REPORT TO THE EMCDDA

by the Reitox national focal point of United Kingdom,

DrugScope

UNITED KINGDOM

DRUG SITUATION 2000

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UK Drug Situation 2000

A report for EMCDDA

DrugScope

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Summary

In keeping with the ongoing devolution of government in the United Kingdom, the individual countries have formulated drug strategies tailored to the particular requirements of each, all within the broader framework of the UK strategy 'Tackling Drugs to Build a Better Britain'. The drug misuse strategy for Wales, for example, is also concerned with actions against the misuse of alcohol and volatile substances. In Scotland the drug strategy is part of a wider policy on social inclusion, making a link between drug misuse and such issues as housing and social deprivation. Northern Ireland's commitment to developing a vigorous drugs strategy was underlined by the opening of itsfirst Drugs Misuse Database in April 2000.

The key organisations for delivering the drugs strategy on the ground are the Drug Action Teams (DATs) in England and Scotland, the Drug Coordination Teams (DCTs) Northern Ireland, and the Drug and Alcohol Action Teams (DAATs) in Wales. These teams contain senior representatives from all the government branches involved in the drugs strategy, including health, local government, education and the law enforcement agencies. Supported by a permanent coordinator, and varying support staff, the DATs, DAATs and DCTs answer directly to the UK Anti Drugs Co-ordinator. In England the boundaries of the DATs are currently being made coterminous with those of local authorities bringing up their numbers from 112 to 150.

DATs, DAATs and DCTs will benefit from the new resources that have been made available by the 1998 Comprehensive Spending Review. An additional £217 million are to be disbursed over a three year period on anti-drugs activities. A substantial share of these new funds will be directed at initiatives designed to break the link between drug misuse and crime, including Arrest Referral Schemes and Drug Treatment and Testing Orders. The idea is to provide every drug misusing offender entering a police station or prison with a chance to seek treatment by the year 2002.

In anticipation of the increase in demand for treatment services, a National Treatment Agency is to become operational in April 2001. Key responsibilities of the new agency currently under consideration include commissioning of rehabilitation places, need assessments, the setting of treatment quality standards, inspections and the supply of management information. At the same time spending on research and evaluation is to be increased in an attempt to put drugs services on a sound, evidence based footing. One of the most ambitious projects, the National Treatment Outcome Research Study (NTORS) is the largest treatment follow-up in the UK, which has been tracking 1,075 drug agency clients since 1995. Valuable information on the long term outcomes of different treatment modalities will be fed back into service delivery and planning.

One of the challenges facing treatment agencies today is the increasing number of cocaine/crack and poly drug users. Most agencies have developed a service that is mainly geared towards an aging group of opiate users, which

is in many ways inappropriate for cocaine/crack users. While the research into the degree of physical dependence to cocaine/crack is still ongoing, there is undoubtedly strong psychological dependence. Yet the slight increase in treatment episodes for cocaine (6% of all treatment episodes up from 4% in 1996), suggests that the majority of cocaine use remains occasional. The rapid increase in availability, suggested *inter alia* by a 25% increase in seizures, stable prices and rising purity, points towards significant shifts in the cocaine user profile. Once the preserve of the wealthy, cocaine has come within the reach of a much wider client group, and is enjoying unprecedented popularity, with 7% of 16 to 24 year olds having taken it at least once.

By contrast, ecstasy and amphetamine use has levelled off and there are indications that it is falling, especially among the under twenty year olds. The most popular illicit drug among all age groups is cannabis, which 44% of 16 to 24 year olds have tried. The use of heroin is stable, but the significant changes in risk behaviour among injecting drug users have led to a sharp cut in the number of HIV infections attributed to intravenous drug use. This drop to 99 cases in 1999, from 447 cases in 1986 is widely attributed to the successful public health policy, characterised by swift harm reduction intervention when prevalence was still low.

This responsiveness could not prevent the outbreak of *clostridium* caused hospitalisations, and over 35 deaths in the United Kingdom excluding Northern Ireland. There is also growing concern over the prevalence of Hepatitis B and C among opiate users with an injecting career going back several years. The latest figures published for Scotland suggest that one in 500 persons is hepatitis C positive.

The widely recognised need for public health measures informs several key publications which have contributed to public debate on the issue of illicit drugs. Two influential documents published in 2000, one by the Police Foundation, the other by the Royal College of Psychiatrists and the Royal College of Physicians, advocate stronger health and educational measures. The former also argues for the legal reclassification of cannabis to schedule 3, and licensed use for medical purposes.

All the material highlighted in this summary is described and referenced in the main text.

PART 1

NATIONAL STRATEGIES:
INSTITUTIONAL & LEGAL FRAMEWORKS

1. Developments in Drug Policy and Responses

1.1.1 UK Strategy

The UK Strategy, Tackling Drugs to Build a Better Britain was published in 1998. The UK drug strategy functions as the UK and English strategy. Scotland and Northern Ireland have each published their own strategies during 1999, and Wales in 2000, which reflect the UK Strategy.

The UK drug strategy sets out four keys aims. These are:

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

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

1.1.2 Scotland Strategy

Scotland's drug strategy (Tackling Drugs in Scotland: Action in Partnership) was published in May 1999. The four key aims are the same as those of the UK strategy.

Within the four UK aims, Scotland has set clear objectives and action priorities. The Scottish Executive's Drugs Action Plan (2000) outlines progress to date and sets out a detailed plan for future action (see Part 4, section 12).

The Scottish Drug Misuse Information Strategy, which was launched in 1998, is a vital part of the strategy in Scotland and covers both routine information collection and a drug misuse research programme. Priority is now being given to activities which aim to assess progress towards the objectives of the Drug

Strategy and to enhancing statistical information in order to support and inform policy development.

1.1.3 Wales Strategy

The Welsh Strategy (Tackling Substance Misuse in Wales: A Partnership Approach), published in 2000 has similar aims to those of the UK strategy (see above) with a key difference being that it also includes prescribed drugs, over-the counter medicines, volatile substances and alcohol.

The strategy emphasises a holistic approach to tackling drug problems in Wales. Partnerships between key agencies including health, social services, education and criminal justice agencies are seen as being crucial to the success of the strategy.

The strategy does not contain performance targets. However, these are currently being developed and will be published separately along with an information and research strategy which will outline arrangements for the monitoring of progress against the key targets.

1.1.4 Northern Ireland Strategy

The Northern Ireland drug strategy, which was published in 1999, is also based upon the four key aims of the UK drug strategy. In 1995, Northern Ireland published *Drug Misuse in Northern Ireland: A Policy Statement* and established an inter-agency approach to tackling drug problems coordinated by the Central Coordinating Group for Action Against Drugs (CCGAAD). Departments and agencies working together launched a range of activities as the Northern Ireland Drugs Campaign.

The key features of the Northern Ireland Drugs Campaign were:

a public information campaign;
drug education training for teachers and other professionals;
drug education material;
specialist information for drug professionals;
a research and information strategy and;
the creation of four Drug Coordination Teams.

The new Northern Ireland Drug Strategy builds on the strengths of the 1995 policy statement and focuses on the need for good information and evidence to support drugs policy and practice across the health, social, education and criminal justice areas. It promotes the idea of partnership between government, the voluntary sector, the private sector and local communities.

1.2 Policy implementation, legal framework and prosecution

Since 1998 the government has provided additional funding to increase the number of drug using offenders engaged with treatment services. This included the introduction of Drug Treatment and Testing Order pilot schemes. Under this order courts may, with the offender's consent, make an order requiring the offender to undergo treatment either as part of another community order or as a sentence in its own right. It is envisaged that such schemes will be available in all courts in England and Wales by 2001.

Police forces in England and Wales are also operating Arrest Referral Schemes whereby problem drug users are identified and encouraged to take up appropriate treatment. These schemes are also currently being expanded, with the target of 100% coverage of all police stations by 2002.

Initiatives and programmes under the UK Drug Strategy also receive financial support from the Confiscated Assets Fund. This fund provides a mechanism for channelling a proportion of assets seized from drug traffickers into anti-drugs activities. In 1999/2000 the fund totalled £3 million, and it is anticipated that this will rise to £5 million over 2000/2001.

1.3 Developments in public attitudes and debates

Throughout 1998 and 1999 an inquiry into the Misuse of Drugs Act 1971 was carried out under the auspices of the independent research charity, the Police Foundation (Police Foundation 2000). The Inquiry team, chaired by Viscountess Runciman, considered changes which have taken place in UK society since the introduction of the Act in 1971 and assessed whether the law as it currently stands needs to be revised in order to make it both more effective and more responsive to those changes. These issues were discussed further in a report published by a working party from the Royal College of Psychiatrists and the Royal College of Physicians (Royal College of Psychiatrists and the Royal College of Physicians 2000).

The Police Foundation report recommends that certain changes be made to the classification of drugs, for example whilst heroin and cocaine would remain in Class A (the most dangerous category) ecstasy and LSD would transfer to class B and cannabis would become a class C drug. The report does not call for any drug currently covered by the Act to be legalised.

The report also suggests that changes be introduced to the penalties for possession of drugs, that laws against dealers and traffickers be strengthened, and that a significant shift in resources towards treatment services be made.

1.4 Budgets and funding arrangements

The 1998 Comprehensive Spending Review settlement provided an extra £217 million for three years (i.e.1999/2000 to 2001/2002) directed to health, local

authorities and criminal justice agencies for targeted anti-drugs activities. This was allocated as follows:

£133 million to provide for the implementation of the strategy to tackle drug misuse in the criminal justice system.

- Prisons receive £60 million for treatment services and £12 million for voluntary drug testing in prisons;

- £61 million made available for piloting and implementation of Drug Treatment & Testing Orders.

£70.5 million will be allocated to health and local authorities to fund new treatment services and to improve community care for drug misusers.

- Health Authorities will receive £50 million for treatment services and for young people at risk;

- Local Authorities will receive £20.5 million to improve access to services and increase numbers in treatment programmes.

£10.5 million will be allocated to support Drug Action Teams across the country and for national research into effectiveness of anti-drugs activity.

£3 million will be allocated to support cross-departmental development of more effective drugs education.

£6 million provided for a major new research programme over 3 years.

An extra £3 million will be available from the Confiscated Assets Fund in 1999/2000, being increased to £5 million and £7 million in subsequent years.

Source: UKADCU

PART 2

EPIDEMIOLOGICAL SITUATION

2. Prevalence, patterns and developments in drug use

2.1 Main developments and emerging trends[1]

All drugs

- Around a third of adults aged 16 to 59 in England and Wales have used illicit drugs and solvents at some point in their lives, rising to half of 16 to 24 year olds. In Northern Ireland 40% of respondents aged between 16 to 29 years report having tried illicit drugs at some time in the past.
- Around one in three 15 year olds in England, and two in five in Scotland, report ever using drugs

Cannabis

- The proportion of people reporting cannabis use, as for most drugs, is highest for young people.
- Thirty to forty % of 15 to 16 year olds in England, Scotland and Wales report ever using cannabis, rising to nearly half of 16 to 24 year olds in England and Wales.

Hallucinogens, amphetamines, cocaine and ecstasy - adults

- Just under two in five (39.2%) of 16 to 24 year olds in England and Wales report ever having taken hallucinogens 16 to 24 (defined as LSD, magic mushrooms and amyl nitrite), whilst two in ten have used amphetamines (21%) and/ or ecstasy (10.7%), and 7% cocaine.
- These percentages decrease with age to almost negligible levels of use for the 55 to 59 year old age group.

Opiates (heroin, methadone)

- Reported lifetime prevalence of opiate use among the 16-59 age range in England and Wales is very low, at 1.1% overall.
- Among males, 0.9% of those aged 16 to 24 report opiate use in the last month, compared to 0.5% for females.

Problem drug use

- Estimates of problem drug use suggest that prevalence of problem drug use is between 3 to 4% for the London districts of Lambeth, Southwark and Lewisham, Camden and Islington, and Newham.
- Further there may be as many as 266,000 problem drug users in Great Britain as a whole.

Health consequences

- There has been an increase in the number of drug related deaths reported in England and Wales and Scotland, with an ongoing trend of deaths

[1] Data sources are provided in the text.

becoming more male dominated. The increase may partly be due to changes in reporting practice.

- HIV prevalence is stable and low, although transmission continues to occur.
- Transmission of hepatitis B continues to be a problem, despite the existence of the hepatitis B vaccine.
- Two in five injectors in England and Wales are infected with hepatitis C antibody. In Scotland and England and Wales, there is a clear relationship between prevalence of infection and duration of injecting career, indicating that harm reduction initiatives may be having an impact on hepatitis C transmission. A total of 56% of all known cases of hepatitis C in Scotland (10161) were known to have ever injected drugs (Codere and Shaw 2000).
- An outbreak of illness among IDUs, thought to be due to *Clostridium novyi*, resulted in the death of at least 43 IDUs in the UK and Ireland in 2000.

Law enforcement indicators

- Seizures rose in 1998 by 8% to 149,900, compared to an increase of 14% in the previous year. Cannabis was involved in 76% of seizures. The number of seizures involving heroin rose by 1% and those involving cocaine (including 'crack') rose by 36%. Seizures of cannabis rose by 7%.
- There was no clear pattern in the quantities of Class A drugs seized: heroin fell by 40%, following an all-time record peak the previous year, while cocaine (including crack) rose by 25%. Amounts of ecstasy-type drugs seized rose by 9%, while LSD quantities continued to diminish, by as much as 76% in 1998.
- The number of drug offenders increased by 13% to 127,900 in 1998. 90% were possession cases, mainly of cannabis. There was an increase of 32% in the number of cocaine offenders (excluding crack ones) to 4,400, of 30% in the number of heroin offenders to 11,400, and of 13% in cannabis offenders to 97,200.
- In 1998 there was a modest fall in the proportion of offenders cautioned to 47%, 23% were fined and 8% sentenced to immediate custody. The number of persons given immediate custodial sentences rose by 4 % compared to a 19% increase between 1996 and 1997.
- Relatively high proportions of prisoners reported using heroin during their current stay in prison – 10-20% of prisoners in England and Wales, and 31% in Scotland.

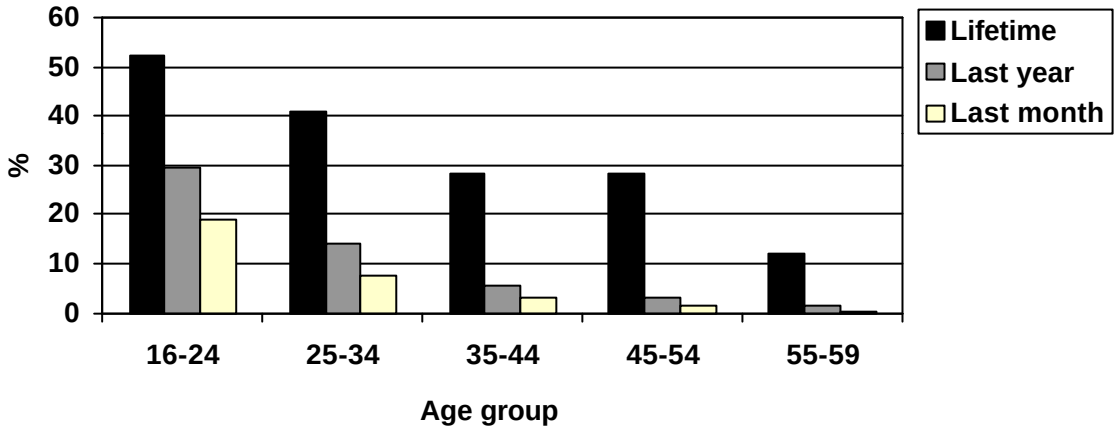
2.2 Drug use in the population

Adults

The 1998 British Crime Survey, conducted by the Home Office, asked respondents in England and Wales if they had used various drugs (Ramsay and Partridge 1999). The Survey is designed to be representative of the general public in England and Wales, it is conducted every two years, and the main focus is on victimization, though other topics, including drugs, are

covered. The response rate for the overall 1998 survey was 78.7%, of whom 97.3% answered the drugs component, with a sample size of just over 10,000. Overall, a third (31.7%) of adults aged 16 to 59 years in 1998 reported having used illicit drugs at some point in the past, compared to 29% in 1996 and 28% in 1994 (Ramsay and Percy 1996; Ramsay and Spiller 1997) Key findings only are presented here as results were described in detail in last year's report (ISDD 1999), available from the DrugScope website.

Figure 1: Adult lifetime, last year and last month use of illicit drugs and solvents by age group, England and Wales 1998



Source: British Crime Survey

Prevalence of drug use was associated with age group (Figure 1), with around half (52.2%) of 16 to 24 year olds having used illicit drugs at some point in the past, compared to just under a third (28.1%) of 45 to 54 year olds.

More recent drug use was less common. Overall 10%-11% of 16-59 year olds reported drug use in the last year in the 1998, 1996 and 1994 survey years, and 6% in each survey year reported drug use in the last month. In terms of age, around thirty % (29.5%) of 16 to 24 year olds reported using drugs in the last 12 months, and 20% (19.1%) in the last 30 days, compared to 3.1% and 1.5% for 45 to 54 year olds respectively.

Table 1: Adult lifetime, last year and last month use of illicit drugs and solvents by age group and sex, England and Wales 1998

	All adults		16-24 years		25-34 years	
	Males	Females	Males	Females	Males	Females
Lifetime	37.6%	26.7%	59.8%	46.1%	49.8%	34.2%
Last year	13.7%	7.8%	36.3%	23.9%	20.0%	9.3%
Last month	8.3%	4.4%	24.3%	14.9%	11.5%	4.5%

Source: British Crime Survey

Table 1 depicts adult lifetime, last year and last month use of illicit drugs by sex and age group. For every age breakdown shown, a higher proportion of males than females reported drug use. Lifetime, last year and last month use of drugs was highest for males aged 16 to 24 years, with the majority of men in this age group in 1998 having used illicit drugs at some point in the past.

Schoolchildren

Surveys of nearly 5,000 English children, and 3,500 Scottish children, attending secondary schools in 1998 asked questions about drug use (Goddard and Higgins 1999a; Goddard and Higgins 1999b; ISD 1999), as did a health survey of 1,300 15 to 16 year olds at Welsh secondary schools (DoH 1998b). The surveys for England and Scotland have been conducted in previous years, although 1998 was the first year in which questions on drug use were asked, and so time trend comparisons are not available. Country comparisons should be interpreted carefully due to possible methodological differences. Some 1999 schoolchildren survey data is now available for England (Goddard and Higgins 1999a).

Overall, 13.0% of respondents aged 11 to 15 years in England reported having ever taken drugs, compared to 18% of respondents aged 12 to 15 years in Scotland (Table 2). Prevalence of drug use increased with age. In England, just under 3% (2.6%) of 11 to 12 year olds reported ever using drugs, compared to 13.3% of 13 to 14 year olds and nearly one in three (31.4%) 15 year olds. Comparable figures for Scotland were 3.0% for 12 year olds, 19.0% for 13 to 14 year olds, and two in five (39.0%) 15 year olds. In Wales 41.5% of 15 to 16 year olds reported ever using drugs. Overall, prevalence of drug use also varied by sex, with boys being slightly more likely to report drug use than their female counterparts for the three surveys.

Prevalence of drug use in the last year for 11 to 15 year olds in England (11.0%) was only marginally lower than lifetime prevalence, possibly reflecting relatively recent initiation to and/or experimentation with drug use by some respondents. Due to different questionnaire designs the data between England and Scotland is not strictly comparable. In Scotland, the figure of 5% of children aged 12 to 15 reporting for drug use in the last 12 months did not include the figures reporting use in the last month. Prevalence of drug use in the last month was 6.7% overall for 11 to 15 year olds in England and 10% for

12 to 15 year olds in Scotland (Table 2). In England and Scotland 1 to 2% of children aged 11 to 12 used drugs in the last month, compared to at least one in six 15 to 16 year olds.

Table 2: Children lifetime and last month use of illicit drugs and solvents by age group, England, Scotland and Wales 1998

Country	Time period	Total 11-16	11-12 years	13-14 years	15-16 years
England	Lifetime	13.0%*	2.6%	13.3%	31.4%****
	Last month	6.7%*	0.9%	6.6%	17.5%****
Scotland	Lifetime	18.0%**	3.0%***	19.0%	39.0%****
	Last month	10.0%**	2.0%***	11.0%	24.0%****
Wales	Lifetime	-	-	-	41.5%
	Last month	-	-	-	22.9%

Source: England, Scotland and Wales school surveys
Notes:
* 11 to 15 year olds only
** 12-15 year olds only
*** 12 year olds only
**** 15 year olds only

Prisoners

The Office for National Statistics conducted a survey of the drug use of remand (n=1435) and sentenced (n=1705) prisoners in England and Wales in 1997 (Singleton, Meltzer and Gatward). Overall, 81% of male sentenced prisoners reported any lifetime illicit drug use prior to imprisonment, compared to 85% for male remand prisoners, 69% for female sentenced prisoners and 77% for female remand prisoners. In terms of more recent drug use, between 10-20% of all prisoners reported having used heroin, and 5-8% of sentenced prisoners reported using crack, during their current stay in prison.

The third Scottish prison survey was conducted in 1998, in which prisoners were asked about their drug use (ISD 1999; Wozniak et.al. 1999) Just under half (44%) reported that they had used drugs at some point in the previous six months in prison, similar to the figure for the second survey conducted in 1994 (45%). Young offenders were more likely to report drug use than adults, as were male prisoners compared to female prisoners.

Among Scottish prisoners, there was a large increase in the proportion reporting heroin use in the last six months in prison, from 9% in 1994 to 31% in 1998 (ISD 1999; Wozniak 1999) In both years one in 20 reported injecting drugs in prison in the previous 6 months, and one in 25 (or 82% of those injecting) reported sharing injecting equipment. Although it seems therefore

that the preferred route of administration of heroin is by smoking, there is still an ongoing risk of transmission of blood borne viruses among those injecting.

2.3 Problem drug use

Four recent UK studies have attempted to estimate the prevalence of problem drug use in the UK. Firstly, three capture recapture studies of problem drug users were conducted in three areas of inner London: Lambeth, Southwark and Lewisham (LSL) in 1992; Camden and Islington (C&I) in 1993/4; and Newham in 1995 (Hickman et.al. 1999). Prevalence of opiate users was also estimated for LSL. Prevalence estimates for problem drug users in the three areas were 14,300 (and 5800 opiate) for LSL, 8,400 for C&I, and 4,400 for Newham. These estimates are equivalent to population rates of 3.1% (and 1.3% opiate) for LSL, 3.6% for C&I, and 3.3% for Newham.

Secondly, a comparison was made of different methods of estimating the prevalence of problem drug use in Great Britain (Frischer et.al. in press). The authors calculated the following best estimates: 143,000 for people among whom there is a risk of mortality due to drug overdose; 161,000 drug injectors (ever); 202,000 problematic opiate users; and 266,000 problem drug users. They suggested that previous national estimates of 100,000-200,000 were conservative.

3. Health consequences

3.1 Drug treatment demand

The Department of Health provides data on drug users presenting for treatment services reporting to the Regional Drug Misuse Databases (RDMDs). For England (DoH 2000a), Scotland (ISD 1999) and Wales combined, 27,810 men and 9,871 women sought treatment for their drug use in the six months period ending 30 September 1999. The majority (83%) were aged between 15 and 34 years. In Northern Ireland, data collection commenced in April 2000.

Nearly half (45%) reported that they were currently injecting drugs, and 17% reported that they were former injectors. Just over a third (37%) reported injecting as the main route of administering drugs. Seven out of every ten (71%) reported that opiates were their main drug of use, of whom around half (47%) reported injecting opiates. Figures for other drugs were 6% for cocaine (4% injecting), 9% for stimulants (39% injecting), and 10% for cannabis. There were no major differences in the age distribution or main drug of use between males and females.

In terms of country breakdowns, during the six month period ending 30 September 1999, 30,545 individuals started new agency episodes throughout England, an increase of 7% on the equivalent period for 1998 (DoH 2000a)

The gender distribution of these individuals showed the familiar male to female ratio of 3:1 overall, and around half (52%) were in their twenties.

For Scotland, during the twelve month period ending 31 March 1999, 9,500 individuals started new agency episodes, an increase of 8% on the equivalent period to 31 March 1998 (ISD 1999). The gender distribution was nearer 2:1 male to female, and 57% were in their twenties.

3.2 Drug related mortality

Time trend data on numbers of drug related deaths for 1990 to 1999 for England and Wales (GRONI; ISD 1999; ONS 2000;) Scotland and Northern Ireland are presented in Table 3, although caution should be taken when comparing countries and years due to potential differences in classification and reporting systems. The standard definition used by the ONS is at variance from that used by the EMCDDA, hence differences may occur. There has been a steady increase in the number of drug related deaths reported in England, from 2,041 in 1990 to 2,922 in 1998. Reported deaths in Scotland show a similar trend, with an overall increase from 422 deaths in 1994 to 492 in 1999. In Northern Ireland for the period 1990 to1999 about 40 drug related deaths are reported annually. All the UK data sources suggest that there is a trend for deaths to become more male dominated, with male deaths in 1998 and 1999 outnumbering female deaths by around two to one (Table 3).

Table 3: Drug related deaths, England and Wales, Scotland and Northern Ireland 1990-1999

Year	England and Wales		Scotland		Northern Ireland	
	Number	Male-female ratio	Number	Male-female ratio	Number	Male-female ratio
1990	2041	1.3	-	-	39	0.6
1991	2053	1.4	-	-	46	0.6
1992	2287	1.4	-	-	28	0.9
1993	2252	1.5	-	-	28	0.8
1994	2404	1.7	422	1.6	35	1.3
1995	2563	1.8	426	1.7	46	1.3
1996	2721	2.0	460	2.2	40	1.1
1997	2858	2.1	447	1.8	39	1.0
1998	2922	2.0	449	2.1	40	1.5
1999	-	-	492	2.3	50	2.3

Source: ONS, General Register Office Scotland, General Register Office Northern Ireland.

The majority of drug-related deaths in the UK occurred among 20 to 34 year olds (44.0% of all deaths in England and Wales in 1998, 49.4% in Scotland in 1999 and 48.0% in Northern Ireland in 1999).

3.3 Drug related infectious diseases

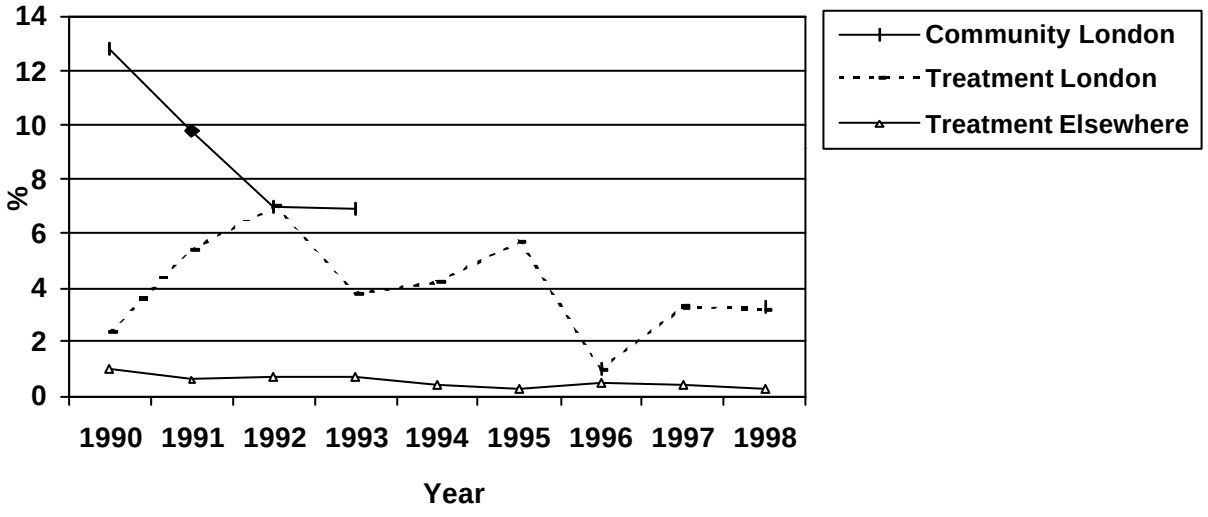
Data on prevalence of antibody to HIV (anti-HIV), HBV and HCV (anti-HCV) among injecting drug users in the UK is available from: the Centre for Research on Drugs and Health Behaviour (CRDHB) at Imperial College (Stimpson et.al 1996); the Communicable Disease Surveillance Centre (CDSC) (DoH 1999a); and the Scottish Centre for Infection and Environmental Health (SCIEH) (Taylor et.al 1994). The three Centres provide complementary data from surveys of IDUs recruited from both treatment and community settings. In addition, CDSC and SCIEH also collect routine information on laboratory reports of HIV infection and AIDS in the UK. (Codere and Shaw 2000; DoH 2000b; SCIEH 2000).

HIV

Cross-sectional surveys conducted throughout the 1990s suggest that prevalence of HIV in the UK has remained relatively stable and low. The number of new diagnoses of HIV infections attributed to IDU has fallen substantially from 447 cases in 1986 to 99 cases in 1999 (DoH 2000b). This has been attributed to the swift introduction of harm reduction interventions, such as needle exchange, early on when prevalence was low (Stimpson 1996).

Figure 2 shows the prevalence of HIV among injectors recruited from community and treatment settings in England and Wales, for 1990 to 1998 (DoH 1998a; Judd et.al. 1999; Stimpson et. al. 1996). Since 1991 HIV prevalence has remained below 10%, with London prevalence around 4%, and prevalence elsewhere in England and Wales at around 1%. In 1998 a key finding in the community sample was that there was no HIV among injectors who had been injecting for less than 5 years (Judd et.al. in press).

Figure 2: Anti-HIV prevalence among IDUs, England and Wales 1990-1998



Source: CRDHB, CDSC.
Notes: 1996 London community data for females only.

A 1997/8 survey measured prevalence of bloodborne viruses among the prison population of England and Wales (Weild et.al 2000). Results for prisoners who reported ever injecting drugs suggested a prevalence of HIV of 0.5%.

Data on injecting drug users in Scotland undergoing named HIV testing suggest that prevalence of anti-HIV among this group has declined from around 3% in the early 1990s to about 1.5% between 1995-1997. In 1998 25 HIV infected injecting drug users were reported in Scotland (ISD 1999), and annually around 30 cases have been reported since 1994, the vast majority being aged 30 years or over. These data suggest that incidence of HIV infection among IDUs in Scotland is low, although new infections are still occurring.

For the UK as a whole, the number of new diagnoses of HIV infection attributed to injecting drug use continues to decline (DoH 2000b). Injecting drug use has played a much smaller part in the epidemic of HIV in the UK than in many other European countries. Of the 42,125 individuals with HIV infection reported in the UK to the end of June 2000, only 9% were classified as having acquired their infection through injecting drug use.

Table 4 depicts the number of AIDS deaths in the UK attributed to injecting drug use between 1990 and 1999. In England and Wales, and Scotland, the number of AIDS deaths attributed to injecting drug use appeared to peak in 1995, at 128 and 52 deaths respectively, and then decline. In Northern Ireland only four AIDS deaths have been attributed to injecting drug use in the whole 10 year period.

Table 4: AIDS deaths attributed to injecting drug use*, England and Wales, Scotland and Northern Ireland 1990-1999

Country	19/90	19/91	19/92	19/93	19/94	19/95	19/96	19/97	19/98	19/99
England & Wales	56	54	74	109	100	128	118	49	50	43
Scotland	13	38	24	32	49	52	43	21	12	13
Northern Ireland	0	0	0	0	0	1	2	1	0	0

Source: CDSC; SCIEH.
Notes:
* Injecting drug use, and injecting drug use and sex between men

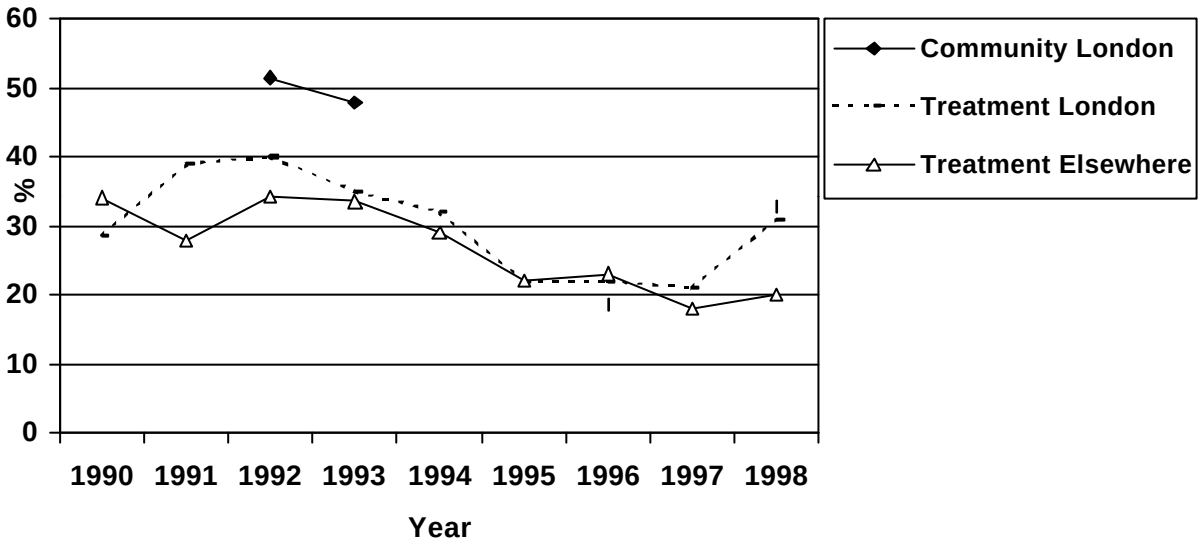
Hepatitis B virus (HBV)

Reports to the Public Health Laboratory Service of acute infection with HBV, attributed to injecting drug use, have nearly tripled between the early 1990s and 1996 (DoH 1999b). In contrast, reports attributed to other exposure categories have remained stable or decreased.

Figure 3 shows the prevalence of hepatitis B core antibody (anti-HBc), which indicates previous or current infection with the hepatitis B virus, for injectors in England and Wales. All percentages are unadjusted (the sensitivity of the test for anti-HBc is estimated to be approximately 82%).

There has been an overall decline in prevalence of HBV between the early 90s and 1995, decreasing from around 35% to about 20% (Figure 3). Since then it has remained relatively stable, with around one in five injectors having been exposed to the virus. A slight increase in prevalence was found in 1998, though it remains to be seen whether this is a persistent trend.

Figure 3: Anti-HBc prevalence among IDUs, England and Wales 1990-1998



Source: CRDHB, CDSC

Notes:

All percentages are unadjusted. The test sensitivity is estimated to be 82%.

A recent national survey of injectors found that less than 30% of respondents reported that they had been vaccinated against HBV, and of these, only half reported having been given the optimal dose of three jabs. Over half of the injectors surveyed were both unvaccinated and had not been exposed to hepatitis B in the past, and so they were all still susceptible to infection (Lamagni et. al. 1999).

A 1997/8 survey measured prevalence of bloodborne viruses among the prison population of England and Wales (Weild et.al. 1999). Results for prisoners who reported ever injecting drugs suggested a prevalence of anti-HBc of 19.9%.

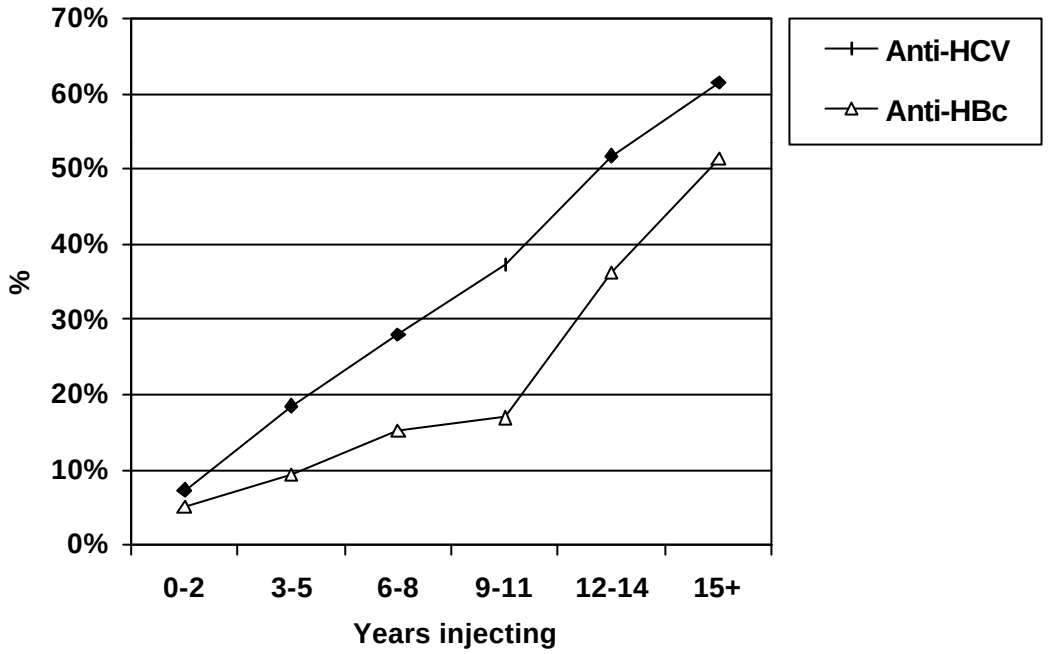
Hepatitis C virus

Latest results from treatment and community surveys of injecting drug users in England and Wales suggest an overall unadjusted prevalence of antibody to

hepatitis C virus (anti-HCV) of 30% (Hope et.al in press). The sensitivity of the test for anti-HCV is estimated to be approximately 80%, so the true prevalence of infection may be nearer 38%.

A strong relationship was found between HCV prevalence and years injecting, with prevalence rising from 7% among those injecting for 0 to two years, to nearly 30% for those injecting for 6 to 8 years, and just over 60% among injectors who have been injecting for 15 years or more (Figure 4).

Figure 4: Prevalence of anti-HCV and anti-HBc by duration of injecting career, England and Wales 1998



Source: CRDHB, CDSC.
Notes:
All percentages are unadjusted. The test sensitivity is estimated to be 80%.
A similar overall prevalence of anti-HCV of 29.8% was found among IDUs in prisons in England and Wales in 1997/8 (Weild et. al. 2000).

An overall estimated prevalence of anti-HCV of 71% was detected among IDUs recruited from treatment and community settings in Glasgow between 1990 and 1994, and also 1996. However, a similar relationship was found between prevalence of anti-HCV and length of injecting career as in England and Wales, with only 31% of those injecting after 1992 (following the full establishment of the city's needle exchange) having salivary antibodies in Glasgow (Taylor et. al. 2000)

The cumulative total number of people being diagnosed with anti-HCV in Scotland to the end of 1998 was 8,075, being a 36% increase on the total to the end of 1997 (Codere and Shaw 2000). This figure equates to one in 600 of Scotland's population being known hepatitis C antibody positive, although experts predict that the number of unknown cases exceeds the number of known cases several-

fold. Two-thirds (68%) of the known cases were male, 86% were aged between 15 and 44, and around half (53%) were known to have ever injected drugs.

3.4 Other drug related morbidity

Serious unexplained illness among injecting drug users

Since April 2000 a serious illness affected drug injectors in the UK and the Republic of Ireland causing a considerable number of deaths. By August 2000 118 cases (60 in Scotland, 23 in Ireland and 25 in England and Wales), all with injection-site soft tissue inflammation resulting in hospitalisation or death, had been identified by investigators, of whom 43 had died (23 in Scotland, 8 in Ireland, and 12 in England and Wales (MMWR 2000). Initial testing of specimens from 76 IDUs identified *Clostridium* species in 18 (24%) patients, of which nine were *Clostridium novyi*.

Surveillance activities to identify additional cases in the UK and Ireland are ongoing, as are efforts to identify cases in other parts of Europe. A case control study is also in progress. Public health information has been distributed to IDUs in the hope that further cases can be prevented.

4. Social and legal correlates and consequences

4.1 drug offences and drug related crime

UK data on drug offences are published annually by the Home Office (Corkery 2000). The number of people dealt with for drug offences in 1998 was 153,200, an increase of 13% on the previous year. Of these, 127,840 were found guilty, cautioned, given a fiscal fine or dealt with by compounding for drug offences in 1998 (Table 5). The cautioning rate for this group was 47%, down from 50% in 1997. Cautioning is not available in Scotland, although greater use is made of a fiscal fine in this country, for which no formal admission of guilt is necessary.

Offences mainly involved cannabis (76%), followed by amphetamine (12%), heroin (9%) and cocaine (4%), with little change in the type of drug from 1997. There was a marked increase in offences involving crack, cocaine and heroin in 1998 compared to 1997 (71% increase for crack, 32% for cocaine and 30% for heroin overall), while offences involving ecstasy decreased by 25% between the two years.

More information from NEW-ADAM (the New English and Welsh Arrestee Drug Abuse Monitoring) indicated a strong correlation between illicit drug use and property crime. Of the 506 sample-providing arrestees, 69% tested positive for at least one drug, 29% tested positive for opiates, and 20% tested positive for cocaine, including crack. The small subgroup (9%) with the costliest drug habits was responsible for 52% of all offences reported by the group (Bennet 1998; Bennet 2000; McKeganey et.al 2000).

Table 5: Persons found guilty, cautioned, given a fiscal fine or dealt with by compounding for drug offences by type of drug and offence, 1997-1998

Drug	Offence	Year 1997	1997 %	1998	1998 %	% inc 1998 v. 1997
Cannabis	Possession	77,943		89,129		14.4
	Other*	8,091		8,120		0.4
	Total	86,034	76.0%	97,249	76.1%	13.0
Heroin	Possession	7,138		9,429		32.1
	Other	1,618		1,972		21.9
	Total	8,756	7.7%	11,401	8.9%	30.2
Cocaine	Possession	2,368		3,461		46.2
	Other	1,001		980		-2.1
	Total	3,369	3.0%	4,441	3.5%	31.8
Amphet*	Possession	11,559		12,926		11.8
	Other	1,772		1,854		4.6
	Total	13,331	11.8%	14,780	11.6%	10.9
Ecstasy	Possession	3,100		2,373		-23.5
	Other	1,051		750		-28.6
	Total	4,151	3.7%	3,123	2.4%	-24.8
LSD	Possession	545		477		-12.5
	Other	171		135		-21.1
	Total	716	0.6%	612	0.5%	-14.5
Crack	Possession	388		682		75.8
	Other	145		231		59.3
	Total	533	0.5%	913	0.7%	71.3
Total	Possession	100,808		115,232		14.3
(all controlled drugs)	Other	12,346		12,608		2.1
	Total	113,154		127,840		13.0

Source: Home Office.
Notes:
Percentages do not add up to 100% as an offence can involve more than one drug type.
* Amphet = Amphetamine

* Note that some persons convicted of possession may also have committed other offences.

5. Drug Markets

5.1 Availability and supply

5.1.1 Availability of different drugs, trends and possible reasons

There is an absence of useful data concerning availability of drugs in the UK, although certain measures (i.e. seizures, see 5.2) may give some indication of the levels.

Recent (1998) reports of high levels of availability of cocaine (Ramsey and Partridge, 1999) seem to remain true for 1999 and indeed 2000. One explanation is that the wholesale price of cocaine per kg in the UK is 10 to 20% higher than any other country in Europe and so the UK is being targeted by large criminal organisations (NCIS, 2000).

In addition, the National Criminal Intelligence Service states that 'the synthetic drug market is possibly the most rapidly expanding drug market in the UK' (NCIS, 2000, p.25).

Poly-drug use has been a growing trend for quite a while among users and therefore it is likely that multi-drug supply will develop throughout all levels of the supply network. Availability is further increased through the networking between these drug suppliers and British criminals that takes place in order to expand the distribution of their products (NCIS, 2000).

A study among arrestees (Bennett, 2000) examined drug markets in Nottingham and Sunderland between 1997 and 1999. The number of dealers known to users, and the ability to buy drugs locally, were taken as indicative of changes in availability of drugs. In Nottingham there was a significant increase over time in the use of crack/cocaine and heroin among arrestees, and in the availability of those drugs locally, while in Sunderland there was no significant increase in these two measures. Thus, changes/trends in availability may vary from locality to locality.

A new method of measuring changes in availability/access for the UK is the Key Informant Survey, which was piloted in 1999/2000 (DrugScope, forthcoming). This survey is UK-wide, producing data for the UK as a whole and for the four constituent nations. It will cover local availability/access concerning four distinct areas: a) perceived change in level of [heroin/cocaine] supply between December 1998 and December 1999 as a percentage of the situation previously; b) perceived change in the numbers of dealers selling [heroin/cocaine] to young people between December 1998 and December 1999 as a percentage of the situation previously; c) perceived change in the proportion of users [heroin/cocaine] that are young people who get the drug [directly] from a dealer on at least some occasion in December 1999 as a percentage of the situation previously; d) perceived changes in the proportion of all young people who could get hold of [heroin/cocaine] within a couple of days with only moderate effort in December 1999 as a percentage of the situation previously. It is anticipated that the methodology will be developed

further in order for it to become a useful tool in the measurement of availability.

In terms of potential measures of international/regional supply, a European Flows 2002 Feasibility Study (DrugScope, HMCE and EMCDDA, not yet available) was carried out in order to move towards development of a methodology for generating information on drug flows and baselines for interpretation of European and UK seizures. This research is intended to measure, for example, drugs 'destined for the UK' and 'UK seizures as a proportion of overall UK availability' (in accordance with targets cited in UKADCU, 1999, p.25).

5.1.2 Sources of supply and trafficking patterns within country

Customs estimate that the majority (up to 80%) of cannabis resin entering the UK originates from Morocco and travels by sea, although large amounts also arrive from South West Asia, mainly Pakistan. Herbal cannabis most commonly comes from Jamaica (Foreign & Commonwealth Office, 2000).

The majority of heroin entering Britain comes from South West Asia, mainly Afghanistan, and travels overland via Europe to the UK. The previously common Balkan road routes from Turkey have recently been less popular, while the trafficking of heroin through Central and North East European countries is on the increase. However, most of the heroin coming into the UK comes via The Netherlands. A great deal of the heroin is destined for markets in London and South East England, although all the major UK cities have large heroin markets (NCIS, 2000).

The majority of cocaine production takes place in Peru, Bolivia and Colombia, and then most commonly travels via Venezuela, Brazil, Ecuador and Panama to the UK. It seems that consignments of cocaine are divided up into small amounts, of usually no more than 20 kg, and then driven through the Channel Tunnel or imported by air or sea to the UK. The major cocaine distribution focal points in the UK are London, Liverpool, Manchester, Birmingham, Bradford, Bristol and Glasgow (NCIS, 2000).

10% to 20% of the synthetics for the UK market are manufactured in the UK, while the rest are thought to be manufactured on the near continent (predominantly The Netherlands and Belgium) and enter the UK at Channel ports or airports. The UK synthetic drug market is supplied mainly by the cities of London and Liverpool (NCIS, 2000).

5.2 Seizures

Statistics on drug seizures made by the police, HM Customs and Excise and other bodies such as the British Transport Police are routinely published by the Home Office (Corkery 2000a). The number of seizures involving controlled drugs rose by 8% between 1997 and 1998, to 149,900, the highest figure yet

to be recorded. Of these, the vast majority (76%) involved cannabis, and 12% involved amphetamines, similar to 1997.

The largest increases in the number of seizures in 1998 compared to 1997 were for crack and cocaine (39.6% and 34.5% respectively), whilst the numbers of seizures of amphetamines and ecstasy showed a slight decrease (Table 6). By far the majority of seizures were made by the police. For example, of the 113,818 seizures of cannabis made in 1998, 94.4% were made by the police.

Table 6: Number of seizures of illicit drugs made by all enforcement agencies by drug type, UK 1997-1998

Year	Total seizures	Of which: Cannabis	Heroin	Cocaine	Crack	Amphet*	Ecstasy	LSD
1997	139,174	106,753	12,474	3,687	1,745	18,575	5,087	851
1997 %	100.0%	76.7%	9.0%	2.6%	1.3%	13.3%	3.7%	0.6%
1998	149,907	113,818	14,860	4,959	2,436	18,290	4,746	609
1998 %	100.0%	75.9%	9.9%	3.3%	1.6%	12.2%	3.2%	0.4%
% inc. 1998 v 1997		6.6%	19.1%	34.5%	39.6%	-1.5%	-6.7%	28.4%

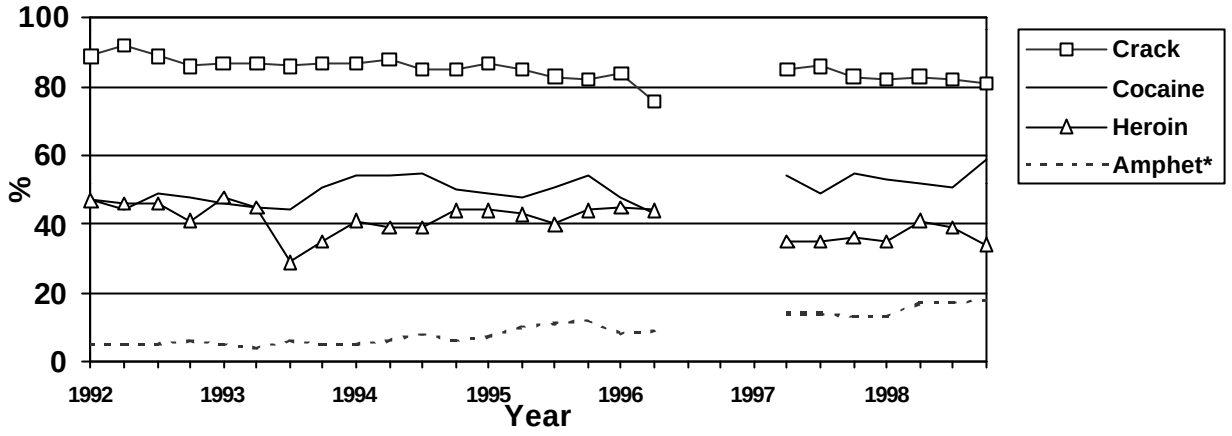
Source: Home Office
Notes:
* Amphet = Amphetamine

5.3 Price, purity

Information on average purities of drugs seized is provided by the Forensic Science Service whose laboratories analyse seizures made by the police (Corkery 2000a) Figure 5 depicts average purities of crack, cocaine, heroin and amphetamine seized in the UK between 1992 and 1998 by year quarter. Purity of crack has remained relatively stable at around 85%, only once falling below 80% in the seven year period. Average cocaine purity has never fallen below 43% or risen above 59% between 1992 and 1998, while heroin purity has jumped between 29% and 48%. Average amphetamine purity was very low at under 10% until 1995, since when it has shown an increase to 18% in the final quarter of 1998.

Other Forensic Science Service data suggest that the average MDMA drug content of tablets was around 80mg between 1996 and 1999, although the number of tablets tested was relatively small and it is not clear how they were selected for testing.

Figure 5: Average purities of drug seizures analysed by the Forensic Science Service by drug type, UK 1992-1998



Source: Home Office
Notes:
No data available for quarters 3 and 4 of 1996 and quarter 1 of 1997.
* Amphet = Amphetamine

Data on the price at street level of various illicit substances are routinely published by the Home Office (Corkery 2000a). They originate from the National Criminal Intelligence Service's Drugs Unit, who analyse the price of drugs reported on an ad hoc basis by police officers making seizures. Between 1995 and 1999 the average price in GB £ of most drugs remained relatively stable. For example, the average price of a gram of cannabis resin varied from £3.28 to £4.02, and average price of crack (per rock) remained at £20. However there was some evidence for a decline in the price of ecstasy tablets from £15 (range £8-£25) in 1995 to £11 (range £5.5-£20) in 1999.

6. Trends by drug

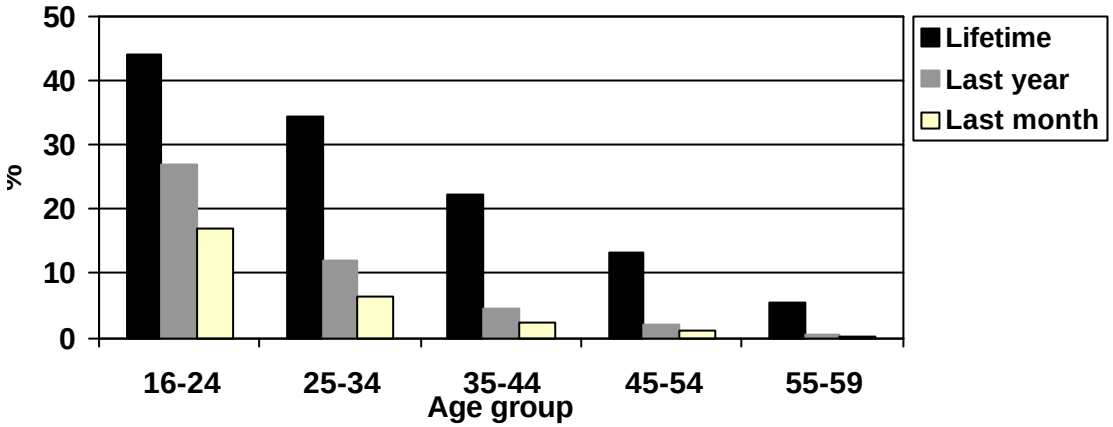
The main sources of information on trends in drug use by drug type are those described in the section earlier entitled *'Drug use in the population'* (ie the British Crime Survey and school surveys). As the findings from the last British Crime Survey (Ramsay and Partridge 1999) were described in detail in last year's Annual Report (ISDD 1999) (available from DrugScope's website) only key findings are presented here.

Cannabis

The 1998 British Crime Survey asked respondents in England and Wales about their use of various different drugs. Cannabis remains the most frequently reported lifetime drug of use, with a quarter (25.1%) of all adults, and nearly half (44.0%) of 16 to 24 year olds, reporting use of this drug at some point (Figure 6). Reported lifetime use declined steadily with age, with only 5% of adults aged 55 to 59 reporting that they had used cannabis at some point previously. Only 5% of all adults reported using cannabis in the

last month, varying from 17.0% for 16 to 24 year olds, to 0.2% for 55 to 59 year olds. In Northern Ireland cannabis prevalence established by the Northern Ireland Crime Survey increased from 12% in 1995 to 18% in 1998 (Hague et.al. 2000).

Figure 6: Adult lifetime, last year and last month use of cannabis by age group, England and Wales 1998



Source: British Crime Survey

Cannabis use reported by children in the England, Scotland and Wales school surveys is described in Table 7. Overall, around one in ten English schoolchildren aged 11 to 15 years, compared to one in six Scottish schoolchildren aged 12 to 15 years, reported lifetime cannabis use. As one would expect, prevalence of use increased with age, with under 5% of English 11 and 12 year olds and Scottish 12 year olds reporting lifetime use. In contrast 30 to 40% of 15 to 16 year olds in England, Scotland and Wales reported ever using cannabis, decreasing to between 16% and 23% in the last month.

Table 7: Children lifetime and last month use of cannabis by age group, England, Scotland and Wales 1998

Country	Time period	Total 11-16	11-12 years	13-14 years	15-16 years
England	Lifetime	11.8%*	1.7%	12.2%	29.6%****
	Last month	5.8%*	0.4%	5.8%	15.7%****
Scotland	Lifetime	16.0%**	3.0%***	17.0%	38.0%****
	Last month	9.0%**	1.0%***	10.0%	23.0%****
Wales	Lifetime	-	-	-	35.8%
	Last month	-	-	-	20.3%

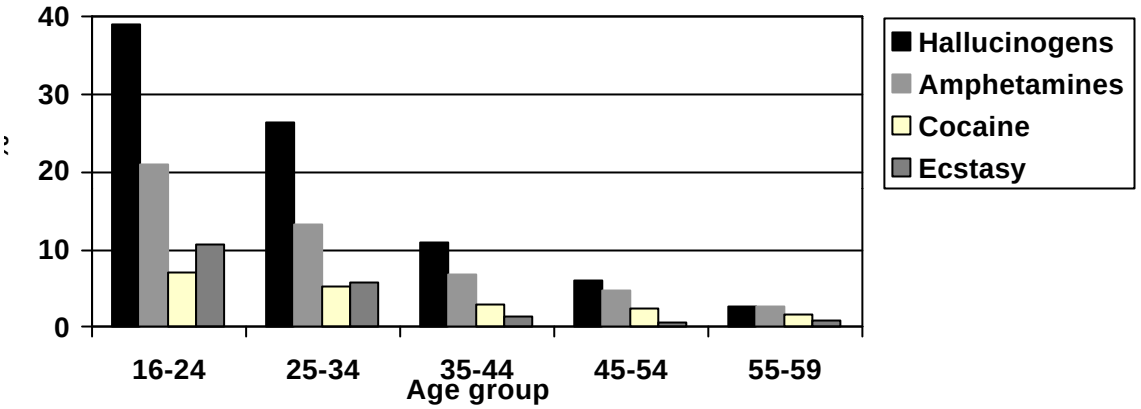
Source: England, Scotland and Wales school surveys
Notes:
* 11 to 15 year olds only
** 12-15 year olds only
*** 12 year olds only
**** 15 year olds only

Hallucinogens, amphetamines, cocaine and ecstasy - adults

The other most commonly reported drugs used by respondents to the British Crime Survey were hallucinogens, amphetamines, cocaine and ecstasy. Lifetime use of these four drugs are compared in Figure 7. There are indications that the use of ecstasy and amphetamine is falling, especially among the under 20s, while cocaine use is on the rise.

Just under two in five (39.2%) of the youngest group of respondents to the British Crime Survey reported ever having taken hallucinogens (defined as LSD, magic mushrooms and amyl nitrite), whilst one in ten had used amphetamines (21%) and/ or ecstasy (10.7%), and 7.0% cocaine. These percentages decreased with age to almost negligible levels of use for 55 to 59 year olds.

Figure 7: Percentages of adults who indicated that they had ever used hallucinogens, amphetamines, cocaine and ecstasy by age group, England and Wales 1998



Source: British Crime Survey

Less than 0.5 % of those aged 35 years and over reported use of each of these four drugs in the last month. In contrast, one in twenty (5.1%) of 16 to 24 year olds used amphetamines in the last month, one in thirty-five (2.8%) hallucinogens, one in fifty (2.0%) ecstasy, and one in a hundred (0.9%) cocaine.

The 1998 school surveys suggest that for English 15 year olds, 3% had taken cocaine, compared to 1% for Scottish 15 year olds and 2% for Welsh 15 and 16 year olds (Table 8). Approximately one in ten 15 year olds in Great Britain (and 16 year olds in Wales) had tried amphetamine at some point, and at least one in 20 had taken hallucinogens.

Table 8: 15 and 16 year old lifetime and last month use of cocaine, amphetamines ecstasy and hallucinogens, England, Scotland and Wales 1998

Country	Time period	Cocaine	Amphetamine	Ecstasy	Hallucinogens
England	Lifetime	2.8%*	7.6%*	2.5%*	6.1%*
	Last month	1.0%*	2.5%*	0.7%*	1.8%*
Scotland	Lifetime	1.0%*	12.0%*	4.0%*	10.0%*
	Last month	0.0%*	4.0%*	1.0%*	3.0%*
Wales	Lifetime	1.8%	14.2%	4.5%	13.5%
	Last month	0.5%	6.3%	2.6%	3.9%

Source: England, Scotland and Wales school surveys
Notes:
* 15 year olds only

Opiates
Reported lifetime prevalence of opiate use among British Crime Survey respondents was very low, at 1.1% overall. Heroin use remained stable, with an increase in methadone use. Trends in the use of opiates mirrored trends for the other drugs. Use was highest among the youngest age groups and among male respondents. Last month use of opiate drugs was negligible (0.3%) for all but the youngest respondents. Among males, 0.9% of those aged 16 to 24 reported opiate use in the last month, compared to 0.5% for females.

Among children, the England survey suggests that around 1% of 15 year olds had tried opiates sometime previously, compared to less than 0.5% for Scottish 15 year olds, and nearly 2% of Welsh 15-16 year olds.

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7. Conclusions

7.1 Consistency between indicators

The trend figures generated by the different data collection mechanisms used across the UK are broadly consistent. Where variance does occur this can be attributed to the different reporting conventions and/or regional variations in the impact of drug availability and use.

7.2 Implications for policy and interventions

There is growing recognition of the need for up to date information sources, and continuous data gathering exercises, for the success of drug policy. Efforts at enhancing and harmonizing data collection are ongoing.

7.3 Methodological limitations, evaluations of data quality, new information needs and priorities for future work

In relation to one harmonized indicator, based on the Regional Drug Misuse Database information, regional variations in reporting requirements and inconsistent reporting compliance continue to adversely effect data collection and interpretation. Shifts in drug use patterns and distribution flows, are also generating a need for new information sources. UK priorities for future work relate to the new targets in the EU Action Plan.

PART 3

DEMAND REDUCTION INTERVENTIONS

8. Strategies in Demand Reduction at National Level

Demand reduction activities in the UK fit within the four key areas of the UK Strategy. Although targeted towards achieving the aims of the national strategy, activities are usually co-ordinated at local level. The Strategy stresses a commitment to partnerships between various agencies, groups and government departments in planning and delivering activities.

9. Intervention Areas

9.1 Primary prevention

9.1.1 School programmes

Effective drug education in schools is being promoted through the Healthy Schools Standard, which was launched in October 1999, and the implementation of the Personal, Social and Health Education framework in all schools, also introduced in October 1999.

The UK Anti-Drugs Co-ordinator's second Annual Plan (July 2000) reports that 93% of secondary and 75% of primary schools have drug education policies, and that 95% of secondary schools have policies covering drug related incidents.

DPAS and DATs are supporting Local Education Authorities, schools and "Healthy Schools Partnerships" by providing information about local drug scenes and helping schools to develop programmes responsive to pupil needs and the local situation.

A number of pilot projects have been established to encourage links between Primary Care Groups and their local schools. Health Professionals support teachers in the delivery of health promotions messages, including drug prevention and education. Projects also cover a wide range of related information on smoking, alcohol and sexual health.

In Scotland, all schools are expected to provide pupils with appropriate drug education and to have a welfare policy for managing drug related incidents. To support schools strengthen provision and meet government requirements, a national School Drug Safety team will provide schools with up-to-date advice on drug education and managing drug related incidents in 1999-2000.

9.1.2 Youth programmes outside schools

Drug prevention projects, targeted at young people at particular risk of drug misuse, have been commissioned by 11 "Health Action Zones" in the UK.

These cover truants and school excludees, young offenders, young homeless people and children of drug misusing parents.

The government is working with Sport England and the Youth Justice Board to set up a range of projects under the “Positive Futures” initiative, which aims to divert vulnerable young people aged 10 to 16 years old into sport and healthy activities and away from drug misuse and antisocial activity.

9.1.3 Telephone help lines

The National Drugs Helpline is a service run by Healthwise under contract to the Department of Health. The service receives around 400,000 calls per year (calls are free) and distributes a range of health promotion materials free of charge.

9.1.4 Internet

The “Resource-Net” service, funded by Department of Health, was launched in October 1999. This internet service enables teachers, parents, voluntary groups and any other interested parties easy access to drug prevention materials. The service has been accessed approximately 65,000 times to date.

“LOCATE” is an internet based database of community activities for drug education and prevention.

9.2 Reduction of drug related harm

9.2.1 Prevention of infectious diseases, low threshold services and outreach

HIV has remained relatively stable and low in the UK throughout the 1990s (although variation exists between the different parts of the UK). This is thought to be due in large part to the introduction of harm reduction measures, such as the introduction of needle exchanges.

Needle exchange schemes and methadone maintenance programmes are not available in Northern Ireland, although this situation is being kept under review.

For further detail on drug related infectious diseases in the UK, see parts 2 and 4 of this report.

9.3 Treatment

9.3.1 Treatments and health care at National level

The UK Anti-Drugs Co-ordinator acknowledged in his First Annual Report that treatment for drug users works, but that the supply of effective treatment services is failing to meet demand. The UK strategy contains a firm commitment to improving the provision of drug treatment across the country, so that all drug users can access appropriate services as they need them.

The Home Secretary, Jack Straw, recently announced the creation of a national treatment agency. It is anticipated that the agency will be funded by the Home Office, Department of Health and local authorities. It will pool the money already spent by the NHS and local authorities on treatment services and the money spent by the Home Office on the testing and treatment of criminals.

The agency is still in the development stage, although it is anticipated that it will become operational in April 2001. Options that will be considered for the role of the agency will include:

- direct commissioning of rehabilitation places for offenders and non-offenders
- assessment of need and demand for residential places
- acting as a clearing house for bids for residential places
- setting quality standards for treatment
- inspecting agencies to ensure quality standards are maintained
- supplying management information systems.

9.3.2 Substitution and maintenance programmes

For a significant amount of detail on substitution treatment in the UK, please refer to the 1999 UK Annual Report.

9.4 After-care and re-integration

9.4.1 Education, Training, Employment and Housing

In its 1998 report *Drug Misuse and the Environment* the Advisory Council on the Misuse of Drugs (ACMD) drew attention to the importance of the wider environment in which drug misuse arises. The government have acknowledged the issues raised in the report, and all four UK strategies make

reference to social issues, education, housing, employment and stress the need for partnerships between agencies at local level.

Following the review of DAT functioning, the government decided to reorganise DATs and align them with local authority boundaries. It is hoped that this will improve the co-operation between DATs and local services such as housing, social services, education and environmental services. DATs are also to improve their links with Youth Offending Teams and local Crime and Disorder Partnerships.

The Scottish drug strategy emphasises the commitment to creating a more inclusive society across Scotland through a comprehensive and concerted programme of action tackling poor housing, high crime levels, high unemployment and the lack of leisure and recreational facilities.

A key feature of the Welsh strategy is integration and coordination. Action to tackle substance misuse in Wales should assume a key role in wider policy agendas such as social inclusion, economic development, public health and crime disorder.

9.5 Interventions in the Criminal Justice System

One of the government's key performance targets is to reduce levels of repeat offending amongst drug misusing offenders by 25% by 2005 and by 50% by 2008.

The comprehensive spending review for 1998 (see 1.4 for details) provided additional funding to increase the number of offenders referred to and engaging with treatment services. Arrest Referral Schemes will be operational in all police custody suites by 2002. As part of the introduction of this scheme, funds have been made available for police forces to invest, through DAT joint commissioning arrangements, to help ensure quick access to appropriate services for those in need identified through local arrest referral schemes.

The government has also introduced Drug Treatment and Testing Order (DTTO) schemes whereby courts can make an order requiring offenders to undergo treatments either as part of another community order or as a sentence in its own right. UKADCU estimate that the roll out of DTTO should result in the region of 3,425 orders being made by 2001. DPAS, in conjunction with Probation Services, will provide on-the-ground support for the national roll out of DTTO, disseminating practice findings from the pilot programmes and assisting DATs in developing appropriate commissioning arrangements locally.

10. Quality Assurance

10.1 Quality assurance procedures

The Department of Health funded SCODA and Alcohol Concern to develop "Quality in Alcohol and Drug Services" or QuADs. Following extensive consultation and piloting, a manual of standards has now been produced, and DrugScope are now providing support and training to drug and alcohol services to enable them to implement the standards.

The Department of Health also funded the Substance Misuse Advisory Service to produce standards for commissioners of drug and alcohol services "Commissioning Standards for Drug and Alcohol Services".

10.2 Research and Evaluation

Research and evaluation are key elements of the four strategies within the UK. In 1999/2000 the government announced a major new research programme funded mainly from a fund of £6 million over three years. This programme is managed from within the Research and Statistics Division of the Home Office, in partnership with UKADCU and other government departments via the Research and Information Group (RIG), which is a steering committee chaired by UKADCU. The primary aim of the research programme is to track the progress of the Strategy in terms of the key performance indicators.

Scotland is producing research strategy for drugs, which will support the implementation of the Drug Strategy. The core of this will be the annual drug misuse research programme, developed by a sub-committee of the Scottish Advisory Committee on Drug Misuse. The sub-committee will identify research priorities by reviewing existing work and by consulting DATs, the Information Strategy Team, local service providers and the research community. It is anticipated that the programme will focus on the effectiveness of drug misuse interventions and services, harmful behaviour and its consequences, drug education, and on work to augment current monitoring systems.

A Research and Information strategy has been in existence in Northern Ireland since 1996. A number of projects were commissioned under this strategy e.g. conferences and seminars on illicit drugs and young people, an evaluation of drug-related provision for young people 11-18 in the Western Health and Social Services Board area, and a review of literature on drug misuse among young people.

In support of the Northern Ireland Drug Strategy, a new information and research strategy is currently being developed. This will build on the work undertaken since 1996, aim to improve the knowledge and evidence base in Northern Ireland, and will be related to the four key aims contained within the strategy.

The National Treatment Outcome Research Study (NTORS) is the UK's largest follow up study of treatment outcomes for drug users. In 1995, the study recruited 1075 clients of drug services, and is tracking these drug users for a five year period. The study will provide information on the long term effectiveness of four treatment modalities: methadone maintenance programmes, methadone reduction programmes, residential rehabilitation programmes and specialist in-patient drug dependence units.

Various government departments also commission and manage research into drug issues as part of their departmental policy research programmes. For example, the following studies have recently been commissioned by the Department of Health:

The effectiveness and cost effectiveness of cognitive behaviour therapy for opiate misusers in methadone maintenance treatment: a multicentre, randomised control trial. Dr Colin Drummond, St George's Hospital Medical School.

Pilot UK Injectable Methadone Trial. Prof Gerry Stimson, Imperial College.

Dexamphetamine substitution as a treatment of amphetamine dependence: a two-centre randomised controlled pilot study. Dr John Merrill, Salford NHS Trust.

A national epidemiological study of dually diagnosed substance misuse and psychiatric disorders between 199301998, using the General Practice Research Database. Dr Martin Frischer, Keele University.

Co-morbidity in the National Psychiatric Morbidity Surveys. Dr Michael Farrell, Institute of Psychiatry.

Co-morbidity of substance misuse and mental health problems: a study of the prevalence and patterns of co-morbidity and the need for services amongst treatment populations. Mr Tim Weaver, Imperial College.

Dual Diagnosis in a Primary Care Group (100,000 population locality): a step by step epidemiological needs assessment and design of a training and service response model. Dr Geraldine Strathdee, Oxleas NHS Trust.

Waiting for Drug Treatment – Effects on uptake and immediate outcome. Dr Michael Donmall, University of Manchester.

Making Waiting Work: Impact of brief motivational interviewing during waiting period for drug treatmentDr Jan Mooring, Tameside and Glossop NHS Trust.

Randomised clinical trial of the effects of waiting time on a waiting list on clinical outcomes in opiate addicts awaiting outpatient treatment. Mr David Best, National Addiction Centre.

Meeting the needs of pre-teen drug misusers. Prof Neil McKeganey, University of Glasgow.

An evaluation of a brief intervention model for use with young non-injecting stimulant users. Dr John Marsden, National Addiction Centre.

The Psychosocial Consequences of Drug Misuse: A Systematic Review of Longitudinal Studies. Dr John Macleod, University of Birmingham.

Long term heavy cannabis use: patterns and problems. Mr Nial Coggans, Strathclyde University.

Wales: In Wales, a research and information strategy to support the implementation of the new substance misuse strategy will be developed. The research and information strategy will outline arrangements for the monitoring of progress against key performance targets, the handling of information and the generation of research studies.

10.3 Training for professionals

In 1999 the four UK government Health Departments published “Drug Misuse and Dependence – Guidelines on Clinical Management”. This document is a revision and expansion of the previous guidelines produced in 1991. Following on from this, a training package – Shared Care, Shared Learning – was produced by DrugScope, funded by the Department of Health, to assist primary care practitioners in implementing the guidelines.

A national drug counsellor recruitment campaign, jointly funded by the Department of Health and the Home Office, was launched to fill existing vacancies and to expand treatment capacity. The aim was to bring between 300-600 new workers into services and provide their initial training.

PART 4

KEY ISSUES

12. Drug Strategies in European Union Member States

12.1 National policies and strategies

The UK drug strategy 'Tackling Drugs to Build a Better Britain' was published in 1998. This serves as the drug strategy for England, and also as a framework for the Scotland, Wales and Northern Ireland strategies.

The key themes of each of these strategies are contained in Part 1 of this report.

12.2 Application of national strategies and policies

Local delivery of the strategy throughout the UK is co-ordinated by Drug Action Teams (DATs). DATs bring together agencies such as health authorities, local authorities, local education authorities, social services, police and probation services.

DATs report on an annual basis to the UK Anti Drugs Co-ordinator on their achievements towards the strategy's goals and their plans for the forthcoming year. Most DATs have adapted the key performance targets under the four aims of the strategy to suit local circumstances.

Following a recent review, DATs are to be increased in number from 112 to 150, with a proportionate increase in central funding, to ensure that they are co-terminous with local authority boundaries.

The Home Office Drugs Prevention Advisory Service (DPAS) is the link between local delivery of the strategy and central government. DPAS provides advice and support to DATs on all aspects of the strategy, and is also responsible for disseminating good practice.

In Scotland, the Scottish Drug Enforcement Agency (SDEA) has been established in support of the strategy. This will provide a strategic focus for the activities of the Scottish Crime Squad, the National Criminal Intelligence Service (NCIS) and HM Customs and Excise (HMCE). It is also envisaged that the SDEA will co-ordinate the work of the aforementioned agencies with that of police force drug squads and assist with co-operation between law enforcement agencies in Scotland and other parts of the UK.

Scotland has also recently formed a Prevention and Effectiveness Unit within the Public Health Policy Unit of the Scottish Executive to advise on what is and is not working and to disseminate examples of good practice.

In Northern Ireland responsibility for co-ordinating action to implement the strategy is with the Northern Ireland Department for Health, Social Services and Public Safety (DHSS&PS) whilst responsibility for law enforcement issues lies within the Northern Ireland Office.

In Wales, the National Assembly for Wales has devolved responsibility in the fields of health, social care and education and, within this context, exercises functions related to treatment and prevention of drug users. Legal and Enforcement responsibilities remain with central government.

12.3 Evaluation of national strategies

The day-to-day co-ordination and monitoring of the UK Strategy is delivered through a number of cross-departmental working groups, which will report to a newly established Strategic Planning Board. The Board contains representatives from all the key government departments responsible for tackling drugs i.e. Home Office, Department of Health, HM Customs & Excise, Foreign and Commonwealth Office, Department for Education and Employment and the Cabinet Office.

Under the four key aims of the strategy, the government has set key performance targets and a range of performance indicators to measure progress towards those targets. Details of progress and achievements to date will be included in the UK Anti-Drugs Co-ordinator's 2nd Annual Report, which will be published in Autumn 2000.

Scotland, Wales and Northern Ireland are currently developing targets and monitoring arrangements in support of their strategies.

13 Cocaine and base/crack cocaine

13.1 Different patterns and user groups

The latest figures (1999) from the British Crime Survey (BCS) conducted in 1998 reveal a 'significant' increase in all the indicators for cocaine use in the UK. Of those drugs defined by the BCS as 'highly addictive', cocaine is the most widely used with 6% of 16-29 year olds saying they have tried it. The figure for the heroin and crack cocaine in the same age range is only 1%.

One of the key factors in the increase may be price. Traditionally cocaine use has been associated with a 'champagne lifestyle', an expensive drug used mainly by those with significant amount of disposal income. Cocaine retains its image, but has been become affordable for many of those who use drugs on a recreational or regular basis, especially in London and the surrounding area.

13.2 Problems and need for services

Cocaine is specifically named in the UK government's strategy along with heroin, whose use the government aims to reduce among young people under 25.

Stereotypically, cocaine has been regarded as the drug of the wealthy white; crack the drug of the poor black. However, both versions of the drug are used across the whole of the drug-using community, although the information is often largely anecdotal.

There are various problems associated with determining the patterns and prevalence of cocaine.

1. Despite the fall in price, cocaine is still a relatively expensive drug: the effects of one dose or line of cocaine wears off in around twenty minutes. This means that most drug users will only use the drug occasionally, not have any real problems with it and so not come to the attention of researchers accessing clients in treatment agencies.
2. Those with a substantial cocaine problem are likely to be among the wealthier groups in society and so will opt for private treatment, again out of the reach of researchers.
3. For those from the ethnic minority and black communities with any drug problems, there is a pre-existing reluctance to come forward to mainstream drug agencies
4. This is exacerbated where cocaine is concerned both for them and the white majority of users, by the fact that excessive use of cocaine powder or crack precipitates paranoia and a further reluctance to come forward for treatment for fear of engaging with the state.
5. Finally there is no pharmaceutical 'carrot' to encourage users to come forward for treatment as there is for heroin users prescribed methadone.

The latest figures for cocaine use are cited in the BCS above. Surveys among schoolchildren reveal very low incidence of cocaine use, but among those frequenting clubs, the prevalence of use is much higher than the average for BCS and other general population household surveys – perhaps a quarter of those attending clubs having tried the drug at least once.

Statistics from the Department of Health Regional Drug Misuse Databases reveal that of those coming forward for drug treatment, around 6% are problem users with cocaine as their main drug, a figure which has increased slightly from 4% in 1996. The percentage figures for the number of people presenting for treatment in Great Britain who reported that cocaine was one of their drugs of misuse are 18% (six month period ending 30 September 1999) and 13% (six month period ending 31 March 1996).

Neither tolerance nor heroin-like withdrawal symptoms are recognised in chronic cocaine or crack use. However, this is a narrow definition of drug dependence. The tiredness and depression experienced after stopping the

drug, although not medically serious may have a similar effect as a withdrawal syndrome in encouraging further use and dependence, particularly as the feeling of depression goes away when drug use is resumed.

Even if cocaine is not physically addictive, a strong psychological dependence on the good feelings experienced by using cocaine can develop with all the accompanying physical and mental problems of long-term use described above.

As far as crack is concerned, claims have been made that, unlike cocaine, it is instantly addictive making occasional or intermittent use impossible. Certainly, crack appears to induce an intense craving in some users which can rapidly develop into a 'binge' pattern of drug use continuing for hours or even days until supplies of the drug, the money to buy it or the users themselves are exhausted. As long ago as 1980, even the literature of America's drug subculture warned about the seductive powers of smoking cocaine. However, studies of people who have ever used crack show that nowhere near all go on to daily, dependent use and that when this happens it usually takes a few months. To become a dependent user of cocaine hydrochloride would usually take longer. For both crack and cocaine there is no inevitability. Whether people become dependent, and if so how quickly it happens, will vary depending on the individual user's mental state and circumstances.

13.3 Market

13.3.1 Price/purity at users' level

In recent years the street price of a gram of cocaine has varied from about £40 to £100 with the late 1990s seeing a fall in price towards the lower figure. A single 'rock' of crack can sell for £5 to £30, partly depending on size. Gram for gram crack may be no less expensive than cocaine hydrochloride powder and in some areas may even be more expensive. However, there is some evidence that crack is broken down into smaller units by users, although not necessarily for resale.

The average purity for cocaine powder is usually between 40-60 %. Crack can be anywhere between 80 -100 % pure. It used to be thought that the purity of the crack was determined by the purity of the original cocaine powder prior to 'processing'. This does seem to be the case - very pure crack can be obtained from powders of varying purity.

13.3.2 Availability

The latest figures from the Home Office (for 1998) show that:

the amount of cocaine seized including crack rose by 25% over the previous year

the number of cocaine offenders excluding crack rose by 32% over the previous year

Customs seized more cocaine that heroin – continuing the trend started in 1990

13.3.3 Trafficking, dealing, supply routes etc

Cocaine powder and crack cocaine are widely available in the UK's main urban and inner-city areas, although crack is more closely associated with more confined areas of poverty and deprivation. Within these areas, crack dealing may be quite open. It is also reported that the use of mobile phones has created a new generation of dealers willing to 'home deliver' drugs.

Previously most cocaine destined to be processed into crack came in small quantities of one or two kilos brought in from the West Indies or east coast of the USA, often by female 'mules'. More recently, much larger consignments of cocaine from the traditional producer areas have been processed into crack and in some areas cocaine powder is sometimes harder to come by.

UK research into crack dealing published in 1995 demonstrated that the networks had become organised into distinct areas and sites suggesting cocaine use among a broader sector of the drug using population than in previous years.

Traditionally shipments of cocaine have reached the UK direct from the main coca cultivator, Colombia with Panama, Brazil, Argentina, Venezuela and the Caribbean as the main exit points. In recent years Colombia has overtaken Bolivia and Peru for both cultivation and production. However, new routes for cocaine have opened up in southern and West Africa. Increased seizures in the Balkans and Eastern Europe indicate that these too, are transit regions for the passage of cocaine into western Europe.

13.4 Intervention projects

Providing adequate helping services for dependent cocaine and crack users has proved as problematic as for users of other stimulants such as amphetamines. A vast amount of research and clinical trials in America have failed to come up with effective treatment methods. Trials of substitute drugs have proved ineffective and cocaine and crack users know that they are very unlikely to be offered any substitute drugs (other than possibly tranquillisers or antidepressants) from a drug agency or doctor.

There are also other reasons that few cocaine and crack users present to agencies. Agencies are more used to dealing with more 'compliant' heroin users and often not equipped to deal with more demanding users. Crack users often want immediate help at any time of the day or night and may expect the same kind of instant service they get from a dealer. As paranoia is

a frequent consequence of long-term use, this may discourage users from revealing their problems to any 'authority'. Black users may not feel comfortable attending what are primarily white drug agencies. A few specialist agencies have been set up in inner city areas to support crack users but have only met with limited success.

Cocaine users may see themselves as a class apart and not wish to be associated with heroin 'junkies' and traditional drug agencies. Wealthy users are more likely to go private, although even these agencies do not see that many primary cocaine users for treatment.

Apart from the few specialist street agencies and the rehabilitation facilities, there is a self-help group which follows the Narcotics Anonymous Model – and also a national forum for those professionals specialising in working with cocaine and crack users.

14 Infectious diseases

14.1 Prevalence and incidence of HCV, HBV and HIV among drug users

The UK has not seen a major epidemic of HIV infection among injectors that was anticipated in the mid-1980s. Various studies suggest that prevalence of HIV in England and Wales has remained relatively stable and low throughout the 1990s. Data published in the Communicable Diseases Report, indicates a total of 3608 cases of HIV infections probably acquired through injecting drug use (DoH 2000b). The available data suggests that a considerable proportion of these infections (32%, 262/817) were contracted abroad, as infections in the UK have been falling since 1986. This has been attributed to the swift introduction of harm reduction interventions, such as needle exchange, when prevalence was low.

The latest results of two independent surveys of the prevalence of antibodies to HCV (anti-HCV) among injecting drug users recruited from multiple drug agencies and community settings in England and Wales suggest an overall prevalence of 38% (Hope et al 2000). There was a clear and strong relationship between HCV prevalence and years of injecting, with prevalence rising from 7% among those injecting for 0 to two years, to nearly 30% for those injecting for 6 to 8 years, and just over 60% among injectors who have been injecting for 15 years or more.

A similar prevalence of anti-HCV of 31% was found among IDUs in prisons in England and Wales in 1997/8 (Weild et al 2000)

An overall estimated prevalence of anti-HCV of 71% was detected among IDUs recruited from treatment and community settings in Glasgow between 1990 and 1994, and also 1996. However, a similar relationship was found between prevalence of anti-HCV and length of injecting career as in England and Wales, with only 31% of those injecting after 1992 (following the full establishment of the city's needle exchange) having salivary antibodies in Glasgow (Taylor et al 2000).

These findings suggest that in England and Wales infection with HCV is not inevitable, and also that HCV is not acquired early on in an injector's career, contrary to the situation in other countries. This means that there is a potentially long window of opportunity for prevention at different stages in an injector's career.

A national community survey of the sharing behaviour of injectors in England in 1998 found that half of all respondents reported sharing needles and syringes, and three quarters had shared injecting paraphernalia, in the preceding four weeks (Hunter et al 2000).

However, injectors reported a median of only two sharing partners, and only 16% reported frequent sharing of needles. This may signify and change in risk behaviour - that people are sharing with fewer people and less frequently than before. But the results need corroboration with other studies assessing sharing and risk behaviour in more detail.

14.2 Determinants and consequences

Encouraging changes in injecting risk behaviour has been the key focus of UK HIV prevention strategies. Considerable research evidence suggests that injectors have modified their injecting risk behaviour (Hunter et al 2000). These results lead to optimism about the prevention of blood borne infection among injecting drug users.

A recent survey of syringe exchange provision in the UK suggested that in 1997 an estimated 2,320,000 syringes were distributed by approximately 2,300 outlets in England, Scotland and Wales (J Parsons, personal communication).
No syringe exchanges in Northern Ireland were identified. Syringe exchanges distributed large numbers of syringes and are probably in contact with more injecting drug users than any other intervention.

Transmission of the hepatitis B virus (HBV) continues to be a problem among injectors in England and Wales. Reports to the Public Health Laboratory Service of acute infection with HBV, attributed to injecting drug use, have nearly tripled between the early 1990s and 1996. In contrast, reports attributed to other exposure categories have remained stable or decreased.

Transmission of HBV is still occurring despite the existence of the hepatitis B vaccine, which was first licensed in the UK nearly two decades ago, in 1982, and which is considered both safe and effective. A recent national survey of injectors found that less than 30 % of respondents reported that they had been vaccinated against HBV, and of these, only half reported having been given the optimal dose of three jabs. Over half of the injectors surveyed were both unvaccinated and had not been exposed to hepatitis B in the past, and so they were still susceptible to infection (Lamagni et al 1999). The low level of coverage probably reflects the practical problems of vaccinating injecting drug users. Drug users are unlikely to maintain regular contact with treatment agencies if they are not receiving methadone and this makes completion of a full course of three vaccine doses difficult.

14.3 New developments and uptake of harm reduction

The government recently announced funding to establish new hepatitis B immunisation programmes.

One such programme for injecting drug users in Manchester was established in four needle exchange sites within the city in its pilot phase. The programme resulted in the improved uptake of immunisation of individuals identified at high risk of Hepatitis B and has since been extended throughout Manchester. The programme has also contributed to the further integration of needle exchange and drug services with primary care services and provided training and development for the nursing and administrative staff involved in the programme.

The Scottish Centre for Infection and Environmental Health (SCIEH) have conducted surveys of the prevalence of bloodborne viruses among injecting drug users from treatment and community settings throughout the 1990s. The centre has recently been awarded a research grant from the Scottish Executive to conduct a new cross-sectional survey of prevalence of HCV among injecting drug users in Glasgow.

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