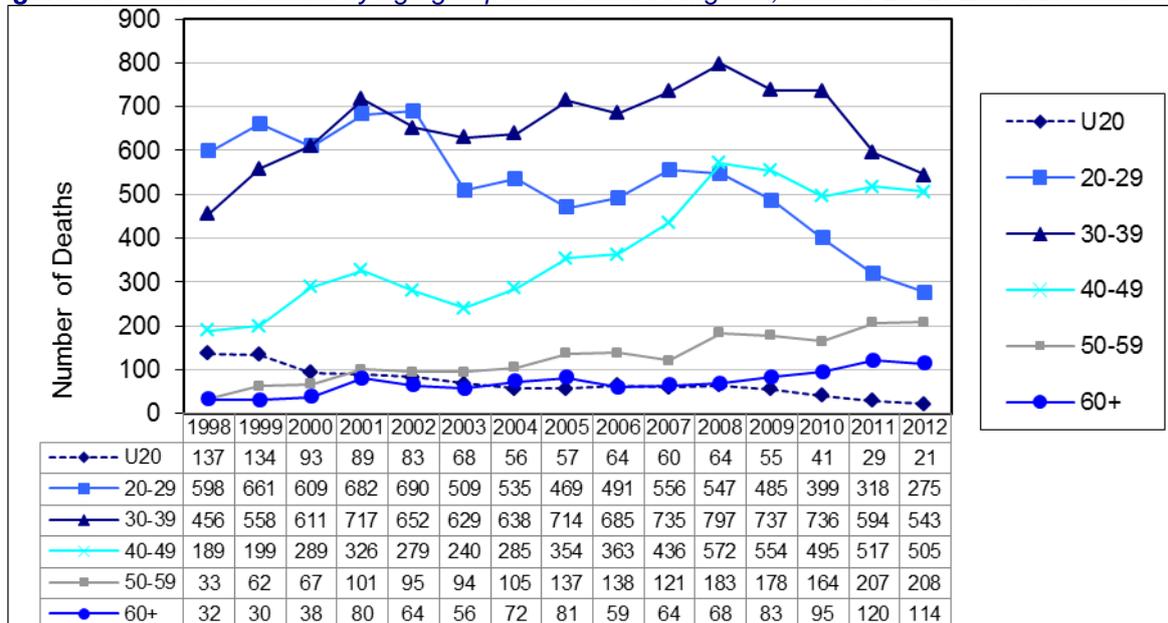
Figure 6.7 shows the number of drug-related deaths separately for Northern Ireland, Scotland and England and Wales from 1996 to 2012 using the EMCDDA definition. DRDs in England and Wales have been falling since 2008 and in 2012 were 1,074, the lowest figure since 1997. DRDs in Northern Ireland rose slightly between 2008 and 2012 and those in Scotland remained broadly steady over the same period. The rate of deaths per 100,000 population (all ages) shows that differences exist between the countries within the UK. In 2012, the rate using the EMCDDA definition was 10.31 deaths per 100,000 in Scotland compared to 1.89 in England and Wales and 2.41 in Northern Ireland. The UK average was 2.62 (this figure was 1.98 in 1996).

**Age and gender**

Of the deaths in 2012, three-quarters (1,257) were males and one-quarter (409) were females. The highest percentage of males was in Northern Ireland (84%), and the lowest in Scotland at 73%. Deaths of males accounted for 76% of deaths in England & Wales. The number of deaths amongst males in the UK over the last ten years rose from 1289 in 2003 to a peak of 1796 in 2008 before falling each following year to reach 1257 in 2012. Deaths amongst females have followed a different pattern. Female DRDs rose from 306 in 2003 to a peak of 435 in 2008 but then remained at around 400 deaths per year apart from an increase to 462 in 2011.

In 2012, the average age of those dying was 41.4 years, with males (40.2 years) tending to be about five years younger than females (45.1 years). The average age of death has increased from 31.5 in 1996. Overall, most DRDs in the UK in 2012 occurred in the 30 to 39 years age-group, although deaths amongst this age group, as well as those amongst people aged under 20 years, 20 to 29 years and 40 to 49 years have fallen since 2008. The largest decrease was amongst those aged 20 to 29 years. Deaths amongst those aged 50 years and over have increased since 2007 (Figure 6.8).

**Figure 6.9** Number of deaths by age group in the United Kingdom, 1998 to 2012: EMCDDA definition



Source: Standard Table 06

**Drugs mentioned on death certificates in the United Kingdom<sup>186</sup>**

The drugs most frequently mentioned on death certificates are opiates (chiefly heroin/morphine and methadone). There are also large numbers of deaths involving diazepam. Deaths often involve a combination of drugs, with alcohol also commonly mentioned: Around two-fifths of deaths involving heroin, methadone, cocaine and benzodiazepines in England and Wales during 2012, also mentioned alcohol (ONS 2013a).

Following reports of a reduced supply of heroin (see section 10.4.4), there was a large decrease in deaths mentioning heroin in 2011, which then remained stable in 2012 (Table 6.2). The number of deaths mentioning methadone in 2012 decreased after a large increase in 2011 but remained higher than in the years before 2011. Deaths involving ecstasy-type substances continue to increase, although the number remains lower than in 2008 and earlier years. Deaths mentioning cocaine increased in 2012 for the first time since 2008, although the number remained lower than in any year between 2004 and 2010.

Deaths mentioning tramadol again increased between 2011 and 2012 (by 24%). The number of deaths involving compound opioid analgesics incorporating paracetamol has declined significantly in recent years following phased withdrawal of co-proxamol between 2005 and 2007. Mentions of tramadol doubled between 2004 and 2006, and then increased steadily before significantly increasing in 2010 to 2012. However, it has not reached the former levels attained by co-proxamol in 1999.

**Table 6.2 Mentions of selected drugs on death certificates in the United Kingdom, 2002 to 2012**

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Heroin/ Morphine	1,118	883	977	1,045	985	1,130	1,230	1,215	1,063	820	825
Methadone	300	292	300	292	339	441	550	586	535	765	660
Cocaine	161	161	192	221	224	246	282	239	181	152	174
Amphetamine	55	43	53	62	60	62	72	57	52	72	67
Ecstasy-type	79	66	61	75	62	64	52	32	9	24	44
Diazepam	356	282	216	210	187	223	277	302	315	336	410
Temazepam	89	114	88	55	55	57	50	48	38	45	45
Tramadol	45	51	56	75	109	116	126	135	185	205	254

Source NISRA 2013, ONS 2013a, NRS 2013

**Information from the National Programme on Substance Abuse Deaths (np-SAD)**

Data from the UK-wide Special Mortality Register (np-SAD) database, which includes data from the Scottish Crime and Drug enforcement agency (SCDEA<sup>187</sup>), are broadly consistent with those from ONS. The np-SAD Annual Report (Ghodse et al. 2013) reports 1,757 notifications of drug-related deaths occurring in 2011 in the UK and Islands. This represents a decrease of 126 (6.7%) over the same reporting period in 2010. Of the 1757 notifications, 1658 of these deaths had psychoactive substances directly implicated and 99 did not.

The overall pattern in the types of psychoactive drugs implicated in death has remained similar to previous years. Heroin/morphine continues to be the substance most commonly implicated in death although the percentage of deaths involving this substance has fallen in recent years, from 53% in 2009 to 41% in 2010, and to 32% (551 deaths) in 2011.

The number of cases involving methadone has steadily risen from 215 in 2003 to 542 in 2011, almost reaching the number of deaths implicating heroin/morphine in 2011 (551).

<sup>186</sup> Drugs mentioned on death certificates include legal and illegal drugs.

<sup>187</sup> In April 2013 SCDEA ceased to exist as a separate organisation and became part of 'Police Scotland'.

Deaths from cocaine reached a peak of 321 in 2007 and fell each following year to reach 155 in 2010 and 161 in 2011. There were 63 amphetamine deaths in 2011. Amphetamine deaths rose from 58 in 2005 to 78 in 2007 before falling back to 50 in 2010. There were 29 deaths associated with ecstasy in 2011, higher than in 2009 (9) and 2010 (11), but still lower than in all other years from 2005 to 2008.

Substances such as piperazines, ketamine and GBH/GBL, which at the time of the 2009 report were 'legal highs' but became controlled drugs, continue to be present in post-mortem toxicology reports - although declining in the case of piperazines (from 17 deaths in 2009, to 9 in 2010, and 6 in 2011) and GHB/GBL (from 22 deaths in 2009, 21 in 2010, and 13 in 2011). Towards the end of 2009 new substances, chiefly methcathinones such as mephedrone started to appear in reports to *np*-SAD. There were 5 deaths associated with Mephedrone in 2009, 29 in 2010 and 13 in 2011.

#### 6.4.3 Drug-related deaths database in Scotland

The third report from the National Drug-related Deaths Database (NDRDD) in Scotland was published in April 2013 (Hoolachan et al., 2013), examining the personal circumstances of those who died. The drug-related deaths in the NDRDD report are a sub-set of the 584 drug-related deaths recorded in Scotland for 2011 (NRS 2012).<sup>188</sup>

In 2011, there were 438 cases identified as eligible for inclusion in the NDRDD cohort (an increase from 365 in 2010). Over three quarters (78.3%) were male, over half (53.4%) lived in the most deprived areas in Scotland<sup>189</sup> and the 35 to 44 years age group accounted for the highest proportion of deaths (38.1%). Over two-fifths (44.5%) of the cohort were a parent or parental figure, nearly two-thirds (63%) had a history of drug injecting and over three quarters (77.4%) had a medical condition recorded in the six months prior to death. Almost two-thirds of individuals (64.5%) had been in contact with a drug treatment service at some point in their lives. In the six months prior to death, one-third (34.3%) had been released from police custody and almost one-fifth (18.1%) had been released from prison.

In the vast majority of cases (97%) more than one drug was *present* in the toxicology and in 68.9% more than one drug was *implicated* in the death.<sup>190</sup>

In 2011, methadone was the drug most frequently *implicated* in the death (234, 53.4%), followed by heroin/morphine (169, 38.6%), diazepam (101, 23.1%), alcohol (93, 21.2%), dihydrocodeine (55, 12.6%), anti-depressants (39, 8.9%), cocaine (33, 7.5%), amphetamines (16, 3.7%), tramadol (9, 2.1%), ecstasy (9, 2.1%) and codeine (8, 1.8%). Cannabis was not implicated in any of the deaths.<sup>191</sup>

<sup>188</sup> The NRS applies the 'UK Drug Strategy' definition of a drug-related death. The NRS figure for 2011, of 584 drug-related deaths is the National Statistics output for Scotland and the 438 cases included in the NDRDD cohort are a subset of these. Annex 5 of the NDRDD report contains details of the reasons for 146 NRS cases not being included in the NDRDD cohort. Thirty-six were excluded because they were suicides.

<sup>189</sup> The Scottish Index of Multiple Deprivation classifies postcode area by deprivation on a scale of 1 to 5, with 1 being the least affluent. Deprivation status was known for 406 individuals in the cohort. Of these, 217 (53.4%) lived in the most deprived areas of Scotland.

<sup>190</sup> The 2011 report (Hoolachan, et al., 2013) includes data on drugs 'present' in the body and drugs 'implicated' in the death. The presence of a drug in the toxicology of the deceased individual does not necessarily mean that the drug was implicated in (contributed to) the death.

<sup>191</sup> For this report, it has been possible to incorporate toxicology information supplied by NRS for the whole NDRDD cohort of 438 cases. The main difference between the NDRDD and NRS toxicology data is that the NDRDD data provide information about the drugs *present* in the body at post mortem

In 2011, diazepam was the drug most frequently found to be *present* in the body at death<sup>192</sup> (81.4%) and the second most common drug was methadone (247, 57.3%). This differs from 2010 when methadone was the fourth most common drug (present in 44.9% of cases) after diazepam, heroin/morphine and alcohol.

Almost three-quarters (73.8%) of individuals in the 2011 NDRDD cohort were not currently in receipt of a prescribed substitute drug. The majority of individuals (150, 60.7%) with methadone found in their toxicology were not in receipt of a methadone prescription at the time of death. For those who *were* in receipt of a methadone prescription, information concerning whether the methadone consumption was supervised or not was available for 98% of cases. Of these cases, 80% were recorded as having supervised consumption and 20% were not.

In relation to drugs *present*, the proportion of deaths with heroin/morphine and alcohol has decreased over the period 2009-2011, while the proportion of deaths with methadone, diazepam and anti-depressants has increased over this period.

#### 6.4.4 Systematic review of drug-related deaths in Wales

The Welsh Government is revising the approach to systematic review of drug-related deaths in Wales to provide more immediate reviews so that learning from the process can feed back into clinical practice as quickly as possible (see section 7.2.1)

#### 6.4.5 Deaths from HIV/AIDS and HCV

In the year to the end of December 2012, there were 36 reported AIDS deaths amongst PWID<sup>193</sup> in the UK but this figure is likely to rise as further reports from that period are gradually received. Numbers of AIDS deaths for PWID in the UK each year since 2006 have been fairly steady at between 60 and 65 each year (apart from in 2009 when there was a slight increase), much lower than the peak level of 212 deaths in 1995 (Public Health England, unpublished data).

In England and Wales, from the first recording of AIDS deaths amongst PWID, up to the end of December, 2012<sup>194</sup>, there had been a total of 1,505 AIDS deaths amongst PWID. This accounted for 7.9% of all AIDS deaths recorded up to that date (n = 19,039). In Northern Ireland, the eight AIDS deaths of PWID accounted for 7.4% of all AIDS deaths (n = 108) but in Scotland, the 864 AIDS deaths of PWID represented a much higher percentage, at 46.2% of all AIDS deaths (n = 1,872).

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whereas the NRS data usually provide separate information about the drugs present in toxicology which are (i) *implicated* in the death and (ii) *not* implicated in the death. The *presence* of a drug (NDRDD data) does not necessarily mean that the drug contributed to the death. However the NRS data make it possible to examine the proportion of cases where a drug was present and also whether or not it was implicated in the death. It is important to note that the decision as to whether or not a drug is implicated in a death lies with the pathologist and that pathologists provide NRS with information about most drug-related deaths. If NRS does not receive information from a pathologist it assumes that all drugs that were mentioned on the death certificate were implicated in the death.

<sup>192</sup> No information was available regarding whether or not individuals had been prescribed diazepam and the report identified this as information that would be useful to have, given the high number of deaths with diazepam present.

<sup>193</sup> This includes individuals who injected drugs and those who were men who had sex with men and also injected drugs.

<sup>194</sup> Numbers for 2012 are likely to increase as further reports are received.

#### 6.4.6 Mortality and causes of deaths amongst drug users (mortality cohort studies)

##### Drug-related deaths and suicides after hospital discharge

Merrall et al. (2013b; ST18) conducted a cohort study to investigate the relationship between the time after hospital discharge and a drug-related death (DRD) or non drug-related suicide in drug users in Scotland. Participants comprised the 69,457 individuals registered through the Scottish Drugs Misuse Database (SDMD) who had attended drug services between 1<sup>st</sup> April 1996 and 31<sup>st</sup> March 2006. Through probabilistic linkages with records in other national registers<sup>195</sup>, deaths, hospital episodes and HCV diagnoses were identified for individuals registered on the SDMD. There was a far higher rate of DRD than non-DRD suicides amongst this cohort but, for both types of death, there was a similar pattern of higher risk of death within 28 days of discharge from hospital<sup>196</sup> and the risk gradually reduced over time after discharge<sup>197</sup>. This highlighted a need for additional support for drug users leaving hospital. DRD rates for each of the periods after hospital discharge were compared for two study eras (April 1996-March 2001 and April 2001-March 2006). DRD rates were lower in the second era for each period except the first 90 days following discharge.

##### Research

##### *Opiates in femoral blood and vitreous humour after heroin or morphine-related deaths.*

Rees et al. (2013) investigated the relationship between concentrations of morphine, codeine and 6AM (6-acetylmorphine, a metabolite of heroin) in femoral blood (FB) and vitreous humour (VH) in 70 cases in which morphine was found in the blood at post mortem examination. They identified 34 cases as 'rapid' deaths (death occurred within approximately 3 hours of drug use) and 12 cases as 'delayed' deaths (death occurred more than 3 hours after drug use) from evidence in police and pathology reports associated with each case and also (for rapid deaths) from the presence of 6AM which is only present in blood in the first 2 or 3 hours after heroin use. The relationship between concentrations in FB and VH, in relation to the time between drug use and death, was then investigated to see how useful it might be to examine the concentrations of opiates in VH to aid interpretation in toxicological assessments. In rapid deaths, the median free morphine concentration in VH was lower than in FB whereas in delayed deaths it was higher in VH than in FB. Free morphine VH/FB ratios were significantly higher in delayed deaths compared to rapid deaths but there were overlaps in the results of the two groups. The authors advised that VH/FB free morphine ratios had limited interpretive value and said concentrations in VH could not be used to reliably infer blood concentrations. They advised against using free morphine to total morphine ratios in blood to estimate survival time after drug use.

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<sup>195</sup> These were national registers held by Scotland's Information Services Division, the General Register Office for Scotland and Health Protection Scotland.

<sup>196</sup> Time periods used in the analysis were; while hospitalised; within 28 days of discharge; 29 to 90 days; 91 days to 1 year; more than one year; and never hospitalised.

<sup>197</sup> Analysis showed the risk of both DRD and non-DRD suicide was highest during hospitalisation but this was anticipated due to the likelihood of a high number of deaths on admission, where resuscitation was not successful following an overdose or other suicide.

## 7. Responses to health correlates and consequences

### 7.1 Introduction

In Wales, the ten year substance misuse strategy *Working Together to Reduce harm* was published in 2008, setting out a national agenda for tackling and reducing the harms associated with substance misuse. Guidance on developing local confidential reviews into drug-related deaths in Wales was published in 2005. In England, the 2010 drug strategy, *Reducing Demand, Restricting Supply, Building Recovery*, includes a key best practice outcome that all drug services are commissioned to prevent drug-related deaths and blood borne viruses.

In relation to the prevention of drug-related infectious diseases, a public health approach aimed at containing HIV transmission began in the 1980s. The subsequent action, involving harm reduction measures, is regarded as having been successful in helping to contain HIV amongst people who inject drugs (PWID). Measures include: the provision of free needles and syringes; promoting the safe disposal of used equipment; information campaigns on safer sex and safer injecting; and HIV/AIDS counselling, support and testing. Needle and syringe provision takes place throughout the UK, principally through pharmacies and specialist drug treatment services and also through some street outreach and mobile vehicle services. In Wales a vending machine is available in a community-based, homeless centre.

Drug treatment services have also focused their efforts to encourage more people who inject drugs to stop injecting, get tested for hepatitis C and HIV, and vaccinated for hepatitis B. Treatment for infectious diseases is provided as part of the National Health Service (NHS), including the provision of anti-retroviral treatment for HIV, hepatitis B (HBV) and hepatitis C virus (HCV).

The Scottish Government launched the *HIV Action Plan in Scotland, December 2009 to March 2014* in November 2009. The plan aims to reduce the number of transmissions taking place in Scotland through increased prevention, increasing early diagnosis and improving the treatment and care of those living with the virus. The Sexual Health and Blood-borne Virus Framework 2011-2015 (Scottish Government 2011a) brings together hepatitis C, HIV, sexual health and hepatitis B into a single integrated strategy, adopting a multi-agency, cross-policy approach. Quality standards applicable to all HIV services (HIS 2011) and quality indicators applicable to all hepatitis C services (HIS 2012) were also published in Scotland. The number of HIV diagnoses amongst PWID decreased following the introduction of harm reduction measures in the early 1990s and has remained relatively low since. In 2012 there were 14 diagnoses of HIV in PWID.

In Northern Ireland, an Action Plan for the Prevention, Management and Control of hepatitis C was launched in 2007 (DHSSPSNI 2007). The Blood-borne Viral Hepatitis Action Plan for Wales 2010-2015 was published in 2010 (WAG 2010).

### 7.2 Prevention of drug-related emergencies and reduction of drug-related deaths

#### 7.2.1 Data collection and information provision

##### Scotland

ISD Scotland has published a report of 2011 data from the National Drug-related Deaths Database (NDRDD) describing the social circumstances and background details surrounding the drug-related deaths of 438 individuals (Hoolachan et al. 2013, see section 6.4.3). The NDRDD reports have sought to contextualise these deaths in order to inform interventions to reduce drug-related deaths (DRD) in Scotland. The report supplements the routine reporting

of drug-related deaths in Scotland by the National Records of Scotland (NRS)<sup>198</sup> in its annual Drug-Related Deaths report. The NDRDD figure of 438 drug-related deaths in 2011 is not a National Statistics output for Scotland but represents a subset of the 584 drug-related deaths recorded by NRS for 2011 (NRS 2012).

The Scottish Drugs Forum published its Annual Report 2011/12 detailing its activities over the preceding year, including playing a role in assisting the expansion of the Scottish Government's Take Home Naloxone initiative and holding a conference programme on drug-related issues (Scottish Drugs Forum 2012).

*The National Forum on Drug-Related Deaths Annual Report 2011/12*

The *National Forum on Drug-Related Deaths Annual Report 2011/12*<sup>199</sup> was published in March 2013 (NFDRD 2013). The Forum's report includes observations on the National Naloxone Programme; developing hepatitis C treatment in the community; through-care for those leaving prison; publishing prison drug and alcohol treatment waiting times; providing alternatives to methadone; needs of older drug users; provision of foil to drug users; and the role of community pharmacies. The Forum also offers two main recommendations; to encourage more GPs to consider the treatment of drug users; and to fund more research into DRDs in Scotland.

Wales

The systematic review processes for DRDs in Wales are being revised to establish more 'real time' reviews to ensure prompt implementation of lessons learnt from the process. The monitoring role of the national Drug Related Deaths Board will also be reviewed and its links with Area Planning Boards (APBs) will be strengthened. The Welsh Government has been working closely with all areas in Wales to help develop harm reduction groups. These groups are within APBs but draw members from a wider range of organisations. They develop operational plans to reduce DRDs and other harm associated with substance misuse and have helped advance other initiatives such as pharmacy interface and needle exchange, Take Home Naloxone and hepatitis services (Welsh Government 2012a).

The Harm Reduction Database (HRD) is collating data from all needle and syringe programmes and this will provide detailed information on the population of (mainly injecting) drug users who access those programmes. In addition, HRD provides a mechanism for recording all activity relating to the National Take-Home Naloxone programme, developed to reduce opioid-related deaths (see section 7.2.2). HRD reports for both programmes are published annually.

Research

*Risk factors for drug-related deaths involving heroin, alcohol or methadone*

McAuley and Best (2012) used retrospective data (between 2006 and 2007) from two Scottish NHS Board areas in the West of Scotland to examine 291 drug-related deaths involving heroin, alcohol or methadone. They investigated the associations between personal and population DRD risk factors and attempted to predict their impact. For DRDs involving both heroin and alcohol, age and geographical area were both significant

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<sup>198</sup>The National Statistics output for the number of drug-related deaths that are registered annually in Scotland is published by the National Records of Scotland (NRS). NRS was formerly known as the General Register Office for Scotland.

<sup>199</sup> The National Forum on Drug-Related Deaths Annual Report 2011/12 is the fifth report from the Forum, which was set up in 2005 in response to one of the actions of the *Scottish DRD Strategy* (SACDM 2005). The forum is independent and has representation from experts in a range of professional fields. It provides advice and recommendations to the Scottish Government and partners on measure to reduce drug-related deaths in Scotland.

predictors. Prison release within the last 14 days was a significant predictor of heroin-related DRDs and males were significantly more likely than females to be affected by heroin-related DRDs. Methadone-related DRDs were more likely to affect females than males and were less likely to co-involve heroin. The analysis suggests new areas where overdose prevention messages should be targeted; such as an increasing risk of alcohol involvement in DRD with age and an increased risk for females of methadone-related DRD.

## 7.2.2 Naloxone

### England

The pilot phase of the naloxone investigation (N-ALIVE) randomised trial began in May 2012, involving prisoners on release from prisons in England (Strang et al. 2013). Recruitment to the preliminary phase, has now finished and a decision is awaited on whether the main trial will be funded. Previous, smaller scale, take home naloxone (THN) schemes have reported positive results but this would be the first *definitive* study of the effectiveness of THN in terms of reducing deaths from heroin overdose. Within the trial, prisoners with a history of heroin use would be randomised to receive either treatment-as-usual on release or treatment-as-usual plus a supply of take home naloxone. For details of the rationale for and design of the trial see Strang et al's recent paper (2013).

### Wales

In Wales, under the 'Take Home Naloxone (THN) Scheme' naloxone has been available in all community treatment sites and prisons, since November 2011. Since the scheme started in July 2009, 2,130 individuals across Wales have been trained in the use of, and issued with THN kits. By 31<sup>st</sup> March 2013, THN had reportedly been used in 215 opioid poisonings in Wales (Welsh Government, personal communication).

Where recorded, data show that, compared to the overall profile of individuals issued THN, a greater number of individuals who had used THN in poisoning episodes, lived in temporary accommodation or were homeless. Work is on-going to distribute THN and disseminate harm reduction messages further to this client group to help prevent fatal poisonings.

Work is also taking place with prisons in Wales to ensure the continued take up of services within prisoner populations and with English prisons which house Welsh female prisoners, to ensure adequate THN training and kits are available.

In some areas of Wales, individuals are being supplied with two THN kits so that they can give one kit to a carer or hostel staff for safekeeping, to use in case of an overdose. Training on the THN scheme has been delivered to police officers as part of their annual first aid training and officer safety training, to ensure they recognise the THN kits and understand their use. An information sharing protocol has been developed to allow Accident and Emergency staff to refer patients on to community drug treatment providers, following a non-fatal overdose. This will encourage services to work together and also enable people who misuse substances but who are not currently in treatment, to access the THN scheme.

Following the completion of the national roll-out of naloxone in both the community and prison estates across Wales, the Welsh Government is now supporting further projects to ensure wider dissemination of naloxone. These include the following:

- Paramedic Feasibility Study- A randomised controlled trial involving paramedics providing overdose awareness training and a take home naloxone kit at the scene of an overdose. This commenced in May 2013 and will run until May 2014. To date 17 kits have been dispensed at the scene of an overdose, with one reported use.
- An Emergency Department Pilot has commenced whereby those at risk of overdose are given take home naloxone.

- Custody Suite Pilot- whereby those at risk of overdose will be given take home naloxone on release from custody.

The Harm Reduction Database for Take Home Naloxone was launched on 1 March 2012, providing reports by area on the distribution, use and outcomes of THN and collecting data to enable onward referral to address clients' wider harm reduction needs (Welsh Government 2012a). The collection of data also provides robust information regarding situational factors surrounding overdose situations. An annual report is currently being developed and will be available in late 2013.

### Northern Ireland

A take home naloxone pilot scheme began in 2012. The scheme currently operates across Northern Ireland and a rolling evaluation is due to begin shortly. It is planned to extend the scheme to increase supply of Take Home Naloxone to those at risk who do not currently access drug and alcohol Services.

### Scotland

Monitoring information from the second year of Scotland's national Take Home Naloxone Programme, which is centrally co-ordinated and funded by the Scottish Government, was reported in July 2013 (ISD Scotland 2013b). There were 3,833 THN kits issued in Scotland in 2012/13 through the national programme- an increase of 11% on the 3,458 kits issued in 2011/12 (revised 2011/12 figures). The total number of THN kits supplied through the national programme is 7291 (2011/12 and 2012/13). This includes kits issued in the community and kits issued by prisons, to individuals with a recent history of opioid use, on their release from prison. In 2012/13 there were 3,087 THN kits issued in the community in Scotland and 746 kits issued by prisons in Scotland (see section 9.6.4).

Expert advice from Scotland's national naloxone advisory group suggests that a minimum of 15% of people with problem opiate use should be supplied with THN kits by 31 March 2014 to ensure that those most vulnerable to opiate overdose have access to THN. This equates to 9,000 kits and, to date, 7,291 kits have been supplied.

### Research

#### *General Practitioner (GP) Engagement with the Scottish National Naloxone Programme*

A needs assessment was conducted in order to determine the best ways to enable General Practitioners to engage effectively with the Scottish National Naloxone Programme (Pflanz-Sinclair et al. 2013). The views, knowledge, awareness and attitudes of GPs, in relation to take-home naloxone were identified through a postal survey and telephone interviews<sup>200</sup>. The research found minimal awareness of the naloxone programme and low levels of involvement (3.3% of those sampled). Fewer than 20% were involved in distributing information and 8% knew who their local naloxone lead was. Half of the survey respondents said they would be willing to provide naloxone prescribing to drug users or their friends and families. GPs were asked what would enable the naloxone programme to expand into primary care and the factors they rated as 'very important' were; 'having supporting evidence' (89.7%); 'appropriate GP training' (82.8%); 'it must be on the local formulary' (67.2%); 'practice nurses should be trained' (52.3%); 'GPs should be paid' (43.5%); 'it should be part of the quality and outcomes framework' (14%). Many GPs felt delivery of naloxone by specialist services was preferable to having it as part of their remit. Both the interviews and the survey showed that the key barrier to GP involvement appeared to be the need for

<sup>200</sup> A quantitative, four-page questionnaire was sent to a representative sample of 500 GPs across Scotland, followed by a postal reminder and a one-page questionnaire for non-responders. This achieved a 55% response rate (240/439). 61 questionnaires did not reach intended addresses. Qualitative telephone interviews were conducted with a purposive sample of 20 GPs selected to provide a range of levels of experience with drug misusers generally and with naloxone specifically.

evidence-based local and online training on drug-related deaths and naloxone prescribing and delivery. There was evidence of some generally negative attitudes to drug users.

#### Naloxone training and promotional materials

The Scottish Drugs Forum released new Naloxone training and promotional materials in April 2013, including posters, cards and two booklets.<sup>201</sup> These new naloxone materials have been distributed to all Alcohol and Drug Partnerships in Scotland. The naloxone website provides further information online.<sup>202</sup>

#### Review of the development of Scotland's National Take Home Naloxone Programme

McAuley et al. (2012) provide a review of the research, advocacy and policy contributions that enabled the establishment of Scotland's National Take Home Naloxone Programme, together with a description of naloxone use in other countries and a discussion of the barriers preventing national programmes in other countries.

#### Service Evaluation of Scotland's National Take Home Naloxone Programme

A service evaluation of Scotland's national take home naloxone programme is currently being carried out and should be completed by the end of March 2014. The specific objectives of the evaluation are to;

- examine the processes and structures put in place to implement the programme locally;
- assess the effectiveness of identified processes and structures for the different stakeholders involved;
- provide an early indication of programme impact including consideration of the outcomes for those who have engaged with the programme, and whether the programme is reaching those who do not typically engage with drug treatment services; and
- establish the key lessons learned and the implications for policy and the future development and implementation of the programme.

#### New scales to evaluate take-home naloxone (THN) training

Two new psychometric scales; the Opioid Overdose Knowledge Scale (OOKS) and the Opioid Overdose Attitudes Scale (OOAS) have been developed as outcome measures of take-home naloxone training for the friends and family members of opioid users (Williams et al. 2013). The paper describes development and testing of the new scales<sup>203</sup> and concludes they will be useful measures for monitoring and assessing future THN training initiatives.

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<sup>201</sup> Materials are available at :

<http://www.sdf.org.uk/drug-related-deaths/new-naloxone-training-and-promotional-materials-2013/>  
(accessed 3 June, 2013)

<sup>202</sup> See: <http://naloxone.org.uk/>

<sup>203</sup> To assess internal reliability and construct validity, the scales were administered to 42 friends and relatives of heroin users and 56 healthcare professionals. Friends and family participants completed the OOKS and OOAS on a second occasion to check test-retest reliability and also completed two other scales to test concurrent validity. Both scales were internally reliable and reliable at retest. Healthcare professionals scored higher on the OOKS compared to friends and family participants. The two scales were the Brief Overdose Recognition and Response Assessment (BORRA) and the General Self Efficacy scale (GSE). The OOKS total scores were significantly positively correlated with the BORRA's Overdose Recognition ( $r=0.5$ ,  $p<0.01$ ). The total score on the OOAS was not positively correlated with the GSE, suggesting that the opioid overdose related attitudes captured by the OOAS do not indicate an underlying general self-efficacy factor.

### Proposal for a supervised drug consumption room

A recommendation has been made by the Independent Drugs Commission for Brighton & Hove (2013) to consider setting up a supervised drug consumption room in Brighton and Hove, to try to reduce the number of drug-related deaths in the city and as a way of engaging more people who inject drugs in treatment. The city council will consider the proposal during 2013.

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

A range of services are provided across the UK that have a role in the prevention of infections amongst PWID. This section considers the key services involved in prevention, other than opiate substitution therapy and drug treatment, which are considered elsewhere (see section 5.3.4 and 5.5.2). In addition, this section looks at the diagnosis and treatment of key infections.

### 7.3.1 Needle and syringe programmes (NSPs)

NSPs are provided throughout the UK in a variety of settings. These provide a range of injecting equipment and also advice on safer injection practice. In addition, many offer other services including testing for infections, injection site care, condoms, and vaccinations.

#### England

NSPs are provided throughout England, principally through pharmacies and specialist services.

The vast majority of the Unlinked Anonymous Monitoring (UAM) Survey of PWID participants reported that they had used a NSP: in 2012, 83% of the survey participants who had injected during the preceding year reported that they had used a NSP during that time; only 5% (95/1,835) of these participants had never used a NSP (PHE 2013b).

Participants in the UAM Survey in England who had injected in the preceding four weeks were also asked about both the number of times they had injected and the number of needles that they had received during that time. In 2012, just less than half (47%) indicated that the number of needles they had received during the preceding four weeks was greater than the number of times that they had injected, this compares to 50% in 2011 (PHE et al 2013b). These data should be interpreted very cautiously. Firstly, some people get more needles than they need from exchanges, and pass them on to partners or friends (secondary distribution). Secondly, on average, more than one needle is likely to be needed per injection, as needles may also be used during drug preparation and an injection may require several attempts (and therefore needles) to access a vein.

In England almost one-third (33%) of UAM Survey participants in 2012 who had injected during the preceding four weeks had injected with a needle that had been previously used and which they had attempted to clean (PHE et al. 2013b).

Together these data suggest that the amount of equipment provided in England, (whilst substantial), needs to be increased.

NICE will be updating its public health guidance *Needle and syringe programmes: providing people who inject drugs with injecting equipment*. The new guidance is due to be issued in March 2014. This update will examine new evidence as it relates to the current recommendations, and will also examine additional evidence related to providing needle and syringe programmes (NSP) to users of performance and image enhancing drugs (for

example, steroids for bodybuilding or injected tanning agents) and evidence relating to providing NSP to young people under the age of 16.

As part of this update, NICE in collaboration with Public Health England and the National Needle Exchange Forum carried out a survey of commissioners and providers of NSPs. The survey aims to understand; how NICE Public Health Guidance 18 (Needle & Syringe Programme) has been implemented, including if there have been any barriers to implementing the guidance; and the current type and level of NSP provision in England, including a snapshot of activity.

#### *Provision of Foil*

In response to the evidence presented in a report by the Advisory Council on the Misuse of Drugs (ACMD 2010b), the Government has announced plans for new legislation to allow the provision of foil by drug treatment services as a means of encouraging drug users to engage in treatment and also as a harm-reduction measure. Foil is used for smoking drugs rather than injecting so provision of foil may help discourage people from injecting drugs and thus reduce the harm associated with injecting. (see section 1.2.4)

#### Scotland

Results from the 2011/12 Injecting Equipment provision (IEP) survey in Scotland have been published (ISD Scotland 2013c; ST10).<sup>204</sup> Following a steady increase in reported attendances at IEP services between 2007/08 and 2009/10 there was an 11% decrease in attendances in 2010/11 and a further 6% decrease in attendances in 2011/12 to 219,000.<sup>205</sup> A total of 3.95 million needles/syringes were reported to have been distributed in 2011/12. This was a decrease of 12% from 2010/11, when 4.51 million needles/syringes were distributed but may be explained by the absence of reports from one area. There has also been a decrease in the percentage of those presenting to treatment reporting that they are currently injecting. There were increases reported in the distribution of some types of injecting paraphernalia, in particular wipes/swabs, citric acid/vitamin C, spoons and syringe identifiers, although in the case of wipes/swabs and citric acid/vitamin C, this increase followed a substantial drop between 2009/10 and 2010/11.

There are indications that services are seeing more clients injecting drugs other than opiates; 85% reported that some of their clients injected stimulants and 93% reported that some of their clients injected performance and image enhancing drugs, this compares to 71% and 84% respectively in the previous survey.

#### Wales NSP services

The Harm Reduction Database (HRD) was implemented in all needle and syringe programmes (NSP) across Wales from 1<sup>st</sup> September 2010. From April 2014, all NSP services, including those based in pharmacies will record activity on the HRD. The database collects data on needle and syringe use and other harm reduction interventions in order to establish a better evidence base on individuals at high risk of infection with blood borne viruses due to injecting drug use. A report from the first 18 months of the database (Public Health Wales 2013) showed 7,343 individuals used NSP services in Wales at least twice during that period. The primary substance recorded was an opioid for 32.7% (2,399) of clients, stimulants for 5.9% (431) and steroid/image enhancing drugs for 34.4% (2,524). No primary substance was recorded for the remaining 27%.

<sup>204</sup> Responses were received from 292 IEP outlets across Scotland. IEP outlets were available in 12 of the 14 NHS Board areas. The majority of these outlets (72%) were situated in pharmacies.

<sup>205</sup> It is advised that caution should be used when looking at trends as there are likely to be inconsistencies across local reporting areas (as some areas have improved the accuracy of reporting mechanisms over time) and some missing data. Also, the proportion of IEPs using estimated figures has increased over the past year.

The report presents valuable data from the database, for example on route of drug administration, sharing of injecting equipment and on self-reported hepatitis C status as well as demographic data. The authors emphasise the need for more complete service user records to be submitted and are working with sites to improve data quality. The next annual report will be published later in 2013.

#### Northern Ireland Needle and Syringe Exchange Scheme

Northern Ireland has operated a Needle and Syringe Exchange Scheme since 2001, and activity monitoring information is collected from 14 pharmacies and one Community Addiction Team that offer the service. In 2012/13, a total of 214,550 syringes were issued, an increase of 9% from the previous year and continuing the trend of year-on-year increases observed since 2005/06. The number of visits to a needle and syringe exchange also increased from the previous year (by 5%).

**Table 7.1** *Syringe Provision: number of visits and syringes issued in Northern Ireland, 2001/02 to 2012/13*

Year	Number of visits	Number of syringes issued
2001/02	5,213	67,989
2002/03	6,043	67,516
2003/04	7,508	82,731
2004/05	7,440	86,056
2005/06	8,797	85,801
2006/07	9,997	97,684
2007/08	11,387	116,935
2008/09	13,389	135,700
2009/10	15,828	153,625
2010/11	17,712	179,700
2011/12	20,407	196,780
2012/13	21,328	214,550

Source: Standard Table 10: personal communication DHSSPSNI

#### Research

##### *Uptake and sharing of paraphernalia amongst injecting drug users in Scotland (IDUs)*

Aspinall et al. (2012) carried out a cross-sectional survey of people attending Scottish injecting equipment provision (IEP) services to see whether uptake of paraphernalia was associated with decreased sharing during drug use. The findings from short questionnaire-based interviews with 2,037 participants, all of whom had injected drugs in the previous six months, suggested that uptake of filters, spoons and sterile water from IEP services was associated with decreased odds of sharing those items in the previous six months. Participants were asked to estimate their own uptake of paraphernalia and the number of times they injected in an average week during the previous six months, and also whether or not they had used filters, spoons and/or water that had already been used by someone else. The shortfall of each of the items was estimated for each individual in an average week. A shortfall of filters, spoons or sterile water was associated with greater odds of sharing those items. The study took place between June 2008 and June 2009 during a period in which distribution of paraphernalia was increasing in the lead up to the May 2010 release of guidelines recommending making paraphernalia available. The study authors note that the impact of paraphernalia uptake on HCV transmission remains uncertain and needs to be investigated.

*Association between harm reduction intervention uptake and hepatitis C infection*

Allen et al. (2012) examined the association<sup>206</sup> between self-reported uptake of harm reduction interventions (injecting equipment provision and methadone maintenance therapy) and recent hepatitis C infection amongst PWID. Information and dried blood spot samples were obtained from 2,555 participants attending sites in Scotland during 2008-09, where sterile injecting equipment was supplied. Recent hepatitis C infection was defined as anti-HCV negative and HCV-RNA positive in blood tests. Fifty-four per cent (1,367) of the participants who tested anti-HCV positive had longer-standing hepatitis C infection. Of the 1,140 who were anti-HCV negative, 24 were HCV-RNA positive, indicating a recent hepatitis C infection<sup>207</sup>, generating incidence estimates between 10.8 to 21.9 per 100 person years. Recent homelessness, recent imprisonment and excessive alcohol consumption were associated with increased odds of recent HCV infection. Factors associated with reduced odds of recent HCV infection were; being older than 30 years of age; having prescribed methadone maintenance therapy; and having sufficient supplies of sterile needles and syringes (defined as- reported receipt of supplies sufficient for double the reported frequency of injecting); and high coverage of combined interventions. The authors concluded future sweeps of this cross-sectional survey would increase the statistical power and enable the impact of harm reduction interventions to be assessed.

7.3.2 Condom provision

Condoms are commonly provided free of charge to people in need by a range of services including NSPs, drug services and sexual health services in the UK.

*Condom use amongst people who inject psychoactive drugs.*

Participants in the UAM Survey of PWID are asked about the number of sexual partners they have had and condom use with these partners during the preceding year. Data from the survey for England, Wales and Northern Ireland indicates that amongst those reporting more than one sexual partner during the past year, only 17% had always used a condom for vaginal or anal intercourse (PHE 2013b).

*Condom use amongst people who inject image and performance enhancing drugs.*

The voluntary unlinked-anonymous survey of male 'image and performance enhancing drug' (IPED) injectors in England and Wales undertaken during 2010-11 found that only one in five (20%) had always used a condom for anal or vaginal sex or had not had sex during the preceding year (Hope et al. 2013).

7.3.3 Hepatitis C prevention, diagnosis and care

England

In 2012, 54% of hepatitis C infected PWID in England participating in the UAM Survey reported being aware of their hepatitis C positive status, an increase from 42% in 2002. In the same survey, 83% of PWID participating in 2012 reported ever having had a voluntary confidential test for hepatitis C, an increase from 58% of those surveyed in 2002 (PHE et al. 2013b; PHE 2013b; 2013c).

Information on access to hepatitis C treatment services by PWID has been obtained from those participating in the UAM Survey in 2012. The survey asked participating PWID who

<sup>206</sup> Logistic regression was used to examine the associations between recent hepatitis C infection and uptake of harm reduction.

<sup>207</sup> Following hepatitis C infection there is a period of between 28 to 65 days, before HCV antibodies are present in the blood and only HCV-RNA can be detected. The classification of infection as 'recent' is based on this delay.

reported having had a positive result to a diagnostic test for hepatitis C: 'Have you ever seen a specialist nurse or doctor (e.g. a hepatologist) about your hepatitis C?' Amongst the survey participants in England with antibodies to hepatitis C who were aware of their infection, 62% reported that they had seen a specialist nurse or doctor about their infection, and 39% reported that they had been given medication related to their hepatitis C infection (PHE et al. 2013b).

The National Institute for Health and Care Excellence (NICE) published new guidance: *Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection* in December 2012, in response to a request from the Department of Health (NICE 2012b). The guidance is based on evidence reviews, economic modelling, expert witness testimony and stakeholder comments and aims to ensure that more people who are at increased risk of contracting hepatitis B and C are tested. The guidance is aimed at commissioners and public health services, local organisations providing services for children and families at an increased risk of infection including the NHS, local authorities, prisons, immigration removal centres, drugs services and voluntary organisations also working with people with a heightened risk. Recommendations for action include;

- awareness-raising about hepatitis B and C amongst the general population and people at increased risk of hepatitis B or C infection;
- developing the knowledge and skills of healthcare professionals and others providing services for people at increased risk of hepatitis B or C infection;
- testing for hepatitis B and C in primary care, prisons, immigration removal centres drug services, sexual health and genitourinary medicine clinics;
- contact tracing;
- effective delivery and auditing of neonatal hepatitis B vaccination;
- commissioning locally appropriate integrated services for hepatitis B and C testing and treatment; and
- providing laboratory services for hepatitis B and C testing.

### Scotland

The 2011-12 Needle Exchange Surveillance Initiative (NESI) survey results indicated that 83% of PWID using NSP in Scotland reported having ever been tested for hepatitis C, this compares to 77% in 2010 and 74% in 2008/2009. In 2011-12, 42% reported having had a test in the last year. When those who reported they had been previously diagnosed with hepatitis C infection (that is, prior to 12 months ago) were excluded, the percentage of respondents who had been tested for hepatitis C in the last year increased to 49%; this figure compares to 40% and 45% reported by PWID surveyed in 2008-09 and 2010, respectively. (PHE et al. 2013b)

Amongst PWID interviewed during 2011-12 and who were hepatitis C antibody positive (in anonymous testing of the Dried Blood Spot samples they provided), 45% reported that they "have hepatitis C" (i.e. were aware of their infection) and a further 13% reported having "cleared hepatitis C". These figures are comparable to the 44% and 12% of hepatitis C antibody positive PWID who reported having the virus and having cleared the virus, respectively, in the 2010 survey. (PHE et al. 2013b)

### Wales

The 'Blood Borne Viral Hepatitis Plan for Wales', published in 2010 (WAG 2010) aims to reduce the transmission of hepatitis infection in Wales, increase diagnosis of infection and improve treatment and support for those infected. The plan sets out actions to be implemented between 2010 and 2015 and the Annual Report for 2012 (Welsh Government 2012a) notes the achievement of a number of those actions, including:

- the Harm Reduction Database has been established;
- Level 1 Blood Borne Virus training has been delivered to staff;
- the Level 1 training package has been adapted for use in prisons;
- a specialist nurse for prisons is supporting staff in training, education and delivery of blood borne virus care and a number of initiatives have been launched in 2012 within prisons to improve liver health; and
- Public Health Wales, together with University of Glamorgan have carried out qualitative work to identify effective health messages and modes of delivery for messages on hepatitis B, hepatitis C and HIV to a range of at-risk groups across Wales.

Amongst PWID participating in the UAM Survey in Wales in 2012, 42% of those with hepatitis C reported being aware of their hepatitis C status, similar to levels reported in previous years. Overall, 84% of the survey participants reported ever having had a voluntary confidential test for hepatitis C in 2012, an increase from 43% in 2002 (PHE et al. 2013b; PHE 2013b; 2013c).

### Northern Ireland

In 2012, amongst PWID participating in the UAM Survey, 53% of those with hepatitis C reported being aware of their hepatitis C status, similar to levels reported in recent years. Overall, 87% of the survey participants in 2012 reported ever having had a voluntary confidential test for hepatitis C (PHE et al. 2013b; PHE 2013b; 2013c).

### People who inject image and performance enhancing drugs

The voluntary unlinked-anonymous survey of male IPED injectors in England and Wales undertaken during 2010-11 found that overall only 22% reported ever having had a voluntary confidential test for hepatitis C (Hope et al. 2013).

### Research

#### *Commissioning of HCV services in London for people who inject drugs*

A public health report on commissioning of HCV services in London for PWID reported findings from; an evidence review of HCV epidemiology in London, HCV testing and treatment and best practice; two baseline surveys of service delivery in drug treatment services in London; and an economic model of the impact of testing and treatment on health care costs in London (Knight 2013). The report made a number of recommendations to increase prevention, testing and treatment of HCV infection amongst PWID in London.

#### *Quality of life and HCV infection amongst PWID*

A study in Scotland explored whether reduction in health-related quality of life (QoL)<sup>208</sup> amongst PWID with chronic hepatitis C infection was associated with the infection itself or with the awareness of infection status (McDonald et al. 2013b). A sample of 2,898 PWID attending injecting equipment provision services in Scotland, were surveyed in 2010 to compare QoL in three groups: chronically-infected/aware, chronically-infected/unaware and not chronically infected. Data were gathered as part of the NESI. The median time since initiation to injecting was 10 years and 84% reported only injecting heroin. The authors found that, beyond any reduction in QoL associated with infection, those infected and aware of their infection status had a significantly lower EQ-5D summary index than those who were chronically infected but not aware of their infection status. The results showed no evidence for a difference in QoL between PWID who were not chronically-infected and PWID chronically infected and unaware. The authors argue that the study provides useful data on changes in post-diagnosis QoL and therefore, clinicians should consider the possible

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<sup>208</sup> QoL measured using EQ-5D: a standard measure of health status. See: <http://www.euroqol.org/>. Out of the total 2,898 respondents, 584 (20%) were chronically-infected and aware, 508 (18%) were chronically-infected and unaware and 1806 (62%) were not chronically-infected.

reduction in QoL when promoting diagnosis if they are unable to provide treatment following a positive identification of an infection.

*Creating enabling environments for people who inject drugs (PWID) to access HCV treatment*

A second study undertook qualitative research in two partnerships providing hepatitis C treatment at drug and alcohol services in London.<sup>209</sup> It explored the barriers to PWID engagement with hospital-based hepatitis C treatment and the practical measures, trust and flexibility that helped PWID to accept treatment based at drug and alcohol services (Harris et al. 2013).

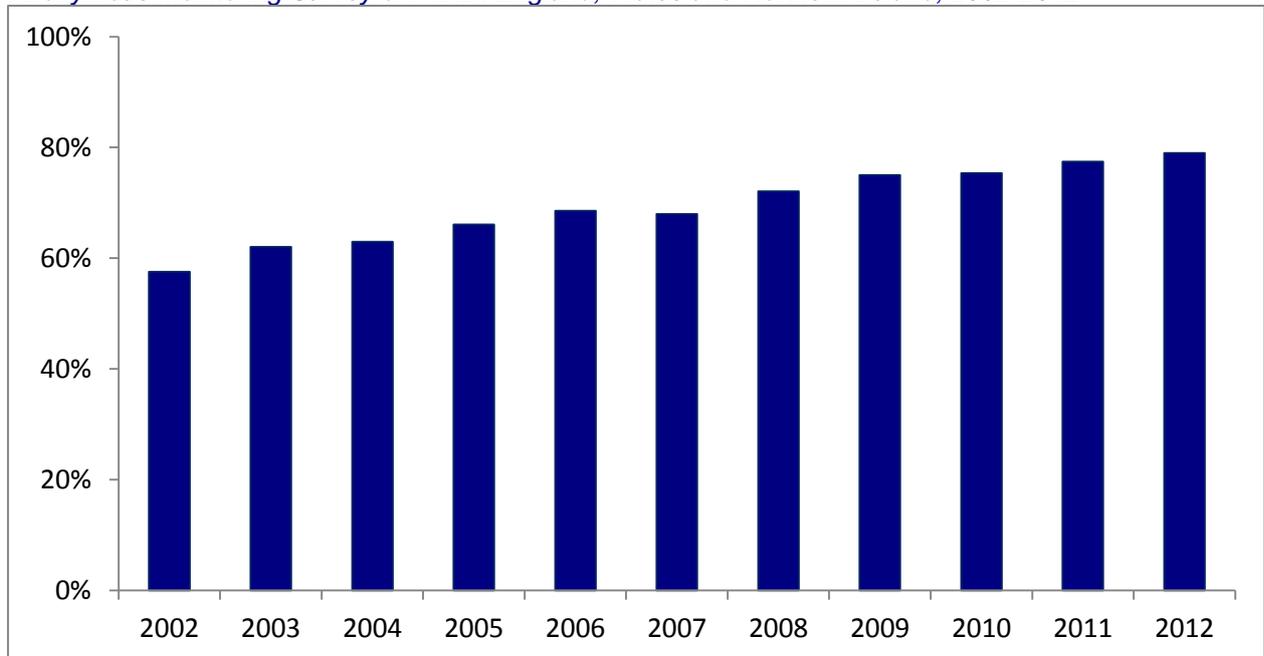
*Hepatitis C prevention education and social relationships.*

Fraser et al (2013) argue for hepatitis C prevention education to acknowledge and address the context of transmission of hepatitis C as usually being within groups or within sexual relationships. They suggest that social relationships and sexual relationships are important elements in understanding the behaviours that can lead to hepatitis C transmission and that it therefore makes sense to consider and include reference to such relationships in health promotion materials by, for example, including more images of couples and groups.

7.3.4 HIV prevention, diagnosis and care

Amongst PWID, there has been an increase in the uptake of HIV testing in recent years (Figure 7.1). In 2012, 79% (95% CI, 77%-80%) of PWID who took part in the UAM Survey reported ever having had a voluntary confidential test for HIV (PHE 2013b; 2013c). This is the highest level ever recorded in this survey, and compares with 58% (95% CI, 56%-59%) having ever been tested in 2002 (PHE 2013b; figure 7.1). Of the participants in the UAM survey who had antibodies to HIV, 95% (95% CI, 83%-99%) reported being aware of their infection in 2012 (PHE 2013b).

**Figure 7.1** Uptake of voluntary confidential HIV testing amongst participants in the Unlinked Anonymous Monitoring Survey of PWID: England, Wales and Northern Ireland, 2002-2012



Source: PHE 2013b

<sup>209</sup> Qualitative interviews were conducted with 35 service users and 14 service providers of HCV treatment at two sites in London. Themes from the interviews were identified and reported.

The voluntary unlinked-anonymous survey of male IPED injectors in England and Wales undertaken during 2010-11, found that overall only 31% of the participants had ever had a voluntary confidential test for HIV (Hope et al. 2013).

The number of HIV-infected people seen for HIV treatment and care in the UK who had acquired their infection through injecting drug use has increased over the past decade, with 1,617 seen in 2012 (PHE et al. 2013a). In 2012, 458 people who had acquired their HIV-infection through injecting drug use, and who were seen for care, had CD4 counts of 350 or less (the level at which it is recommended to start anti-retroviral therapy (Gazzard et al. 2008). Of these, 88% were on anti-retroviral treatment; this level is comparable to that for other groups (PHE et al. 2013a).

## Research

### *Low dead-space syringes*

Vickerman et al. (2013) evaluated the available evidence and used statistical modelling to predict whether the transmission of HIV could be reduced, as suggested by many recent studies, if injecting drug users used low dead-space syringes (LDSS) rather than high dead-space syringes (HDSS).<sup>210</sup> The authors systematically reviewed the literature on dead-space volume of syringes to estimate the factor difference in blood volume transferred from sharing LDSS or HDSS and analysed data on the relationship between host viral load and HIV transmission risk. They found that dead-space volume of syringes was very variable but, on average, HDSS had 10 times the dead space volume of LDSS. They used conservative estimates of a 2-fold increase in HIV transmission risk per 10 fold increase in the amount of infected blood and estimated the impact of changing to LDSS on HIV transmission in populations with different prevalence of HIV infection and different existing levels of LDSS use. They concluded that the modelling showed increasing LDSS use could be effective in preventing the spread of HIV. They highlight a need for evaluation of the real life efficacy of this change and to better understand the preferences of injecting drug users for different syringes and costs and effectiveness of interventions to change preferences as well as the costs of supplying LDSS syringes.

### *Effectiveness of Interventions to prevent HIV and HCV in people who inject drugs*

MacArthur et al. (2013) conducted a review of reviews (not including primary research papers) considering evidence of the effectiveness of public health interventions for preventing injecting risk behaviour, and transmission of HIV and HCV. Interventions included needle and syringe programmes (NSP); the provision of injection paraphernalia; opiate substitution treatment (OST); information, education and counselling (IEC) and supervised injection facilities (SIF). Evidence from the review showed that harm reduction interventions, particularly OST and NSP, can reduce injecting risk behaviour. There was also sufficient review level evidence that OST was an effective intervention for preventing HIV transmission. However, there was only tentative evidence for NSP and insufficient evidence for provision of paraphernalia, SIF or IEC preventing HIV transmission. There was tentative evidence for OST, but for none of the other interventions preventing HCV transmission and tentative evidence for NSP preventing HIV transmission. The authors suggested a need for further studies to assess the impact of more comprehensive packages of harm reduction measures.

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<sup>210</sup> When an individual injects a drug the dead space in the syringe (the space left when the plunger is pushed up to the hilt) can fill with blood. High dead-space syringes (HDSS) can hold a larger volume of blood than low dead-space syringes (LDSS) so there may be more potential for infection from one injecting drug user to another through infected blood if HDSS rather than LDSS are shared.

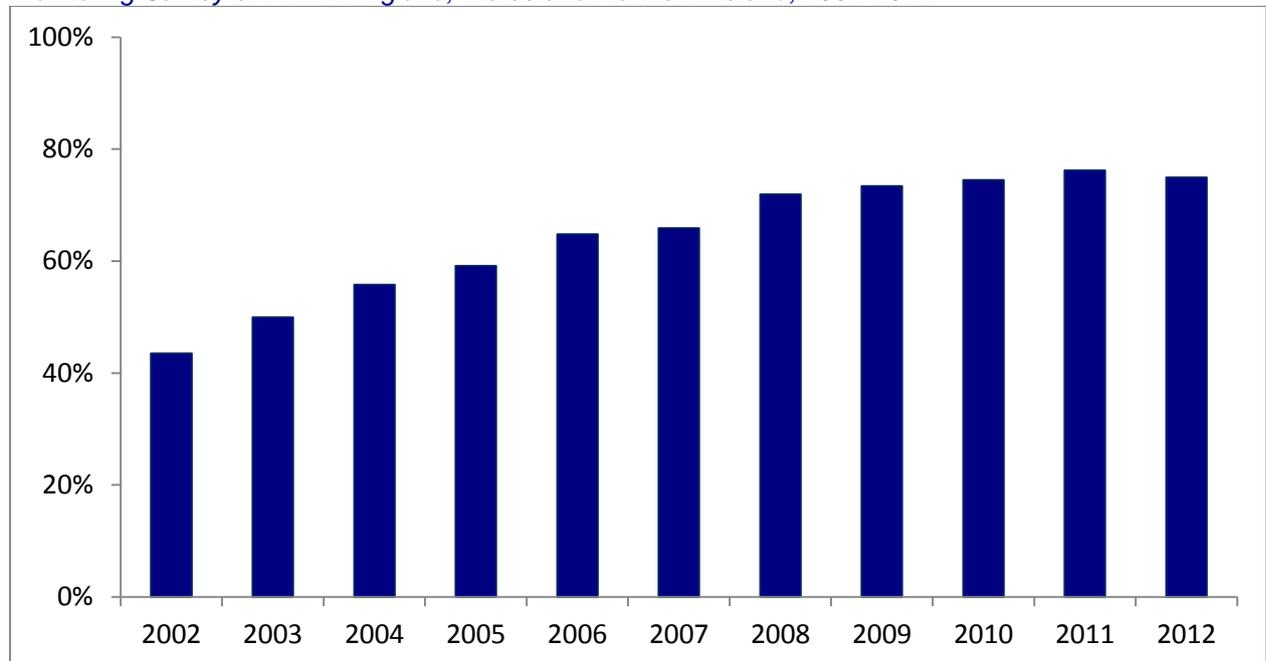
### 7.3.5 Vaccination against hepatitis B

The proportion of the PWID participating in the UAM Survey in England, Wales and Northern Ireland who reported having taken up an offer of the hepatitis B vaccination has increased markedly over time, rising from 43% (95% CI, 42%-45%) in 2002 to 75% (95% CI, 73%-76%) in 2012 (self-reported data) (PHE et al. 2013a; PHE 2013b; 2013c; Figure 7.2). In Wales uptake was 77% in 2012 (up from 25% in 2002), in Northern Ireland it was 68% (up from 49% in 2002/03) and in England it was 75% (up from 45% in 2002) (PHE 2013b).

In Scotland, amongst individuals participating in NESI, a voluntary anonymous survey of PWID attending NSP, in 2011-12, 73% reported receiving at least one dose of hepatitis B vaccine. This compares to 69% in 2008/09. Amongst those who had first injected during the preceding three years, uptake was 51% in 2011-12 (PHE et al. 2013a).

The voluntary unlinked-anonymous survey of male IPED injectors in England and Wales undertaken during 2010-11 found that, overall, only 23% of the participants reported receiving one or more doses of vaccine against hepatitis B (Hope et al. 2013).

**Figure 7.2** Uptake of the vaccine against hepatitis B amongst participants in the Unlinked Anonymous Monitoring Survey of PWID: England, Wales and Northern Ireland, 2002-2012



Source: PHE 2013b

### 7.3.6 Interventions related to bacterial infections

#### Anthrax

In response to the most recent anthrax outbreak,<sup>211</sup> guidance for health service staff on preventing, detecting and dealing with anthrax infection was revised and advice for drug users was also updated. Key messages were that anthrax can be lethal but can be cured if medical treatment is started quickly. The source of anthrax infection in the UK is believed to be contaminated heroin or a contaminated cutting agent, so prevention advice involved discouraging street heroin use by providing quick access to effective treatment for drug use and adequate dosage of substitute medication. Those working with people who use drugs were asked to continue advising users not to sharing needles, syringes, and other

<sup>211</sup> See: [www.hps.scot.nhs.uk/bbvsti/anthrax.aspx](http://www.hps.scot.nhs.uk/bbvsti/anthrax.aspx) ; [www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Anthrax/AnthraxOutbreak2012/](http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Anthrax/AnthraxOutbreak2012/)

equipment, in order to prevent cross-infection and also to advise limiting use of citric acid which could damage tissues and make tissues more vulnerable to infections.<sup>212</sup>

In this context, general advice was also produced for PWID about avoiding infections due to spore-forming bacterial infections such as anthrax, tetanus and wound botulism.<sup>213</sup>

### 7.3.7 Tuberculosis treatment and care

Of the tuberculosis (TB) cases in the UK with at least one of the four social risk factors (problem drug use, alcohol misuse/abuse, homelessness and a history of imprisonment), only 43% (239/551) were reported to have been placed on Directly Observed Therapy (PHE 2013d). Patients with a history of at least one of the four social risk factors completed treatment less often than patients without such a history (74.7%, 469/628 versus 84.4%, 6,602/7,825), and a higher proportion died (6.8%, 43/628 versus 4.2%, 331/7,825) or were lost to follow-up (7.5%, 47/628 versus 4.6%, 361/7,825) (PHE 2013d).

The National Institute for Health and Care Excellence (NICE) has published guidance on Identifying and managing TB amongst hard to reach groups (NICE 2012c). The guidance is based on evidence including three reviews of published research, economic modelling, expert witness testimony, stakeholder comments and fieldwork. The guidance is intended for commissioners and providers of tuberculosis (TB) services and other statutory and voluntary organisations that work with hard-to-reach groups. It aims to improve the way TB within hard-to-reach groups is identified and managed. The recommendations cover;

- strategic oversight and commissioning of TB prevention and control activities;
- local needs assessment;
- cohort review;
- commissioning multidisciplinary TB support for hard-to-reach groups;
- raising and sustaining awareness of TB amongst health professionals and those working with hard-to-reach groups;
- raising and sustaining awareness of TB amongst hard-to-reach groups;
- identifying active pulmonary TB amongst those using homeless or substance misuse services;
- identifying and managing active TB in prisons or immigration removal centres;
- identifying and managing active and latent TB: vulnerable migrants;
- identifying and managing latent TB: substance misusers and prison populations;
- contact investigations;
- rapid-access TB services;
- enhanced case management; and
- accommodation during treatment.

## Research

*Tuberculosis, injecting drug use and integrated HIV-TB care: a review of the literature*  
Grenfell et al. (2013) reviewed the literature on rates of TB infection occurring on its own or together with HIV infection in PWID and on TB care and care of TB with HIV amongst PWID. Latent TB infection prevalence was high amongst HIV-positive PWID and active disease more common amongst these individuals. Where TB treatment was co-located with needle and syringe provision and opioid substitution therapy (OST) and incentives were also offered, there was improved uptake of screening and prevention. Small-scale TB treatment in combination with OST achieved good adherence to treatment. Successful interventions

<sup>212</sup> See: [www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListName/Page/1317135273668](http://www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListName/Page/1317135273668);  
[www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListName/Page/1317135273720](http://www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListName/Page/1317135273720)

<sup>213</sup> See: [www.hpa.org.uk/webc/HPAwebFile/HPAweb\\_C/1317134799924](http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317134799924)

involved collaboration across services; a client-centred approach; and provision of social care. The authors concluded integration with drug treatment improves PWID engagement in TB services but identified a need to document approaches to HIV-TB care, improve surveillance of TB and co-infections amongst PWID and advocate for improved OST availability.

## 7.4 Responses to other health correlates amongst drug users

### 7.4.1 Substance Misuse: Health and Wellbeing Compendium

The Welsh Government (2013g) published a document in July 2013 that provides an overview of the principles of substance misuse harm reduction and outlines the context in relation to theoretical and operational approaches. The guidance document has been structured to provide a clear summary of evidence along with recommendations for action under seven specific elements of health care;

- oral health;
- sexual health;
- safer injecting and other routes of ingestion;
- wound management;
- prevention, testing and treatment for blood borne viruses;
- reducing fatal and near fatal poisonings; and
- targeting especially vulnerable groups

All areas will be expected to provide a baseline position in relation to the recommendations via regional harm reduction groups.

### 7.4.2 Mental health

#### Impact of staff training within a comprehensive dual diagnosis strategy

Copello et al. (2012) report on a training programme (the Combined Psychosis and Substance Use Programme COMPASS) for staff in mental health services in the Birmingham area, working with clients with combined mental health and substance use problems. Needs assessments showed a need for this type of training and follow-up surveys showed significant improvements in self-reported staff skills and confidence in dealing with dual diagnosis clients. The self-reported improvements were still found at 10 year follow-up although lasting effects were more apparent in some areas than others.

### 7.4.3 Substance use amongst pregnant women

#### Wales

The Welsh Government's *Strategic Vision for Maternity Services in Wales*, published in 2011, aims to promote healthy lifestyles for pregnant women to benefit their health and the health of their families. All women are now asked at the beginning of their pregnancy about their illegal drug and prescribed drug use. Reported details are documented in the All Wales Hand Held Maternity Records. If a woman is misusing drugs, support and advice will then be given to them and their partner. Services for pregnant mothers with substance misuse problems are available throughout Wales, including specialist midwifery liaison services and posts in some areas (Welsh Government 2012a).

#### Research

#### *Methadone dosing in opioid-dependent pregnant women and neonatal abstinence syndrome*

A study in Ireland by Cleary et al. (2013) investigated the methadone doses and dispensed medications of 117 women in the year before they delivered their babies and the month after delivery, in 2009/10. Sufficient dosing data were available for 89 women who had methadone maintenance treatment throughout pregnancy. Of these, 36 women had their

dose decreased and 31 had their dose increased during pregnancy. There was no difference between the dosage groups in the incidence of medically treated neonatal abstinence syndrome in their babies. Other drugs prescribed to the women included benzodiazepines (to 43 women) and antidepressants to 29 women (with a decrease in numbers taking antidepressants from pre-pregnancy to after delivery).

#### *Midwives' attitudes towards illicit drug use in pregnancy*

Jenkins (2013) carried out a survey of midwives' attitudes towards pregnant women who misuse drugs<sup>214</sup>. Many substance misusing women avoid contact with maternity services during pregnancy, sometimes leading to poor pregnancy outcomes. The reason most frequently given for avoiding antenatal care is their fear of negative attitudes from healthcare staff. Jenkins found 23% of midwives agreed with a statement 'I feel angry in reaction to women who use drugs in pregnancy', 36% agreed that 'individuals are responsible for their problematic drug use' and just 5% agreed that women who use drugs when pregnant should be prosecuted. Almost all (99%) agreed that women who use drugs in pregnancy deserve the same quality care as those who don't and 49% agreed they felt sympathetic towards women who use drugs in pregnancy. The attitudes of midwives in this study were more positive than those of other healthcare professionals in previous research. Midwives were less likely to agree with negative statements if they had received formal education on substance misuse and the author recommends the implementation of an education programme on substance misuse for midwives to further promote positive attitudes.

### 7.4.3 New psychoactive substances

#### Wales

The Advisory Panel on Substance Misuse in Wales led on a specific piece of work to inform the national response to the reported increase in the use of new psychoactive substances (NPS). The aim was to provide consistent education, prevention and harm reduction messages to ensure a wide understanding of the risks and harms of NPS. Information has been made available through a campaign on DAN24/7 (the national drug and alcohol helpline), through training for substance misuse treatment professionals and to school children through the All Wales Schools Liaison Core Programme.

The Welsh Emerging Drug and Identification of Novel Substances (WEDINOS) project has been established to provide a framework for the collection and testing of new psychoactive substances and combinations of drugs. Following testing, the drug profiles are disseminated, together with implications for health and pragmatic harm reduction advice, via the website.<sup>215</sup> This project is designed to provide trend data on NPS use in a timely manner and to reduce the harms associated with use.

Worker and Carer training manuals have been developed and disseminated across Wales in conjunction with a national mephedrone training programme which was completed in April 2013 to raise awareness of new psychoactive substances and to ensure early identification and effective responses by service providers to new types of drug use (Welsh Government 2012a).

#### Scotland

The Scottish Government's Minister for Community Safety and Legal Affairs convened a workshop on the 17 April 2013 in Edinburgh on New Psychoactive Substances, where a

<sup>214</sup> From one NHS trust, 180 midwives were recruited using convenience sampling and 127 useable (sufficiently completed) questionnaires were returned (70% response). The participants were asked to respond to series of attitudinal statements by indicating their level of agreement on a 5 point scale, using a previously validated questionnaire.

<sup>215</sup> See: [www.wedinos.org](http://www.wedinos.org)

range of individuals were invited from across enforcement, health, drug and young people's services and research to discuss the challenges that NPS bring to Scotland and to identify practical actions that could be taken across Scotland, by organisations and individuals working in this area.<sup>216</sup>

A conference was held by the Scottish Drugs Forum and Crew in September 2013 on latest drug trends with a focus on New Psychoactive Substances and service developments to meet users' needs.<sup>217</sup> The opening address was provided by the Minister for Community Safety and Legal Affairs, Roseanna Cunningham.

For the first time, drug deaths where New Psychoactive Substances (NPS) were implicated have been reported by National Records Scotland in their publication of annual drug-related deaths. In 2012, there were 47 drug deaths where NPS were present, 32 where they were found to be implicated (along with other drugs and/or alcohol) and five cases where they were the only drug present.<sup>218</sup>

Following a consultation with stakeholders, the questions in the 2013 Scottish Schools Adolescent Lifestyle and Substance Use Survey have been amended to include a question on 'powders or pills that are sold as legal highs.' The 2013 results will be reported in 2014.

Alcohol and Drug Partnerships (ADPs) are responsible for developing local strategies to address alcohol and drug use in their community. Funding allocation letters from the Scottish Government for 2013/14 outlined ministerial priorities to be delivered by ADPs at the local level. ADPs submitted annual reports in September 2013 describing how they have performed against agreed core outcomes and established local improvement goals to meet ministerial and locally identified priorities. NPS was identified as a ministerial priority in 2013/14 and in their annual reports ADPs have been asked to share any needs assessments and responses they have undertaken locally in relation to NPS.

Crew continue to be commissioned in 2013/14 to provide training and information resources on New Psychoactive Substances and emerging trends to Alcohol and Drug Partnerships (ADPs) and drug and youth services across Scotland, to help enable drug services and wider services to respond to the use of these substances.

#### 7.4.4 Other research

##### Managing acute recreational drug toxicity at an outdoor festival

Archer et al. (2012) conducted a study to determine the best way to manage acute recreational drug and alcohol toxicity in individuals at festivals. Using the published ambulance referral criteria (ARC) for assessing individuals with acute recreational drug and alcohol toxicity, they assessed 28 such individuals presenting to a physician-led medical centre, at a large outdoor festival. They determined that, in the absence of an on-site doctor, 16 of the individuals would be sent to hospital by first aiders using the ARC criteria whereas only 4 needed transfer to hospital following physician-led management at the festival site (including two who were transferred because the medical facility was closing at the end of the event). The authors concluded that having doctors present at the festival reduced the need for individuals with acute recreational drug and alcohol toxicity to be transferred to hospital, reducing the impact on local ambulance services and hospitals. They suggested

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<sup>216</sup> <http://www.scotland.gov.uk/News/Releases/2013/04/psychoactivedrugs17042013>

<sup>217</sup> See conference presentations: <http://www.sdf.org.uk/resources/presentations/>

<sup>218</sup> Drug Related Deaths in Scotland in 2012, published 27 August 2013. <http://www.gro-scotland.gov.uk/statistics/theme/vital-events/deaths/drug-related/2012/index.html>

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festival and similar event organisers should consider arranging physician-led medical facilities to reduce the burden on local health services.

## 8. Social correlates and consequences

### 8.1 Introduction

There is a large volume of evidence from the United Kingdom showing an association between problem drug use and social exclusion. A high proportion of problem drug users have been socially excluded as children and young people; many are poorly educated; and high proportions live in inappropriate housing (Seddon 2006). Research in 2008 suggested that around 80% (266,798) of problem drug users in England in 2006/07 were in receipt of state benefits, representing seven per cent of all those receiving such benefits (Hay and Bauld 2008). There are also further concerns about the effect of parental drug use on children, leading to problems of social deprivation for them.

Social reintegration is a key element within recent drug strategies in England, Scotland and Wales. The strategy for Northern Ireland also recognises the need to provide support with housing and employment, and wider support with social reintegration. In Scotland the recovery programme has identified 7 core outcomes for Alcohol and Drug Partnerships (ADPs) to aim to achieve: These include outcomes related to health; prevalence; recovery; families; community safety; local environment and service provision (Scottish Government 2013a). A number of core indicators will be used to measure progress against these outcomes and individual ADPs will also use locally identified indicators to measure progress against local needs and priorities. There are various programmes to help drug users including The Supporting People Programme<sup>219</sup>, introduced in 2003, which provides housing-related support to vulnerable groups generally, including people with drug problems. As a reserved matter, employment support for drug users is delivered through the Department for Work and Pensions, with many referred to the Work Programme<sup>220</sup>, which replaced a number of previous employment support programmes. In 2013 two new pilot projects to specifically help individuals with substance misuse problems gain sustained employment, were announced as part of the Work Programme. In Scotland, DWP has been working with the Scottish Government and ADPs to increase referrals of DWP claimants for treatment. Social inclusion programmes such as Positive Futures<sup>221</sup> can bridge the gap between universal and targeted services. Attention is also focused on the impact of parental substance misuse through 'Improving outcomes for children affected by their parents' substance misuse' (CAPSM)<sup>222</sup>. There are a number of responses aimed at addressing neighbourhood problems associated with problem drug use, including drug dealing. For example, the *Anti-Social Behaviour Act 2003* seeks to stop the use of premises for drug dealing. There is also guidance to tackle the inappropriate disposal of drug paraphernalia.

### 8.2 Social exclusion and drug use

The Centre for Social Justice, a think tank set up by former Conservative leader and current Secretary of State for Work and Pensions, Iain Duncan Smith, published a report on Britain's drug and alcohol problem, as a follow-up to its previous Breakthrough Britain report (CSJ 2013). It aims to provide an audit of social breakdown in relation to addiction and will be the basis for a report containing policy recommendations that is due to be published in 2014.

<sup>219</sup> <http://www.nidirect.gov.uk/supporting-people-programme>

<sup>220</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/49884/the-work-programme.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/49884/the-work-programme.pdf)

<sup>221</sup> <https://www.gov.uk/government/policies/reducing-reoffending-and-improving-rehabilitation>

<sup>222</sup> <http://www.scotland.gov.uk/Topics/People/Young-People/protecting/child-protection/capsm>

## 8.2.1 Housing

### Northern Ireland

In Northern Ireland, data on the living conditions of individuals presenting to drug misuse services showed that in 2011/12; 24% lived alone; 22% were living in prison or in a Youth Offender Institution; 21% lived with their parents; 9% with their spouse/partner and children; 8% with only their spouse/partner; 4% alone with their children; and 6% with other drug users (NISRA and DHSSPS 2012).

### Scotland

Data from the Scottish Drug Misuse Database (SDMD) *Overview of Individuals Assessed in 2011/12*<sup>223</sup> (ISD Scotland 2013d) show that over two-thirds (69%) of individuals who provided information, reported living in owned or rented accommodation at the time of initial assessment, a fall from 72% in 2010/11 and from 80% in 2009/10. Fourteen per cent reported they were homeless<sup>224</sup> and one per cent reported living in supported accommodation (including residential rehabilitation).

### Homelessness and drug-related deaths

A study by Crisis has noted that drug abuse is particularly common amongst the homeless population in England and claims that homeless people are twenty times more likely to die from drugs than those in the general population. The study also found that deaths due to drugs accounted for an eighth of all homeless deaths in London (Thomas 2012).

## 8.2.2 Employment and education

In Northern Ireland, data on individuals presenting for substance misuse treatment from 1 April 2011 to 31 March 2012 showed that, at the time of presenting, 13% were employed, 46% were unemployed, 5% were students, 4% were receiving a pension and 9% were receiving other benefits (NISRA and DHSSPS 2012).

The report of data from the Scottish Drug Misuse Database (SDMD) *Overview of Individuals Assessed in 2011/12*<sup>225</sup> shows that 67% of individuals were unemployed in 2011/12, a similar percentage as in 2010/11. Eleven per cent of individuals were in paid or unpaid employment (ISD Scotland 2013d).

Data from the Department for Work and Pensions show that, in August 2012 in Great Britain, there were 18,050 individuals claiming Incapacity Benefit or Severe Disablement Allowance (IBSDA) with 'drug abuse' recorded as their primary disabling condition and 20,610 individuals claiming Employment and Support Allowance (ESA)<sup>226</sup>. This compares to 33,040 and 10,610 respectively in August 2011 (DWP 2013).<sup>227</sup>

<sup>223</sup> The report is based on data from 11,380 individuals' initial assessments by drug treatment services. The 2011/12 data in the report is provisional and may change in future publications as revised data will be used. Caution should therefore be used in comparing 2011/12 data with previous years.

<sup>224</sup> 'Homeless' includes those reporting living in temporary or unstable accommodation, or a hostel.

<sup>225</sup> The report is based on data from 11,380 individuals' initial assessments by drug treatment services. The 2011/12 data in the report is provisional and may change in future publications as revised data will be used. Caution should therefore be used in comparing 2011/12 data with previous years.

<sup>226</sup> Severe Disablement Allowance (SDA) was replaced by Incapacity Benefit (IB) in April 2001. In January 2011 Incapacity Benefit was replaced by Employment and Support Allowance (ESA). Those who were already receiving either SDA or IB will continue to do so until a review of all cases is completed in 2014, by which time all claimants will receive ESA if they are still eligible.

<sup>227</sup> See: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/203331/2013-1854.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/203331/2013-1854.pdf)

### 8.2.3 Families

Data from the Scottish Drug Misuse Database (SDMD) *Overview of Individuals Assessed in 2011/12* (ISD Scotland, 2013d) show that 38% of individuals reported having dependent children under the age of 16 years. This is lower than the 41% who reported they had dependent children in 2010/11 although figures have stayed largely stable since 2006/7.

For 425 cases (97%) included in Scotland's NDRDD (National Drug-related Deaths database)<sup>228</sup> 2011 cohort, it was known whether or not the deceased was a parent or parental figure to a child or children under the age of 16 years (Hoolachan et al. 2013)<sup>229</sup>. Of these cases, 189 individuals (44.5%) were a parent/parental figure compared to 140 (39%) in 2010. The total number of children who lost a parent/parental figure due to a drug-related death in 2011 was 331. In 2010, this figure was 238. Of the 331 children who lost a parent/parental figure in 2011, 67 (20.2%) of them were living with the parent/parental figure at the time of death. This figure is comparable to 2010 (18.9%). Over half of the 2011 cohort (53.4%) had lived in the most deprived areas in Scotland.

The Munro Review of child protection (Munro 2011) found that many services (including substance misuse agencies) were not focused enough on the children affected by adults' problems. In response, the National Treatment Agency (NTA) and the Department for Education published guidance to encourage drug treatment services to work with children and family services and to focus more on the parental status of those in treatment and the needs of their children (NTA 2012a). NTDMS data show that 54% of adults receiving drug treatment in 2011/12 (105,780 of the total 197,110 adults) were either parents or lived with children who were not their own. Of all adults in treatment in 2011/12, 21% (40,852) were parents living with their own children, 13% (25,341) were living with children not their own and 20% (39,587) were parents who did not live with their children. Of those 70,560 adults *starting* treatment in 2011/12, 16% (11,074) were parents living with their own children, 12% (8,467) were living with children not their own and 25% (17,640) were parents not living with their children.

In Northern Ireland in 2011/12, 9% of those presenting for substance misuse treatment were living with their spouse/partner and children and another 4% were living alone with dependent children (NISRA and DHSSPS 2012).

## Research

### *Working with parents who misuse substances*

Adfam has published a report aiming to share the experiences and attitudes of frontline drug treatment practitioners of working with parents who misuse substances (Adfam 2013a)<sup>230</sup>. The report identified common strengths and barriers encountered by practitioners in local approaches to parental substance misuse and made recommendations to Government, Local Authorities, local Safeguarding Children's Boards, service providers and managers, and professional bodies for social workers.

<sup>228</sup> In 2011, there were 438 cases identified as eligible for inclusion in the NDRDD cohort, an increase from 365 in 2010.

<sup>229</sup> This is the third report from the National Drug Related Deaths Database (NDRDD) for Scotland which presents data for the calendar year 2011. The NDRDD was established to collect detailed information regarding the nature and social circumstances of individuals who have died a drug-related death. This report supplements the routine reporting of drug-related deaths in Scotland by the National Records of Scotland (NRS), formerly known as the General Register Office for Scotland.

<sup>230</sup> Research was undertaken with mixed methods: four focus groups (with a total of 40 participants), a follow-up online survey, in-depth interviews and examination of existing literature. Practitioners involved in the research were from a variety of backgrounds in voluntary and statutory services.

*Childcare arrangements in two significantly different groups of opioid dependent mothers*

Eke and Luty (2012) surveyed two groups of opioid- dependent mothers being treated in inner-city and urban drugs services<sup>231</sup> to explore their childcare arrangements and the number of children born. Twenty women from each location were interviewed using an adapted version of the Maudsley Addiction Profile and the HIV Risk-Taking Behaviour Scale. The forty women, between them had a total of 85 children, only 11 of whom were living with their mothers. Twenty-one women had one or more children living with a family member and 22 children had been adopted. The women from the inner-city service tended to have more children than those from the urban service (a total of 51 for the inner-city group compared with 34 for the urban group). The study found clinically relevant differences between the two groups: the women in the inner-city service were older and had more severe substance misuse problems. They were more likely to have ever used volatile substances, to currently use crack cocaine (in addition to opioids) and to be prescribed significantly higher doses of methadone. The authors concluded that the differences they found between the two groups suggest other findings from research carried out in large inner-city centres may not be generalizable to other populations of substance users.

*Attitudes of opioid-dependent parents in Scotland to opioid substitution therapy*

Chandler et al. (2013) carried out semi-structured interviews with 19 individuals in South East Scotland (14 women, 5 men) who were dependent on opioids and were either pregnant themselves or had a partner who was pregnant. Follow-up interviews then took place up to nine months post-natally. The study asked participants how their opioid substitution therapy (OST) affected their parenting and family life. Participants explained their choice of having OST, cutting down on their treatment or stopping it in terms of doing the best for their family and trying to be a good parent. Some felt OST was vital to enable them to stop using illicit drugs and to show that they could look after their children, often in the context of close supervision by health and social services. In contrast, many felt OST prevented them having a normal family life, either because of the physical effects of the treatment, or the structural requirements such as daily supervised consumption or the way OST identified them as drug-using parents with the associated stigma. Participants reported concealing illicit drug use from services and relapsing following attempts at reducing OST dosage or abstinence. The study illustrated the challenges and dilemmas facing opioid- dependent parents.

*Substance-misusing parents' views of their own parenting behaviour*

Qualitative in-depth interviews with parents who had been problematic users of drugs and alcohol<sup>232</sup> were carried out in order to illustrate the impacts of substance misuse on family life, including neglect, instability and physical and sexual abuse (Holland et al. 2013). Those interviewed described their lives, including their views of the quality of parenting they had provided to their children. For most of the interviewees, domestic abuse had been a dominant factor in their lives. The authors reported that for those interviewed, alcohol and drug misuse was usually a result of other problems and then almost always became a powerful reinforcer and creator of further problems for the families. Implications for social work practice and research were discussed.

<sup>231</sup> The 'urban' service was South Essex Partnership NHS Trust (SEPT), and the patients were mainly residents of Basildon, Essex. The inner-city service was the South London and Maudsley NHS Foundation Trust (SLAM) and the patients were mainly residents of Southwark, London.

<sup>232</sup> The study was part of a mixed methods research project aiming to investigate outcomes for children in families referred for a therapeutic intervention. The children of these families were all in child protection or care proceedings because of parental substance misuse. Outcomes are not reported in this paper. The interviews were semi-structured and took place with 31 parents (25 women and 6 men), 28 of whom had been problematic users of drugs and alcohol.

#### 8.2.4 Barriers to accessing health and social care

**Understanding barriers to sexual health service access amongst substance-misusing women**  
Qualitative interviews with twenty substance-misusing women in Hastings, England, explored their experiences and beliefs around access to sexual health services. The research found that there were a range of practical, social and emotional barriers to sexual health service access that need to be addressed to enable substance-misusing women to get the care they need. The participants reported experiencing great difficulty in accessing this kind of health care (Edelman et al. 2013).

#### **Social Care Practitioners' attitudes to working with substance abuse**

A recent online survey aimed to measure the attitudes of social care practitioners<sup>233</sup> (who were not substance use specialists) towards working with alcohol and other drug (AOD) users and to identify factors that could predict positive attitudes towards substance using clients (Hutchinson et al. 2013). Most responses indicated attitudes that were neither positive or negative, however some factors were predictors of 'overall therapeutic attitudes' and appeared important for positive engagement with AOD amongst these practitioners. These factors were;

- practitioners' *perceived* preparedness by qualifying training, (but not their *actual hours* of AOD-related training);
- employing directorate: working in Children's Services predicted more positive attitudes than working in Adults' services;
- having had AOD-related practice experience predicted more positive attitudes than not having this experience; and
- gender; being male predicted a more positive attitude than being female.

#### 8.2.5 Sex workers

Data from the Scottish Drug Misuse Database showed that two per cent of individuals assessed for substance misuse treatment in Scotland in the year up to 31 March 2012 reported 'sex work' as a source of income (ISD Scotland 2013d).

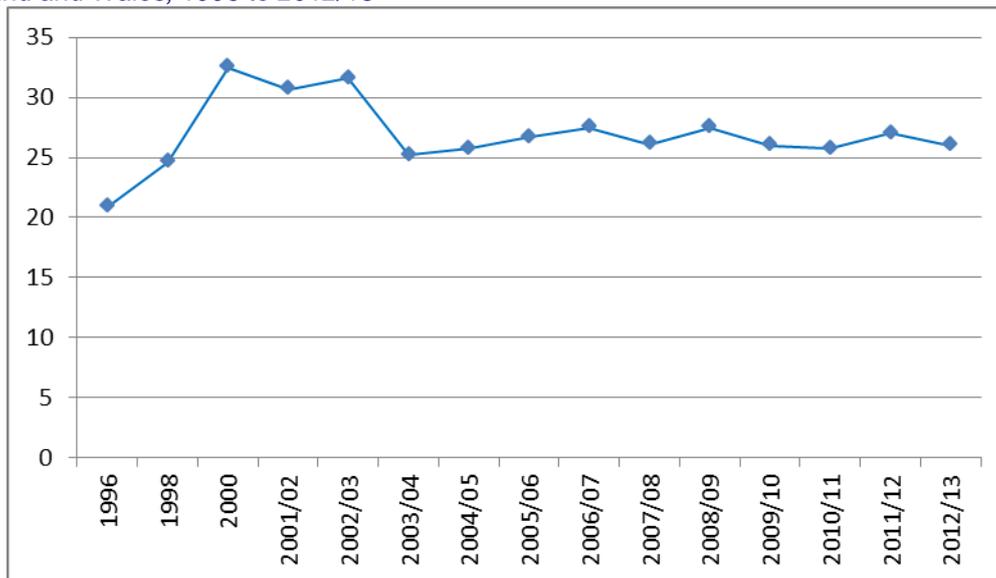
#### 8.2.6 Perceptions of anti-social behaviour

##### England and Wales

Measures of anti-social behaviour in the 2012/13 Crime Survey for England and Wales (CSEW) (ONS 2013b) show that 13% of adults perceived there to be a high level of anti-social behaviour in their local area. This represented a statistically significant decrease compared with figures for 2011/12. One of the seven indicators used to compile this measure is 'people using or dealing drugs' and 26% of participants in 2012/13 indicated that this was a big problem in their area, a small decrease from 27% in 2011/12. Current perceived levels are higher than in the late 1990's but lower than those between 2000 and 2002/3. Perceptions of drug use and dealing being a problem have remained fairly stable since 2003/4 (Figure 8.1).

<sup>233</sup> Social workers and other social care practitioners from 11 English Local Authorities completed an online survey and data were analysed from 597 responses. The survey included an adapted version of the Drug and Alcohol Perceptions Questionnaire. The response rate was 20% and responses were particularly low from black and minority ethnic professionals, which was identified as a limitation of the study.

**Figure 8.1** Percentage of adults reporting people using or dealing drugs to be a problem in their area in England and Wales, 1996 to 2012/13



Source:ONS 2013b

### Northern Ireland

In 2011/12, 71% of respondents to the Northern Ireland Crime Survey (NICS)<sup>234</sup> (the same percentage as in NICS 2010/11) said they believed drugs were one of the major causes of crime in Northern Ireland (Campbell and Freil 2013). This was the factor most commonly identified as a major cause of crime in Northern Ireland today. When asked which single factor they considered to be the *main* cause of crime, 20% cited ‘drugs’. The survey also asked participants about their perceptions of anti-social behaviour and 12% of respondents said they felt levels of anti-social behaviour were high in their local area, similar to the 2010/11 and 2009/10 sweeps of the survey. One of the seven measures of anti-social behaviour in NICS (as in the Crime Survey for England and Wales) is people dealing or using drugs. This was cited as a very/fairly big problem in their area by 27% of respondents in NICS 2011/12 (compared with 23% in 2010/11).

### Scotland

In Scotland, 12.9% of respondents to the Scottish Household Survey 2012 (Scottish Government 2013b) said drug misuse or dealing was very/fairly common in their neighbourhood. This is an increase from 11% in 2010 and 11.7% in 2011 and is higher than in the last seven years.

### 8.2.7 Social harms

#### Khat use

In response to a government request, the Advisory Council on the Misuse of Drugs (ACMD) carried out a review of the health and societal harms of khat use in the UK (ACMD 2013a). Evidence gathering meetings were conducted by the ACMD with experts, stakeholders and

<sup>234</sup> NICS is a representative, continuous, personal interview survey of the experiences and perceptions of crime. Participants are adults aged 16 years and over, living in private households at randomly selected addresses throughout Northern Ireland. The survey was conducted on an ad hoc basis in 1994/5, 1998, 2001 and 2003/4 and has operated on a continuous basis since January 2005. The core questions and format of the 2011/12 NICS are similar to those of the 2011/12 Crime Survey for England and Wales (formerly known as the British Crime Survey), allowing for comparisons with data from England and Wales, with some additional questions and modifications to reflect local issues and the smaller sample size of the NICS. In 2011/12 NICS 4064 individuals were interviewed.

community groups. Anecdotal evidence has been reported from communities in the UK that khat use causes a number of societal harms. Studies undertaken in the 1990s established that the consumption in the UK is limited to Diaspora communities: Ethiopians, Somalis, Yemenis and some Kenyans. The review raised the suggestion that the recreational consumption of khat in khat cafes in the UK for long hours, followed by a recovery phase, may become a barrier to employment. However, recent research has shown that the majority of users moderate their usage to fit in with their work patterns and the review concludes that no causal link has been established between khat use and unemployment. Links between khat use and family breakdown, income diversion, anti-social behaviour, violence, and poor levels of integration were also explored in the review. The main conclusion was that there is a lack of robust evidence of a link between khat use and societal harms yet the reported harms are a concern which remains associated with the UK's Somali community. It was noted that little research has been carried out in khat-using communities other than amongst UK Somalis. The Government has announced its intention to make khat use illegal under the *Misuse of Drugs Act 1971*, as a Class C drug (see section 1.2.3).

### Domestic Violence

DrugScope and the London Drug and Alcohol Network (2013) published a report from their project to develop a cross-sectoral network of domestic violence and drug and alcohol services. The report sets out research evidence on the links between domestic violence and substance misuse. For example, research found that women who have experienced gender-based violence are more than 5 times more likely than others to be diagnosed with a substance use problem (Rees et al. 2011). The Drugscope and LDAN briefing also reported research showing that women who misused substances found it difficult to gain access to refuges when fleeing domestic violence and that domestic violence was a barrier to women being able to access drug treatment (Galvani and Humphreys, 2007).

### Use of stop and search powers

A report was published by Release, in partnership with the London School of Economics, examining the ethnic inequalities in the use of stop and search powers (see section 9.2.1). Around half of all stop and searches by police in 2011/12 were to search for drugs (Home Office 2013b). The Home Office ran a public consultation between July and September 2013, on the police powers to stop and search people.

## 8.3 Social reintegration

### 8.3.1 Housing

#### Interactions between emergency hostel staff and homeless residents who use drugs

Stevenson (2013) conducted semi-structured interviews with 40 people who were homeless, used drugs and were staying or had recently stayed in an emergency hostel or shelter in South Central England. The interviews explored the interactions between hostel staff and the homeless participants who used drugs and found that the participants' experiences were generally negative with the exception of a few positive examples. Participants reported not being treated well or in a professional way, not being listened to and not being treated as adults, as well as being given little privacy. This poor level of interaction with staff was felt to have a negative impact on helping homeless drug users to overcome their problems and it was felt that more care and consideration could have a positive impact.

#### Recovering heroin users

Neale et al. (2012) conducted an in-depth qualitative study on the everyday experiences of recovering heroin users. They explored themes such as building and rebuilding relationships, day-to-day self-care, living arrangements, and income.

### 8.3.2 Employment

*Employment and Recovery: A good practice guide* was published by the NTA as an update to *The Joint-Working Protocol Between Jobcentre Plus and Treatment Providers* published in 2010. The updated guide aims to reflect the changes to the way Jobcentre Plus provides support, which have been in place since December 2010 (NTA 2012g).

The Secretary of State for Work and Pensions launched two new Work Programme pilot programmes in April 2013 specifically targeted at supporting people addicted to drugs and/or alcohol into work. This is in recognition of the extra challenges faced and support needed by people recovering from substance dependency. The first, 'Recovery Works' located in West Yorkshire and East of England, tests the impact of paying a larger job outcome payment to providers when they support someone engaged in treatment for their dependency, into sustained work. The second pilot, 'Recovery and Employment' provides a flagship example of co-operation between providers to support people through recovery and into longer term employment. This is being run in two pilot sites in the West Midlands (Iain Duncan Smith, 2013).

As part of Universal Credit, the Department for Work and Pensions introduced 'tailored conditionality' where work search and work availability requirements can be suspended for a period of up to six months in any 12 month period for claimants actively participating in structured recovery-orientated treatment. This is to give claimants the time and space to engage in treatment, and begin their recovery journey. After the end of the period of 'tailored conditionality', on-going treatment commitments are still taken into account when an individual is looking for employment. This is recognised as a critical step in enabling people with dependencies to become ready for sustainable employment.

#### Wales: ESF Peer Mentoring Scheme

By the end of September 2013, the Peer Mentoring Scheme funded by the European Structural Funds (ESF), had worked with over 9,600 participants throughout Wales, 863 of whom entered paid employment. Peer Mentors have also helped participants to access training and unpaid employment opportunities. As announced in May 2012 (see UK Focal Point Report 2012), the scheme expanded in three areas to raise awareness of substance misuse in the work place through the Employment Support Service. The Welsh Government and the Department for Work and Pensions have launched a joint protocol – it is hoped that the focus on those with substance misuse issues who are seeking work will also increase referrals (Welsh Government 2012a). The scheme is due to close in June 2014 and a final evaluation of the scheme is due to be published in December 2013.

### 8.3.3 Families

#### Scotland

##### *Scottish Families Affected by Alcohol and Drugs (SFAD)*

In Scotland, Scottish Families Affected by Alcohol and Drugs (SFAD) provides information and support to families across Scotland affected by a loved one's substance misuse. SFAD provides a telephone helpline for family members, provides a website, and runs family support groups across Scotland<sup>235</sup>. SFAD has published guidance for family services: *Services toolkit - A best practice guide to working with family support groups* (SFAD 2012). The toolkit aims to guide services wishing to set up a support group for families affected by drugs, in the practicalities of doing so. This includes information on how to structure the group and plan sessions, how to provide supervision, maintain confidentiality, provide monitoring and training and how to evaluate the impact of the group. SFAD has recently widened its remit to include alcohol.

<sup>235</sup> See: <http://www.sfad.org.uk/>

The Scottish Government has published updated good practice guidance for all agencies and practitioners working with children, young people and families affected by problematic alcohol and/or drug use. It has been updated in the particular context of the national *Getting it Right for Every Child* (GIRFEC) approach and the Recovery Agendas, both of which have a focus on 'whole family' recovery. Another key theme is the importance of services focusing on early intervention activity (Scottish Government, 2013c).

#### *Scottish policies and practices for parents who misuse substances*

Using a mixed methods approach<sup>236</sup>, Robertson and Haight (2012) examined the opinions and experiences of Scottish child welfare experts of working with parents who misuse substances and the impact of new policies and programmes. Recent policy changes and changes to the Scottish Child Welfare System were discussed and the following five key issues were identified:

- Raising public awareness of the adverse effect of parental substance misuse on children is an important step towards developing policies and interventions to address it.
- Treating those affected by substance misuse with respect and valuing them, recognising that addiction is a multi-faceted health problem, has been shown to help with engagement of these individuals in treatment.
- There is a need to consider different responses to families with less serious cases of parental substance misuse.
- Relational social work approaches seem to be a good foundation for successful outcomes.
- Multi-disciplinary approaches incorporating child welfare practice into a variety of disciplines including education, healthcare and business are important.

#### England

##### *The Troubled Families Programme: a guide to the evidence and good practice*

The Troubled Families Programme was launched in England in 2011 (see UK Focal Point Report 2012) with the aim of improving the lives of 120,000 families who have problems (including drug and/or alcohol misuse), and who often cause problems to their community, putting high costs on the public sector. For some, the behaviour of the family has put the tenancy of the family home at risk. The programme involves a dedicated worker assigned to the whole family, providing challenge and hands on support as intensively and persistently as necessary with a common purpose and actions agreed with the family. A new report (Department for Communities and Local Government 2012a) suggests some positive impacts which appear to have been sustained after the end of the intervention, although the authors acknowledge it is difficult to be certain whether changes were directly attributable to the intervention. Feedback from families involved in the programme has been positive and the intervention appears to be cost-effective. The report offers evidence of effectiveness of family intervention programmes, highlighting the important elements and examples of good practice.

##### *Treatment helps families*

A National Treatment Agency (NTA) report, *Parents with Drug Problems: How Treatment Helps Families* (2012f) argues that although parents with drug problems present risks to the health, safety and life opportunities of children, treatment is a protective factor, helping parents to stabilise their lives and providing support to help them address wider problems and to look after their children better. The report notes that drug treatment is necessary but rarely sufficient to deal with the needs of drug-dependent parents and that treatment

<sup>236</sup> Methods included a review of 43 documents, observations and in-depth interviews with 13 purposively sampled professionals involved in child welfare in two regions of Scotland, Lothian and North Ayrshire councils. The professionals included 3 professors, 6 social workers and 4 administrators.

services must work together with children and families services, health visitors and other local support services. The NTA reports that parents who live with their own children are completing treatment at a greater rate each year, but warns that children need substantial ongoing support to deal with the impact of their parent's drug use and recovery (which may include relapses) and that children and families services need to provide this support. The NTA argues that, as the responsibility for commissioning drug treatment moves to local authorities in 2013, this provides an opportunity for ensuring stronger links between drug treatment services and other support services that drug-using parents require.

## Wales

### *Integrated Family Support Services (IFSS)*

The IFSS works with families in which a child's welfare is affected by parental substance misuse problems (see UK Focal Point Report 2012). The IFSS has been rolled out across most of Wales, with the last two areas being included within 2014 (Welsh Government, 2013e). It is intended that funding for IFSS will be mainstreamed by transferring the funding to the Local Government Revenue Support Grant Arrangements.

### *Safeguarding children*

As part of the provisions in the *Social Services and Well-Being (Wales) Bill 2013*, the Welsh Government proposed the establishment of a new National Independent Safeguarding Board, new Safeguarding Children Boards and Safeguarding Adult Boards to reflect the Public Service Delivery footprint (Welsh Government 2013h). A Child Practice Review Framework has been introduced to replace Serious Case Reviews. This framework is intended to improve the culture of learning from child protection cases and support inter-agency practice to help protect children. The Welsh Government will review the effectiveness of this new framework within two years of its introduction.

### *Protecting vulnerable adults*

The Welsh Government has proposed a more coherent approach to protecting adults at risk, through the *Social Services and Well-Being (Wales) Bill* (Welsh Government, 2013h).

### *Conferences on families affected by drug and alcohol use and parental substance use*

Adfam and Drink and Drug News held a joint conference for families affected by drug and alcohol use in late 2012. The conference aimed to challenge the stigma attached to families affected by drug and alcohol use. Adfam chose the theme of parental substance misuse for its Annual Conference in 2013 (Adfam 2013b), entitled *Hidden Harm: 10 years on – where next for responses to parental substance use?* to mark the ten year anniversary of the ACMD Enquiry: *Hidden Harm* (2003).

In Scotland, the Scottish Drugs Forum in partnership with Parenting Across Scotland and the University of Stirling's School of Nursing, Midwifery and Health held a conference in 2012, on *Looking Beyond Risk-Improving Outcomes for Children and Families Affected by Substance Misuse*. The conference sought to show how improved joint working between adult addiction services and child welfare services can improve outcomes for children affected by parental substance misuse. Scottish Families Affected by Alcohol and Drugs (SFAD) held a conference in February 2013 entitled 'Families can recover too'<sup>237</sup>

### *Pocket guides for social workers on problematic substance use*

The Special Interest Group on Alcohol and Other Drugs of the British Association of Social Workers (BASW) has produced a set of pocket guides on problematic substance misuse. The guides are intended to help social workers to feel informed enough to confidently ask their clients about their substance use (McCarthy and Galvani 2010).

<sup>237</sup> See: <http://www.sfad.org.uk/media-centre/conference>

## Research

### *New measure of perceived social support in families with problem drug use*

Toner and Velleman (2013) report on the development of a new measure of perceived functional social support for family members of problem substance users. They present preliminary evidence of the reliability and validity of the 25-item self-completion *Alcohol, Drugs and the Family Social Support Scale*. The whole questionnaire and the three component subscales were found to have satisfactory internal consistency. Qualitative information from family members showed that the measure appeared to be applicable to them. The authors discuss how, with further, larger scale psychometric testing of the measure, with a wider range of ethnic groups within the UK and different cultural groups internationally, it will become more generalisable to other populations. The authors discuss the potential for the new measure to provide data which will enable a re-appraisal of the support component of the Stress-Strain-Coping-Support model of addiction and family, helping to identify the most important elements of the support component.

### 8.3.4 Sex workers

In Wales, *A Review of Multi-Agency Approaches to Tackling Sex Work/ Prostitution* was undertaken (Cardiff County Council 2012). Cardiff has women, men and transgender individuals involved in both on and off-street sex work/ prostitution. Women involved in off-street sex work/ prostitution account for approximately 90% of sex work/ prostitution in Cardiff. The Inquiry found research and evidence from local frontline workers indicating that the situation in Cardiff mirrors the national picture with regard to the experiences of women involved and the differences between on and off-street sex work/ prostitution. As at November 2011, witnesses to the Inquiry estimated that there were between 100 and 120 women involved in on-street sex work/ prostitution in Cardiff. The vast majority (over 95%) of these women come from abusive, deprived backgrounds, with high numbers experiencing sexual and physical abuse in their childhood and domestic violence as adults.

Recent research in Cardiff (Matt and Hall 2007) has shown that many of the women involved in on street sex work/ prostitution have been exploited or coerced into street sex work, often before they are eighteen years old. At least 95% of women involved in on street sex work/ prostitution have very high levels of Class A (mainly heroin and/ or crack) misuse and have poor physical health. Normally, substance misuse follows entry into street sex work, for three main reasons; pimps use it as a control mechanism; it temporarily helps women to cope with/forget trauma of sex work; and drug use is often normalised in the upbringing of the women concerned. Research in Cardiff by Matt and Hall (2007) and by Sagar and Jones (2010) shows that women involved in on street sex work/ prostitution are subjected to extreme levels of sexual and physical violence and harassment.

During 2012/13, work has commenced to assess the accessibility of substance misuse treatment for those who are engaged in sex work. The Welsh Government is evaluating pathways into treatment and has engaged with substance misuse agencies and specific sex work projects. Interviews with service users have been undertaken and the Welsh Government is currently considering what specific actions (including the promotion of sexual health advice) need to be taken with this traditionally hard to engage client group.

Drugscope/AVA has produced a research report and policy briefing, *The Challenge of Change*, looking at needs and service provision for women involved in substance misuse and prostitution.<sup>238</sup>

Bournemouth LINK (Local Involvement Network)<sup>239</sup> has published its report: *Health needs assessment of sex workers – substance misuse*, which was developed to look at the current

<sup>238</sup> See: <http://www.drugscope.org.uk/POLICY+TOPICS/Prostitution+and+substance+use.htm>

service provision for sex workers and to identify their health needs (LINK 2012). The authors concluded that sex workers have many complex needs including substance misuse and mental health problems, linked to issues with housing and homelessness, sexual health, violence, safety, and children who are no longer in their care. The authors recommend that good practice should reflect the need for effective and holistic assessment of street sex workers. They advise that it is important to try to understand the factors which lead women/men to becoming involved in sex work, as well as ensuring that there are clear pathways into appropriate services. Secure accommodation, the report states, can be a crucial part of supporting this group to leave sex work: However, the number of housing providers who are able to support this level of need is often too low.

### 8.3.5 Domestic Violence

DrugScope and the London Drug and Alcohol Network (2013) report on a four year project focused on the development of a cross-sectoral network bringing together domestic violence and drug and alcohol services. Meetings were held to discuss topics of common interest, to provide information and support, and facilitate collaboration and partnership. The project hosted regular peer support meetings for agencies delivering services to survivors of domestic violence, together with those working with perpetrators. The project produced several written briefings as well as the main report which sets out data on substance misuse and domestic violence (see section 8.2.7), summarises the key learning from the project and provides examples of good practice and good practice guidelines as well as a list of contacts and resources for those working in the domestic violence and substance misuse sectors.

### 8.3.6 Stigmatisation of drug users

#### Challenging Stigma

Adfam published their report *Challenging Stigma* in late 2012, which aims to improve awareness and understanding of how stigma can affect families of alcohol and drug users and to provide a person-centred perspective (Adfam 2012).<sup>240</sup> Adfam firstly set out to define stigma, with input from the focus groups, and presented the current research on the stigma attached to alcohol and drug users. They identified a number of concepts discussed by the focus groups; isolation; permanence; and concealment. Participants highlighted the important role that families play in recovery and in providing vital social capital. The importance of supporting such families was also identified by Adfam. The authors conclude by recommending ways in which stigma can be challenged.

#### Literature review on stigmatization of problem drug users

Lloyd (2013) reviewed 185 papers related to the stigmatisation of people who misuse substances. He found that stigmatising attitudes towards problem drug users were common amongst the general public and non-specialist professionals. One reason for these attitudes was negative feelings about injecting, associated with danger and blame. The author reported that there is a significant negative impact of stigmatisation on drug users and that this reduces their chances of recovery. The report identified some responses to this problem including encouraging public figures to speak out about their own experiences, improved training for non-specialist staff, greater contact between drug users and the public and challenging media language and stereotypes.

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<sup>239</sup> LINKs began in April 2008 and consist of a network of people and groups who have joined forces to improve health and social care services by listening to communities. There are a number of LINKs throughout England and they have the power to ask the NHS and Social Services for information and to make recommendations to them.

<sup>240</sup> Participants were recruited to take part in 4 focus groups, with participants representing London, the South West of England, the East Midlands and the North East of England.

### [A Guide for Journalists](#)

The UKDPC published a guide for journalists when reporting on drug-related issues (UKDPC 2012c). The guide aims to provide an alternative style and language for journalists to use when referring to drug users, by moving away from attaching a deviant social status to the user. By removing the shame of addiction through an alteration of the language used by journalists, the authors argue that a barrier to their recovery may be removed.

## 9. Drug-related crime, prevention of drug-related crime and prison

### 9.1 Introduction

Drug use is not a crime in the United Kingdom, but possession, production and dealing, as well as trafficking (including importation and exportation) are specific offences under the *Misuse of Drugs Act 1971*. Recorded drug crimes, after increasing following the introduction of the cannabis warning in England and Wales in 2004, have decreased in the past three years, which coincides with the removal of the police target regime. The number of persons dealt with by the courts or cautioned for drug offences has risen since 2005; mainly for cannabis and cocaine powder related offences, although the latter has decreased since 2009. A prison sentence is the most common outcome when found guilty at court of import/export and trafficking offences but a fine, community sentence or conditional discharge are the most common disposals for possession offences.

Police records on general criminal offences do not contain information on the offenders' drug habits, neither do records of specific drug law offences. It is therefore not possible to provide an accurate estimate of the number of offences that are drug-related. Despite the complexity of the drugs-crime relationship, there is research evidence of the link between drug use, particularly use of heroin and crack cocaine, and acquisitive crime (Boreham et al. 2007). Around two-thirds of those in custody are reported to be recent drug users with an estimated 40% of prisoners received into custody being problematic drug users, 40% of whom identify themselves as people who inject drugs (Stewart 2008).

The Drug Interventions Programme (DIP) was operational in every local area in England and Wales, from 2003 to March 2013, to tackle Class A Drug misusing offenders, managing around 88,000<sup>241</sup> into drug treatment in 2011/12. Following the removal of central ring-fenced funding for DIP, it is now for Police and Crime Commissioners (PCCs), elected in each local area, to determine what (if any) interventions to address Class A drug-related offending are funded in their area. This may include the operation of arrest referral schemes. There are a number of interventions available at various stages of the criminal justice system to engage drug misusing offenders with treatment services through legislative sanctions and voluntary programmes, offering support to reduce offending.

In Scotland, there are a number of interventions at different levels of the criminal justice system, including diversion from prosecution to drug treatment/education, community payback orders with a drug treatment requirement, Drug Treatment and Testing Orders (DTTOs) for particularly high tariff offenders who are entrenched in their drug use, as well as services for prisoners post-release, including Throughcare Addiction Services. DTTOs provide offenders with access to treatment services which they are required to comply with, combined with regular progress reviews from the Court. A less intensive version (DTTO II) has been developed for lower tariff offenders and rolled out on a pilot basis in Edinburgh and Lothians from June 2008.

There is a range of measures to prevent drugs entering prison including 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 visit areas and low-level fixed furniture; and comprehensive measures to tackle visitors attempting to smuggle drugs, including closed visits, visit bans and police arrest. Recently introduced initiatives include

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<sup>241</sup> This figure is the number of offenders identified through DIP in the community and in prison in England and Wales, entering Tier 2 and Tier 3/4 drug treatment.

drug-free wings and further developments of mobile phone signal denial equipment, including the *Prisons (Interference with Wireless Telegraphy) Act 2012*.

Since April 2006, in England and Wales, responsibility for prison health services moved gradually to the National Health Service (NHS) and an Integrated Drug Treatment System (IDTS) was introduced in England to improve the availability and quality of drug treatment in prison, bringing it in line with treatment in the community. From April 2011, the Department of Health assumed responsibility for funding both clinical and non-clinical drug and alcohol treatment in all prisons and the community in England, with responsibility for commissioning substance misuse services devolved to local partnerships in line with the key Patel Review (DH 2010) recommendation that integrated and needs-led treatment services are best commissioned at a local level. In April 2013, as part of the new health and care changes set out in the *Health and Social Care Act 2012*, NHS England<sup>242</sup> became responsible for commissioning health services in prisons and other secure accommodation in England

In Wales, health services are the responsibility of the Welsh Government, with responsibility for commissioning devolved to Local Health Boards. The National Offender Management Service (NOMS) retains responsibility for its non-clinical substance misuse services for sentenced offenders. In Scotland, responsibility for health care in prisons was transferred to the National Health Service in November 2011.

Those in prison have access to HIV and hepatitis testing, and vaccination against hepatitis B. Naloxone is increasingly available for prisoners at risk of drug overdose on release from prison.

## 9.2 Drug law offences

Data on drug law offences are available at various points in the criminal justice system. Recorded crime data count the number of drug offences brought to the attention of police and represent the widest measure of drug offences available in the UK. However, at present the individual drug involved is not recorded (except for cannabis possession offences). Arrests data record the number of persons who are arrested for a drug offence and represent a smaller proportion of drug offences since some penalties such as formal warnings for cannabis do not constitute an arrest. These data are not available by drug or by offence type. Finally, cautions and convictions data record the number of offences where an individual is found guilty at court or cautioned for a drug offence. Data from each level of the criminal justice system cannot be compared for a number of reasons including: time lag between offence and conviction; the basis on which the data are provided (offender or offence); counting rules<sup>243</sup>; and year of data (calendar or financial year). Further information on the recording of drug offence data are contained in a selected issue chapter on sentencing statistics in the UK Focal Point Report 2008.

The recording of drug offences is dependent on police activities and priorities and is not a reliable indicator of the level of drug offending.

### 9.2.1 Recorded crime: drug offences

There were a total of 247,083 recorded drug offences in the United Kingdom in 2012/13, an eight per cent decrease from the previous year (n=268,036). The number of recorded drug offences decreased for both possession and trafficking with a slight increase in 'other drug offences', albeit relatively small numbers. While there have been decreases in England and Wales, and Scotland in the past five years, the number of offences has increased substantially in Northern Ireland over this period (Table 9.1).

<sup>242</sup> NHS England is also known as the NHS Commissioning Board

<sup>243</sup> See: <http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/counting-rules/count-drug?view=Binary>

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**Table 9.1 Recorded crime: Drug offences in the United Kingdom by offence type and country, 2004/05 to 2012/13**<sup>244</sup>

	Year								
	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
<b>England and Wales</b>									
Trafficking*	24,190	25,276	26,550	28,323	29,885	33,234	32,336	31,316	29,765
Possession	120,866	152,602	167,003	200,773	212,528	201,240	199,444	196,656	177,219
Other drug offences**	781	601	680	816	1,123	1,122	1,142	1,127	1,033
<i>Total offences</i>	<i>145,837</i>	<i>178,479</i>	<i>194,233</i>	<i>229,913</i>	<i>243,536</i>	<i>235,596</i>	<i>232,922</i>	<i>229,099</i>	<i>208,017</i>
<b>Northern Ireland</b>									
Trafficking	375	349	475	530	607	668	762	846	890
Possession	2,246	2,594	1,934	2,186	2,364	2,472	2,708	2,924	3,473
Other drug offences	1	1	4	5	3	6	15	10	15
<i>Total offences</i>	<i>2,622</i>	<i>2,944</i>	<i>2,413</i>	<i>2,721</i>	<i>2,974</i>	<i>3,146</i>	<i>3,485</i>	<i>3,780</i>	<i>4,378</i>
<b>Scotland</b>									
Trafficking	9,333	9,613	10,890	9,827	10,315	9,901	7,138	6,684	5,136
Possession	32,268	34,440	31,329	30,559	31,805	29,179	26,960	28,326	29,150
Other drug offences***	222	194	203	360	389	328	249	147	402
<i>Total offences</i>	<i>41,823</i>	<i>44,247</i>	<i>42,422</i>	<i>40,746</i>	<i>42,509</i>	<i>39,408</i>	<i>34,347</i>	<i>35,157</i>	<i>34,688</i>
<b>United Kingdom</b>									
Trafficking	33,898	35,238	37,915	38,680	40,807	43,803	40,236	38,846	35,791
Possession	155,380	189,636	200,266	233,518	246,697	232,891	229,112	227,906	209,842
Other drug offences	1,004	796	887	1,181	1,515	1,446	1,406	1,284	1,450
<i>Total offences</i>	<i>190,282</i>	<i>225,670</i>	<i>239,068</i>	<i>273,379</i>	<i>289,019</i>	<i>278,140</i>	<i>270,754</i>	<i>268,036</i>	<i>247,083</i>

\* Trafficking usually includes production, supply, possession with intent to supply, possession on a ship, carrying on ship and unlawful import and export.

\*\* For England and Wales, and Northern Ireland 'other drug offences' mainly concern permitting premises to be used for the production, supply and use of drugs.

\*\*\* For Scotland 'other drug offences' include production and manufacture of drugs (not illegal cultivation), offences related to money laundering, and other drug offences not designated as trafficking or possession.

Source: Smith et al. 2013; Taylor and Bond 2012; Chaplin et al. 2011 PSNI 2013; Scottish Government 2013d

**Stop and searches for drug offences**

In 2011/12 there were around 570,000 stop and searches for drugs carried out by the police in England and Wales accounting for half of all police stop and searches for any reason (Home Office 2013b). This is a three per cent decrease on the previous year after a long trend of increased use of this power. Just under half (45%) of the drug searches recorded were carried out in London. Overall, a stop and search for drugs resulted in an arrest in eight per cent of cases across England and Wales, similar to the previous year (7%). There were geographical differences with just 3.0% arrested following a stop and search for drugs in the Police Force with lowest arrest rate, Cambridgeshire, to 18.3% in the highest area, Northumbria. The number of arrests as a result of drugs stop and search was 42,966 accounting for just over one-third (35%) of all drug offence arrests (Table 9.2).

Release, a charity and campaigning organisation on drugs, the law and human rights published a study in conjunction with the London School of Economics looking at the ethnic disparities in the policing and prosecution of drug offences in England and Wales (Release 2013).<sup>245</sup> It found that the white population were least likely to be stopped and searched for

<sup>244</sup> Police forces in England and Wales revise their data as further information becomes available and figures in this table therefore may not agree with those previously published.

<sup>245</sup> The study team sent Freedom of Information requests to every police force in England and Wales asking for the ethnic breakdown for 2009/10 of those who were stopped and searched for drugs, and for each of the disposals available to police: cannabis warnings, penalty notice for disorders, caution; and charge. Twenty-eight of 42 police forces responded with the Metropolitan Police Service data used for more detailed analysis as it was seen as robust and accounts for 50% of all stop and searches for drugs in England and Wales.

drugs (7 per 1,000 population) with an increased rate amongst those identified as mixed race (14 per 1,000), Asian (18 per 1,000) and black (45 per 1,000). Around half of the stop and searches for drugs made by the London Metropolitan Police (n=280,000) were carried out on young people aged 21 or younger. The authors argue that police stop and searches for drugs is a “key driver of ethnic inequality throughout the criminal justice system.” Furthermore, the report suggests that inequality continues through the criminal justice system with black people caught in possession of cannabis in London charged at a rate five times that of white people. For those caught in possession of cocaine, 44% of white people were charged compared to 78% of black people. The report also highlights the increase in the number of prosecutions for possession offences since 1983. Some of the reasons for the increased use of stop and search are explored including the fact that detecting a cannabis possession offence is an easy way to increase rates of sanction detections. However, the impact of stop and search on ethnic minorities is illustrated through the stories of individuals affected by this policing. The report sets out a number of recommendations with the principal one being that “there is an immediate review of drug policy in the UK, in recognition of the urgency and need to address the disproportionate impact of drug law enforcement on those from BME communities.”

The Home Office launched a consultation on the police powers on stop and search in July 2013, which ran until the end of September.<sup>246</sup>

### 9.2.2 Arrests for drug offences

The number of arrests for drug offences decreased by three per cent between 2010/11 and 2011/12, with England and Wales accounting for the whole of the decrease; arrests in Northern Ireland increased by four per cent over this period (Table 9.2). In England and Wales, 11.3% of all persons arrested for drug offences were female compared to 15.4% for all offences. This is lower than the proportion of females amongst those entering treatment in the UK in 2011/12 (26%; ST34) or the proportion of estimated opiate and crack cocaine users who were female (23.3%; Hay et al. 2013) in England in 2010/11.

**Table 9.2** Arrests for drug offences in England and Wales, and Northern Ireland, 2003/04 to 2011/12

	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
England and Wales	113,100	84,800	88,600	89,200	104,500	115,300	121,000	124,900	121,200
Northern Ireland	1,754	1,356	1,440	1,726	1,896	2,014	2,250	2,435	2,543
<i>Total</i>	<i>114,854</i>	<i>86,156</i>	<i>90,040</i>	<i>90,926</i>	<i>106,396</i>	<i>117,314</i>	<i>123,250</i>	<i>127,335</i>	<i>123,743</i>

Source: Home Office Arrests Table A.02 (ppp-arrests-1112-tabs); PSNI 2004; 2006; 2008; 2010; 2012a

### 9.2.3 Convictions and cautions for drug offences

There were 152,406 drug offences where the person was found guilty at court or cautioned in the United Kingdom during 2011 (Table 9.3; ST11), around the same number as the previous year (n=152,451). Convictions for heroin decreased by around one-quarter reflecting the reduced supply of heroin in late 2010 and early 2011, a pattern seen in most other indicators. Cannabis convictions continued to increase, by five per cent on the previous year. This demonstrates the increased use of more punitive sanctions for cannabis possession (see section 9.2.4) and, more notably, the increase in drug trafficking (including

<sup>246</sup> See:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/212014/Stop\\_and\\_Search\\_consultation\\_Revised\\_WEB\\_v2.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212014/Stop_and_Search_consultation_Revised_WEB_v2.pdf)

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production) convictions. There was a ten per cent increase in cannabis trafficking convictions between 2010 (n=15,534) and 2011 (n=17,165) and a 55% increase since 2009 (n= 11,054) reflecting the continuing discovery of cannabis farms.

The number of convictions for other drugs remained stable apart from ecstasy offences, which increased in 2011 after a large decrease in 2010; albeit still lower than 2009 levels.

**Table 9.3** Drug offences where the offender was found guilty or issued a caution in the United Kingdom<sup>247</sup>, 2003 to 2011 by individual drug

	2003	2004	2005*	2006*	2007*	2008*	2009*	2010*	2011*
Amphetamines	6,163	6,249	6,864	7,422	7,478	7,822	7,096	7,487	7,749
Cannabis	85,768	82,845	54,813	55,984	55,563	63,103	66,598	75,284	79,377
Cocaine powder	7,905	9,382	12,028	15,470	19,216	22,874	22,529	20,034	19,979
Crack cocaine	2,270	2,450	3,734	4,076	4,613	5,895	4,241	3,679	3,754
Ecstasy	5,940	6,209	6,337	6,233	7,189	5,107	3,608	1,812	2,486
Heroin	11,277	12,412	15,629	15,741	16,557	17,926	16,354	16,648	12,733
LSD	150	90	183	172	165	156	106	69	83
<b>Total</b>	<b>117,532</b>	<b>122,459</b>	<b>118,706</b>	<b>124,344</b>	<b>135,655</b>	<b>146,909</b>	<b>147,013</b>	<b>152,451</b>	<b>152,406</b>

\* Data since 2005 are on an all offence basis; data for 2000 to 2004 are based on principal drug offence.

Source: Standard Table 11

### Cathinone offences

Mephedrone and other cathinone derivatives became controlled drugs in April 2010. Data from England and Wales show that there were 1,615 methylmethcathinone cautions and convictions in 2011 and 2,873 in 2012, a 78% increase on the previous year. When looking at the breakdown of methylmethcathinone offences by offence type, possession offences constituted a higher percentage than for any other drug; 92% (n=2,641) of all methylmethcathinone offences were for possession compared to 84% for ecstasy and 79% for cocaine powder.

### Home Affairs Committee review of drug policy

In order to allow former drug users to actively participate in society, the Home Affairs Committee (HAC) recommended that the Government review the inclusion of convictions for offences of simple possession of a controlled substance (as opposed to offences relating to supply, or any other drug-related crime such as burglary) in Criminal Record Bureau checks after they become spent, or after three years, whichever is shorter (HAC 2012). It also recommended that cannabis warnings be treated as spent immediately. The United Kingdom Drug Policy Commission in its publication, *A Fresh Approach to Drugs* (UKDPC 2012d) also raised the question of whether giving people a criminal record for possession of drugs is a proportionate response to the problem. It suggested that "proportionality should be considered both between different types of drug/drug offence, and between drug offences and other offences."<sup>248</sup>

The Government's response to the HAC stated that this would be addressed within the framework of the wider consideration of conviction information and the filtering mechanism for enhanced criminal records checks (HM Government 2013). This filtering mechanism operates under the *Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975*<sup>249</sup> so that certain old and minor convictions will no longer be subject to disclosure. Offences of supply and production will remain subject to disclosure regardless of the disposal, but simple possession offences may be subject to filtering if the criteria are met. An adult caution for a non-specified offence will no longer be disclosed after six years (two years for a caution or

<sup>247</sup> Data from Northern Ireland for 2007 onwards are for cautions only. No court data are available.

<sup>248</sup> See: <http://www.ukdpc.org.uk/wp-content/uploads/Briefing%20-%20Submission%20to%20the%20Labour%20Justice%20Policy%20Working%20Group.pdf>

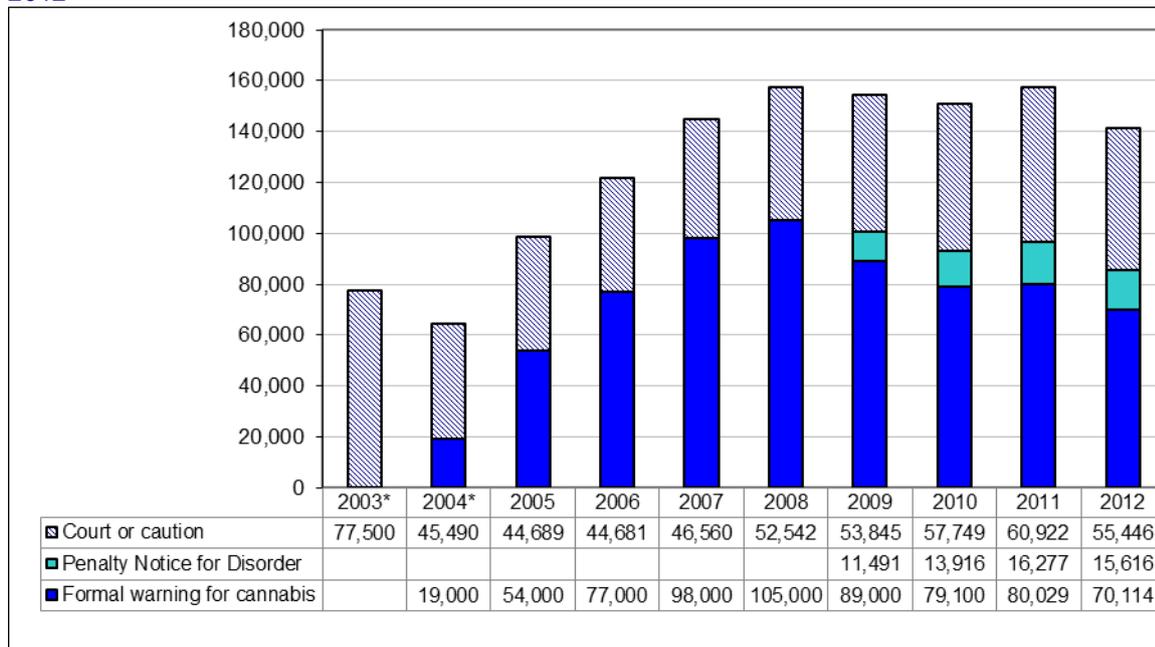
<sup>249</sup> See: <http://www.legislation.gov.uk/ukdsi/2013/9780111537718/contents>

equivalent received as a young offender), and an adult conviction for a non-specified offence which results in a non-custodial sentence will be filtered after 11 years (5.5 years for a young offenders) but only if it is the sole conviction on the individual's record (in other words, if you have two or more convictions filtering will not apply).

**9.2.4 Convictions, cautions and administrative penalties for cannabis possession in England and Wales**

The number of cannabis possession offences dealt with by the criminal justice system in England and Wales decreased by ten per cent between 2011 and 2012 (Figure 9.1). There were decreases across all sanction types but most prominently in the number of formal warnings for cannabis possession, which decreased by 12% and is now at a lower level than in 2006. It is unclear what has driven this reduction, whether it is a decrease in the use of cannabis (see section 2.2.1) or a decrease in the use of stop and search (see section 9.2.1). It follows, however, a trend towards more punitive sanctions for cannabis possession since 2009 when the Association of Chief Police Officers (ACPO) issued guidance on the escalation framework for cannabis possession offences (ACPO 2009). However, the number of cautions and court convictions also decreased in the last year, by nine per cent between 2011 and 2012.

**Figure 9.1** Number of cannabis possession offences by sanction type in England and Wales, 2003 to 2012



\*Data for 2003 and 2004 were based on principal drug offence while data since 2005 are on an all offence basis

Source: Standard Table 11; MOJ 2013h

**9.2.5 Other drug-related crime**

**Cutting agents**

A consultation document was issued in May 2013 on proposals to introduce new powers allowing law enforcement to seize drug cutting agents, principally those detected in adulterated cocaine; benzocaine, lidocaine and phenacetin (Home Office 2013c; see section 1.2.6).

While there are no current laws or regulations that specifically target the 'grey market' trade in drug cutting agents, other legislation can be used to prosecute offenders; whether for conspiracy to supply Class A drugs or assisting in the commission of an offence under the

*Serious Crime Act 2007*. It is estimated that there were over 23 criminal prosecutions undertaken by law enforcement in relation to the supply of drug cutting agents during 2012 and over 154 seizures of mis-described importations of benzocaine, lidocaine and phenacetin.

### Homicides

Data from Scotland show that of the 83 persons accused of homicide in 2012/13, five per cent were recorded as being 'on drugs' with a further two per cent recorded as being 'drunk and on drugs'. This compares to 36% who were recorded as being drunk only (Scottish Government 2013e). In 2011/12 when, of the 124 persons accused of homicide, four per cent were recorded as being 'on drugs', a further six per cent were recorded as being 'drunk and on drugs', and 58% were recorded as being drunk only (Scottish Government 2012a).

### Drug driving

In England and Wales during 2011, just over 2,600 proceedings were brought under section 4 of the *Road Traffic Act 1988* for the offence of driving whilst being unfit to do so through drink or drugs.<sup>250</sup> Of these, only 53% were found guilty. The Government has brought forward a new drug driving offence to increase rates of detection and prosecution (see section 1.2.6). The new offence was created in the *Crime and Courts Act 2013* which inserts a new section 5A in the *Road Traffic Act 1988* making it an offence to drive with a specified drug over a specified limit. The drugs and the limits are to be specified in regulations following a consultation<sup>251</sup> and approval by Parliament expected in 2014. The UK government will make the regulations for England and Wales whilst the Scottish Government will make them in relation to Scotland.

### Acquisitive offending by drug misusers

Hayhurst et al. (2013) used data from the Drug Treatment Outcomes Research Study (DTORS)<sup>252</sup> to explore the link between drug spend and acquisitive offending by substance misusers in contact with treatment services. Based on reported offending, participants were split into an acquisitive offender group (40%) and a no acquisitive offending group (60%). Acquisitive offenders were more likely to be heroin users (81% compared to 64%), crack cocaine users (57% compared to 38%), benzodiazepine users (17% compared to 11%) and polydrug users (87% compared to 58%) and to report risky behaviour. Drug spend in the last 4 weeks was significantly higher for acquisitive offenders than for those reporting no acquisitive offending (median of £911 compared to £240). While expenditure was a significant predictor of acquisitive offending, it was a weak substantive predictor with a three per cent increase in the likelihood of acquisitive offending for each £100 increase in drug spend. This, the authors suggest, challenges the theory of a direct causal link between drug use and acquisitive offending as does the fact that the majority of the cohort did not report any acquisitive offending (including 54% of heroin users).

## 9.3 Prevention of drug-related crime

### 9.3.1 Drug Interventions Programme (DIP) in England and Wales

The Drug Interventions Programme (DIP), which was established in 2003 has been the primary method of engaging drug misusing offenders with drug treatment services in England and Wales. DIP has referred large numbers of offenders to treatment and alongside

<sup>250</sup> See: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/98431/fs-mg-drug-driving.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98431/fs-mg-drug-driving.pdf)

<sup>251</sup> See: <https://www.gov.uk/government/consultations/drug-driving-proposed-regulations>

<sup>252</sup> DTORS was a longitudinal, observational, multi-site cohort study of 1,380 adult drug users entering treatment in England between February 2006 and March 2007. Participants were followed-up at 3-5 months and 1 year. Baseline interviews included details on reported drug misuse expenditure and offending behaviour in the last four weeks. See: <http://www.dtors.org.uk/>

drug treatment orders handed down by Courts, it has resulted in the criminal justice system becoming the largest referral source into treatment (see section 5.4.2).

In November 2012, Police and Crime Commissioners (PCCs) were elected by the public in England and Wales. Their purpose is to formulate the Policing Plan for the local area, set the police budget and hold the police force to account. Reflecting the increased focus on localism, the Home Office Community Safety Fund (CSF) came into existence on 1<sup>st</sup> April 2013. The CSF is not ringfenced so local Police and Crime Commissioners have the flexibility to use the funding as they see fit.

In April 2013, funding for a number of crime, community and drugs grants ceased. These included: Drug Interventions Programme (DIP); DIP Drug Testing Grant; Community Safety Partnership Funding; Youth Crime and Substance Misuse Prevention activities; Positive Futures; Communities against Gangs, Guns and Knives; Ending Gang and Youth Violence programme; Community Action Against Crime: Innovation Fund; and Safer Future Communities.

In Wales, an options appraisal for the future commissioning and delivery arrangements of DIP is being led by the South Wales Deputy PCC, on behalf of the PCCs in Wales with support from Welsh Government.

#### Drug Interventions Programme activity data

DIP data show that, in 2011/12, around 88,000 individuals were helped into drug treatment and recovery services, including non-structured treatment in England. Treatment data (NTA 2012d) show that, in 2011/12, there were 8,881 adults entering structured treatment from arrest referral/DIP in England<sup>253</sup>, accounting for 13% of all those entering structured treatment.

This is a decrease from 2010/11 (n=9,926) and 2009/10 (n=10,626) but as a referral source, accounts for a similar percentage of all referrals.

Data from Wales show that in 2011/12, there were 3,907 referrals to DIP, a 33% increase from 2010/11 (n=2,937). There was a decrease, however, in the percentage of referrals taken onto the DIP caseload from 98% in 2010/11 to 82% in 2011/12. Drug testing on arrest data from 2011/12 show that 29% of tests were positive for opiates or cocaine<sup>254</sup>, the same rate as in 2009/10. Of those testing positive, 37% tested positive for cocaine, 47% for opiates and 16% for both (Welsh Government 2012b).

### 9.3.2 Reoffending and reconviction

Although sometimes used interchangeably, there is a difference between re-offending and re-conviction. It is difficult to measure the level of re-offending without self-report data. Data provided here generally refer to re-conviction and are drawn from administrative systems.

#### Re-offending in England and Wales

Data on re-offending is published quarterly in England and Wales.<sup>255</sup> The most recent data show that 57% of drug misusing offenders<sup>256</sup> identified between October 2010 and September 2011 re-offended within 12 months (MOJ 2013g). This is the same level as those

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<sup>253</sup> This figure refers to structured treatment so cannot be compared to the DIP figure, which includes non-structured treatment.

<sup>254</sup> 12,549 tests were carried out.

<sup>255</sup> See: <https://www.gov.uk/government/publications/proven-re-offending-statistics-october-2010-to-september-2011>

<sup>256</sup> Drug misusing offenders are classed as those who have been given drug orders as part of their sentence or test positive for opiates on arrest.

identified between October 2009 and September 2012 and slightly higher than those identified between October 2008 and September 2009 (55%). The reoffending rate across local authorities ranged from 43.8% to 84.1%.

The average number of offences per re-offender was four, which has remained stable since 2005. The total number of offences committed by drug misusing offenders decreased slightly (-0.4%) due to a reduction in the number of drug misusing offenders identified (n=44,108 compared to 45,544 between October 2009 and September 2010 and 55,680 between October 2008 and September 2009). The number of offences committed per offender increased slightly to 2.37 compared to 2.30 in the previous year's cohort.

Interim data from the two prison Payment by Results (PbR) pilots<sup>257</sup> (MOJ 2013e) show that, in Peterborough, there has been a decrease in the frequency of re-conviction events (-7%) while nationally there has been an increase (+13%). Data from the Doncaster pilot show a decrease in the binary re-conviction rate in the cohort period compared to the two periods covering the baseline year. Both pilots will use a 12 month reconviction final measure while the interim figures used a six month reconviction measure.<sup>258</sup> Final results are due in 2014.

### Reconviction rates in Scotland

Data from Scotland show that the one-year reconviction rate for offenders convicted of drug law offences has fallen since 2005/06 and currently stands at 25% for the 2010/11 cohort.<sup>259</sup> The reconviction frequency rate<sup>260</sup> has also fallen, and is now 37 reconvictions per 100 offenders. Of those who were reconvicted within one year (n=1,545), around half (48%) were convicted of another drug offence, with the next most common offences being crimes against public justice (22%), common assault (18%), breach of the peace (15%) and shoplifting (14%) (Scottish Government 2013f). This breakdown by offence type was similar to the 2009/10 cohort (Scottish Government 2012b). Information on reconviction rates for Drug Treatment and Testing Orders is in section 9.4.3.

Data on reconvictions for people receiving a Drug Treatment and Testing Order (DTTO) in Scotland can serve as a proxy for drug misusing offenders. Data show that both the reconviction rate and reconviction frequency have decreased since 2006-07 and now stand at 65% and 147 per 100 offenders respectively amongst the 2010/11 cohort compared to 75% and 203 per 100 offenders in 2006-07.

<sup>257</sup> The MoJ currently has two prison based PbR pilots operating in HMP Peterborough and HMP Doncaster. The Peterborough pilot began on 9 September 2010 and the Doncaster pilot on 1 October 2011. Offenders enter the PbR pilots after their first eligible release from the prison within the cohort period. For Peterborough, cohort 1 closed at the end of the month in which the 1000th eligible offender was released. Data presented here for cohort 1 is all eligible offenders released between 9 September 2010 and 1 July 2012. For Doncaster, cohort 1 included all eligible offenders released from 1 October 2011 to 30 September 2012. There are a number of differences in the design of the two pilots to enable different PbR approaches to be tested.

<sup>258</sup> At this stage the interim figures include all offenders in cohort 1 of the Peterborough pilot, but only about three-quarters of the offenders in cohort 1 of the Doncaster pilot. This is because some offenders in the Doncaster pilot were released from prison too recently for the 6 month re-offending window and 3 month waiting period (allowing time for cases to progress through the courts) to have elapsed.

<sup>259</sup> The cohort is all offenders released from a custodial sentence or receiving a non-custodial disposal in 2010-11 in Scotland. Data are drawn from the Scottish Offenders Index (SOI), which contains data on 450,000 offenders and 1,700,000 convictions from when SOI records began in 1989.

<sup>260</sup> The reconviction frequency is the average number of reconvictions within a specified follow-up period from the date of the index conviction per 100 offenders

### 9.3.3 Research

#### Drug enforcement and treatment engagement

McGallagher and McKeganey (2012) presented data from an evaluation of three drug enforcement operations, reporting an increase in the proportion of local drug users contacting methadone treatment clinics, following those operations<sup>261</sup>. They argue that this shows how enforcement can act as a stimulus to engaging with drug treatment and that enforcement and treatment should be seen as complementary rather than opposing elements of a comprehensive drug strategy. It was not clear from the report how many of the respondents interviewed immediately after the enforcement operations were interviewed again six weeks later.

#### Drug testing amongst offenders

Wilson and Hodgson (2013) present a critical assessment of the evaluation of drug testing of offenders, particularly those tested 'on-charge' at police stations. They discuss the issues specific to the evaluation that made it difficult to retain participants in the follow-up stages of the research, and discuss more generally the difficulties in retaining 'hard-to-reach' drug users in longitudinal research and the consequences of losing this group to follow-up. The authors critically assess the strength of evidence produced by evaluations of criminal justice interventions against drug use and question the extent to which government drugs policy has been underpinned by good research evidence.

## 9.4 Interventions in the criminal justice system

### 9.4.1 Transforming rehabilitation in England and Wales

In January 2013, the Ministry of Justice released a consultation paper outlining proposed changes to the management of offender rehabilitation in England and Wales (MOJ 2013a). Following the consultation<sup>262</sup>, *Transforming Rehabilitation: A Strategy for Reform* was presented to Parliament (MOJ 2013b). The strategy focuses on the management of offenders who are released on licence back into the community after serving a prison sentence or who are subjected to a community sentence. It contains proposals to make every offender released from custody subject to statutory supervision and rehabilitation in the community for a minimum of 12 months, even those on short-term sentences. The legislative changes these proposals require are contained in the *Offender Rehabilitation Bill* that is currently before Parliament.<sup>263</sup> In addition to changes to licence and supervision requirements, the Bill extends drug testing on licence to specified Class B as well as Class A drugs, and also contains provisions to amend the *Misuse of Drugs Act 1971* to remove the current 'trigger offence' filter to testing on licence.<sup>264</sup> The Bill also introduces a new licence requirement for offenders to attend drug appointments.

The Strategy also contains a commitment to introduce competition into the market for the provision of offender rehabilitation services for medium and low risk offenders. A newly reformed public sector probation service will retain assessment of risk and management of high risk offenders. It also extends the 'payments by results' programme to offender rehabilitation services, with part of the payment to the new providers being based on their

<sup>261</sup> Structured interviews were carried out with 149 Class A drug users across the three locations where the enforcement operations took place, in the period immediately following those operations and then again, where possible, 6 weeks later. They were asked about their recent drug use, drug buying, local availability of heroin and cocaine, local drug-related criminality and their contact with drug treatment services.

<sup>262</sup> A summary of consultation responses is available. See: <https://consult.justice.gov.uk/digital-communications/transforming-rehabilitation/results/transforming-rehabilitation-summary-responses.pdf>

<sup>263</sup> See: <http://services.parliament.uk/bills/2013-14/offenderrehabilitation.html>

<sup>264</sup> Being arrested for a trigger offence allows the police to drug test the offender.

success in achieving desistance of offending for 12 months but also taking into account the total number of re-offences committed to ensure that the most prolific offenders are not neglected. The aim of this incentivised scheme is to encourage service providers to focus on addressing the causes of reoffending such as substance abuse. It is envisaged that these changes will take effect from autumn 2014.

#### 9.4.2 Sentencing for drug offenders

Figure 9.2 shows the flows through the criminal justice system (CJS) for drug offenders in England and Wales during 2012 from recorded drug offences, the use of out-of-court disposals, cautions, court proceedings, sentencing and reception to custody (MOJ 2013h). Some offenders proceeded against at Court may have committed their offence in a previous year but the chart shows the general flow through the CJS for those who come into contact with law enforcement for drug offences.<sup>265</sup>

The figure shows that around two-thirds of those subject to action by law enforcement receive an out-of-court disposal reflecting the predominance of cannabis possession offences (see section 9.2). The majority (88%)<sup>266</sup> of those tried at Crown Court are suspected of drug trafficking, production or supply offences while the remaining defendants dealt with by magistrates' courts are most likely to be suspected of drug possession offences (66%)<sup>267</sup>. Correspondingly, only two per cent of those sentenced at magistrates courts are sentenced to immediate custody compared to just over half (53%) of those sentenced at Crown Court. A fine is the most common penalty imposed at magistrates court, meted out to half of all drug offenders sentenced in 2012.

#### 9.4.3 Alternatives to prison

##### Drug Rehabilitation Requirement in England and Wales

The Drug Rehabilitation Requirement (DRR) within a community order or suspended sentence of imprisonment is an intensive vehicle for tackling the drug misuse and offending of many of the most serious and persistent drug misusing offenders in England and Wales (SQ31). DRRs involve treatment, regular testing and court reviews of progress. In 2012, there were 13,283 DRR commencements, 9,284 under a community order and 3,999 under a suspended sentence order (MOJ 2013c). This is a similar number to 2011 DRR commencements (n=13,602) but an 18% decrease from 16,207 commencements in 2009/10. The decrease is partly due to police initiatives, which divert offenders from charge and a change in focus from commencements to maximising completion rates. Recently there has been a reduction in the numbers coming via arrest referral and testing on arrest, with significantly fewer positive tests for opiates and cocaine.

<sup>265</sup> In addition, recorded drug offences refer to the number of offences while the remainder of the flow chart is based on the number of offenders. It is, therefore, not possible to compare the two numbers.

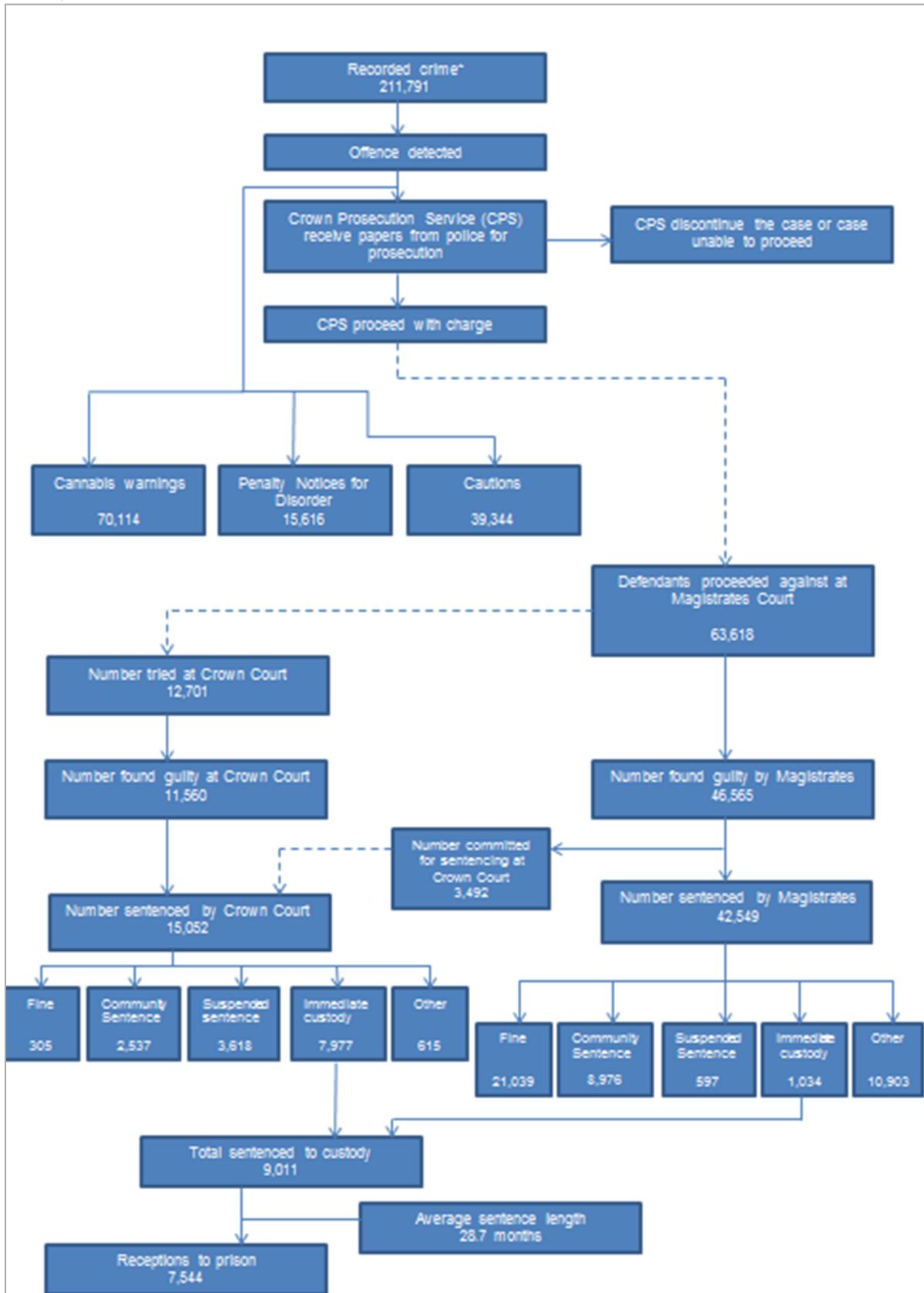
<sup>266</sup> See:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/203855/volume-2-2012.zip](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/203855/volume-2-2012.zip)

<sup>267</sup> See:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/203854/volume-1-2012.zip](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/203854/volume-1-2012.zip)

**Figure 9.2** Flows through the Criminal Justice System for drug offences/offenders in England and Wales, 2012

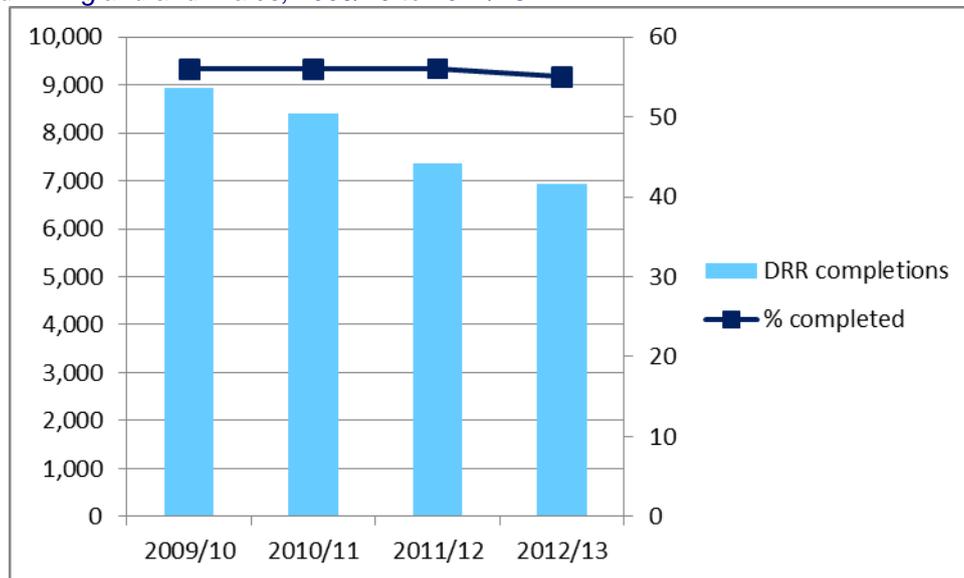


\* recorded drug offences refer to the number of offences while the remainder of the flow chart is based on the number of offenders. It is, therefore, not possible to compare the two numbers

Source: MOJ 2013h

The number of DRR completions decreased in 2012/13 (n=6,924), in line with the decrease in the number of DRR starts (MOJ 2013f). The completion rate was 55%, which has been stable since 2009/10 (Figure 9.3).

**Figure 9.3** The number of Drug Rehabilitation Requirement (DRR) completions and percentage completed in England and Wales, 2009/10 to 2012/13



Source: MOJ 2013f

#### Offender Management Community Cohort Study

The first report from the Offender Management Community Cohort Study (OMCCS) based in England and Wales, was published in 2013 (Cattell et al. 2013).<sup>268</sup> The report explores which offenders are sentenced to Community Orders, which offenders on Community Orders have their needs assessed, what their needs are, sentence planning, and how sentences are tailored for these offenders. The most common offence committed by those starting Community Orders was violence against the person (31%) followed by theft, burglary or fraud (29%) and motoring offences (13%), with drugs offences accounting for seven per cent. Around two-thirds (65%) of the cohort starting Community Orders received an assessment that was recorded in the Offender Assessment System (OASys)<sup>269</sup>. Not all offenders are required to have an assessment but the data showed that 16% of those who were required to have a full assessment did not receive one. Overall, 53% of the cohort received a drug misuse assessment, with one-third (32%) of these assessed as having a drug misuse need (Table 4.5). Across the whole cohort, just under one-fifth (17%) were assessed as having a drug misuse need. Of the eight criminogenic needs scored in OASys assessments,<sup>270</sup> offenders who were assessed had an average of three needs identified, with relationship problems as the most frequently identified need (61%).

<sup>268</sup> The OMCCS is a longitudinal cohort study of offenders who started Community Orders between October 2009 and December 2010. The study uses a dataset based on a cohort of offenders given these sentences between October 2009 and December 2010, drawing on three sources: a longitudinal survey of a representative sample of 2,919 offenders; central administrative records for all those offenders starting a Community Order during the period (144,388 offenders); and local administrative records from the 10 Probation Trusts selected for the survey (covering 48,943 offenders).

<sup>269</sup> OASys is an IT based Offender Assessment System, developed jointly by the Prison and Probation Services. It is a joint prison/probation programme, whose assessments are completed and used by both services.

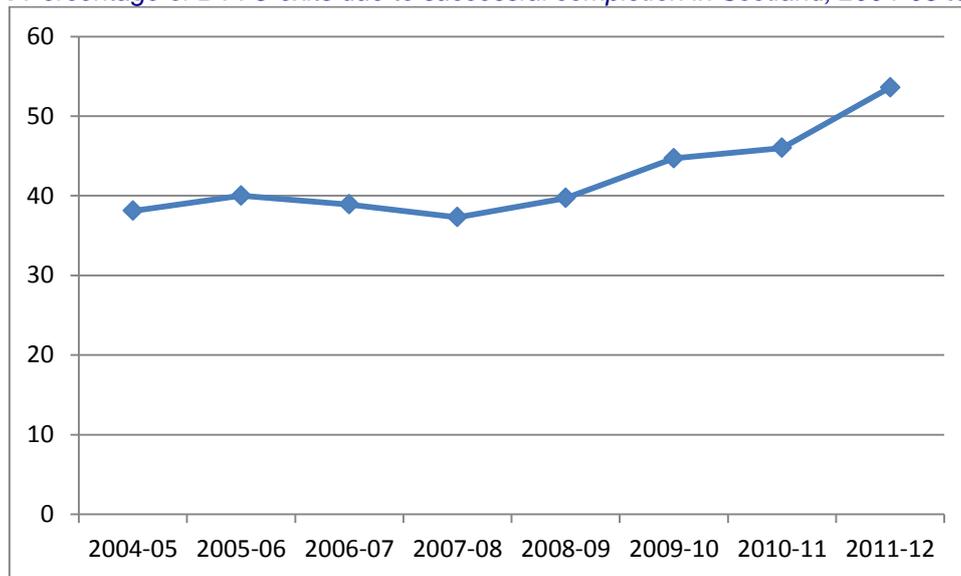
<sup>270</sup> Accommodation; education, training and employment; relationships; alcohol misuse; drug misuse; lifestyle and associates; think and behaviour; and attitude.

Data from the representative survey were matched to OASys data, showing that 21% of those who did not receive an assessment had a self-assessed drug misuse need and 13% had a hard drug use need (defined as using a Class A drug weekly or more or injecting) (Table A.22). The study found that there was a good association between the survey measures of drug misuse need and the OASys assessment of drug misuse need. Similarly, there was a strong relationship between the OASys assessment of drug misuse need and the Offender Manager perception of a need (professional judgement recorded in the OASys). Of the offenders whose OASys assessment identified a drug misuse need, 63% had this need addressed within their sentence plan, higher than for most of the other identified criminogenic needs. Those who had their drug misuse needs addressed within the sentence plan had higher levels of need than those who did not (an average assessment score of 5.7 compared to 3.7).

### Scotland

There are a number of interventions at different levels of the criminal justice system in Scotland to deal with drug misusing offenders (SQ31). In 2011/12 there were 129 diversion from prosecution cases referred to drug treatment/education (Scottish Government 2012c). This is a large increase from 31 cases in the previous year. Between 2010/11 and 2011/12, there was a substantial increase in the use of diversion from prosecution amongst 16 to 17 year olds, possibly as a result of the Scottish Government's publication of a toolkit in June 2011 on diversion from prosecution for young people (Scottish Government 2011b). However the data on cases referred to drug treatment/education are not broken down by age.

**Figure 9.4** Percentage of DTTO exits due to successful completion in Scotland, 2004-05 to 2011-12



Source: Scottish Government 2012c

The number of probation orders commenced with a condition of drug treatment/education decreased from 498 in 2010/11 to 158 in 2011/12, primarily due to the introduction of the community payback order (CPO) for offences committed on or after 1 February 2011. The CPO replaces the probation order, community service order and supervised attendance order and in 2011/12 there were 236 CPOs issued with a drug treatment requirement. In addition, there were 557 Drug Treatment and Testing Orders (DTTOs)<sup>271</sup> commenced in 2011/12, a decrease from 661 the previous year.

<sup>271</sup> The DTTO is a high tariff disposal for offenders with drug misuse problems, who might otherwise receive a custodial sentence. This order contains features unique to a community disposal, including

While there has been a decrease in the number of DTTOs commenced since 2008/09 (n=752), there is evidence of more successful outcomes for those subject to a DTTO over this period. Figure 9.4 shows that there has been an increase in successful completions of DTTOs over this period from 40% of all DTTO exits to 54%.

#### Northern Ireland

In Northern Ireland, since 2010 the administration of justice has come under the local Department of Justice, within the Northern Ireland Assembly governance arrangements. The Probation Board for Northern Ireland (PBNI) provides community supervision of offenders on statutory orders or licences.

At 31st August 2012, PBNI were supervising 4,350 people with its Assessment and Case Management and Evaluation tool recording an Offending Related Score (the extent to which the factor is relevant to the person's recent and/or potential offending) of 65% for alcohol/drugs and 43% for drugs/alcohol, with approximately 10% being drugs only.

There is no Drug Treatment and Testing Order legislation in Northern Ireland, however, drugs testing can be written into licences. PBNI supervises life licencees with a requirement of abstinence from drug use and random drug testing.

#### 9.4.4 Drug Courts

##### Scotland

Drug Courts are targeted at offenders over 21, with complex and deeply entrenched drug problems that relate to their offending behaviour, to help them recover from addiction and rebuild their lives. The aim is to reduce the level of drug-related offending behaviour and to reduce or eliminate offenders' dependence on, or propensity to use, drugs. The Scottish Government has funded two drug courts; in Glasgow since 2001, and in Fife since 2002. It was announced that funding for the Fife Drug Court would cease in March 2014.

### 9.5 Drug use and problem drug use in prisons

#### 9.5.1 Drug use amongst prisoners

##### Surveying Prisoner Crime Reduction study in England and Wales

Light et al. (2013) used data from the first wave of the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study<sup>272</sup> to explore substance use and gender differences. Eighty-one per cent of the cohort reported having taken illegal drugs at some point in their lives, with no difference between genders in this measure or for drug use in the last four weeks before custody (64% overall). Females were more likely than males to report ever using heroin (55% compared to 39%) and to report the use of Class A drugs in the four weeks prior to custody (58% compared to 43%). Nineteen per cent of those who reported ever using heroin said that they had first done so in prison, with male heroin users (38%) more likely to report doing so than female heroin users (10%). Just under one-third of prisoners said their offending was always connected with their drug use with females (50%) more likely to report this than males (28%). Females were also more likely to report that they needed help with a drug problem (49% compared to 29% of males).

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a requirement for regular reviews by the court and a requirement that the offender consent to frequent random drug tests throughout the lifetime of the order.

<sup>272</sup> Data used are from sample 1 of the SPCR. A representative sample of 1,435 newly sentenced prisoners were interviewed between two and four weeks after reception, and prisoners were eligible if they had been sentenced for between one month and four years. Fieldwork took place between November 2005 and November 2006 at 4049 prisons in England and Wales. A response rate of 60% was achieved. The SPCR sample 1 consisted of 1,303 male prisoners and 132 female prisoners

The authors compared the findings to those found in a survey of offenders in the community and in the Crime Survey for England and Wales showing that drug use amongst prisoners was higher than for both of the other groups. Data were also matched to those from the Police National Computer to look at the impact of drug use on reconviction. There was a significant association between drug use and reconviction; 62% of those reporting drug use in the four weeks before custody were reconvicted within 12 months compared to 30% of those who had never used drugs.<sup>273</sup>

#### Addiction prevalence testing in Scotland

Data show that, of the 1,176 addiction prevalence tests carried out on reception to prisons in Scotland<sup>274</sup> during 2012-13<sup>275</sup>, 72% were positive for illegal drugs, similar to previous years. Benzodiazepines were the most frequently detected drug; 47% tested positive for benzodiazepines with 45% testing positive for cannabis and 31% testing positive for opiates. There was an increase in the percentage of prisoners testing positive for cannabis and buprenorphine (Table 9.5).

**Table 9.4** Percentage of positive tests on reception to Scottish prisons, 2008-09 to 2012-13

	2008-09	2009-10	2010-11	2011-12	2012-13
Amphetamines	2	1	2	1	3
Barbiturates	-	0	1	1	0
Benzodiazepines	49	38	53	48	47
Buprenorphine	3	0	2	3	9
Cannabis	42	28	40	35	45
Cocaine	6	6	8	9	9
Methadone	4	6	11	7	11
Opiates	36	36	36	34	31
All illegal drugs	71	56	73	70	72

Source: Scottish Government 2010a;b; 2012; Scottish Public Health Observatory

Similar to the findings from drug testing on reception, data from testing on release show an increase in the percentage testing positive for buprenorphine, from five per cent in 2011-12<sup>276</sup> to nine per cent in 2012-13, making it the most commonly identified drug followed by cannabis and benzodiazepines (both 7%). While positive tests for buprenorphine have increased, the percentage of prisoners testing positive for illicit use of opiates or methadone on release has decreased. Overall, 23% tested positive for illegal drugs on release compared to 20% the previous year, with 40% testing positive for drugs including those prescribed to them.

#### Audit of past drug use amongst prisoners in Wales

Between May and July 2012, remand prisoners being received into Swansea adult male prison who indicated that they had problems with substance misuse, took part in an 'audit' of the range of drugs ever used prior to imprisonment (Richards 2012). In particular this audit

<sup>273</sup> See <http://www.justice.gov.uk/downloads/statistics/mojstats/spcr-sample1-wave1-questionnaire-tables.xls>

<sup>274</sup> Addiction Prevalence Testing (APT) is conducted across all Scottish prisons annually. Prisoners arriving in custody are tested for the prevalence of illegal drugs during one month of the year. Similarly, those leaving custody during the month are tested to assess progress and distance travelled towards the 'reduced or stabilised' offender outcome.

<sup>275</sup> See: <http://www.scotpho.org.uk/downloads/drugs/SPS-Addiction-Prevalence-Testing-Stats-Final-2012-13-v2.pdf>

<sup>276</sup> See: <http://www.scotpho.org.uk/downloads/drugs/SPS-Addiction-Prevalence-Testing-Stats-Final-2011-12.pdf>

sought to record use of new psychoactive substances (NPS).<sup>277</sup> The sample was relatively small in size (n=104) with the majority of the sample being over 30 years old and residing in the Swansea area.

Just over one-third (34.6%) of the prisoners reported ever using mephedrone, rising to half of those aged 18 to 21 and 22 to 24. Amongst the youngest age group, mephedrone was the third most used drug after cannabis and diazepam. Cannabis was the most widely used illicit substance overall and amongst all age groups apart from the oldest where diazepam was reported by 33 out of 43 prisoners. Reported use of NPS other than mephedrone was relatively low.

### 9.5.2 Mandatory drug testing

#### England and Wales

The target for Mandatory Drug Testing (MDT) was removed in 2011/12 although the information was still collected for management purposes. In England and Wales during 2012/13, 7.0% of prisoners tested positive for drugs through random MDT, the same percentage as the previous year (NOMS, MoJ 2013f).

The HAC (2012) report recommended that, in addition to random mandatory drug testing, there should be mandatory drug-testing for all prisoners arriving at and leaving prison whether on conviction, transfer or release with tests carried out for both illegal and prescription drugs. The Government's response stated that: "investing in costly and comprehensive drug testing programmes on entry and release would be an additional funding and resource burden, with a risk of funds being diverted from treatment provision to bear the costs, without being clear of the benefits that would ensue over and above existing random testing arrangements" (HM Government 2013).

### 9.6 Responses to drug-related health issues in prison

In April 2013, as part of the new health and care changes set out in the *Health and Social Care Act 2012*, NHS England<sup>278</sup> became responsible for commissioning health services in prisons and other secure accommodation in England such as immigration removal centres and secure children's homes (NHS Commissioning Board 2013). An agreement made under section 7a<sup>279</sup> of the *National Health Service Act 2006* between the Secretary of State and NHS England also transferred responsibility for some public health services to NHS England, including for the provision of substance misuse services in secure accommodation. NHS England is developing a national commissioning framework to ensure a consistent approach to commissioning services across the ten offender health area teams. A service specification sets out requirements for, and evidence underpinning, the public health services to be commissioned in secure accommodations by NHS England for the financial year 2013-14 (DH 2012b).

The key service outcome for substance misuse services is the proportion of individuals in secure environments that engage in structured drug and alcohol treatment interventions who at the point of departure from that establishment either:

- Successfully completed a treatment intervention in custody and did not re-present to treatment (either in custody or the community) within 6 months of release; or

<sup>277</sup> The audit comprised of 104 prisoners who completed a questionnaire at second reception covering age, area of residence and drug use history. Four age groups were used: 18-21 (n=15); 22-24 (n=22); 25-30 (n=24) and 30+ (n=43) and results were presented by age group.

<sup>278</sup> NHS England is also known as the NHS Commissioning Board

<sup>279</sup> See: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/192992/s7A-master-131114-final.pdf.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192992/s7A-master-131114-final.pdf.pdf)

- Successfully engaged in community based drug and alcohol treatment interventions following release; or
- Where they were transferred to another prison/Young Peoples' Secure Estate (YPSE), successfully engaged in structured drug and alcohol treatment interventions at the receiving establishment.

The HAC report (2012) highlighted concerns that the co-ordination arrangements between NHS England (which is responsible for prison drug treatment) and local areas (which are responsible for commissioning drug treatment in their communities) are unclear and that this could exacerbate existing issues with the link between drug treatment in prisons and drug treatment in the community. The Government's response (HM Government 2013) stated that the proposals contained within the *Transforming Rehabilitation* strategy document (MOJ 2013b) would strengthen co-ordination arrangements between prison and community drug treatment (see section 9.7). It also pointed to the explicit requirement within the Section 7a agreement to ensure "continuity of care between secure environments and community". The Department of Health's Mandate also commits NHS England to demonstrating progress with "healthcare services for offenders and people in the criminal justice system which are integrated between custody and the community".

#### [HM Chief Inspector of Prisons for England and Wales, Annual Report 2011-12](#)

Each annual report produced by the HM Inspectorate of Prisons (HMIP) draws upon findings from inspections carried out in different establishments each year so it is difficult to compare findings between years. One of the substance misuse findings from the 2010-11 report (HM Inspectorate of Prisons 2012), is that first night treatment of men with substance misuse issues was inconsistent across the inspected prisons, with some being described as 'inadequate'. However, in other prisons, the clinical management of prisoners was noted to have improved and included the provision of support services, measures to prompt access to clinical support, and the involvement of prisoners in the development of treatment plans.

Variations in maintenance and opioid substitution treatments were also reported within the inspected prisons, with offenders in one prison being subject to mandatory dosage reduction without individualised dosage plans, and other prisons merely encouraging a reduction in dosage. The Home Affairs Select Committee (2012) received submissions expressing concern over the practice of long term methadone maintenance without a focus on eventual abstinence. In line with the direction of the drugs strategy, the HMIP reports that, in some prisons, there has been a shift towards recovery and abstinence based outcomes with prisoners encouraged to gradually reduce their dosage.

Substance use within prisons was highlighted as an ongoing concern with the diversion of prescription drugs reported as occurring in the majority of inspected prisons. Of the mandatory drug tests conducted for illicit drugs, cannabis and subutex were the most commonly identified substances (see section 9.5.2). Diversion of prescription drugs amongst women prisoners was flagged as an issue in one prison but the low mandatory testing rates across women's prisons makes it difficult to generalise findings.

#### [9.6.1 Drug treatment in prisons](#)

##### [England and Wales](#)

From 1st April 2012, data on substance misuse treatment in prisons has been reported to the National Drug Treatment Monitoring System (NDTMS) (see section 5.4) in England. Public Health England is supporting prisons to migrate their data systems on a voluntary basis to a new system, the Data Entry Tool (DET), which will facilitate monthly reporting to NDTMS. It is expected that data for 2013/14 will be of sufficient quality to enable reporting and to form the baseline for the Public Health Outcomes Framework measure on people

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entering prison with substance dependence issues who are previously not known to community treatment (DH 2012a; see section 5.2.2).

In 2011/12, there were a total of 64,916 clinical drug interventions in prisons in England and Wales. Of these, 33,198 (51%) were maintenance prescriptions for opioid (heroin) dependency of either methadone or buprenorphine. The remainder were detoxification treatments (Table 9.x). The proportion of maintenance prescriptions has increased year-on-year in line with an increase in prison drug funding and the introduction of the Integrated Drug Treatment System (IDTS) in prisons (see selected issue in UK Focal Point Report 2011).

**Table 9.5** Number of clinical drug interventions for opioid (heroin) dependence in prisons in England and Wales, 2004/05 to 2011/12

Year	Detoxification treatments <sup>280</sup>		Maintenance prescriptions <sup>281</sup>		Total
	n	%	n	%	
2004/05	No separate reporting of detoxification and maintenance prescribing.				53,903
2005/06					53,773
2006/07					51,520
2007/08	46,291	78.7	12,518	21.3	58,809
2008/09	45,135	69.7	19,632	30.3	64,767
2009/10	36,323	60.5	23,744	39.5	60,067
2010/11	30,459	49.8	30,650	50.2	61,109
2011/12	31,718	48.9	33,198	51.1	64,916

Source: NHS Commissioning Board 2013; Offender Health

NOMS Interventions Services continues to be available for commissioning evidence-based interventions that are accredited by the Correctional Services Accreditation and Advisory Panel. Interventions are assessed by the panel against a set of accreditation criteria based on the lessons learnt from international research about what works in reducing re-offending and substance misuse. Such interventions aim to reduce reoffending behaviour through the exploration of previous and current substance use and the acquisition of a skill set to prevent future relapse into former patterns and behaviours. These include a range of programmes based on life skills acquisition, cognitive behavioural theory, a therapeutic community, a 12 Step abstinence approach and a programme which combines cognitive behavioural and educational approaches. It should be noted that the NOMS suite use the umbrella term of 'recovery focused interventions' which covers both alcohol and drug treatment, with some programmes addressing both.

Data show that, in 2012/13, there were 3,748 starts on substance misuse programmes, a large decrease from the previous year (n=8,139) (Table 9.7). This reflects the recent changes in the funding and commissioning of substance misuse services within prisons with some commissioners opting for alternative ways to address substance misuse related offending i.e. a blend of evidence-based services, with a particular emphasis on case management/continuity, mutual aid (i.e. self-help), life skills and couples and family work.

<sup>280</sup> Detoxifications of up to 21 days duration.

<sup>281</sup> Maintenance prescriptions and slow reduction programmes, i.e. detoxifications of more than 21 days duration.

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**Table 9.6** Substance Misuse programme starts and completions<sup>282</sup> delivered in prisons in England, 2008/09 to 2012/13<sup>283</sup>

	2008/09	2009/10	2010/11	2011/12	2012/13
Treatment starts	10,881	10,206	9,402	8,139	3,748
Treatment completions	8,054	7,655	7,363	6,653	3,101

Source: MOJ 2013d

### Wales

The Welsh Government's *Substance Misuse Delivery Plan, 2013-2015* (Welsh Government 2013a; see section 1.3.1) states that it will work with NOMS and Local Health Boards (LHBs) to implement the Integrated Drug Treatment System (IDTS) within public sector prisons in Wales with a delivery date of March 2015. It also plans to review joint working protocols between the prison estate and substance misuse services. NOMS is currently working with Local Health Boards, Welsh Government and Police and Crime Commissioners in Wales in reviewing its public sector prisons' provision to develop more integrated services which addresses harm reduction, recovery and reducing re-offending. This would build on the current IDTS and CARATs (Counselling, Assessment, Referral, Advice and Throughcare services) models of delivery.

### Northern Ireland

In 2011/12, 640 individuals presented to drug treatment in prisons in Northern Ireland. Primary cannabis use was the most common reason for presentation (42.3%) followed by benzodiazepines (12.7%), cocaine powder (11.6%) and other opiates (10.6%). The percentage of treatment presentations that were primary cannabis users is similar to those presenting to outpatient treatment in the community (40.6%). Primary benzodiazepine users were more common in the community (26.5%) and primary opiate users were less common (11.2% compared to 20.2%).

## 9.6.2 Prevention, treatment and care of infectious disease

### Viral hepatitis testing and treatment in Scottish prisons

A study measuring risk behaviours associated with hepatitis C took place within 14 closed prisons in Scotland (Taylor et al. 2012).<sup>284</sup> Injecting drug use is a known risk factor for the transmission of hepatitis C and approximately one third of prisoners surveyed identified themselves as ever having injected drugs, with eight per cent ever injecting in prison and 2.5% reporting injecting within the current prison stay. Of those who had injected during the current sentence, 26% reported weekly or daily injection with the majority (69%) reporting

<sup>282</sup> Data on starts and completions cannot be used to determine the percentage of successful completions since a programme could span two financial years.

<sup>283</sup> The data for 2009/10 to 2012/13 have been drawn from the Accredited Programmes Annual Bulletin 2012/13, first published July 2013. This uses a consistent definition of programme completion to allow more meaningful comparisons over time. This may differ slightly from previously published information on accredited programmes, such as for the purposes of monitoring performance against service level agreements and delivery requirements, which have been subject to definitional changes over the years.

<sup>284</sup> Between June 2010 and March 2011 research was conducted within 14 closed prisons in Scotland using a cross sectional survey of 5,076 prisoners including information on drug use history. Of these people 97% also provided an anonymous blood sample to test for prevalence and incidence of HCV. Qualitative interviews with staff in five prisons were also conducted including residential officers, healthcare and addiction staff, and managerial staff. The majority of the sample were male (95%) with two thirds of prisoners surveyed within the 20-39 year age range.

that they injected less than once a month. Over half (58%) of the current injectors reported that they had shared equipment with someone else.

The overall prevalence of hepatitis C (antibodies) was 19%<sup>285</sup> with a prevalence of 53% amongst those with a history of injecting drug use. The prevalence of hepatitis C amongst injecting drug users in prison is similar to that found in studies in community settings (see section 6.2.2). Incidence of hepatitis C<sup>286</sup> was low with four prisoners identified as recently infected, one of whom had only been incarcerated for nine days and was assumed to have been infected prior to imprisonment. Of the remaining three, two had a history of previous injecting drug use but no injecting was reported in the current imprisonment period.

The report draws a link between the low incidence of infection and the low rates of injecting within the prison and suggests that, in part, this may be a result of the increased availability of opiate substitution therapy and in particular methadone maintenance, within Scottish prisons. Most of the injecting drug users identified in the study had been tested for hepatitis C at some point in their life, with 66% of these reporting that they had been tested whilst incarcerated. Approximately 44% of those people who tested positive were not aware that they had hepatitis C. The authors identified this as a concern for policy and practice.

The report states that the number of prisoners receiving treatment for hepatitis C has increased in the past five years and over half of the prisoner surveyed had been vaccinated against hepatitis B, with most vaccination occurring within prison (79%). Around half (48%) of prisoners felt that needles and syringes should be provided to prisoners, with injecting drug users more likely to agree. However, when injecting drug users were asked if they would approach a staff member for equipment, 50% said that they would not with just over one-third (34%) of IDUs reporting that they would ask for needles and syringes.

#### Wales

The Welsh Government's *Substance Misuse Annual Report 2012* (Welsh Government 2012a) reports on the progress made in implementing the *Blood Borne Viral Hepatitis Action Plan for Wales* (Welsh Assembly Government 2010). It states that a Level 1 training package has been adapted for use by prison staff and a specialist nurse for prisons is supporting all relevant prison staff in training, education and delivery of clinical blood borne virus care within the custodial environment.

Hepatitis B vaccinations are part of the Prison Health Performance and Quality Indicators (PHPQIs).<sup>287</sup> Each prison in Wales sends monthly reports of their hepatitis B vaccination statistics to the health protection team at Public Health Wales. Data show that between January and June 2013, 38% of prisoners had received at least one hepatitis B vaccination, an increase from 29% between July and December 2012. One quarter of all prisoners had received three vaccinations and a booster during this period compared to 17% in the previous six months. Each prison in Wales has been asked to maintain a 1-2% increase in vaccine coverage each month for the remainder of 2013.

<sup>285</sup> Based on a sample of 4,904 valid antibody samples taken from blood spot (98%) and saliva samples (2%).

<sup>286</sup> Determined by using the RNA from dried blood spots which allows for detection within two weeks of exposure. Using information from previous studies the researchers allowed for a period of at least 70 days for the virus to have been contracted with the RNA showing during this time. As a result, only prisoners who had been in prison for longer than that period were tested, of which 19% were unsuitable for testing resulting in a sample size of 2454.

<sup>287</sup> See: <http://www.wales.nhs.uk/sites3/page.cfm?orgid=457&pid=60197>

### NICE Guidance

In December 2012, the National Institute for Health and Care Excellence (NICE) issued public health guidance on ways to promote and offer testing to people at risk of contracting hepatitis B and C (NICE 2012b).<sup>288</sup> Prisoners and people held in immigration centres were identified as some of the most at-risk groups. Amongst the recommendations for closed settings, there was an emphasis on fostering strong partnerships and co-ordination between detention authorities and community health providers. The guidance recommends that each establishment appoint a staff member to act as a hepatitis lead and that the NHS lead for hepatitis within the community should be responsible for developing the care pathways of prisoners identified as having hepatitis. It is also recommended that hepatitis treatment be provided by community specialists with full support from prisons.

The guidance also identifies areas in which detection and treatment can be improved, such as: offering access to hepatitis B and C testing on arrival; ensuring that all test results are delivered to the prison even if a prisoner is no longer at that prison; sharing of results with community GPs if consent has been given; training for all staff on hepatitis B and C and on how to test for and treat them; and ensuring access to dried blood spot testing in all prisons.

### Audit of Hepatitis C services in English prisons

An audit of hepatitis C services was undertaken in a representative sample of 21 prisons in England to assess the extent to which best practice standards are being met (PHE 2013f). The audit tool contained questions designed to judge the level of compliance with 13 quality criteria, as set out in various good practice guides including the NICE public health guidance (NICE 2012b). The main finding of the audit was that, although there were many areas of good practice, the quality and content of hepatitis C service provision across English prisons is variable. A number of recommendations were made including; having a written policy covering testing, treatment and care; offering testing to all prisoners and proactively targeting those most at risk; and improving surveillance systems so that data on testing, results and the provision of treatment are accurate.

In 2012, 5.9% (11,690/197,389) of new receptions to English prisons received a hepatitis C test, a similar level to 2011 (6.2%; 9,970/161,125) (PHE et al. 2013b).

### 9.6.3 Drug recovery and drug free wings

There are a number of prisons across England and Wales operating a Drug Recovery Wing (DRW) model. These wings are aimed at those in the process of recovery and contain an integrated range of intensive treatment and support to meet the needs of drug misusing offenders who are motivated to work towards abstinence. A number of these DRWs are included in a Department of Health pilot programme, which includes an independent evaluation being undertaken by the University of York to assess whether and how this approach can successfully support the sustained recovery of prisoners and their rehabilitation across the prison estate. The evaluation contract started in October 2012. An initial scoping and feasibility phase to help inform a detailed evaluation approach is expected to report in late 2013.

The overall aim of the evaluation is to assess whether, how and to what extent a drug recovery wing approach, co-ordinated across a range of drug treatment services, can successfully initiate and support the sustained recovery of prisoners from drug and/or alcohol dependence, and lead to their successful rehabilitation.

Drug Free Wings (DFWs) are aimed at prisoners abstinent from drugs and substitute prescribing. This includes those who have successfully completed treatment but also

<sup>288</sup> For a description of where in the UK NICE guidance applies see: [http://www.nice.org.uk/aboutnice/whatwedo/niceandthenhs/nice\\_and\\_the\\_nhs.jsp](http://www.nice.org.uk/aboutnice/whatwedo/niceandthenhs/nice_and_the_nhs.jsp)

prisoners who have never had a substance misuse problem and want to avoid the temptation to use. Some prisons have combined both the DRW and DFW models, where prisoners progress through treatment in the DRW to abstinence in the DFW.

The Home Affairs Select Committee report into drug policy commended the introduction of drug recovery wings and drug free wings in some prisons and recommended rolling them out as a priority if the pilot shows them to be successful (HAC 2012). This recommendation was accepted by the Government, dependent upon evaluation results.

#### 9.6.4 Prevention of overdose risk upon prison release

##### Naloxone

###### *Scotland*

The supply of 'take home' naloxone by prisons was introduced, incrementally, from February 2011 and by June 2011 all Scottish prisons were participating in the programme. A total of 1,461 'take home' naloxone kits were issued by prisons in 2011/12 and 2012/13<sup>289</sup>; 746 in 2012/13 and 715 in 2011/12, an increase of 4.3% (ISD 2013b). A high percentage of recipients consented to the collection of personal data for monitoring purposes (96%). Of these, 20.1% were under 25 years of age, 44.5% aged 25-34 and 34.4% aged 35 years and over. Compared to kits issued in the community, prison recipients were relatively younger. Just under one-quarter (23%) of kits were issued to females despite only making up six per cent of the prison population, possibly suggesting greater engagement with the programme amongst females.

Of the 746 kits issued by prisons in 2012/13, 644 (86.3%) were reported as a 'first' supply, 79 (10.6%) a 'repeat' supply and 23 (3.1%) 'unknown'. Data on drug-related deaths on release from prison are used to measure the impact of the naloxone programme. There was no significant decrease in opioid related drug-related deaths within four weeks of prison release in 2011 (8.4%) compared to the 2006-10 Baseline Indicator (9.8%).

###### *Wales*

Within prisons in Wales, 414 individuals have been trained in overdose awareness and the use of take home naloxone. Since the start of the project in 2009/10, 244 prisoners have been released from prisons with take home naloxone in an attempt to reduce drug-related deaths.

#### 9.7 Reintegration of drug users after release from prison

##### Throughcare Addiction Service in Scotland

Data from Scotland show that 1,390 individuals received assistance from the Throughcare Addiction Service<sup>290</sup> on release from prison in 2011/12, similar levels to previous years and representing 57% of all voluntary assistance cases (Scottish Government 2012d).

##### Resettlement in England and Wales

*Transforming Rehabilitation* (MOJ 2013b) proposes a nationwide 'through the prison gate' resettlement service so that offenders receive continuous support by one provider from

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<sup>289</sup> Kits are supplied to the individual on release not in prison.

<sup>290</sup> The Throughcare Addiction Service (TAS) commenced on 1 August 2005 and forms part of the voluntary aftercare service. TAS is delivered by local authority criminal justice social work who will work with the offender in the 6 week period prior to release from custody through the 6 week period post-release offering an intensive motivational service to help the offender address their addiction and link them to appropriate services.

custody into the community. To enable this, offenders will be held in a prison designated to their area of residence in the months before their release. The Ministry of Justice has agreed with the Department of Health to develop and test a comprehensive 'end-to-end' approach to tackling addiction from custody into the community in a number of the prisons in the North West that will become designated 'resettlement prisons' in the new system. The learning from this will inform the wider roll out of the service.<sup>291</sup>

#### House of Commons Home Affairs Committee Report

The House of Commons Home Affairs Committee report, *Drugs: Breaking the Cycle* (2012) reported on work being carried out to help substance-misusing prisoners to maintain progress they had made with recovery from addiction while in prison and to reintegrate into society on release. They noted that the Prison Reform Trust identified the provision of housing, employment, health and social care, and family support to be "pivotal to successful rehabilitation." The Committee described how the drug recovery wing of Brixton Prison in London organise housing and treatment within the community to start on the day of release and register inmates on courses to provide structure to their day. This is done mainly by a peer support mentor working with a number of agencies including voluntary sector agencies such as the St Giles Trust which supports prisoners on release. The Committee noted that it would be difficult to expand the programme nationally as it currently depends on working with a cohort of prisoners who come from the local area, although HMP Brixton suggested that each prison could serve a limited number of boroughs in order to make release easier to manage.

Another example of successful reintegration came from Pentonville Prison where a Prison Officer was funded by Islington Council to work with substance-misusing prisoners in their Integrated Offender Management cohort who had lived in Islington before they had been incarcerated. Preparation for release is started early and as much as possible is completed before release, for example the Housing Needs Assessments that local authorities need in order to provide an individual with housing. The impact on the local community as well as on the individual ex-prisoners appears to be very positive. Islington Council's monitoring of reducing re-offending rates and other targets, such as completions of licences, shows a reduction in crime. As this cohort tends to consist of prisoners convicted of acquisitive crime and those with a history of substance misuse, this has had a huge impact on the local community.

#### Social reintegration of prisoners

Data on education, employment and accommodation of all individuals (not just drug users) released from prison in England and Wales in 2012/13 are available from the NOMS Annual Report (MOJ 2013f).

#### Out for good: Taking responsibility for resettlement

The Prison Reform Trust published findings from research aimed at building an evidence base about effective resettlement policy and practice (Edgar et al. 2012).<sup>292</sup> It found that drug treatment, courses, and support inside prison, including RAPt (The Rehabilitation of Addicted Prisoners Trust)<sup>293</sup>, PASRO (Prisoners - Addressing Substance Related Offending)<sup>294</sup> and CARATs (Counselling, Assessment, Referral, Advice and Throughcare

<sup>291</sup> See: <http://www.justice.gov.uk/transforming-rehabilitation/resettlement-prisons>

<sup>292</sup> The study gathered the views of prison governors and staff, prisoners, voluntary sector providers and others through visits to 9 prisons, discussion groups with about 40 prisoners and 30 staff members, and interviews with 34 prisoners and staff from the prison service and voluntary sector. The study also used quantitative data and a literature review was conducted. Peer research methods were utilised with former prisoners feeding into the research design and carrying out interviews.

<sup>293</sup> See: <http://www.rapt.org.uk/>

<sup>294</sup> See: <http://www.natcen.ac.uk/study/evaluating-p-asro-outcomes>

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Services) were highly regarded by many prisoners, with others noting the need for more support for alcohol misuse. The authors state that this support should continue in the community. Some prisoners highlighted the impact of staying in hostels post-release with other offenders and drug users, suggesting it made it difficult not to use drugs.

It concludes that the key to effective resettlement is through “promoting personal responsibility by motivating prisoners to make decisions about how to resolve the practical problems they will face on release”. The report sets out a number of recommendations by prisoners including; starting the process early in a sentence; improving lines of communication with the agencies they will engage with on the outside; motivating prisoners; making more use of open conditions and release on temporary licence; targeting help with housing; and facilitating improved contact with families.

## 10. Drug markets

### 10.1 Introduction

Most of the identified drug supply chains to the United Kingdom follow well-established trafficking routes. Cannabis continues to be imported in large quantities to the United Kingdom from Europe despite increased domestic cannabis cultivation over the past five years. Throughout the UK, large numbers of commercial cannabis cultivation operations have been discovered and there is an increasing recent trend towards smaller operations in multiple locations.

The overall picture of United Kingdom drugs distribution is increasingly complex and diverse, and is better described as a network as distribution occurs through long chains. Many traffickers in the United Kingdom, particularly White British criminals, import and distribute more than one type of drug. London, Birmingham and Liverpool continue to be important centres for drugs distribution but other smaller cities and towns are also involved. In Scotland, the main source of heroin is from the North West of England via the Glasgow area. Organised crime groups in Merseyside impact on the drug supplies into Wales.

The number of seizures increased in the United Kingdom until 2008/09 then decreased in 2009/10 and 2010/11 but remained stable in 2011/12. Cannabis is the most seized drug and the number of herbal cannabis seizures has increased since the introduction of cannabis warnings in England and Wales in 2004, although the quantity seized is around the same level. Both the number and quantity of cannabis plant seizures have increased substantially since 2004. The number of cocaine powder seizures increased substantially from 2004 until 2008/09, although quantities decreased. Since then the number has decreased although there was an increase in quantity seized between 2010/11 and 2011/12. The number of seizures and quantity of heroin seized decreased in 2010/11 after reported disruptions in the supply of heroin during 2010. Seizures, mainly of Class A drugs, have achieved short-term disruptions rather than a sustained reduction in the size of the United Kingdom drugs market.

Purity of cocaine powder fell substantially at street level between 2003 and 2009 with increases since 2010. The street-level price of most drugs has remained relatively stable in the past five years with increased wholesale price more likely to manifest itself in purity changes rather than price changes. When adjusting for purity, cocaine powder prices increased substantially between 2003 and 2009 but have since fallen to the level seen between 2003 and 2005. Following a reported reduction in the supply of heroin in late 2010 and early 2011, heroin purity has decreased and purity-adjusted price has increased.

It has been estimated that the size of the illicit drug market was approximately £3.3 billion in England and Wales in 2010. In Scotland the size of the illicit drug market has been estimated at £1.4 billion for 2006.

### 10.2 Availability and supply

#### 10.2.1 Availability

Twenty-eight per cent of pupils in the Smoking, Drinking and Drug Use Survey 2012 (Fuller 2013) reported that they had been offered drugs in their lifetime. Cannabis (19%) was the drug most commonly offered with cocaine powder the next most offered individual drug (6%). Thirteen per cent of pupils reported that they had been offered a stimulant. The findings were similar to recent years but lower than in 2003. At age 15 half of pupils reported having ever been offered drugs with two-fifths (41%) having been offered cannabis and one-quarter (24%) having been offered a stimulant.

### 10.2.2 The scale of the illicit drug market

A recent Home Office report estimated that the scale of the illicit drug market<sup>295</sup> was approximately £3.3 billion in England and Wales in 2010, a reported reduction from £3.6 billion in 2004. The reduction reflects a decrease in the number of drug users. The crack cocaine and heroin market (£1.3 billion) accounted for the biggest share of the overall drug market followed by the cannabis market (£1.1 billion) and the cocaine powder market (£0.6 billion). The study splits the estimates between arrestees and non-arrestees with a different methodology used to estimate each. The percentage of the market that arrestees accounted for differs between drugs; for the crack cocaine market it was 90% while for the cannabis market it was 23%.

The underlying methodology in the recent study differed from previous estimates for 2003/04 produced by Pudney et al. (2006). The primary difference between the two estimates was the split in methodology between arrestees and non-arrestees and the use of a different survey as the basis of estimates for those aged 11 to 15.<sup>296</sup> The impact of small changes in methodology on estimates of the size of the illicit drug market is apparent with these two differences accounting for a reduction of £1 billion between the study's 2004 estimate and Pudney et al.'s 2003/04 estimate (£4.6 billion).

### 10.2.3 Production, sources of supply and trafficking patterns within the country and from and towards other countries

#### Trafficking patterns

##### *Cannabis*

Increased seizures at the UK border (cannabis resin and herb) and declining numbers of UK grown cannabis plants (Sensimilla) suggests that the UK is still unable to produce sufficient cannabis to satisfy user demand and is reliant on herbal cannabis and cannabis resin produced overseas. Key trafficking routes into the UK are from Morocco, through the Iberian Peninsula and via air freight from South Africa (mainly Afghan) and the Caribbean (mainly Jamaican). Within the UK there is a move away from large scale cannabis cultivations to smaller production especially in living rooms, smaller houses and flats.

##### *Heroin / Opiates*

Although Afghanistan remains the main producer of opiates in the world, most seizures of heroin at the UK border are made from consignments originating in Pakistan. Since 2010, supplies of heroin to the UK from Afghanistan via Iran, Turkey and the European Balkan route have reduced. The heroin route via Turkey has been squeezed by multi-agency international activity against the main traffickers, which has resulted in an increase in the direct trafficking of heroin via Pakistan. UK heroin seizures indicate supply from Pakistan via air freight, fast parcels and the postal system. Ethnicity and family ties continue to underpin the importation and distribution of heroin into and within the UK with the Midlands continuing to be a hub for British based south Asian criminal groups exploiting familial links to import heroin, mainly from Pakistan. There are also indicators that east Africa is developing as a key nexus point for heroin sourced from Pakistan. However, the Netherlands and Belgium still remain important transit points for heroin trafficking to the UK via large goods vehicles and ferries.

<sup>295</sup> The study excluded drugs where a large proportion of use was legitimate prescription such as methadone and tranquilisers and new drugs such as mephedrone. Eight drugs were included in total: cannabis; cocaine powder; amphetamines; ecstasy; LSD; magic mushrooms; heroin; and crack cocaine.

<sup>296</sup> Data on drug use and expenditure for arrestees was taken from the Arrestee Survey (Boreham et al. 2007). For non-arrestees, the Offending, Crime and Justice Survey was used. This also covered those aged 10 to 17 years old.

### *Cocaine*

Peru, Colombia and Bolivia continue to produce the vast majority of the global supply of cocaine. Shipments are trafficked to Europe via a variety of means, including by air and sea, either direct from Latin America or via the Caribbean and West Africa. Near Europe remains a major threat for cocaine importations to the UK. For example, eight tonnes of cocaine was seized in Belgium in the autumn of 2012. The Netherlands, Belgium and Spain regularly report large seizures of cocaine. British organised criminals continue to dominate the supply and distribution of cocaine within the UK. However, Colombian organised crime groups, based in the London area, are still responsible for a substantial supply of cocaine to the UK.

### *Amphetamine-type stimulants*

The Netherlands, and to a lesser extent Belgium, play a principal role in the production and distribution of synthetic drugs, predominantly MDMA and amphetamines with importation through traditional road and ferry routes. Criminal groups in Europe continue to exploit the uncontrolled nature of the pre-precursor alpha-phenylacetonitrile (APAAN) in order to produce the amphetamine precursor BMK (also known as 1-phenyl-2-propanone or phenylacetone). Reporting from regions within the UK indicates that amphetamine-type substances and new psychoactive substances are mostly sourced from China and India via the Internet and imported through the postal system, predominantly by dealers. Even prior to the control of the more commonly used NPS such as mephedrone, only a small percentage of users reported obtaining these drugs from the Internet with most using established drug dealing networks.

Organised criminals from the Merseyside region are influential in the sale and distribution of illicit drugs across the whole United Kingdom. Their reach extends across the length and breadth of the United Kingdom where they supply Class A drugs, cutting agents, amphetamine, ketamine, mephedrone and MDMA.

### *Sources of supply*

Data from the Crime Survey for England and Wales (CSEW) (Home Office 2013b; see section 2.2.1) show that just over one-half (54%) of last year's drug users aged 16 to 59 years obtained drugs from someone well known to them, such as a friend, the last time they took drugs. Young people aged 16 to 24 were most likely to report obtaining drugs from this source (59%). A known dealer (14%) was the next most common source followed by a dealer not known personally (11%). Only one per cent of last year drug users reported obtaining drugs through the Internet the last time they took drugs with older age groups and those who were married most likely to cite this source (3%).

The most common location to have last obtained drugs was at someone else's home (36%) followed by at home (16%). Eleven per cent reported last obtaining drugs in a pub/bar and at a party/rave/club.

Coomber and Moyle (2013) discuss the concept of social supply and suggest extending the concept to include 'minimally commercial supply', to encapsulate heroin user-dealers. The authors suggest that this type of supply is closer to social supply than drug dealing in general.

## **10.3 Seizures**

### **10.3.1 Drug seizures in the United Kingdom in 2011/12**

There were around one quarter of a million drug seizures in the United Kingdom in 2011/12, a 2.7% increase from the previous year, when there were 243,043. The largest increase was for ecstasy (+27.9%) and mephedrone (+16.4%). Reflecting the relatively high prevalence of use, cannabis was involved in 78% (n=195,479) of all drug seizures. Cocaine powder was the second most commonly identified drug in seizures, reported in eight per cent of all drug

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seizures. Similar to 2010/11, the number of mephedrone seizures was lower than the number of ecstasy seizures although in Northern Ireland it was higher.

**Table 10.1** Number of seizures of individual drugs in the United Kingdom by country in 2011/12 and percentage change from 2010/11

Drug	England and Wales	Scotland*	Northern Ireland*	UK	% change from 2010/11
Amphetamines	6,693	984	108	7,785	-7.7
Cannabis – herbal	147,384	9,591	2,027	159,002	7.8
Cannabis – resin	14,178	9,778	916	24,872	-15.2
Cannabis plants	16,386	1,149	286	17,821	14.8
Total Cannabis	173,153	19,292	3034	195,479	4.5
Cocaine powder	17,449	2,037	302	19,788	-1.3
Crack cocaine	4,971	336		5,307	-4.2
Ecstasy type substances	3,181	434	165	3,780	27.9
Heroin	9,150	2,789	24	11,963	-16.3
Ketamine	1,540	34		1,574	-13.7
Mephedrone*	2,440	189	205	2,834	16.4
Total	216,296	29,509	3,920	249,725	2.7

\*police seizures only

Source: Standard Table 13

The quantity of ecstasy and heroin seized more than doubled in 2011/12 compared to 2010/11 after decreases in recent years. This mirrors other drug indicators that show a small recovery in the heroin market and signs of the re-emergence of ecstasy and suggests that, despite primarily reflecting law enforcement activity, seizures data are useful for building a better picture of the drug situation. The absence of seizures data for NPS, however, and the lack of knowledge about the extent of the diversion of medicines, leave a sizeable gap in the data when the drug situation is increasingly characterised by polydrug use encompassing licit, illicit and medicinal substances.

### 10.3.2 Trends in drug seizures in England and Wales

As UK drug seizure data have not been available on a consistent basis in the past five years, data from England and Wales are used to comment on trends. After the introduction of the formal warning for cannabis possession in 2004, the number of seizures increased substantially as police were provided with a means of dealing with cannabis possession offences that was relatively non-resource intensive (Table 10.3). The fact that the quantity of cannabis seized remained stable despite such a large increase in the number of seizures and the corresponding increase in cannabis possession offences (see section 9.2.4) suggests that these seizures were primarily as a result of possession offences. Nevertheless, over this period the number of seizures of cannabis plants increased, reflecting the increasing cultivation of cannabis and impacting on overall cannabis seizure

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numbers. Data from the UK Border Force (UKBF),<sup>297</sup> however, show that in 2011/12, there was still a substantial amount of cannabis being imported into the country; around 33 tonnes were seized by UKBF in 2011/12 (Coleman 2012) representing 12% of the estimated amount of cannabis (270 tonnes)<sup>298</sup> required to supply the UK market.

**Table 10.2** Quantity of individual drugs seized in the United Kingdom by country in 2011/12 and percentage change from 2010/11

Drug	Unit	England and Wales	Scotland	Northern Ireland	UK	% change from 2010/11
Amphetamines	Kg	1,042	131.5	6	1,180	20.0
Cannabis – herbal	Kg	22,000	619.5	402	23,022	5.9
Cannabis – resin	Kg	19,473	1,196.5	192	20,862	5.3
Cannabis plants	Plant	612,373	34,773	14,307	661,453	-14.6
Cocaine powder	Kg	3,456	99.1	12	3,567	40.3
Crack cocaine	Kg	34	6.3		40	-29.5
Ecstasy type substances	Tablet (000s)	656	157.9	30	844	113.2
Heroin	Kg	1,849	120.5	1	1,971	136.8
Ketamine	Kg	79	0.1		79	-90.1
Mephedrone*	Kg	83	9.7	2.3	95	-20.0

\*Police seizures only

Source: Standard Table 13

The number of ecstasy seizures, despite increasing in the past year, is still less than half of the number taking place each year between 2004 and 2008. Despite indications of increased misuse of benzodiazepines, the number of seizures has remained stable over the past few years and is well below the peak in 2008/09. The number of heroin seizures continued to decrease, although this is entirely due to a decrease in police seizures; the number of seizures at the border has been stable throughout the period of reported supply problems.

The number of cocaine powder seizures is more than double the number in 2004 although there have been decreases since 2008/09. After decreases since 2008/09, the number of cocaine powder seizures remained stable between 2010/11 and 2011/12.

<sup>297</sup> The UK Border Force split from the UK Border Agency in March 2012 becoming a separate operational command within the Home Office, responsible for entry controls and customs functions at the border.

<sup>298</sup> See: <http://www.soca.gov.uk/threats/drugs>

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**Table 10.3** Number of seizures of drugs by police and Border Force in England and Wales, 2004 to 2011/12

Drug	2004	2005	2006/07*	2007/08	2008/09	2009/10	2010/11	2011/12
Amphetamines	6,504	7,837	8,477	8,863	7,760	7,302	7,185	6,693
Cannabis – herbal	43,072	76,157	109,649	137,526	145,353	144,456	139,237	147,384
Cannabis – resin	35,219	41,454	32,590	30,870	35,795	24,339	18,312	14,178
Cannabis plants	2,930	4,327	5,805	8,539	9,380	12,920	14,423	16,386
Cocaine powder	8,279	12,512	16,917	21,346	24,659	21,377	17,710	17,449
Crack cocaine	5,164	6,705	6,955	7,578	6,623	5,081	5,385	4,971
Ecstasy	6,256	6,688	8,184	7,173	5,218	3,724	2,537	3,181
Heroin	11,668	14,072	13,942	14,186	13,302	12,836	10,821	9,150
Benzodiazepines**	830	1,747	2,261	2,815	4,038	2,957	2,489	2,689
Ketamine	-	-	-	-	1,269	1,612	1,793	1,540
Total	112,923	169,802	196,099	228,131	241,473	224,401	212,786	216,296

\*in 2006/07 data moved to a financial year basis

\*\* includes diazepam and other benzodiazepines but not temazepam

Source: Coleman 2012

Despite the continued increase in the number of seizures of cannabis plants, the number of plants seized has decreased supporting the assertion that there is a growing trend towards smaller grow operations.

**Table 10.4** Quantity of seizures of drugs by police and Border Force in England and Wales, 2004 to 2011/12

Drug	Unit	2004	2005	2006/07*	2007/08	2008/09	2009/10	2010/11	2011/12
Amphetamines	Kg	1,257	2,091	1,390	1,811	2,939	1,326	711	1,042
Cannabis – herbal	Kg	21,535	20,583	25,832	20,093	33,363	17,951	20,693	22,000
Cannabis – resin	Kg	63,234	50,591	19,851	16,710	31,799	12,563	18,659	19,473
Cannabis plants	Plant	93,469	220,019	363,679	535,888	643,510	758,943	729,502	612,373
Cocaine powder	Kg	4,640	3,821	3,244	3,453	2,916	2,643	2,387	3,456
Crack cocaine	Kg	140	51	60	37	33	59	50	34
Ecstasy	Tablet (000s)	4,740	3,019	6,685	965	547	171	357	656
Heroin	Kg	2,170	1,907	1,030	1,059	1,552	1,516	732	1,849
Ketamine	Kg					27	293	802	79

\*in 2006/07 seizures data moved to a financial year basis

Source: Coleman 2012

### 10.3.3 Other seizures data

It is reported that, during 2012, more than seven tonnes of benzocaine, lidocaine and phenacetin were seized by law enforcement agencies after being imported into the UK under suspicious circumstances (Home Office 2013c). Over the last three years, SOCA (Serious Organised Crime Agency) has detained over 40 seizures of benzocaine, lidocaine and phenacetin that were suspected of being intended for use as cutting agents in Class A drug supply.<sup>299</sup>

## 10.4 Price/purity

Wholesale and street drug price data are provided by law enforcement agencies with street-level price data also available from DrugScope<sup>300</sup>.

### 10.4.1 Wholesale price data

The wholesale price of cocaine powder remained stable in 2012 at around £50,000 per Kg, similar to previous years but above the £35,000 reported in 2008. The wholesale price for heroin continued to increase in 2012 with a typical price of around £30,000, up from £25,000 in 2011, £21,000 in 2010 and £16,000 in 2009. The typical wholesale price of skunk cannabis remained at £5,000 per kilogram after increasing in 2011. There are reports of a market for 'branded' skunk with a choice of different types that vary by strength (THC), flavour, and effect duration. A new pricing structure has reportedly emerged, with indications that 'branded' skunk commands premium prices compared to generic norms. In comparison, cannabis resin and herbal cannabis costs much less at £1,000 per kg (SOCA, personal communication).

The wholesale price of amphetamines increased between 2011 and 2012 (see section 10.4.4) although the price appears to fluctuate regularly between years. At wholesale level, the range of prices for mephedrone remained stable. Ketamine and MDMA powder were more expensive than mephedrone at wholesale level, while amphetamine powder was slightly cheaper (SOCA, personal communication).

### 10.4.2 Street-level price data from law enforcement sources<sup>301</sup>

Street-level price data from law enforcement sources suggest that the price of drugs remained stable in 2012. A decrease in the price of ecstasy tablets was reported although that follows a large increase the previous year (Table 10.5). There was an apparent decrease in the price of ketamine in 2012 from £25.00 to £20.00, although no purity data are available to determine whether changes in purity have affected price.

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<sup>299</sup> See: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/200020/cutting-agents-impact-assessment.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200020/cutting-agents-impact-assessment.pdf)

<sup>300</sup> See: <http://www.drugscope.org.uk/>

<sup>301</sup> Prices are collected from police services across the UK on a rolling basis by the Serious Organised Crime Agency (SOCA) and also during the course of SOCA business. These originate from an array of sources such as detainee debriefing, test purchase deployments, general intelligence, evidence from arrests and searches, expert witness interpretation of criminal ledgers and communications, informants, social surveys and internet forum/ website research. Prices are not formally recorded in the UK on an individual receipt basis but are qualitatively assessed as being 'current and representative'.

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**Table 10.5** Law enforcement agencies: Mean price of illegal drugs in the United Kingdom, 2005 to 2012

Drug	Price per gram except where otherwise stated							
	2005	2006	2007	2008	2009	2010	2011	2012
	Exch. rate: £1=€1.4629	Exch. rate: £1=€1.467	Exch. rate: £1=€1.4619	Exch. rate: £1=€1.2588	Exch. rate: £1=€1.1233	Exch. rate: £1=€1.1752	Exch. rate: £1=€1.1462	Exch. rate: £1=€1.2337
Amphetamines	£10.00	£9.00	£9.00	£10.00	£10.00	£10.00	£10.00	£10.00
	€14.63	€13.20	€13.16	€12.59	€11.23	€11.75	€11.46	€12.34
Cannabis herb*	£2.64	£2.68	£3.95	£2.85	£2.85	£2.82	£5.00	£5.00
	€3.86	€3.93	€5.77	€3.59	€3.20	€3.31	€5.73	€6.17
Cannabis resin*	£1.94	£2.12	£2.82	£2.85	£2.85	£2.82	£5.00	£5.00
	€2.84	€3.11	€4.12	€3.59	€3.20	€3.31	€5.73	€6.17
Cannabis (sinsemilla)*			£6.21	£5.63	£7.15	£7.15	£10.00	£10.00
			€9.08	€7.09	€8.03	€8.40	€11.46	€12.34
Cocaine powder	£49.00	£49.00	£46.00	£40.00	£40.00	£40.00	£40.00	£40.00
	€71.68	€71.88	€67.24	€50.35	€44.93	€47.01	€45.85	€49.35
Crack cocaine**	£19.00	£18.00	£65.00	£65.00	£60.00	£50.00	£50.00	£60.00
	€27.80	€26.41	€95.02	€81.82	€67.40	€58.76	€57.31	€74.02
Ecstasy (per tablet)	£4.00	£3.00	£3.00	£3.00	£2.50	£2.50	£5.00	£3.00
	€5.85	€4.40	€4.39	€3.78	€2.81	€2.94	€5.73	€3.70
Heroin	£54.00	£52.00	£48.00	£45.00	£45.00	£45.00	£40.00	£40.00
	€79.00	€76.28	€70.17	€56.65	€50.55	€52.88	€45.85	€49.35
LSD (per dose)	£3.00	£3.00	£3.50	£3.00	£3.00	£3.00	-	-
	€4.39	€4.40	€5.12	€3.78	€3.37	€3.53	-	-
Mephedrone						£10.00	£20.00	£20.00
						€11.75	€22.92	€24.67
Ketamine						£25.00	£25.00	£20.00
						€29.38	€28.66	€24.67

\*Before 2007 the cannabis values were based on the price for an ounce. In 2007 this changed to being based on a usual street deal of 1/8oz and the price was converted to gram equivalent. In 2011 prices were provided on a gram basis.

\*\*Crack cocaine prices before 2007 were provided per rock (0.2g) not per gram. Prices after 2007 cannot be compared to earlier prices.

Source: Standard Table 16

#### 10.4.3 Street-level price data from non-law enforcement sources

DrugScope<sup>302</sup> carry out an annual survey of drug prices by contacting drug agencies across the UK. Unlike law enforcement data, 2012 data suggest that the price of ecstasy tablets has continued to increase with an average cost of £6.30 per pill compared to £2.00 at its lowest point in 2009. This may reflect both the increased purity of ecstasy tablets and the fact that a higher proportion of pills contain MDMA (ST15). Similarly, the price for MDMA powder is higher than reported in previous years. The price of mephedrone and ketamine is relatively stable at around £20 although the reported price of cocaine powder has fluctuated slightly. Although there has been an increase in the price of amphetamine from £10.00 per gram in 2011 to £13.00 per gram in 2012, the price is still lower than for other stimulant drugs.

In contrast to the law enforcement data, DrugScope's heroin price data suggest an increase in price during 2011 followed by a decrease in 2012 to around £50 a gram.

<sup>302</sup> See: <http://www.drugscope.org.uk/>

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There are signs that the price of herbal cannabis (both traditional and high quality) has increased.

**Table 10.6 DrugScope: Mean price of drugs at street level in the United Kingdom, 2007 to 2012**

Drug	Price per gram except where otherwise stated					
	2007	2008	2009	2010	2011	2012
	Exch. rate: £1=€1.4619	Exch. rate: £1=€1.2588	Exch. rate: £1=€1.1233	Exch. rate: £1=€1.1664	Exch. Rate: £1=€1.1462	Exch. rate: £1=€1.2337
Amphetamines	£9.80	£9.00	£9.00	£9.00	£10.00	£13.00
	€14.33	€11.33	€10.11	€10.50	€11.46	€16.04
Cannabis herb* (standard quality)	£3.07	£3.14	£4.43	£4.29	£4.29	£5.21
	€4.49	€3.95	€4.98	€5.00	€4.92	€6.43
Cannabis resin*	£1.94	£1.80	£3.00	£3.71	£3.71	£3.80
	€2.84	€2.27	€3.37	€4.33	€4.25	€4.69
Cannabis (high quality)*	£4.73	£4.63	£5.71	£7.14	£6.57	£7.75
	€6.91	€5.83	€6.41	€8.33	€7.53	€9.56
Cocaine powder	£43.00	£42.00	£39.00	£42.00	£50.00	£46.00
	€62.86	€52.87	€43.81	€48.99	€57.31	€56.75
Ketamine	£25.00	£20.00	£22.00	£20.00	£21.00	£21.00
	€36.55	€25.18	€24.71	€23.33	€24.07	€25.91
Ecstasy (per tablet)	£2.40	£2.30	£2.00	£2.65	£4.58	£6.30
	€3.51	€2.90	€2.25	€3.09	€4.61	€7.77
Heroin	£43.00	£49.00	-	£50.00	£66.67	£52.38
	€62.86	€61.68	-	€58.32	€76.42	€64.62
MDMA powder	£38.00	£39.00	£36.00	£32.00		£39.00
	€55.55	€49.09	€40.44	€37.32		€48.11
Mephedrone	-	-	-	£19.00	£17.00	£19.00
	-	-	-		€19.49	€23.44

\*Until 2008, cannabis prices were converted from ounce prices but in 2009 they were converted from quarter ounce prices.

Source: DrugScope 2008, 2009, 2011; 2012

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

Until 2007 drug purity data were provided by the Forensic Science Service (FSS). Following the growth of private forensic services, in 2008 and 2009 data were combined with data from the second largest provider, LGC Forensics. In December 2010 it was announced that the FSS was to be closed down by the end of March 2012 with SOCA taking custodianship of the national drugs intelligence function. Data for 2010 onwards has been provided by SOCA from an expanded number of forensic agencies.

Data on cannabis potency are not provided due to concerns about the representativeness of samples submitted for forensic analysis. A cannabis potency study was carried out in 2008 (Hardwick and King 2008). No further study has been carried out. Purity data are shown in Table 10.7 and commentary is provided by individual drug.

#### Amphetamines

The purity of amphetamines decreased substantially to 5% in 2012 from around 10% in 2011 although wholesale purity remained stable at around 30%. Almost all amphetamines seized are cut with caffeine while common diluting agents include lactose and glucose. The wholesale price increased from £1,500 to £2,500 between 2011 and 2012, which may account for the reduction in purity as dealers look to maintain profits. At wholesale level, amphetamine is already adulterated and there is the potential for high purity amphetamine to attract a higher wholesale price of around £4,000.

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**Table 10.7** Street-level mean percentage purity of certain drugs seized by police in England and Wales, 2003 to 2012

Drug	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Amphetamines	10.8	9.0	10.1	10.6	10.9	7.8	8.0	8.0	10.4	5.4
Cocaine powder	51.2	42.4	42.7	34.5	33.2	28.8	20.3	23.8	26.2	36.8
Crack cocaine	69.6	63.7	64.8	49.5	52.3	43.1	27.1	31.0	26.3	30.1
Ecstasy*	64.5	66.7	66.3	48	51.8	33.1	43.5	49.0	71.0	102.0
Heroin (brown)	32.7	39.9	46.5	43.5	49.8	42.7	44.4	34.9	17.6	19.5

\*mg of MDMA base per tablet.

Source: Standard Table 14

**Cocaine powder**

The mean purity of cocaine powder continued to increase after decreases between 2005 and 2009 and is now at the level seen in 2006 (Table 10.7). Levamisole is commonly detected in wholesale cocaine seizures while benzocaine is used to bulk out the product within the UK. Other adulterants detected by forensic agencies include caffeine and phenacetin. The increase in purity and stable price meant that there was another decrease in purity-adjusted price in 2012, and it is now only slightly higher than in the indexed year (Table 10.8).

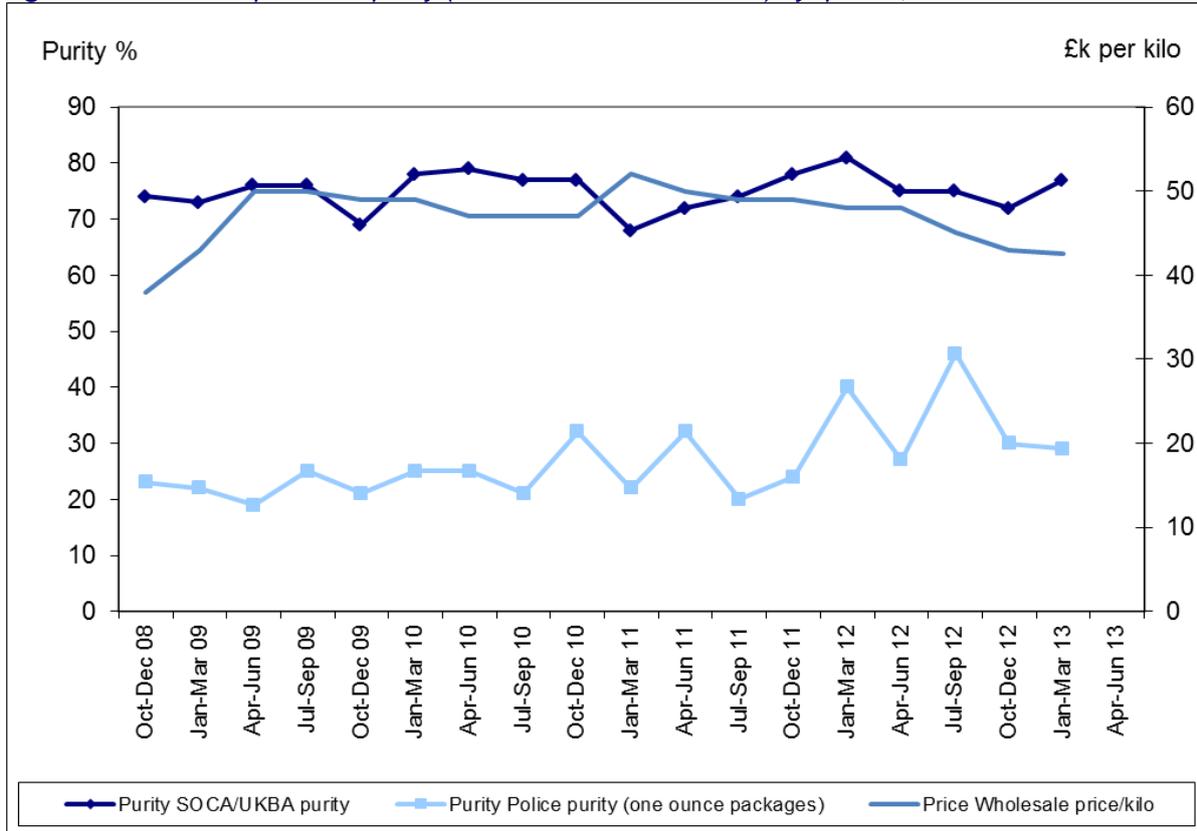
**Table 10.8** Purity-adjusted price of cocaine powder per gram in the United Kingdom, 2003 to 2012: indexed to 2003

Year	£	€
2003	£55	€ 79.51
2004	£61.58	€ 90.76
2005	£58.75	€ 85.95
2006	£72.70	€ 106.63
2007	£70.94	€ 103.71
2008*	£71.11	€ 89.51
2009	£100.89	€ 113.33
2010	£86.05	€ 101.13
2011	£78.17	€ 89.60
2012	£58.51	€72.18

Source: Standard Tables 14 and 16

Figure 10.1 shows changes in wholesale purity and price and street-level price by quarter. This suggests that wholesale price has decreased in the past year with some increase in street-level purity over this time.

Figure 10.1 Cocaine price and purity (wholesale and street-level) by quarter, 2008 to 2013.



Source: SOCA

Heroin

The purity of heroin increased slightly to 20% after a large decrease between 2010 and 2011 following a reduction in the supply of heroin in 2010 (Table 10.7). A similar small increase in purity at wholesale level was detected to 45%. Heroin is commonly adulterated with caffeine and paracetamol and occasionally with diazepam and other opiates. Due to the stable nature of price and the slight increase in purity there was a small decrease in purity-adjusted price to £65.40 a gram, slightly higher than in 2003 but double the price of 2007, when heroin was at its lowest purity-adjusted price (Table 10.9).

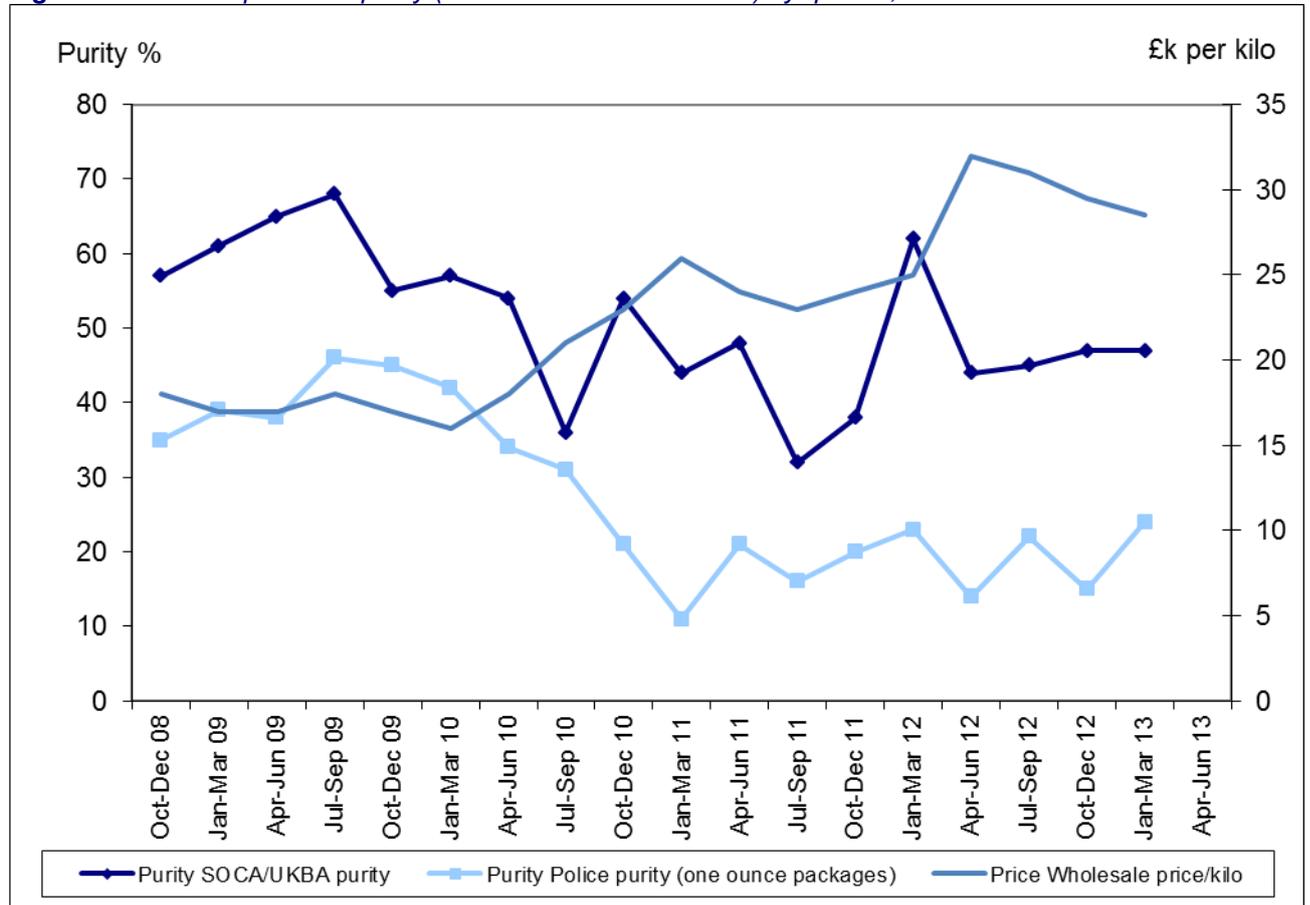
Table 10.9 Purity-adjusted price of heroin per gram in the UK, 2003 to 2012: indexed to 2003

Year	£	€
2003	£62.00	€ 89.63
2004	£45.08	€ 66.44
2005	£37.97	€ 55.55
2006	£39.09	€ 57.35
2007	£31.52	€ 46.08
2008*	£34.46	€ 43.38
2009	£33.11	€ 37.19
2010	£42.16	€ 49.55
2011	£74.32	€ 85.19
2012	£65.40	€ 80.68

Source: Standard Tables 14 and 16

Figure 10.2 shows a potential recovery in the heroin market with wholesale price decreasing in the past year after steep rises from the beginning of 2010. It is uncertain whether this has resulted in increased purity at street-level but it has certainly not returned to pre-2010 purity levels.

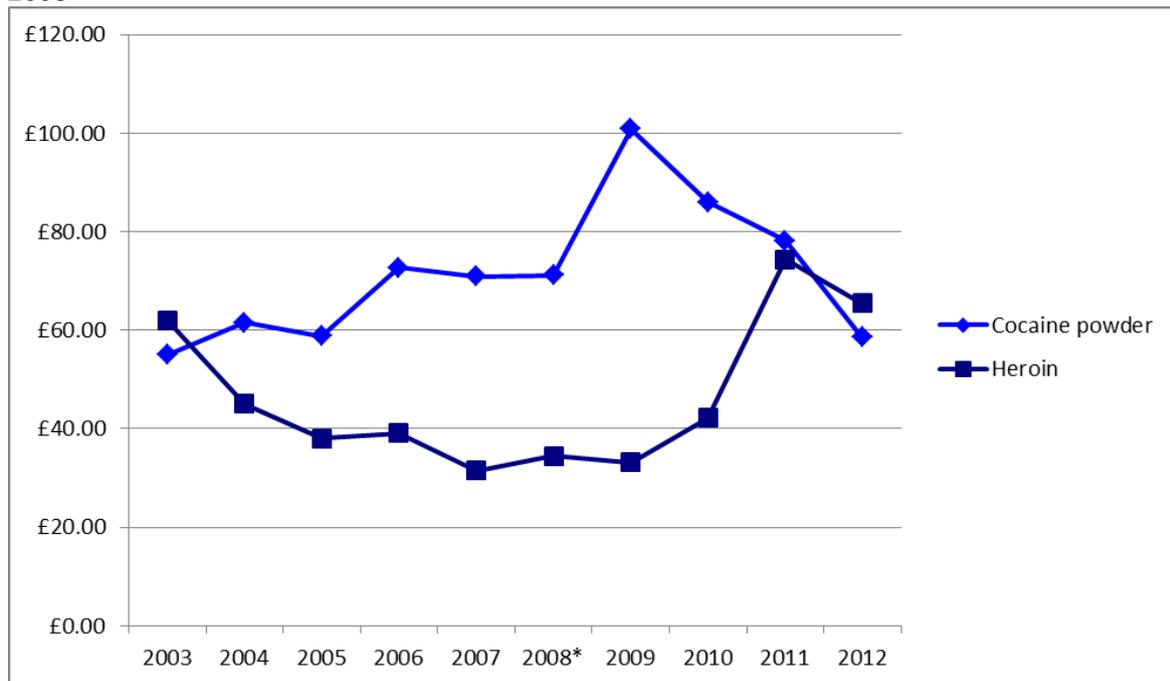
**Figure 10.2** Heroin price and purity (wholesale and street-level) by quarter, 2008 to 2013.



Source: SOCA

Figure 10.3 shows that purity-adjusted price of cocaine powder and heroin were around the same in 2003 before taking divergent paths; cocaine powder price increased while heroin decreased. In the past two years those trends have reversed and now, once again, cocaine powder and heroin are around the same price and only slightly higher than in 2003. While price has not been adjusted for inflation, when correlated with prevalence of use data, there is no association between use of cocaine powder and purity-adjusted price ( $r = -0.05$ ).

**Figure 10.3** Purity-adjusted price of cocaine powder per gram in the UK, 2003 to 2012: indexed to 2003



\*Since 2008 data have been received from more forensic providers  
 Source: Standard Tables 14 and 16

### Ecstasy

The mean MDMA content of ecstasy has increased to 102mg from 71mg the previous year (Table 10.7). It is now three times more potent than in 2008 and the increased number of samples that purity data are based upon (sample size was 10 in 2011 and 108 in 2012) suggests that the ecstasy market is increasing. Of all the tablets analysed by forensic providers in 2012, 30% contained MDMA compared to 43% in 2011 but only 11% in 2010. This is based on a larger number of records but does not show the whole picture of the ecstasy market as surveys have shown that MDMA in powder form is now more common than in pill form (see section 2.5.1).

#### 10.4.5 Research

McKeganey and McGallagly (2013) conducted semi-structured interviews with 54 heroin users in three areas where drug enforcement operations took place.<sup>303</sup> Participants suggested that, following law enforcement operations, the price of heroin tends to remain stable but purity often decreases. Some users reported travelling to different areas to source drugs after a shortage due to a major seizure but this only lasted for a short time with local markets recovering quickly. The authors conclude that intensive police operations that target heroin dealers within well-developed street drug markets are unlikely to have a sustained impact unless these operations are of a long-term nature.

<sup>303</sup> Heroin users were identified in each of the three areas by snowball sampling.

# PART B

Bibliography and Annexes

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## List of Abbreviations used in the Text

£	Pound sterling (UK)
2-AI	2- aminoindan
2-DPM	diphenylprolinol
2-DPMP	desoxypipradrol
ACE	Assessment and Case Management and Evaluation Tool
ACMD	Advisory Council on the Misuse of Drugs
ACPO	Association of Chief Police Officers
ADAPT	Addiction Dimensions for Assessment and Personalised Treatment
ADEPIS	Alcohol and Drug Education and Prevention Information Service
ADFSS	Alcohol, Drugs and the Family Social Support Scale
ADPs	Alcohol and Drug Partnerships
AIDS	Acquired Immunodeficiency Syndrome
AOD	Alcohol and other drug
APAAN	alpha-phenylacetoacetonitrile
APBs	Area Planning Boards
APoSM	Advisory Panel on Substance Misuse
APPG-DPR	All-Party Parliamentary Group for Drug Policy Reform
APT	Addiction Prevalence Test
ARC	Ambulance Referral Criteria
AWSCLP	All Wales School Liaison Core Programme
BBV	Blood-borne Virus
BCS	British Crime Survey
BMI	Body Mass Index
BMK	1-phenyl-2-propanone or phenylacetone
BORRA	Brief Overdose Recognition and Response Assessment
BZE	benzoylecgonine
BZP	Benzylpiperazine
CAF	Common Assessment Framework
CAPI	Computer Assisted Personal Interviewing
CAPSM	Improving outcomes for children affected by their parents' substance misuse
CARATS	Counselling, Assessment, Referral. Aftercare and Throughcare Services
CASI	Computer Assisted Self Interviewing
CAYT	Centre for Analysis of Youth Transitions
CI	Confidence Interval
CIS-R	Revised Clinical Interview Schedule
CJS	criminal justice system
CMO	Chief Medical Officer
COSLA	Convention of Scottish local Authorities
CPO	Community Payback Order
CRC	Capture, Re-Capture
CSEW	Crime Survey for England and Wales
CSJ	Centre for Social Justice
CSP	Community substitute prescribing
D2PM	Diphenyl-2-pyrrolidinylmethanol
DANOS	Drug and Alcohol National Occupational Standards
DBS	Dried Blood Spot
DCLG	Department for Communities and Local Government
DCSF	Department for Children, Schools and Families
DEF	Drug Education Forum
DET	Data Entry Tool
DfE	Department for Education

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DfT	Department for Transport
DFW	Drug Free Wing
DH	Department of Health
DHSSPSNI	Department of Health, Social Services and Public Safety Northern Ireland
DIP	Drug Interventions Programme
DMD	Drug Misuse Definition
DORIS	Drug Outcomes Research in Scotland
DRD	Drug-Related Deaths
DRR	Drug Rehabilitation Requirement
DRW	Drug Recovery Wing
DSD	Drug Strategy Definition
SDSDC	The Scottish Drugs Strategy Delivery Commission
DTOC	Drug Testing on Charge
DTORS	Drug treatment Outcomes Research Study
DTTO	Drug Treatment and Testing Order
DWP	Department for Work and Pensions
EDDRA	Exchange on Drug Demand Reduction Action
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EMQ	European Model Questionnaire
ESA	Employment and Support Allowance
ESF	European Social Fund
FB	Femoral blood
FEWS	Forensic Early Warning System
FSS	Forensic Science Service
GBL	Gamma-butyrolactone
GHB	Gamma-hydroxybutyrate
GIRFEC	Getting It Right For Every Child
GMR	General Mortality Register
GP	General Practitioner
GSE	General Self Efficacy scale
HAC	Home Affairs Committee
HBsAg	Hepatitis B surface Antigen
HBSC	Health Behaviour in School Age Children Survey
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HDSS	high dead-space syringes
HEAT	Health improvement, Efficiency, Access Treatment
HIS	Healthcare Improvement Scotland
HIV	Human Immunodeficiency Virus
HM	Her Majesty/ Her Majesty's
HMIP	Her Majesty's Inspectorate of Prisons
HPA	Health Protection Agency
HRD	Harm Reduction Database
HWW	Healthy Working Wales
IB	Incapacity Benefit
IBSDA	Incapacity Benefit or Severe Disablement Allowance
ICD-10	International Statistical Classification of Diseases and Related Health Problems-tenth edition
ICNHS	NHS Information Centre for Health and Social Care
IDTS	Integrated Drug Treatment System
IDU/s	Injecting Drug Use/user/users
IEC	information, education and counselling
IEP	Injecting Equipment Provision
IFSS	Integrated Family Support Services

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IMG	Inter-Ministerial Group on Drugs
IPED	Image and Performance Enhancing Drugs
ISD	Information Services Division
ISER	Institute for Social and Economic Research
JCP-MH	Joint Commissioning Panel for Mental Health
LASARS	Local Area Single Assessment and Referral System
LDSS	low dead-space syringes
LHB	Local Health Board
LSD	Lysergic Diethylamide Acid
MDMA	3,4-Methyldioxy-n-methylamphetamine
MDT	Mandatory Drug Testing
MIM	Multiple Indicator Method
MOJ	Ministry of Justice
N-ALIVE	NALoxone InVEstigation (Prison-based Naloxone-on-release pilot randomised controlled trial)
NDRDD	National Drug-Related Deaths Database
NDTMS	National Drug Treatment Monitoring System
NESI	Needle Exchange Surveillance Initiative
NFDRD	National Forum on Drug Related Deaths
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NICS	Northern Ireland Crime Survey
NISRA	Northern Ireland Statistics and Research Agency
NOMS	National Offender Management Service
NPIS	National Poisons Information Service
NPS	New Psychoactive Substances
np-SAD	National Programme on Substance Abuse Deaths
NRS	National Records of Scotland
NSD	New Strategic Direction for Alcohol and Drugs
NSP	Needle and Syringe Programmes
NTA	National Treatment Agency
NWIS	NHS Wales Informatics Service
OASys	Offender Assessment System
OCU	Opiate and/or crack cocaine user
OFMDFMNI	Office of the First Minister and Deputy First Minister of Northern Ireland
ONS	Office for National Statistics
OOAS	Opioid Overdose Attitudes Scale
OOKS	Opioid Overdose Knowledge Scale
OST	Opiate/Opioid Substitution Therapy/Treatment
PASRO	Prisoners – Addressing Substance Related Offending
PBNI	Probation Board for Northern Ireland
PbR	Payment by Results
PCCs	Police and Crime Commissioners
PDI	Partnership Drugs Initiative
PDU	Problem Drug Use(rs)
PHA	Public Health Agency for Northern Ireland
PHE	Public Health England
PHIRB	Public Health Information and Research Branch
PHPQI	Prison Health Performance and Quality Indicator
PIED	Performance and Image Enhancing Drugs
PSA(s)	Public Service Agreements
PSHE	Personal, Social and Health Education

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PSNI	Prison Service Northern Ireland
PWID	People Who Inject Drugs
RAPt	The Rehabilitation of Addicted Prisoners Trust
RCGP	Royal College of General Practitioners'
RCT	Randomised Controlled Trial
RIOTT	Randomised Injectable Opioid Treatment Trial
RR	Residential rehabilitation
SACDM	Scottish Advisory Committee on Drugs Misuse
SALSUS	Scottish Schools Adolescent Lifestyle and Substance Use Survey
SCDEA	Scottish Crime and Drug Enforcement Agency
SCJS	Scottish Crime and Justice Survey
SCVS	Scottish Crime and Victimisation Survey
SDA	Severe Disablement Allowance
SDF	Scottish Drugs Forum
SDMD	Scottish Drug Misuse Database
SDS	Severity of Dependence Scale
SDSDC	Scottish Drugs Strategy Delivery Commission
SEPT	South Essex Partnership NHS Trust
SFAD	Scottish Families Affected by Alcohol and Drugs
SFP	Strengthening Families Programme
SIF	supervised injection facilities
SLAM	South London and Maudsley NHS Foundation Trust
SMAF	Substance Misuse Action Fund
SME	Substance Misuse Education
SMMGP	Substance Misuse Management in General Practice
SMNPB	Substance Misuse National Partnership Board
SMR	Special Mortality Register
SOCA	Serious Organised Crime Agency
SOI	Scottish Offenders Index
SPCR study	Surveying Prisoners Crime Reduction study
SQ	Standard Questionnaire
SROM	Slow-release oral morphine
SSC	Sector Skills Council
ST	Standard Table
TAS	Throughcare Addiction Service
TB	Tuberculosis
TCDO	Temporary Class Drug Order
TDI	Treatment Demand Indicator
TFMPP	3-Trifluoromethylphenylpiperazine
THN	Take-Home-Naloxone
TOP	Treatment Outcomes Profile
TRACER	Tracking Residential Addiction Clients for Effectiveness Research (study)
UAM Survey	Unlinked Anonymous Monitoring survey
UK	United Kingdom
UKBA	United Kingdom Border Agency
UKDPC	United Kingdom Drug Policy Commission
UN	United Nations
VH	Vitreous humour
WAG	Welsh Assembly Government
WEDINOS	Welsh Emerging Drug and Identification of Novel Substances
WNDSM	Welsh National Database for Substance Misuse

## List of Standard Tables

Number	Title	Source
ST01	Basic results and methodology of population surveys on drug use	England and Wales - Crime Survey for England and Wales (CSEW); Scotland – Scottish Crime and Justice Survey (SCJS); Northern Ireland – Northern Ireland Crime Survey (NICS); Drug Prevalence Survey
ST02	Methodology and results of school surveys on drug use	England – Smoking, Drinking and drug use amongst school children in England Scotland – Scottish Adolescent Lifestyle and Substance Use Survey (SALSUS) Northern Ireland – Young Persons Behavioural and Attitudes Survey (YPBAS)
ST05	Acute/direct related deaths	General Mortality Registers (GMRs) for England and Wales, Scotland and Northern Ireland
ST06	Evolution of acute/direct related deaths	General Mortality Registers (GMRs) for England and Wales, Scotland and Northern Ireland
ST07	National prevalence estimates on problem drug use	Home Office; NHS ISD Scotland; DHSSPSNI; Welsh Government
ST08	Local prevalence estimates on problem drug use	Home Office; NHS ISD Scotland;
ST09	Prevalence of hepatitis B/C and HIV infection among injecting drug users	Public Health England; Health Protection Scotland (HPS); National Public Health Service for Wales (NPHSW); Communicable Disease Surveillance Centre Northern Ireland
ST10	Syringe availability	Injecting Equipment Provision in Scotland Survey, NHS ISD Scotland; Northern Ireland Needle & Syringe Exchange Scheme (NSES); Harm Reduction Database, Public Health Wales
ST11	Arrests/Reports for drug law offences	Ministry of Justice; Scottish Government; Northern Ireland Office; Northern Ireland Police Service (NIPS)
ST12	Drug use among prisoners	Scottish Prison Service
ST13	Number and quantity of seizures of illicit drugs	Home Office; UK Border Force; Scottish Government; Northern Ireland Police Service (NIPS)

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ST14	Purity at street level of illicit drugs	Serious Organised Crime Agency (SOCA)
ST15	Composition of tablets sold as illicit drugs	Serious Organised Crime Agency (SOCA)
ST16	Price in Euros at street level of illicit drugs	Serious Organised Crime Agency (SOCA)
ST24	Access to treatment	National Drug Treatment Monitoring System (NDTMS) in England; Welsh National Database for Substance Misuse (WNDSM)
SQ25	Universal prevention	Consultation with relevant UK government officials
SQ26	Selective and indicated prevention	Consultation with relevant UK government officials
SQ27	Treatment programmes	Consultation with relevant UK government officials
SQ28	Social reintegration	Consultation with relevant UK government officials
SQ31	Treatment as an alternative to imprisonment	Consultation with relevant UK government officials
SQ32	Policy and institutional framework	Consultation with relevant UK government officials
ST34	TDI data	National Drug Treatment Monitoring System (NDTMS) in England; the Scottish Drug Misuse Database (SDMD), the Welsh National Database for Substance Misuse (WNDSM); and the Northern Ireland Drug Misuse Database