REPORT TO THE EMCDDA

by the Reitox National Focal Point

UNITED KINGDOM

DRUG SITUATION 2001

REITOX

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INTRODUCTION

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

This report contains information on the situation in the United Kingdom up to 2002. In due course, some of this information will be selected for inclusion in the EMCDDA's *Annual report on the state of the drugs problem in the European Union 2003.* The EMCDDA's report for 2003 contains information collated in 2001 and 2002. The format is common to all national focal points in the European Union.

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

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SUMMARY: MAIN TRENDS AND DEVELOPMENTS

PART 1 NATIONAL STRATEGIES: INSTITUTIONAL AND LEGAL FRAMEWORKS

1 Developments in Drug Policy and Responses

1.1 Political Framework in the Drug field

1.1 (a) Objectives and priorities at national level

In April 1998 the UK Government launched its 10-year anti-drugs strategy, 'Tackling Drugs to Build a Better Britain' for the UK and England. The strategy has four main elements:

1. Young People – to help young people resist drug misuse
   Key objective: to reduce the proportion of people under 25 reporting the use of illegal drugs.
   Key target: to halve the numbers of young people using Class A drugs by 2008.
2. Communities – to protect communities from drug-related anti-social and criminal behaviour.
   Key objective: to reduce levels of repeat offending among drug misusing offenders.
   Key target: to halve the levels of re-offending by drug misusing offenders by 2008.
3. Treatment – to enable people with drug problems to overcome them.
   Key objective: to increase participation of problem drug misusers, including prisoners, in drug treatment programmes.
   Key target: to double the number of drug misusers in treatment by 2008.
4. Availability – to stifle the availability of illegal drugs on the streets.
   Key objective: to reduce access to drugs among 5 to 16 year olds
   Key target: to halve the availability of Class A drugs in the UK by 2008.

(UK Anti-Drugs Co-ordinator, First Annual Report and National Plan, 1999)

A review of the drugs strategy took place in 2002. This review, by the Drugs Strategy Directorate, took into consideration the recommendations of the Home Affairs Select Committee. An updated strategy and associated targets will be published when the current Spending Review has been concluded and further consultations made. In response to the Home Affairs Select Committee report the Home Secretary, David Blunkett, announced that the top priority was to tackle Class A drugs and problem users. More money was allocated for treatment in the next three years and emphasis was placed on the need for harm minimisation.

Scottish Strategy
The Scottish anti-drug strategy 'Tackling Drugs in Scotland: Action in Partnership' (May 1999) has the same four key aims as the UK strategy. The key objectives and targets under each strategy differ, however, to that of the UK strategy. See http://www.scotland.gov.uk/library2/doc15/dap-00.asp

Northern Ireland Strategy
Northern Ireland's Drug Strategy (1999) is also based on the four key aims of the UK strategy. In May 2001 the Northern Ireland Executive endorsed the model for the Joint Implementation of the Drug and Alcohol Strategies. Through this model both strategies will proceed together. A Ministerial Group provides a strategic focus, at an official level the Drugs and Alcohol Implementation Steering Group review progress and ensure a co-ordinated approach. Six working groups have been established to develop action in specific area. These include Communities, Treatment, Education and Prevention, Information and Research, Social Legislation and Criminal Justice. These groups comprise relevant representatives from all sectors including the statutory and voluntary/community sectors. A Drug and Alcohol Information Research Unit has been established to develop baselines from which performance against the targets set in both strategies can be more accurately measured.

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

1.1 (b) <u>New initiatives and major changes in political approach (e.g. public position taken by a minister, plan of actions, political note, etc.)</u>

In October 2001, Home Secretary asked the Advisory Council on the Misuse of Drugs (ACMD) to review the classification of cannabis preparations in the light of current scientific evidence. The subsequent report from ACMD recommended that cannabis and cannabis resin should be transferred from Class B to Class C. At the same time, Class A cannabinols should also be transferred to Class C. Drugs in Class C are considered to be the least harmful controlled drugs and include anabolic steroids and benzodiazepines. No changes were recommended to the classification of cannabis preparation under the Misuse of Drugs Regulations. The intention is that cannabis should remain in Schedule 1, which includes those substances not normally permitted for medical use.

In July 2002, the Home Secretary accepted these recommendations, which also echoed the findings of a report of the Home Affairs Select Committee (HASC), an earlier report from the Independent Inquiry into the Misuse of Drugs Act (The Runciman Report) and had the support of the Association of Chief Police Officers (ACPO). In conjunction with reclassification, Parliament will also be asked to change the law so that police will have the powers of arrest for the possession of Class C drugs.

The HASC and the Runciman reports (see above) also recommended that the 'ecstasy' drug should be reclassified from Class A to Class B. The Government did not accept these recommendations stating that "Ecstasy can and does, kill unpredictably". Some support from the Government's position was published in August 2002 showing that deaths from 'ecstasy' (principally MDMA) in the UK reached a record level in 2001(see section 3.2).

The Government published its White Paper 'Justice for All', on the reform of the Criminal Justice System. Part of this reform proposes to make 'Caution Plus' a national scheme. Caution Plus acts as an alternative to being charged with a minor offence and in drugs and alcohol cases an opportunity will be provided to undergo treatment.

Also as part of this reform the Government are considering the introduction of a greater degree of specialization within the criminal court system which will cover certain types of crime including those involving drugs. This strategy included developing DTTOs to increase judicial involvement in supervising the requirement of an offender to take part in the treatment programme, or a programme to prevent re-offending. They will also consider ways in which the DTTO framework might be adapted to deal with more offenders whose drug habits have contributed to their offending.

There is a commitment within the White Paper by the Government to get probation and prison services to work more closely together to ensure that aftercare is improved. This commitment was developed on the basis of the Social Exclusion Unit's report on ex-offenders in which it concluded that aftercare for those in prison with drug problems rarely existed.

There is also an intention to extend the drug testing provisions of the Criminal Justice and Court Service Act 2000 to the under 18s, providing a procedure for parental or appropriate adult consent. It is also proposed to add further offences such as 'handling stolen goods' to the list of 'trigger offences' (which currently include theft, burglary and drug offences in respect of specified Class A drugs).

1.1 (c) Coordination policies (such as new or modified coordination bodies and agencies, existent and/or planned)

Ministers have agreed to integrate more fully the Home Office role in Government Offices (GO) at regional level. Following on from the integration of the Crime Reduction Teams in June 2002, DPAS teams will be fully integrated into the structure of the GO along with other Home Office interests such as Race, Community Cohesion and Family Policy.

A White Paper on Policing Reform, 'Policing a new century: A blueprint for reform', suggests a merger of Crime Disorder Reduction Partnerships (CDRPs) and Drug Action Teams (DATs) to create a single body. During 2002 an implementation group created by the Home Office will consider ways that CDRPs and DATs can work more effectively together. Ministers will be looking for draft guidance for their consideration by August 2002 with a view to publication in September 2002. Following the introduction of the Communities Against Drugs Initiative it is hoped that the merger of these two partnerships with overlapping aims, interests and membership, will produce synergies.

In 2001, the Government also set up a Special Health Authority within the NHS, the National Treatment Agency, to increase the availability, capacity and effectiveness of drug treatment in England. The commissioning and delivery of high quality effective drug treatment for drug misusers is fundamental to the success of the Government's drug strategy. See http://www.nta.nhs.uk/

1.2 Legal Framework

1.2 (a) Major changes in laws and regulations existent and/or planned in the field of drug demand, supply, precursors and drugs related money laundering concerning:

- Penal laws

- Administrative laws

- New substances under control in the reporting year

A Modification Order to the Misuse of Drugs Act that was issued in 2001 and came into force on 1st February 2002. This added 35 phenethylamine derivatives to Class A and a further phenethylamine derivative to Class B. All of these drugs could be described as 'new synthetic drugs' and most are chemical relations of the 'ecstasy' drugs. Although the Act already includes a generic definition of MDMA-like substances, none of the additional drugs falls within the definition and are therefore set out by name in the Modification Order.

Following decisions made by the United Nations to add further substances to the Schedules of the International Drug Conventions, the Government set out proposals in early 2002 for gammahydroxy butyrate and zolpidem to be added to Class C and for dihydroetorphine and remifentanil to be added to Class A. At the same time it was proposed that four additional anabolic steroids should be added to Class C, namely:

4-Androstene-3,17-dione
19-Nor-4-Androstene-3,17-dione,
5-Androstene-3,17-diol
19-Nor-5-Androstene-3,17-diol

A revised version of the Misuse of Drugs Regulations came into effect on 1st February 2002. One of the major changes was that all benzodiazepine drugs listed in the Act would now be subject to a possession offence. Previously, most benzodiazepines, when in the form of a medicinal preparation, had been exempted from the offence of possession. The change was a consequence of earlier decisions by the United Nations concerning the import and export restrictions on the trade in these drugs.

- Relevant directives or guidelines

In April 2002, the Government issued a 'safer clubbing' guide to club owners with information on harm reduction measures in an attempt to reduce drug-related deaths.

The brochure, aimed at club managers, licensing authorities and promoters includes tips on how to prevent drugs being brought into and used in clubs as well as emphasizing that the licensing authorities need to ensure that clubs: provide adequate supplies of drinking water, prevent overcrowding, ensure proper air conditioning and ventilation, prevent overheating and maintain venues complying with health and safety regulations. The guide implies that those who do not follow this guidance will not retain their licence.

Available at
http://www.drugs.gov.uk/ReportsandPublications/Communities/safer_clubbing.PDF

The Government has published new guidelines entitled 'Tackling Drug Use in Rented Housing' designed to crack down on drug dealing in England's housing estates. The guidelines provide advice on how police and local authorities can work together, what physical improvements can be made and how social landlords should deal with tenants with drug problems and aims to make it easier for police and local authorities to take swift action to deal with drug dealers. Available at
http://www.drugs.gov.uk/ReportsandPublications/Communities/Housing.pdf

In March 2002, the British Medical Association called for drug driving tests to be issued. Driving while unfit under the influence of drugs is an offence and the penalties are the same as for those who drive under the influence of alcohol. However, there is currently no legal limit for drugs and there are no drug testing devices that can effectively prove driving impairment due to drugs. This makes enforcing the legislation extremely difficult. For more information
http://www.bma.org.uk/ap.nsf/Content/__hub+science+drug+driving

1.2 (b) Legal framework in the demand reduction field: prevention, treatment and harm reduction (especially focus on substitution treatment, after-care and reintegration, injecting rooms, pill-testing, etc)

Section 38 of the Criminal Justice and Police Act 2001 amends section 8(d) of the Misuse of Drugs Act 1971 to read 'administering or using a controlled drug which is unlawfully in any person's possession at or immediately before the time when it is administered or used.' Section 8(d) was previously only concerned with 'smoking cannabis, cannabis resin or prepared opium'.

Section 8 of the Misuse of Drugs Act is concerned with occupiers and managers of premises where certain drug offences may take place. The above change could have major implications for those working in treatment agencies and it is expected that that part of the Criminal Justice and Police Act 2001 will not come into force until suitable guidelines have been established.

1.2 (c) Any other important project of law, parliament, government initiative

The provisions of sections 33 to 37 of the Criminal Justice and Police Act 2001 came fully into force on 1 April 2002. Among other things, the provisions enable the courts – as part of their sentencing – to impose travel restriction orders on certain drug trafficking offenders and to confiscate the passports of those who are British nationals for the period of the travel ban. The related Travel Restriction Order (Prescribed Removal Powers) Order 2002 (S.I. 2002/313) also came into force on 1 April 2002. It lists those statutory powers to order or direct the removal of a person from the United Kingdom, which supersede the provisions of a travel restriction order.

The first drug court in Scotland was introduced in Glasgow in November 2001. The aim of the drug court was to break the vicious cycle of crime and drug-dependency. The courts specialize in dealing with drug-dependent offenders and offer them the opportunity to participate, if they are ready, in a rigorous programme of testing and treatment.

The courts have now been judged a success by Scottish Executive Ministers. Since the court has been running it has heard more than 60 cases and imposed 33 DTTOs. The court hopes to hear more than 150 cases a year. Furthermore, since the court began there has been an increase in the number of DTTOs imposed throughout the city

The Executive commissioned research which was carried out by Stirling University to evaluate the success of the DTTOs over this period. The evaluation is due to be published in autumn 2002.

The report shows that after six months on a DTTO programme, an offender had reduced his/her habit by almost 90 per cent. Offenders reported a marked reduction in drug use and drug related offending since being placed on a DTTO, spending an average £57 (€ 89) a week on drugs six months into a DTTO, compared to £490 (€ 769) a week before being given an order

The cost to the local community (Glasgow) from stolen property alone is estimated at more than £3 million (€ 4.7m) a year. Each offender costs society £31,200 (€ 48,984) a year in costs of stolen property.

The average cost of a 12 month DTTO was £7992 (€ 12,547) compared to the estimated cost of a six month prison sentence in 1999/00 at £14,187 (€ 22,274)

A second drug court pilot will be introduced in summer 2002 in Fife and if these prove successful Ministers will look at extending them to other parts of Scotland. See http://www.scotland.gov.uk/pages/news/2002/05/SEJD039.aspx

Arrest Referral Schemes, partnership initiatives between the police, local drug services and DATs/DAATS, are used at the point of arrest within custody suites as an opportunity for independent drug workers to engage with problem drug using offenders and help them access treatment. The schemes work on a completely voluntary basis. If an arrestee agrees to meet with an independent drug worker this does not have a bearing on how the police deal with the arrestee in terms of whether their case is proceeded with.

The Home Office established a three-year monitoring programme of research to monitor and evaluate the arrest referral scheme which is due to be completed in Spring 2003,

but research published by the Home Office in Summer 2002 shows that the scheme has so far been effective in targeting problematic drug users and it reduces their level of re-offending.

Over half of all problem drug-using offenders screened had never had a previous treatment episode. Of the 48,810 individuals screened between October 2000 and September 2001 in England and Wales, over half were voluntarily referred to a specialist drug treatment service. Of those referred, 5,520 made a demand for treatment (Sondhi et al., 2002b)

Evidence also suggested that the level of police re-arrest rates significantly declined six months after contact with an arrest referral worker compared to the six months prior to the contact. Self reported drug use fell, as did reductions in the amounts spent on drug use and in levels of injecting in the six month follow-up. Self –reported follow-up interviews also identified substantial and statistically significant reductions in offending (Sondhi et al., 2002a).

The research further identified key groups of problem drug using offending that did not engage with specialist drug treatment services following referral. These are Black and Asian problem drug using offenders; older (aged 31 or over) heroin and crack users with extensive prison and treatment histories and young, male crack using street robbers. Female crack using sex workers were identified as a group who may benefit from treatment but often did not get referred (Sondhi et al., 2002a).

The Lambeth policing experiment is an operational policing matter. From 1 August 2002, the Metropolitan Police amended the scheme to bring it into line with the emerging national policing model for cannabis. As at September 2002 the police enforcement model is subject to consultation within police service. At the ACPO Council new policing guidelines will be agreed on in due course.
The main features are:

- for adults, most cannabis possession offences would be dealt with by way of a warning on the street, together with confiscation of the drug;

- for subsequent offending occasions, an officer would give a second warning, then a caution, and then would report for court summons (this aspect has been widely reported in the media as “three strikes and you're out”);

- some or all of these stages could be bypassed where there are aggravating circumstances;

- the police would retain the power of arrest, to be used in exceptional cases (e.g. person blowing smoke in the face of an officer);

- young persons would be dealt with under the final warning scheme under the Crime and Disorder Act 1998. This would necessitate arresting the offender in most cases, in order to administer a reprimand/final warning at the police station. But the process is under review.

1.3 Laws Implementation

1.3(a) Implementation of law

The Proceeds of Crime Bill became an Act in 2002. The Bill set up an Assets Recovery Agency and under the new legislation police and customs officers are granted the power to seize and search for money. The Act contains measures that will assist investigators in tracing the proceeds of crime and investigate money laundering. For more information see http://www.homeoffice.gov.uk/proceeds/index.htm

1.3(b) Prosecution policy: change in priorities and objectives in relation to drug users, offenders and drug-related crime.

The drug testing pilot programme, introduced in 3 sites in 2001, under the provisions of the Criminal Justice and Court Services Act 2000 was extended in Summer 2002 to a further 6 sites. The provisions include the power to take samples for testing for specified Class A drugs (heroin and cocaine/crack) from persons in police detention, aged 18 and over, charged with a “trigger offence” (mainly acquisitive crime offences and drug offences involving specified Class A drugs). Those who test positive are offered the opportunity to see an arrest referral worker for an assessment for treatment and the drug test results are made available to the courts to assist with bail and sentencing decisions.

The provisions also allow for testing as part of a new community sentence – the Drug Abstinence Order – or as part of a Drug Abstinence Requirement which can be attached to a community order; or as a condition of release on licence or notice of supervision.

A preliminary interim evaluation report confirmed that it is too early to detect any impact of drug testing on drug misuse or offending (Mallender et al 2002). A second interim evaluation report, which will outline outcomes from the pilots, is due in Spring 2003.

1.4 Developments in Public Attitudes and Debates

1.4(a) Public perception of drug issues: main results from surveys

The July 2001 Guardian/ICM poll showed two out of three people in Britain agreed that police should not make the prosecution for possession of cannabis a priority compared to street robbers, burglars, heroin users and car thieves. 18% believe that personal use of cannabis should remain a criminal act with typical penalties as a caution or fine. 27% believe the personal use of cannabis should remain illegal but should not be a prosecution priority. 37% say cannabis should be legalized now. Opposition was strongest among the over-65's (Travis, 2001a)

A Guardian/ICM poll in October 2001 found that 54% approved of David Blunkett's decision to reclassify cannabis from Class B to Class C. Support for the proposal rose to 65% among 25-34 year olds. 82% opposed the reclassification of ecstasy to Class B and only 15% of the 18-24 age group favoured the reclassification (Travis, 2001b)

In contrast, a Guardian/ICM poll conducted in July 2002 showed that 53% of all British adults oppose the reclassification of cannabis as a less harmful drug, while 38% support the move. Opposition was found to be strongest amongst older people with 75% of the over 65s and 54% of 35-64 year olds opposing the policy. Young people backed the new approach with 54% of 18-24 year olds and 55% of 25-34 year olds approving the change.

70% of Conservative voters were against the new proposals while 26% were for it and with regard to Labour voters 46% were for the policy and 45% were against (Travis, 2002)

In Scotland, a phone poll conducted by Evening News found 79% of those who voted were in favour of a cannabis café and only 21% objected (Smith, 2001).

1.4 (b) Orientations of the main public debates in civil society, national Parliament, organizations, NGO's

1.4(c) Media presentation and imaging drug use

1.5 Budgets and Funding Arrangements (2001)

1.5 (a) Funding directly related to drug issues at national, regional and local level

Exchange rate = 1.57
See section 1.5b below

The Scottish Executive is providing extra funding for anti-drugs activity in support of implementation of the strategy. Since coming into office the Executive has committed

funding of over £27 million (€ 42.4m) to new anti-drugs initiatives, including over £14 million (€ 22m) for treatment and prevention.

1.3 (b) Drugs Direct Funding at national level in the following fields:

- Law enforcement (police, customs, justice, custodial)

The Government will spend £220m (€ 345.4m) over 3 years for police and communities in England and Wales to focus on reducing drug-related crime. £50m (€ 78.5m) will be given to accelerate the drug testing programme within criminal justice scheme.

The Scottish Executive is providing £10 million (€ 15.7m) to establish the Scottish Drug Enforcement Agency; £3.1 million (€ 4.9m) over the next three years to expand the drug testing and treatment order pilots and help offenders break their dependency before re-entering society and £4.8 million (€ 7.5m) for intensive probation and diversion from prosecution schemes. http://www.scotland.gov.uk/library2/doc15/dap-01.asp

- Social and health care (treatment, prevention, etc)

In response to the Home Affairs Select Committee Report, the Government announced that more money was to be allocated for treatment over the next three years - £40m (€ 62.8m) in 2003/4, £45m (€ 70.7m) in 2004/5 and £98m (€ 153.9) in 2005/6.

The Government will provide £15m (€ 23.6) over 3 years to help DATs work effectively in their local communities and £5m (€ 7.9m) over 2 years to increase involvement of sport stars as role models and developing 'Positive Futures'.

The Government has provided an extra £712 million (€1117.8m) for tackling drugs for 2001-2004 and the 2001 budget allocated more than £200 million (€ 314m) to support drug prevention work in local community partnerships. The 2001 budget allocated £40million (€ 62.8m) to the Employment Service to help benefit claimants whose drug problems may be preventing them getting work and £1 million (€ 1.6m) has been allocated to support a major initiative to tackle drug problems in minority ethnic communities. http://www.neighbourhood.gov.uk/formatteddoc.asp?id=231

The Scottish Executive is providing £6m (€ 9.4m) for treatment services over 3 year period; £1m (€ 1.6m) to double the annual support for DATs in recognition of their increased responsibility under the strategy; £2m (€ 3.1m) to fund work in communities to tackle drug misuse through Social Inclusion Partnerships in collaboration with DATs; £1m (€ 1.6m) for Scotland Against Drugs to increase existing community and business work and £300,000 (€ 471,000) has been allocated for annual funding of specialist Prevention and Effectiveness Unit within the Public health Policy Unit of Executive. http://www.scotland.gov.uk/library2/doc15/dap-01.asp

- Research (studies, surveys)

Table 1: Estimated total current expenditure on drugs research by Government Departments

Department	Cost (£)	%
Home Office	4,386,492 (€ 6,886,792)	30%
Dept of Health	3,741,854 (€ 5,874,711)	26%

NHS plus	1,962,239 (€ 3,050,715)	13%
Scottish Executive	3,330,759 (€ 5,229,292)	23%
DETR	770,000 (€ 1,208,900)	5%
Northern Ireland Assembly	266,000 (€ 417,620)	2%
Welsh Assembly	140,354 (€ 220,356)	1%
TOTAL	14,597,698 (€ 22,918,385)	100%

Source: MacGregor (2000)

This table summarises the total amount invested in currently funded projects.

Table 2: Estimated total current Government department expenditure on drugs research by the four pillars of the ten year strategy

Pillar	Cost (£)	%
Young People	2,954,802 (€ 4,639,039)	21%
Communities	4,289,641 (€ 6,734,736)	30%
Treatment	6,059,855 (€ 9,513,972)	42%
Availability	963,564 (€ 1,512,795)	7%
TOTAL	14,267,862 (€ 22,400,543)	100%

Source: MacGregor (2000)

- International actions (funding, activities)

The Drug and International Crime Department (DICD) at the Foreign Office provided assistance to law enforcement agencies in partner countries along the main drug trafficking routes. Activities included training for customs services, the provision of dog handling teams, and computer equipment. In order to address domestic concerns over the spill-over of transit shipments in partner countries DICD decided to expand its budget for demand reduction activities. Activities in 2001 included support for rehabilitation centres in Pakistan and for a demand reduction needs assessment in the Anglophone Caribbean.

- Budget for National Strategy and Coordination

Table 3: Government funding on drugs strategies (excluding devolved administrations)

	2000/2001	2001/2002	2002/2003	2003/2004
Drug Treatment	£234m (€367.4m)	£328m (€515m)	£377m (€592m)	£401m (€629.6m)
Protecting Young People	£63m (€98.9m)	£90m (€141.3m)	£97m (€152.3m)	£120m (€188.4m)
Safeguarding Communities	£45m (€70.7m)	£79m (€124m)	£81m (€127.2m)	£95m (€149.2m)
Reducing Availability	£353m (€554.2m)	£373m (€585.6m)	£376m (€590.3m)	£380m (€596.6m)
Source: HM Treasury				

http://www.hm-treasury.gov.uk/spending_review/spending_review_2000/spending_review_report/spend_sr00_repchap29.cfm

Table 4: Budget 2001 – New Resources for Anti-Drugs Measures*

	2001-02	2002-03	2003-04
Strengthening communities	50	70	100
Extending drug testing in the CJS	0	20	30
Providing more help to find jobs	5	15	20
Strengthening DATs	5	5	5
Expanding Positive Futures	2	3	**

Source: Home Office, 2002
* Excludes devolved spending
** Provision to be decided in the light of other sources of funding

1.5 (c) Results from specific national surveys on expenditures carried out in the recent years.

The Joseph Rowntree Foundation (JRF) has invested £1million (€ 1.6m) over 3 years in a Drug and Alcohol Research Programme (DARP). The JRF conducted inquiries into research in this area and estimated that total annual spend on drugs research in UK amounted to between £2.5 (€ 3.9m) and £3million (€ 4.7m): representing 0.2% of the £1.4billion (€ 2.2b) that the Government spends on drug-related problems.
http://www.jrf.org.uk/funding/priorities/darp.asp

PART 2 EPIDEMIOLOGICAL SITUATION

2. Prevalence, Patterns and Developments in Drug Use

2.1 Main Developments and Emerging Trends

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

England and Wales
Self-report surveys indicate that around one third of those aged 16 to 59 years have tried drugs in their lifetime. However, the proportion using drugs in the last year is 11% and in the last month at 6% (Aust et al, 2002). Major trends in drugs prevalence in recent years has involved an increase in cocaine use and a decrease in use of amphetamines, LSD and magic mushrooms (Ramsey et. al. 2001).

Scotland
In a reversal of previous trends, 'last year' drug use in the general population dropped from 9% to 7% between 1996 and 2000. Most significantly, the rate for males aged 16-24 fell from 33% to 18%. Rates for females from the same age group remained steady (20% - 1996; 19% - 2000) (Fraser, 2002). The National prevalence study estimates that 55,800 individuals are misusing opiates and benzodiazepines in Scotland (2% of 15-54 year olds) (Fraser, 2002). Problematic drug use is occurring in both rural and urban areas, although the prevalence in clearly lower in rural areas (Fraser, 2002).

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

England and Wales
There has been a decrease in prevalence in amphetamine. Amphetamine use in the last year decreased from 7.9% of 16-29 year olds in 1998 to 5.2% in 2001 (Ramsey et al., 2001). This corresponds with data from other indicators. There has been a decrease of 53% in the number of seizures of amphetamine and a decrease of 87% in the quantity of amphetamine seized in 2001 (Corkery, 2001). The number of clients presenting to treatment agencies with amphetamine being their main drug of use has decrease from 8% in 1999 to 4% in 2000 (Dept of Health, 2001a) After peaking in 1999, deaths mentioning amphetamines on the death certificate have declined by 74% in 2000 (ONS, 2001). Also see section 7.1.

Northern Ireland
The social changes brought about by the peace process and the transmission of general, UK wide patterns of consumption and youth culture are encouraging drug related risk behaviour. The main drug of concern is cannabis, which many practitioners regard as a powerful and damaging substance in itself, and as a gateway drug leading to other substance misuse patterns. The wider moves in the UK as well as other European countries, to reschedule the status of cannabis and depenalise its use, are read with alarm as carrying the potential of exacerbating the drug use problem in Northern Ireland by removing an important layer of disincentives to experimental drug use. The peace process has however introduced a new social mobility, and has facilitated the supply and distribution of drugs. Given the sensitivity of the political situation and the intermeshing

of different trends and problems, the direct impact of drug use must at all times be distinguished from other social trends (Daykin, J (2002) verbal communication)

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

2.2 Drug Use in the Population

2.2 (a) (b) Main results of surveys and studies (prevalence, incidence, patterns of use, characteristics of users, geographical differences) with indication of trends and possible reasons/associated factors: General Population

Data from the 2001/2002 sweep of the British Crime Survey (Aust et al, 2002) shows 'ever use' for adults aged 16-59 is unchanged from the previous year. In the 2001/2002 and 2000 survey 34% of 16-59 year olds had ever used an illicit drug compared to 32% in 1998, 29% in 1996 and 28% in 1994 (Aust et al, 2002).

12% of adults aged 16-59 had used drugs in the last 12 months in 2001/2002 compared to 11% in 2000 and 1998, and 10% in 1996 and 1994. Reported illicit drug use in the last month for 16-59 year olds in 2001/2002 increased to 8%, compared to 6% in all the previous sweeps of the survey (1994-2000). Most of this reported drug use is accounted for by cannabis (Aust et al, 2002).

The Governments drug strategy emphasizes reducing the proportion of young people under 25 reporting the use of Class A drugs. 49% of 16-24 year olds in 2001/2002 reporting ever using an illicit drug compared to 52% in 1998. For 16-24 year olds drug use in the last 12 months has decreased from 30% in 1998 to 29% in 2001/2002. For the same age group drug use in the last month has remained stable at 19% in 1998 and 19% in 2001 (Aust et al, 2002).

Differences in gender appear to have remained stable between 1998 and 2001/2002, with 41% of males and 28% of females reporting ever using any illegal drugs in their lifetime in 2001/2002. The corresponding figures for 1998 were 38% of males and 27% of females. Drug use in the last year has also remained stable, with 15% of men and 9% of women in 2001/2002 reporting using any drug in the last 12 months compared to 14% of men and 8% in 1998.

Scotland
The latest data from Scotland comes from the Scottish Crime Survey 2000 (Fraser, 2002). Between 1996 and 2000, there was a significant drop (from 9% in 1996 to 7% in 2000) in the proportion of 16-59 year olds who had used any drug in the last 12 months. This contrasts with the difference between the 1993 and 1996 sweep, in which the proportion of any drug use in the last 12 months rose from 7% to 9% for the 16-59 age group.

Cannabis is still the most widely consumed illicit drug, although there was a significant drop between 1996 and 2000 in last year use for respondents aged 16-59 from 8% to

6%. Amphetamines, LSD, magic mushrooms, ecstasy and temazepan use also decreased significantly for the same group during the same period (Fraser, 2002).

This indicates that after an upward trend in drug use from 1993 to 1996, drug use is now decreasing to levels similar to those of 1993 particularly amongst those aged under 25 (Fraser, 2002).

However, heroin, crack cocaine and methadone use has remained rare in both 1993 and 2000 Scottish Crime Surveys with no suggestion of significant changes between 1996 and 2000. Cocaine use increased significantly between 1993 and 1996, but again there was no significant change between 1996 and 2000 (Fraser, 2002).

37% of 16-29 year olds reported having ever tried drugs compared to 13% of those aged 30 or over. This suggests that drug use is concentrated among young people (Fraser, 2002).

One of the greatest changes is related to young male drug use. Last year drug use in the 16-24 age group for men has decreased significantly from 33% in 1996 to 18% in 2000. Whereas, last year use for women in the same age group appears to have remained stable at 20% in 1996 and 19% in 2000 (Fraser, 2002).

2.2 (a) (c) School and youth population

England
Preliminary results from the 2001 'drug use, smoking and drinking among young people in England' by the National Centre for Social Research and the National Foundation for Educational Research, show that 12% of pupils aged 12-15 had used drugs in the last month and 20% had used drugs in the last year. Between 1998 and 2000, last month drug use among young people aged 11-15 increased from 7% to 9% and last year use increased from 11% to 14%. A revised method of measuring prevalence was used in 2001 and thus the data between 2001 and previous years are not strictly comparable. It is likely though that drug use has remained stable or slightly increased from 2000 (NCSR & NFER, 2002).

As in previous years, cannabis was the most likely drug to have been used with 13% of pupils aged 11-15 having used it in the last year. Use of cannabis in the last year among boys was slightly higher (at 14%) than girls (12%). Cannabis use increased sharply with age with 1% of 11 year olds having used the drug in the last year compared to 31% of 15 year olds. Again, this is similar to results from 2000 (NCSR & NFER, 2002).

Volatile substances such as sniffing glue, gas, aerosols or other solvents were the second most frequently reported drugs of use in 2001 with 7% of 11-15 years olds reporting misusing them in the last year. Among 11 and 12 year olds misuse of volatile substances last year was more common than the use of cannabis. 4% of 11 year olds had used volatile substances in the last year and 1% had used cannabis and 5% of 12 year olds had used volatile substances in the last year and 3% had used cannabis (NCSR & NFER, 2002).

4% reported using a Class A drug in the last year (NCSR & NFER, 2002).

The proportion of boys that had used drugs in the last month (13%) and in the last year (21%) was higher than that for girls (11% last month and 19% last year). There were significant differences by age; 6% of 11 year olds had taken drugs in the last year in 2001 compared to 39% of 15 year olds. These differences in age and gender are similar to the previous four years of surveys (1998-2001) (NCSR & NFER, 2002).

42% of 11-15 year olds had been offered one or more drugs in the last year. Boys were more likely to have been offered drugs than girls (44% compared with 39%) and older pupils were more likely to have been offered drugs than younger pupils - 66% of 15 year olds had been offered drugs compared to 18% of 11 year olds (NCSR & NFER, 2002).

Cannabis was the drug most likely to have been offered, similar to previous years. 27% of pupils had ever been offered cannabis, 22% had ever been offered stimulants (a group of substances which includes crack, cocaine, ecstasy, amphetamines and poppers) and 20% had ever been offered volatile substances (NCSR & NFER, 2002).

Scotland

There has been no new data concerning young people and drug use since 'Smoking, Drinking and Drug Use Among Young People in Scotland (NCSR & NFER, 2000). Data from this study were reported in last year's annual report.

10% of pupils aged 12-15 reported using drugs in the last month in 2000. This was the same level as in 1998. Drug use in the last year seemed to decrease slightly between the 1998 and 2000 surveys from 15% to 14% and the proportion reporting ever using drugs decreased from 18% to 17% in the same period. None of these changes was statistically significant (NCSR & NFER, 2000).

With regard to age, 1% of 12 year olds had used drugs in the last month compared with 22% of 15 year olds. Boys (11%) were slightly more likely to have used drugs in the last month than girls (8%). This is consistent with the 1998 survey (NCSR & NFER, 2000).

Similarly to England, cannabis was by far the most likely drug to have been used. 13% of pupils aged 12-15 had used cannabis in the last year. 1% of pupils had taken opiates (heroin or methadone) in the last year and 3% had taken stimulants (NCSR & NFER, 2000).

39% had been offered one or more drugs and boys were more likely to have been offered drugs than girls (41% compared with 36%). Cannabis was the most likely drug to have been offered (32%), 15% of pupils reported being offered glue or gas, 10% had been offered ecstasy, 7% had been offered heroin, 7% had been offered amphetamine and 6% had been offered cocaine. The likelihood of being offered drugs increased with age (NCSR & NFER, 2000).

All the above data and information also relates to Standard Table 2 School Surveys on Drug Use, in which sample sizes rather than percentages are shown.

Northern Ireland

Data from 'Drinking, Smoking and Illicit Drug Use Amongst 15 and 16 year old School Students in Northern Ireland' (Miller & Plant, 2001) shows that in 1999, forty percent (40%) of boys and 30% of girls had used an illicit drug.

Cannabis was the most commonly used drug with 38% of boys and 30% of girls reporting they had used it. This use seems to have been brief experimentation as only 13% of boys and 5% of girls reported having used this drug 20 times or more (Miller & Plant, 2001).

Nearly 28% of boys and 24% of girls aged 15-16 reported use of volatile solvents and 7% of boys and 6% of girls reported having taken ecstasy. 11% of boys reported using magic mushrooms. Heroin and cocaine was reported to have been used by between 2-3% for boys and girls and less than 1% of respondents reported ever having injected drugs. 16% of girls and 9% of boys had reportedly used combinations of 'alcohol and pills' (Miller & Plant, 2001).

Comparing these results to the 1995 ESPAD study (Hibell et al., 1997) shows a marked increase in illicit drug use among girls. Northern Irish girls had extremely low drug use relative to the rest of the UK in the 1995 study, but the findings of the 1999 study show that the proportion of girls who had repeatedly tried cannabis was approaching that of the rest of the UK (Miller & Plant, 2001). This comprises an increase of nearly 14%. There was no such increase among boys and Northern Irish girls are the only group within the UK to have provided evidence of such as increase (Miller & Plant, 2001).

Use of nearly all illicit substances appears to have decreased since 1995 except cannabis and heroin, the use of which continues to be rare (Miller & Plant, 2001).

2.2 (a) (d) Specific groups (eg. Conscripts, minorities, workers, arrests, prisoners, sex workers, etc)

To complement household surveys of adults, surveys have been conducted with those people resident in 'communal establishments'. These surveys found very high levels of drug use among those in hotels (eg YMCA, tourist and student hostels) and hostels (eg homeless hostels and shelters). For example, 25 per cent of those in 'hotels' had used heroin in the last 12 months. The corresponding figure for those in 'hostels' was 19 per cent. However, combining these figures with household surveys is unlikely to lead to a larger overall figure. Those living outside households make up only 2 per cent of the population and drug use would have to be exceptionally high for them to have any serious impact on population estimates (ONS, 2002).

Following the publication of the latest census results there are however concerns over the accuracy of the methodology in contacting some of the most difficult to reach population groups. For the results of the 2001 UK census see http://www.statistics.gov.uk/census2001/default.asp

Discrepancies in the gender statistics, resulting in the so-called missing 100,000 men, suggest that a sizeable section of the population is unaccounted for. There is also a growing population of immigrants and transients, with an unclear residential status who do not show up in the population census and other forms of surveys. If drug use patterns among these different unaccounted population groups were to differ widely from that reported by the remaining population, it may well alter the overall figures.

The Unlinked Anonymous Prevalence Monitoring Programme (2002) found that in 2000, 56% of IDUs in the survey had previously been in prison or a young offenders institution. Of IDUs who had been in prison, 18% reported injecting drugs while in prison.

25% of IDUs who had previously been in prison had been infected with hepatitis B, compared to 15% of those who had not and 38% of IDUs who had previously been in prison had been infected with hepatitis C compared to 24% of those who had not (UAPMP, 2002).

A national survey of England and Wales showed that of 2,769 adult male prisoners, 660 had injected and of these 3 (0.5%) had antibodies to HIV, 131 (20%) had antibodies to HBV and 5% of these (6-7 people) will have chronic HBV and 200 (30%) had antibodies to HCV and 80% of these (160 people) will have chronic HCV (Weild et al, 2000)

The correlation between drug use and offending is corroborated by the high levels of drug use found among those arrested by the police and held in custody. A programme of urine testing across England and Wales found that 67% of arrestees tested positive for drugs. The most commonly used drug was cannabis followed by opiates (24%), cocaine/crack (15%), benzodiazepines (13%), amphetamines (9%), and methadone (5%) (Bennett, 2001)

2.3 Problem Drug Use

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

The most recent estimate of problem drug use in the UK relates to 1996. Current studies will provide new estimates in 2003 as well as figures for smaller (Drug Action Team) areas. Recent work has been undertaken to provide more accurate figures for 1996 (Frischer et al., 2001). This work looked at estimates using three different types of methodology. The findings estimate that in England, Scotland and Wales:

- 143,000 people are at risk of mortality due to drug overdose;
- 161,000 to 169,000 people have ever injected drugs;
- 202,000 are opiate users;
- and 266,000 are problem drug users.

55, 800 people were estimated to be misusing opiates or benzodiazepines in Scotland in 2000 (Hay et al, 2001)

Between the 1st November 2000 and 31st October 2001 it is estimated that there was a total number of 828 problem heroin users in Northern Ireland. The number of problem heroin users in the 15-29 age group was estimated to be 466 and within the 30-54 age group the estimated number of problem heroin users was 362 (McElrath, 2002)

2.3 (b) Risk behaviours (injecting, sharing, sex …) and trends

Statistics from the regional drug misuse database for 6 months ending 31st March 2001 show that of those whose injecting status was known 65% of users had ever injected, the corresponding figures for users injecting in the last four weeks was 43%. Men (45%) were more likely to have injected than women (38%) in the last 4 weeks. Under a third of users (28%) aged under 20 had injected in last four weeks compared to nearly half of those (45%) aged 30 and over (Department of Health, 2002b).

Of those known to have injected and whose sharing status was known, 49% had shared injecting equipment in the last 6 months ending 31st March 2001 compared to 42% in 6 months ending 31st September 1996. The equivalent figure for the last four weeks was 20% compared to 12% in 6 months ending Sept 1996 (Department of Health, 2002b).

Of those injected in last four weeks: women (24%) were more likely to have shared than men (18%) and younger users (27% under age 20) were more likely to have shared than older users (16% of those 30 and over) (Department of Health, 2002b).

Underreporting remains likely since RDMD data is based on a single question, when Stimson et al (1998) found that a range of detailed questions elicited higher reports of sharing than a single question.

Data from the Unlinked Anonymous Prevalence Monitoring Programme (UASSG, 2001) show the sharp increase in level of sharing that occurred between 1997 and 1999 leveled off in 2000. Direct sharing was reported by 31% of drug users who had injected in the previous month, a slight decrease from 1999 when 33% reported sharing in the same period. The level of direct sharing among current IDUs was significantly higher in London (41%) than rest of England and Wales (29%). Self-reported sharing of any injecting equipment (indirect sharing) in the past month was 69% in London and 59% in rest of England and Wales. These rates have been increasing over past few years. Females IDUs reported significantly higher rates of both direct and indirect sharing compared to males (UASSG, 2001).

According to McElrath (2001) high risk behaviour among IDUs in Northern Ireland (sharing needles) is related to the difficulty in obtaining needles and syringes (limited supply and availability). Needle exchange schemes were not implemented in Northern Ireland until 2001 (McElrath, 2001)

In Scotland, the percentage of injectors reporting sharing injecting equipment in the previous month has remained reasonably static in recent years. There has been a fall in the number of under 20s sharing, contrasted with a slight percentage increase among older age groups (Scottish Drug Misuse Database, 2002)

3. Health Consequences

3.1 Drug Treatment Demand

3.1 (a) Characteristics of clients, patterns of use and trends (especially in new client sub-groups)

For England, Scotland and Wales combined, a total of 40,200 persons sought treatment for their drug use in the six month period ending 31st March 2001. This represents a 3% increase over the same period in 2000, and decrease of 0.6% on the previous six month period (ending 30th September 2000). As in previous years, there was a 3:1 male (29,669 – 74%): female (10,512 – 26%) gender ratio. Over 50% of persons presenting were aged between 20 and 29, thirteen percent (5131) were aged 19 or under and the remainder were aged 30+ (Dept of Health, 2002b).

38% of users were known to inject their main drug (40% in 2000, 37% in 1999). Most cases reported were opiate users and 77% reported opiates were their main drug of use (76% in 2000 and 71% in 1999). Just under half of these (46%) were injectors (55% in 2000 and 47% in 1999) (Dept of Health, 2002b).

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

Current systems in the UK do not distinguish between different types of treatment so it is not possible to comment on client profiles. Data in the future will be provided by the National Drug Treatment Monitoring System which was implemented in 2001.

There are continuing concerns that drug services are geared mainly for opiate users, and that the provisions for Black and Ethnic Minorities as well as for female drug users remain inadequate.

3.1 (c) Comments on treatment demand for different drugs

Heroin was reported to be the main drug of use in 66% cases, compared to 62% in 2000 and 48% in 1995. The proportion of users said to be injecting heroin as their main drug was 54%. This is relatively consistent with data from previous years (58% in 2000, 1999 and 1995) (Dept of Health, 2002b).

Methadone was the second most frequently reported main drug of use (by 9% of clients) and cannabis was the third most frequently reported main drug of use (by 9% of users). Main drug cannabis use continues to account for about 1 in 10 reported cases (9% in 2000, 10% in 1999). Other drugs reported as the main drug of use each represented 6% or less of the presenting treatment population reported (Dept of Health, 2002b).

Cocaine increased slightly as a main drug of use (6% in 2001, 5% in 2000, 6% in 1999 and 4% in 1995). The proportion reported to be injectors has remained stable at 12% in 2001 (12% in 2000, 4% in 1999). The proportion of users who report cocaine as their main drug of use and are injecting it has remained stable at around 6% (6% in 2000, 5% in 1999 and 7% in 1995) (Dept of Health, 2002b).

Amphetamine as a main drug of use has continued it's declining trend in 2001 with 3% of users reporting it as their main drug (4% in 2000, 8% in 1999 and 10% in 1995). Of

these, 40% were said to be injecting their amphetamine which is a slight increase from 2000 (38%) but less than 1999 (47%) (Dept of Health, 2002b).

3.2 Drug-related Mortality

3.2 (a) Drug-related deaths, direct (overdoses) and indirect (AIDS, accidents, etc)

2,968 people died from drug-related poisoning in 2000 an increase of 32% from 1993. However, there has been a slowing down on the rate of increase in recent years. For example, there was an increase of 6.7% in 1993-4 compared to 0.7% in 1998-9 and 0.8% in 1999-2000 (ONS, 2002a).

Over the period 1993- 2000, the number of male deaths rose by 50%, the number of female deaths, by only 10%. There have been falls in the numbers dying for those aged 15-19 and 20-24 in the period 1997-9 (ONS, 2002a)

During the period 1993-2000 most deaths for both genders were given an underlying cause of suicide/undetermined poisoning. This proportion was highest for females. More male deaths were ascribed to drug dependence/non-dependent abuse of drugs and also to accidental poisonings (ONS, 2002a)

In Scotland, under the new, more restricted, definition of a 'drug-related death' there were 332 drug-related deaths in 2001, 14% more than 2000 and 88 more than in 1996 (see table 5). The total number of deaths of known or suspected habitual drug abusers increased slightly from 220 in 2000 to 227 in 2001. There has been a 30% increase in the number of deaths in this category since 1996. Between 2000 and 2001, there was an increase of 25 deaths (from 27 to 52) coded to the 'undetermined' category. This category represents persons who were not known or suspected drug abusers and where it was not clear if the death was accidental or suicide (Jackson, 2002).

Table 5: Drug-related deaths, Scotland, 1996-2001

Year	1996	1997	1998	1999	2000	2001
Total	244	224	249	291	292	332

Source: Jackson, 2002

All UK data sources suggest that there is a trend for 'acute' DRDs to become more male-dominated, with male deaths in 1998-2000 outnumbering female ones by two to one in Northern Ireland and by four to one in Great Britain. Generally speaking, the majority of DRDs in the UK occurred amongst 20-34 year-olds.

Using the ONS 'standard' definition, the number of DRDs in the UK has risen from 2,260 in 1985 to 3,495 in 2000, an increase of 55%. From 1985 to 1989 there was no consistent pattern, but since 1989 the number has increased each year. The rate of increase was most pronounced between 1991 and 1998 since when the rate of increase has slowed down (Table 6). The rate of DRDs per 100,000 population was 5.6 for England and Wales in 2000; corresponding figures for Scotland and Northern Ireland are 9.2 and 3.2 respectively.

Table 6: Drug-related deaths using ONS 'standard' definition, United Kingdom, 1985-2000

Year	England & Wales	Scotland	Northern Ireland	United Kingdom
1985	1971	242	47	2260
1986	2077	224	40	2341
1987	2034	250	32	2316
1988	2061	238	44	2343
1989	1942	264	32	2238
1990	2041	276	39	2356
1991	2053	275	46	2374
1992	2287	313	28	2628
1993	2252	374	28	2654
1994	2404	422	35	2861
1995	2563	426	46	3035
1996	2721	460	40	3221
1997	2858	447	39	3344
1998	2922	449	40	3411
1999	2943	492	50	3485
2000	2968	473	54	3495
Sources: Personal communications, ONS, GROS, GRONI, February and March 2002.				

3.2 (b) Deaths related to opiates (including methadone) and to other drugs (cocaine, ecstasy, etc)

From 1993-2000 more than one drug was mentioned on the death certificate in 21% of cases, and alcohol in 22% of drug related deaths. Most deaths are associated with opiates (chiefly heroin/morphine and methadone), often in combination with other drugs and/or alcohol. Large numbers of deaths also involve benzodiazepines such as temazepam and diazepam. However, the types of drugs most often mentioned are anti-depressants – especially dothiepin and amitriptyline – and paracetamol (which is not a controlled drug) – either on its own or in compound preparations such as distalgesic. By comparison, aspirin was implicated in only one-tenth of the number of cases involving paracetamol compounds.

The number of deaths where heroin/morphine was mentioned was 5 times higher in 2000 (at 926) than in 1993. The number of cases in which methadone was implicated rose steadily from 232 in 1993 to peak at 421 in 1997, since which time it has fallen (to 238 in 2000). Mentions of cocaine, although still comparatively low when compared to heroin/morphine, rose more then seven-fold between 1993 and 1999 (Corkery, 2000). Although much media attention has been given over recent years to deaths involving ecstasy, they only account for 0.7% of drug related deaths. Deaths mentioning ecstasy rose from 8 in 1993 to 36 in 2000. GHB has been mentioned in 5 deaths from 1993 to 2000 (ONS, 2002).

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

In Scotland in 2001, heroin/morphine was involved in 65% of the deaths; diazepam was involved in 47% of deaths; methadone in 21% of deaths and ecstasy and cocaine were involved each in less than 0.6% of deaths (see table 7)

Table 7: Drug-related deaths; selected drug involved, Scotland, 1996-2001.

	1996	1997	1998	1999	2000	2001
Heroin/morphine	84	74	121	167	196	216
Diazepam	84	93	113	142	146	156
Methadone	100	86	64	63	55	69
Temazepam	48	33	58	56	39	20
Ecstasy	9	2	3	8	11	20
Cocaine	3	5	4	12	4	19

Source: Jackson, 2002

Notes:
Individual deaths often involved more than one of these drugs. The numbers given are mentions of the drug and should not be added to give total deaths.

A wide range of drug combinations were recorded and diazepam was also mentioned in over half (110) of 216 deaths involving heroin/morphine. There has been a significant increase in the involvement of heroin/morphine between 1996-2001. There has also been marked increases in the numbers involving cocaine and ecstasy. Between 1996 and 2000 there was a downward trend in the number of deaths involving methadone but there was an increase between 2000 and 2001.

A National Confidential Enquiry into Methadone Related Deaths in Scotland (Squires et al., 2002) was conducted in 2000. The basis of this report was that despite an 18% year-on-year increase in the number of methadone prescriptions since 1996 there has been a continuing decrease in the number of methadone related deaths. Furthermore there had been variable methadone death rates per head of the population by Health Board.

The main findings show that in 2000, methadone was cited on 54% (30) of all death certificates relating to cases referred to the enquiry. In 37% (11) cases methadone was the only drug (not including alcohol) cited and a combination of drugs was present in 63% (19) deaths. There were no accidental deaths of children or of any individuals under 16 years of age. There were no deaths of individuals who were obviously unaware that they were taking methadone. There was one death of a recreational drug user. Forty-five percent (45%) of deaths referred to in the enquiry involved people who were not on prescription for methadone and all but two cases involved established drug users. Methadone tablets were associated with one death. No patients died within one month of commencing a methadone programme. Of those on prescription, 60% were on supervised consumption at the time. Urinalysis continued to be performed at regular intervals in all but one case and for 65% of cases a co-morbid psychiatric condition, usually depression was diagnosed (Squires et al., 2002). The enquiry made a number of recommendations on the basis of these findings which can be found in section 11.2(g).

3.2 (c) Number, characteristics and trends, possible reasons for changes

Nearly half the DRDs amongst young men in 1994-6 were accounted for by opiates. Between 1995 and 2000 the male death rate for heroin/morphine rose from 11 per million population to 29, the greatest increase occurring in 1997-9. Male deaths involving amphetamines doubled between 1995 and 1999, although numbers are still very low. By contrast, deaths mentioning methadone fell 47% in 1997-2000. Death rates for opiates fall off at older ages. Amongst elderly men there has been an increase in deaths due to barbiturates and tranquillisers, and a decline in anti-depressants (ONS, 2002a)

Opiates generally account for a lower proportion of female deaths; other painkillers and anti-depressants account for about half the drug deaths of women. Death rates from heroin/morphine increased from 1.7 per million population in 1995 to 5.3 in 2000. These rates are still far lower than those for males. Over the period 1995-2000 there was little variation in females death rates for the other main drugs, although rates for temazepam and anti-depressants appear to be decreasing (ONS, 2002a)

In Scotland, 87% of deaths in 2001 were to persons aged under 45, with 24% of these aged under 25. Men accounted for 80% of the 332 drug-related deaths in 2001. Seventy-three percent of the male deaths were known or suspected drug abusers compared to 49% of the female deaths (Jackson, 2002)

St Georges' Hospital released their figures for deaths related to ecstasy in England, Wales and Northern Ireland and reported that there were 40 deaths for 2001

3.2 (d) Overall mortality and causes of death in drug-users (eg. Cohorts studies), trends

The annual mortality of all addicts is not known. However, a study of the relationship between notification to the Home Office and deaths of notified addicts shows that the proportion of addicts dying compared to the number of new notifications 20 years earlier rose from 2 to 7 in 10 between 1988 and 1993 (Corkery 2002a). There is constancy in the relationship between numbers of deaths and new notifications for up to 10 years before death. The proportion of the cumulative notified population dying between 1985 and 1993 remained consistent at 0.6% or 0.7%. The average length of time between first notification and death increased by six months between 1995-90 and 1991-96. Whilst the absolute number of deaths rose between 1984 and 1993, the proportion of newly notified addicts dying each year fell from 2.1% to 0.5%.

3.3 Drug-related Infectious Diseases

There are three different large scale surveys of blood borne prevalence among injecting drug users in the UK: the Unlinked Anonymous Prevalence Monitoring Programme's survey of injectors attending drug agency services in England and Wales; the Centre for Research on Drugs and Health Behaviour's surveys of injecting drug users recruited from community settings in England; and SCIEH's surveys of injecting drug users attending both community and drug agency settings in Glasgow (Unlinked Anonymous Prevalence Monitoring Programme, 2000).

All three surveys collect behavioural data and oral fluid for testing for antibody to HIV (anti-HIV), hepatitis B core (anti-HBc) and hepatitis C (anti-HCV). All anti-HCV data presented in this report for England and Wales have been adjusted for 83% assay sensitivity. More recent work suggests that the sensitivity of the assay can be improved if a different cut-off point is used (Judd et al., 2002), and future data returned to the EMCDDA for England and Wales will use this enhanced cut-off. Similarly the anti-HCV data for Glasgow have been adjusted for 85% assay sensitivity (Cameron et al., 1999), and the anti-HBc data for England and Wales have been adjusted for 75% assay sensitivity (Judd et al., 2002)

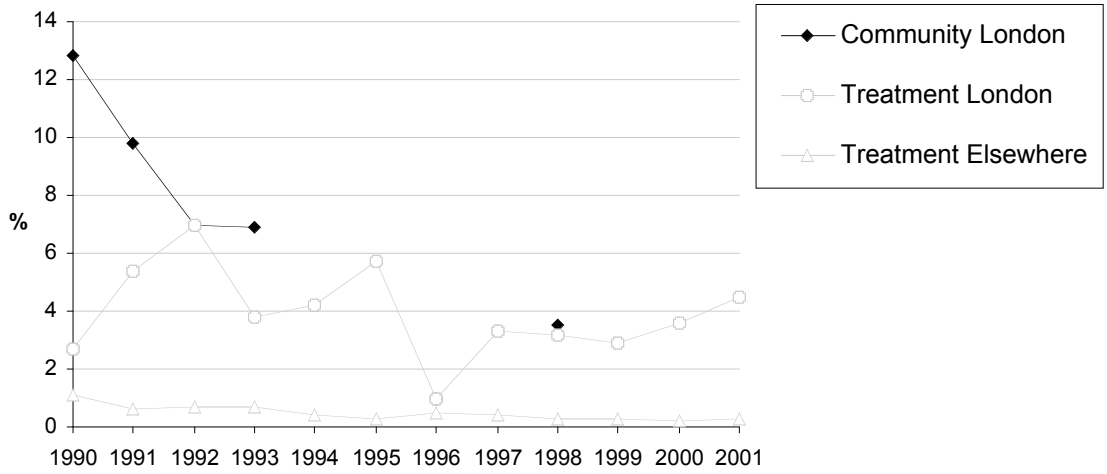
An unlinked anonymous survey recruiting IDUs from drug agency services in Northern Ireland commenced in June 2002, and the first data for this survey may be available next year.

In Scotland, the HIV Denominator Study collects data on all persons undergoing a named HIV test since 1989 (SCIEH, 2000). UK infectious disease data are also available from routine surveillance systems which measure the number of reports of hepatitis B and C, and risk factors associated with these infections (Balogun et al., 1999). (http://www.show.scot.nhs.uk/scieh/)

3.3 (a) <u>HIV and AIDS</u>

Figure 2 shows the prevalence of HIV among injecting drug users recruited from community and agency settings in England and Wales between 1990 and 2001. From 1995 HIV prevalence in London has remained at or near 4%, and prevalence among injectors in the rest of England and Wales is extremely low at under 1%.

Figure 2: HIV prevalence among injecting drug users in the UK, 1990-2001



Data from the HIV Denominator Study suggest that in Scotland HIV prevalence among IDUs undergoing a named HIV test ranged from 1.5% in 1996 to 0.5% in 1999 and 0.8% in 2001.

Since 1995 prevalence of HIV infection among IDUs has not fallen indicating a continuing low rate of HIV infection among IDUs (UASSG, 2001). In 2000, none of those who had begun injecting in past three years was infected with HIV and the proportion of newly diagnosed HIV infections through IDU was 3% (99 of 3412) (UASSG, 2001). This is considerably less than other European countries such as Portugal where 57% (2141 of 3733) of newly diagnosed infections were attributed to exposure through drug use and 42% (13 of 31) of newly diagnosed HIV infections in the UK associated with drug use were likely to have been acquired in Portugal (UASSG, 2001).

90% (18 of 20) of IDUs were aware of their infection. This proportion is higher than in other groups at increased infection risk such as homosexual and bisexual men and pregnant women (UASSG, 2001).

The prevalence of HIV infection in those who had been in prison was similar to that in those who had never been in prison 0.8% (15 of 1907) and 0.7% (9 of 1285) respectively (UASSG, 2001).

In Scotland, HIV infection among IDUs continues to be rare in 2000 with prevalences of between one in 62 and one in 167 being reported since 1994. The prevalence of HIV infection among genitourinary clinic attendees who reported ever injecting was one in 64 men and one in 42 women (UASSG, 2001).

There has been an increase in needle sharing with 34% of IDUs in 1999/2000 reporting sharing a needle or syringe (Scottish Drug Misuse Database, 2002) which indicates that the potential for HIV transmission among IDUs has increased (UASSG, 2001).

As of 31 December 2000, injecting drug use was identified as the probable route of transmission in 1,248 HIV cases in Scotland. Injecting drugs makes up 39% of all reports of HIV infection (SCIEH, 2001)

Data from Standard Table 9 Prevalence of Hepatitis B/C and HIV Infection among recent Injecting Drug Users in EU Countries shows that for England and Wales, prevalence in 2001 was 1% of a sample of 2,963 IDUs. This is a slight increase from 2000, where prevalence was 0.8% of a sample of 3425 IDUs but is consistent with prevalence rates between the years of 1992-2001 which has remained less than 2%.

Prevalence was lower among younger IDUs compared to their older counterparts in 2001 with 0.4% (N= 625) of those under 25 infected and 2.1% (N=802) of those aged above 34 infected.

There was no discernable trend in prevalence by gender. 0.9% (N=2126) of males were infected in 2001 and 0.7%(N=698) of females.

As in previous years, London had a higher prevalence rate of HIV infection than the rest of England and Wales with 4.5% (N=515) of IDUs infected compared to 0.3% (N=2448) of IDUs outside of London. Prevalence, in London, was generally lower among younger IDUs (in line with the rest of England and Wales) and with regard to gender 4.7% (N=365) of males and 2.2% (N=139) of females were infected in 2001.

In Scotland, prevalence of infection among IDUs in 2001 was 0.84% (N=2153). This appears to be a slight increase from 2000 where prevalence was 0.55% (N=2163) but prevalence over the period from 1996 to 2000 has remained less than 2%. This is in line with figures from England and Wales.

In Northern Ireland rates of HIV infection through IDU is reported to be very low. Cumulative data through June 2000 show seven cases of HIV infection through IDU with the first case being reported in 1987. However, these data are based on voluntary testing and there is little information on the extent of routine testing among IDUs in Northern Ireland (McElrath, 2001)

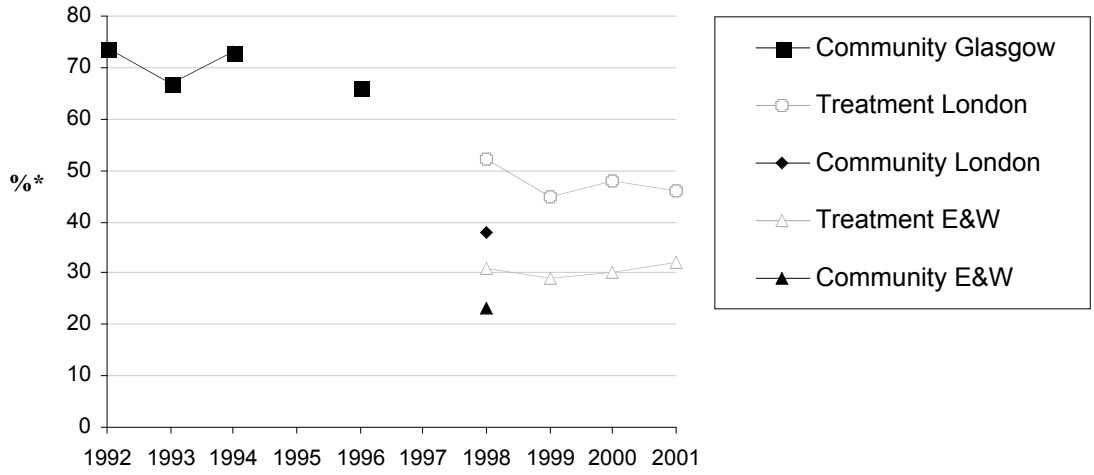
Unlinked anonymous salivary antibody testing for HCV, HBV and HIV of IDUs is now being undertaken at four locations in N Ireland. This commenced in June 2002, and hopefully data will be available for the EMCDDA from 2003.

3.3 (b) Hepatitis B and C

Hepatitis C

Figure 3 shows estimates of prevalence of antibody to hepatitis C among injectors in the UK. Prevalence was extremely high in Glasgow in the early 1990s, and then fell slightly to about 65% in 1996. Prevalence data for England and Wales are only available from 1998, and show a clear trend of higher prevalence in London than elsewhere. For example in 2001, prevalence among injectors recruited from agency settings in London was just under 50%, compared to about 30% for the rest of England and Wales.

Figure 3: Hepatitis C prevalence among injecting drug users in the UK, 1992-2001



Two key predictors of prevalence of HCV in England and Wales are region of residence and duration of injecting. Table 8 shows the prevalence of HCV by NHS region in England and Wales, for injecting drug users recruited from agency and community settings between 1998 and 2000 (Unlinked Anonymous Prevalence Monitoring Programme, 2000; Hope et al., 2001). Overall prevalence was 37%, and 10% for those injecting for less than 3 years. However there were major differences between regions, for both the whole sample, and for those who had recently started injecting, with prevalence being much higher in London and the North West than elsewhere.

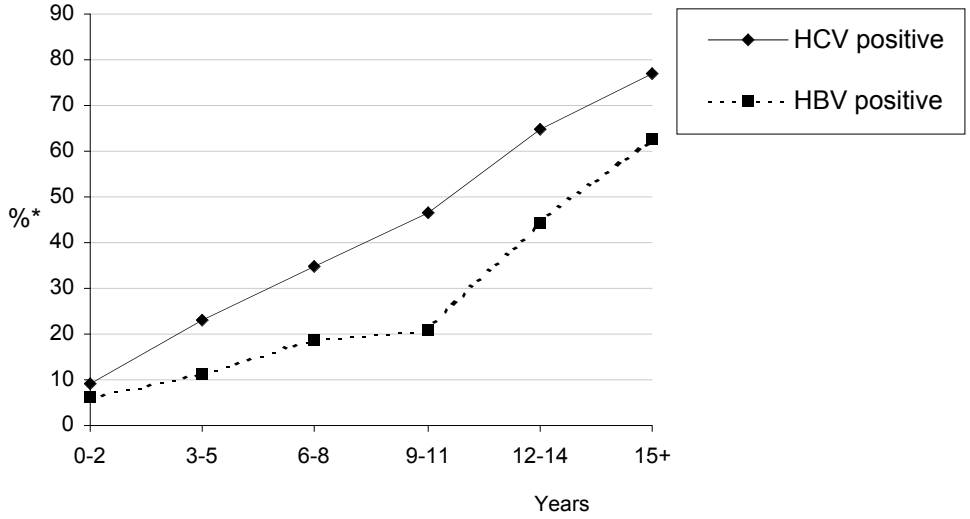
Table 8: Hepatitis C prevalence among injecting drug users in England and Wales by NHS region, 1998-2000

Region	total sample	<3 years injecting
Eastern	36%	11%
London	53%	20%
South East	24%	6%
South West	27%	7%
W. Midlands	26%	4%
North West	57%	24%
Northern & Yorks	18%	5%
Trent	29%	9%
Wales	26%	4%
Overall	**37%**	**10%**

These findings suggest that hepatitis C is not acquired early on in an injector's career in most regions in England and Wales, contrary to the situation in other countries, implying that there is a potentially long window of opportunity for prevention. However the situation appears to be very different in London and the North West, with between one in four and one in five injectors being infected within the first two to three years of injecting.

Figure 4 shows the prevalence of antibodies to hepatitis B and C by duration of injecting career, for injecting drug users recruited from both agency and community settings in England and Wales. For both viruses, there is a strong relationship with duration of injecting. For hepatitis C, the green line on the graph, prevalence rises from 9 per cent among those injecting for zero to two years, to 35 per cent for those injecting for 6 to 8 years, and just over 75 per cent among injectors who have been injecting for 15 years or more.

Figure 4: Hepatitis C prevalence in injecting drug users in England and Wales by duration of injecting (years), 1998



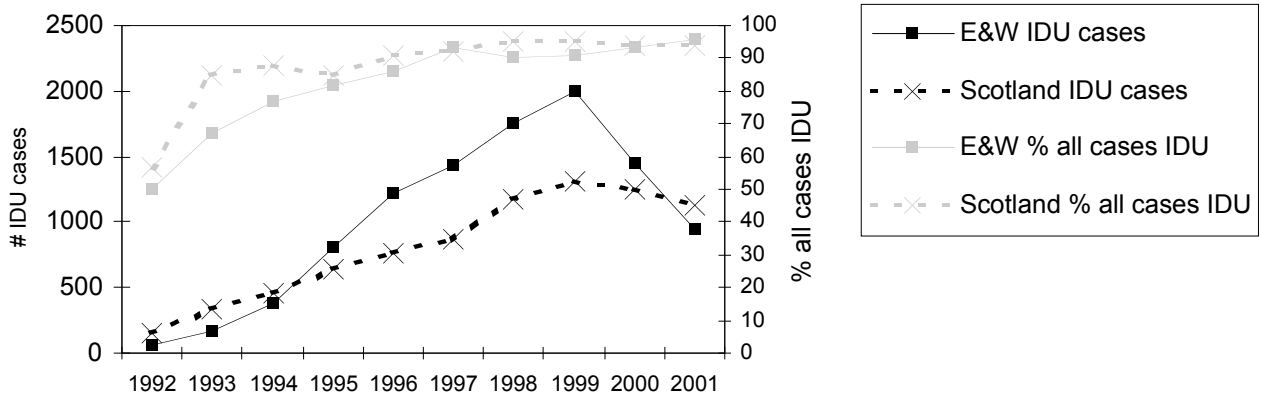
However, more recent data from the agency survey suggest that for those who began injecting in the previous three years the prevalence of hepatitis C was higher in 2001 than in any previous year. There was an increase in males from 7.9% (53/378) and in females from 10% (24/247) to 22% (41/191) between 2000 and 2001. This trend was observed both inside and outside of London.

One explanation for the differences in prevalence between England, Scotland and Wales, and within England, could be the level of syringe exchange provision. In 1997 Parsons et al estimated that that 27 million syringes were distributed from approximately 2000 sites in 1997, of which 25 million were distributed in England, and approximately a million each in Wales and Scotland (Parsons et al., 2002). The study suggested that Scotland distributed 3-4 times fewer syringes per estimated injector than England and Wales.

In Scotland, residual sera from injectors in Glasgow, Lothian, Tayside and Grampian who had undergone named HIV testing were tested anonymously for anti-HCV (Goldberg, 2001; Hutchinson, 2002 #458). In all regions, there were no significant changes in prevalence among those aged under 25 years between 1997 and 1999, with prevalence in Glasgow being around 42%, Lothian 15%, Tayside 40% and Grampian 28%. However, among those aged 25 years or more, significant decreases in prevalence were found in Glasgow, from 79% in 1997 to 72% in 1999/2000, and Lothian, from 54% in 1997 to 45% in 1999.

Figure 5 shows the number of reports of hepatitis C attributed to IDU, and the proportion of all reports attributed to injecting, for England, Wales and Scotland. The England and Wales data include acute and chronic cases, while the Scottish data only include chronic cases. Both sets of data show a similar trend of an increase in the number of IDU reports to 1999 and a decrease thereafter, and a steady rise in the proportion of all reports attributed to IDU, from around 50% in 1992 to 95% in 2001.

Figure 5: Hepatitis C laboratory reports among IDUs – Public health laboratories, UK* 1992-2001



Notes: * England and Wales, and Scotland, have different case definitions. Please see text.
Source: PHLS Communicable Disease Surveillance Centre, SCIEH

In Northern Ireland, between 23 and 70 cases of acute or chronic hepatitis C have been reported each year from 1994 to 2001. Unfortunately the data on risk factors for infection are poor, and so it is not possible to calculate the percentage of cases attributed to IDU from all reports.

A third of injecting drug users attending specialist agencies in England and Wales had antibodies to the hepatitis C virus and only 40% (389 of 964) of those infected were aware of their infection. One in 12 injecting drug users who began injecting in the last 3 years was anti HCV positive, indicating ongoing transmission (UASSG, 2001).

Injecting drug use is by far the commonest route of transmission for new cases of hepatitis C in the UK. It accounts for at least 80% of the new cases of HCV (Action of hepatitis C Group, 2002). The prevalence of HCV infection in current injectors in the community is high at about 40% (Hope et al, 2001)

In Scotland, 6,326 of the 10,929 known Hepatitis C cases (58%) have 'Injecting drug user' as the probable cause of transmission. It is likely that a further 3,780 cases (35%) with an 'unknown' cause of transmission include a high proportion of injecting drug users. These figures are almost certainly an underestimate (SCIEH, 2002)

Information from Standard Table 9 Prevalence of Hepatitis B/C and HIV Infection among recent Injecting Drug Users in EU Countries shows that for England and Wales prevalence has increased from 33% (N=3425) in 2000 to 35% (N=2963) in 2001. Again, as with HIV and hepatitis B, there was a marked increase in prevalence with age, this is also in line with data from previous years. Prevalence was 15% (N=699) in IDUs under the age of 25, increasing to 33% (N=1382) among IDUs aged 25 to 34 and 52% (N=822) among IDUs over 34 years of age. 34% (N=2201) of males and 35% (N=729) tested anti-HCV positive in 2001.

Prevalence was higher in London than elsewhere in 2001 at 46% (N=515) versus 32% (N=2448) respectively.

Information from Northern Ireland shows that out of 70 of the notified cases of HCV in 2001, 15 were notified cases of IDUs only.

Hepatitis B and hepatitis C transmission through IDUs remains a major concern in the UK, however, reports of acute hepatitis B have declined in recent years; hepatitis B vaccine coverage of IDUs increased significantly in 2000 and the rate of direct sharing has leveled off after increasing for several years (UASSG, 2001).

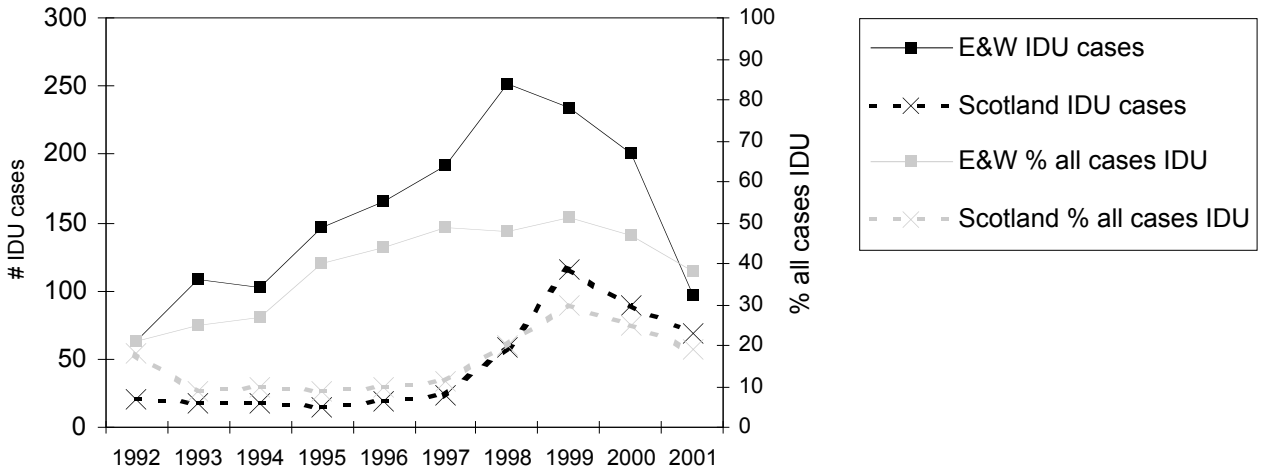
The HCV data for the UK indicate that the incidence of hepatitis C infection, the opportunity to prevent transmission, and the need to target an expansion in syringe exchange services may vary between cities and geographical areas. The more recent agency data indicate ongoing transmission among recent initiatives and that hepatitis C is not exclusively concentrated among those who have had longer injecting careers. It is important that surveillance of syringe exchange activity is strengthened in order to estimate and monitor coverage. In addition, estimates of the prevalence of injectors are urgently required.

Hepatitis B

Prevalence of anti-HBV among IDUs recruited from agency settings in England and Wales declined overall from 47% in 1992 to 29% in 1995, and since then it has leveled off at around 27-28%. In the vast majority of years prevalence was higher in London compared to elsewhere in England and Wales. For example prevalence in London in 2000 was 35%, compared to 27% in the rest of England and Wales.

Figure 6 shows the number of laboratory reports of hepatitis B attributed to IDU, and the proportion of all reports attributed to injecting, for England and Wales, and the same data for hepatitis B notifications for Scotland. The England and Wales data include only acute hepatitis B laboratory reports (HbsAg positive and anti-HBc IGM positive with discrete onset of jaundice or other comparable illness), while the Scottish data only include notifications of chronic cases.

Figure 6: Hepatitis B laboratory reports/ notifications among IDUs – Public health laboratories, UK* 1992-2001



Notes: * England and Wales, and Scotland, have different case definitions. Please see text.
Source: PHLS Communicable Disease Surveillance Centre, SCIEH

For England and Wales, the number of acute hepatitis B laboratory reports among IDUs, and the percentage of all acute reports attributed to IDU, increased steadily to 1998. Since then, the number of reports among IDUs have declined dramatically, although the percentage attributed to injecting has fallen less rapidly. In Scotland, there was a marked increase in the number of notifications of chronic hepatitis B among IDUs to 1999, and since then both the number and the percentage attributed to injecting have fallen.

In Northern Ireland, hepatitis B laboratory reports are for both acute and chronic cases. There was no more than one case of hepatitis B reported each year for IDUs between 1992 and 2001. The total of all notified reports for hepatitis B averaged around 30 per year during the same time period.

In England, Wales and Northern Ireland the overall prevalence of anti-HBc in injecting drug users attending genitourinary clinics in 1999 was 11% (26 of 240) (UASSG, 2001). Even though there is an effective vaccine hepatitis B continues to be transmitted though IDU. In those injectors who had begun injecting in the past 3 years, 7% of those tested in 2000 had been infected with hepatitis B, an increase on the prevalence in 1999 of 5.4% (UASSG, 2001).

35% (1179 of 3341) of injecting drug users reported having been vaccinated against hepatitis B in 2000. This is a significant increase from 1998 where 25% of IDUs reported having been vaccinated.

In Scotland, 89 of 360 cases (25%) of Hepatitis B infections mentioned injecting drugs as the probable route of transmission. However, it is thought that the majority of the cases acquired the infection through injecting practices (ISD 2002)

Information from Standard Table 9 Prevalence of Hepatitis B/C and HIV Infection among recent Injecting Drug Users in EU Countries shows that for England and Wales in 2001 21% (N=2963) of those sampled tested positive for anti-HBc. Prevalence of anti-HBc has declined from 35% (N=3328) in 1992 to around 20% (between 1995 and 2001). Prevalence increased with increasing age, 9% (N=669) of those aged under 25 tested anti-HBc positive, increasing to 16% (N=1382) among those aged 25 to 34 and 39% (N=822) for those aged above 34 years. There was not much difference in relation to gender with 22% (N=2201) of males and 19% (N=729) of females testing anti-HBc positive. These figures are in line with those from previous years. Anti-HBc prevalence was generally higher in London at 23% (N=515) than elsewhere (21%, N=2448).

In Northern Ireland, there were 37 notified cases for hepatitis B, however, route of transmission is unknown.

3.3 (c) Other (eg. TB)

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

3.4 Other Drug-related Morbidity

3.4 (a) Non-fatal drug emergencies

Five clinical cases of wound botulism were reported to the Public Health Laboratory Service Communicable Disease Surveillance Centre and the Scottish Centre for Infection and Environmental Health since the beginning of February 2002. All five patients were known to be injecting drug users. One case is due to Clostridium botulinum type B and two cases are due to Clostridium botulinum type A. (CDR Weekly, 2002)

In July 2001, the PHLS warned a possible batch of contaminated heroin that may have been responsible for a number of deaths from severe systemic sepsis in IDUs in 2000 may be circulating on the drugs market again. Between April 1st and August 1st 2000 over 30 heroin injectors died from serious infection (PHLS, 2001). For more information see: http://www.phls.org.uk/topics_az/injectingdrugusers/iduCEM2001-8.pdf

In Scotland, opioids were identified in 46% of all general acute hospital admissions for drug misuse. The true figure is, however, likely to be higher as some patients recorded as using 'multiple/other psychoactive substances' may use opioids (ISD 2002)

3.4 (b) Psychiatric co-morbidity

In Scotland between 1994/5 and 1999/00 there was an increase in the number of admission to psychiatric hospitals involving drug misuse. Of the 1,257 cases where a main diagnosis of drug misuse was recorded, 51% were in their twenties and 68% were males (ISD 2002)

In Scotland, 16.8% of male patients with a drug misuse diagnosis were also diagnosed with depression and 14.6% with anxiety, compared to 6.1% and 5.6% respectively of males without a drug misuse diagnosis. Drug misusing males were also more likely to have been diagnosed for alcohol problems (8.9%) than males attending with no drug misuse diagnosis (1.6%) (ISD 2002)

3.4 (c) Other important health consequences (eg. Drugs and driving, acute and chronic drug effects…)

In Scotland, in 1999/00, of 53,047 recorded maternities (live or stillborn), mothers had a diagnosis of drug misuse in 188 cases (3.5 per 1000 discharges). Drug misuse in maternities is believed to be under-recorded and, therefore, these figures are an underestimate (ISD 2002)

Durham constabulary are investigating every fatal RTA for drugs. According to press reports, blood screenings suggest that 12 out of the 23 fatalities examined so far involved drugs.

4 Social and Legal Correlates and Consequences

4.1 Social Problems

4.1 (a) Social exclusion (eg. Housing, unemployment, minorities, education)

Neighbourhood Renewal
Tackling drugs is part of the Government's Neighbourhood Renewal Programme which was launched in 2001. The aim of the initiative is to improve the country's most deprived neighbourhoods by raising standards of employment, educational attainment, housing, health and lowering crime rates. The Neighbourhood Renewal Unit is responsible for taking forward the National Strategy for Neighbourhood Renewal. Three New Deal for Community partnerships – a key neighbourhood renewal programme – have been chosen to integrate effective drugs prevention into regeneration strategies (NRU, 2002)

A Communities Against Drugs (CAD) initiative, announced in the 2001 budget, aims to build communities that are resistant to drugs. Under this initiative each CRDP is to receive a grant to help communities develop new solutions to drug problems (NRU, 2002). For further information see
http://www.neighbourhood.gov.uk/formatteddoc.asp?id=231

Working with prisoners
Job Centre Plus, working with the Prison Service, has introduced the Progress2Work employment initiative that provides specialist support to help those with a history of drug misuse find employment. Prisoners with a history of drug misuse are a priority group of potential clients.

Rough sleepers and Homeless People
It is estimated that the population of 'hidden homeless' people exceeds over 400,000 (Crisis, 2002), in addition to those in hostels, B&B's, squats and sofas. A study (Fountain & Howes, 2001) conducted in London (and therefore, may not be representative of the

whole of the UK) found 83% of those who had slept rough for at least 6 nights in the last six months had used a drug in the last month. Heroin was the main drug for 43% of respondents and all 43% scored as dependent on it. There is a very close link between drug use and homeless. 50% reported that drug use was one of the first reasons they became homeless and 80% had used at least one new drug since becoming homeless. Drug use, daily drug use, drug dependency and injecting increased with length of time in homelessness and the use of drug services, except needle exchange, was very low.

The Rough Sleepers Unit with the Dept of Health have set up initiatives to try and tackle drug use in homeless people. This included disbursing Drug and Alcohol Specific Grants to named people entrenched in rough sleeping and drug use. In 1997-1998, 20 schemes were approved (SEU, 1998)

Black and Ethnic minorities
It is apparent that there is a lack of health and social care service provision to Black and minority ethnic (BME) communities, although it is a very under-researched area. In some areas of England BME make up the majority of the population, not the minority. There is evidence that most serious drug-related problems are in areas of high unemployment and social deprivation. These areas are where the majority of BME groups live (Bashford et al., 2000; Bashford et al., 2001; Prinjha et al., 2001a; Prinjha et al., 2001b; Sheikh et al., 2001; Sheikh et al., 2002).

In the 1990s, general population drug use surveys and school-based surveys have suggested that BME respondents are the least likely ethnic group to use illicit substances. However, other more focused, qualitative research suggests the BME groups have similar drug taking patterns to the white population. The risk of involvement with drugs e.g.) trafficking, increases within BME groups due to the geographical proximity of Pakistan to Afghanistan. Evidence has shown that BME groups regard much of existing drug treatment services as run by, and for, white people (Bashford et al., 2000; Bashford et al., 2001; Prinjha et al., 2001a; Prinjha et al., 2001b; Sheikh et al., 2001; Sheikh et al., 2002).

The Department of Health and the Centre for Ethnicity and Health at the University of Central Lancashire have completed an initiative to include BME communities in the planning and delivery of drug services. 47 BME community organizations were trained and supported to conduct own drug needs assessments (Buffin et al., 2002)

4.1 (b) <u>Public nuisance, community problems</u>

Drug misuse isn't just a problem in deprived areas, but drug misuse and the crime and anti-social behaviour that is often associated with it compounds other problems that deprived neighbourhoods face and creates a downward spiral (UKADCU, 2001).

The visible effects of drug misuse scar communities and add to the fear of public safety and alienation. Other factors include a culture of hostility towards police and perceived lack of police presence; poor housing management in public and private sectors; high rates of truancy; poor physical design of housing estates and public areas, with dark corners and alleyways providing easy opportunity for crime and drug dealing; highly mobile populations leading to high turnover of tenancies and no stable community

support and properties standing empty and effectively abandoned also strengthen the cycle of deprivation (UKADCU, 2001).

Research by Lupton et al (2002) into drug markets in deprived neighbourhoods, while identifying the drug market as a problem, found it an insufficient condition for neighbourhood decline or depopulation on its own. Established markets were found to impede regeneration, by damaging community confidence and adding to the poor reputation of the area. Responses of local agencies were not adequate for the scale of the problem and there was an absence of co-ordinated multi-agency strategies at local level.

The Government funded CAD initiative is specifically aimed to remove drug-related obstacles to regeneration, by achieving close co-operative working between agencies related to the police, housing, education, employment, health and communities. Crime Disorder Reduction Partnerships work with DATs to strengthen communities, disrupt local drug markets and generally tackle drugs and drug related crime (UKADCU, 2001). It was decided by Home Office in 2002 to merge DATs and CDRP.

4.2 Drug Offences and Drug-Related Crime

4.2 (a) 'Arrests' for use/possession/traffic (distinguish police and Customs if possible) and trends

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

Data from police stop and searches, collected by the Home Office, show that arrests from searches are estimated to make up 9% of all arrests nationally for England and Wales (Home Office, 1999). As can be seen from Table 8, the police overall use searches most often to look for stolen property (2 out of every 5 searches) and drugs (a third of searches). 11% of searches lead to arrest.

Table 9: Searches and arrests from searches, 1998/9

Object of search/reason for arrest	All searches (%)	All search arrests (%)	Proportion of searches resulting in arrest (%)
Stolen property	40	30	9
Drugs	34	37	12
Firearms	1	1	11
Offensive weapons	5	7	14
Going equipped	14	7	5
Other	6	17	30
Total (number)	**100 (1,080,700)**	**100 (121,300)**	**11**

Source: Wilkins and Addicot (2000)

Notes

The reasons for a particular search may not always be the same as the reasons for the arrest. This occurs if the person searched is found to have a different illegal item than originally suspected.

'Other' searches describe those under other powers, such as the Prevention of Terrorism (Temporary Provisions) Act 1989, section 15; various poaching and wildlife conservation legislation; The Aviation Security Act 1982, section 27(1); the Customs and Excise Management Act 1979, sections 163 and 164; and the Sporting Events (Control of Alcohol etc.) Act 1985.

Figures may not total 100 because of rounding

Data from Drug Seizure and Offender statistics (calender year) 2000 show that there were 124,808 persons dealt with for drug offences. This is a decrease of 15% on the previous year and continues the downward trend from 1998. Fifty-seven percent (71,491) of persons were dealt with at court, the remainder were dealt with by compounding, a fiscal fine, a caution or other means such as recorded informal warnings (Corkery, 2002).

The majority of persons dealt with were male, 110,948 compared to 13,850 females. This is consistent with data from previous years (Corkery, 2002).

4.2 (b) Prosecution data (for drug offences and drug users)

The following figures relate to offences under The Misuse of Drugs Act 1971 such as unlawful production, unlawful supply and possession with intent to supply unlawfully (dealing), unlawful possession, permitting premises to be used for unlawful purposes, other Misuse of Drugs Act offences, unlawful import or export, and other offences involving drugs.

Of the 71,491 persons dealt with at court in 2000, 85% (60,837) were sentenced and the remainder found not guilty (Corkery, 2002).

4.2 (c) Convictions data and court sentences for drug offences

Of the 60,837 persons found guilty in 2000, 15% (9,386) were sentenced to immediate custody. Of these 8,073 were sentenced to unsuspended imprisonment and 1,312 were given a Youth sentence (Corkery, 2002). Of those 60,837 persons found guilty, 44% (26,515) were fined and 41% (24,961) received a Combination Order, fully suspended imprisonment, Community Service Order, Probation or Supervision Order, Absolute or Conditional discharge or were otherwise dealt with (Corkery, 2002).

Table 10: Persons found guilty by sentence of order given

	1995	1996	1997	1998	1999	2000
Total persons sentenced to immediate custody	7,086	8,788	10,580	11,052	11,428	9,386
Total persons fined	20,867	20,316	25,254	30,364	29,845	26,515
Total persons otherwise found guilty	16,186	17,380	20,719	27,595	27,479	24,961
Total found guilty	44,139	46,484	56,552	69,012	68,749	60,837

Source – Corkery 2002

Notes

Where a person is found guilty of two or more drugs offences at the same court appearance, the sentence or order shown in this table is the most severe penalty.

Court appearance data not available for Northern Ireland in 1998 to 2000.

4.2 (d) Imprisonment for drug law offences

Of the 9,386 persons sentenced to immediate custody in 2000 the following length of sentences were given:

Table 11: Persons sentenced to immediate custody for drug offences by length of sentence and year.

	1995	1996	1997	1998	1999	2000
Up to and including 1 month	1,107	1,286	1,514	1,995	2,039	1,692
Over 1 month and up to 3 months	953	1,141	1,424	1,845	1,924	1,390
Over 3 months and up to 6 months	892	1,123	1,307	1,442	1,382	1,118
Over 6 months and up to 1 year	1,128	1,345	1,541	1,601	1,376	1,128
Over 1 year and up to 2 years	1,171	1,495	1,628	1,583	1,575	1,284
Over 2 years and up to 5 years	1,429	1,854	2,338	2,134	2,468	2,377
Over 5 years and up to 7 years	226	287	330	262	358	259
Over 7 years	180	254	498	190	306	138
Total	7,068	8,788	10,580	11,052	11,428	9,386

Source – Corkery 2002

Notes

Immediate custody includes unsuspended imprisonment, partly suspended sentences, youth custody, detention centre sentences, training school orders and young offender institute sentences.

In the case of offenders with two or more sentences of immediate custody the offender is shown against the longest one except for Customs cases for 1995 when consecutive sentences were aggregated.
Court appearance data not available for Northern Ireland in 1998 to 2000.
Customs figures are not available for 2000; import/export figures are therefore based on police and court data.

The average sentence length was 20 months in 1999 and 2000 (Corkery, 2002).

On the 30th June 2000, the population under sentence in Prison Service establishments in England and Wales for drug offences was about 8,450 (Corkery, 2002).

According to the Prison Reform Trust report two in five of all female prisons are jailed for drug offences compared to one in fourteen of male offenders. See http://www.prisonreformtrust.org.uk/news-pr14.html

4.2 (e) Other drug-related crime:

- drug induced offences (violence, sexual offences, disorderly behaviours, driving offences…)

Data do not distinguish between drink-driving offences and drug-driving offences. However, there were 96,300 offences of driving after consuming alcohol or taking drugs in 2000 in England and Wales (Ayres & Hayward, 2001).

- revenue-raising offences (property crimes, drug dealing, illegal prostitution, prescription offences…)

Table 12 shows that unlawful possession was the most common offence in 2000, the same as previous years. 89% of drug offenders were found guilty of or cautioned for this offence. Most of these offenders were found in possession of cannabis, which is consistent with data throughout the last decade. However, the proportion is diminishing, 80% of people were dealt with for possession of cannabis in 1990 compared to 67% in 2000 (Corkery, 2002).

Offences of dealing fell from 15,400 in 1999 to 13,000 in 2000 (Corkery, 2002).

The most recent data regarding drug use and property crime come from 'Drugs and crime: the results of the second developmental stage of the NEW ADAM programme' (Bennett, 2000). Data from this study show that arrestees who tested positive for three or more drug types reported on average three times as many acquisitive crimes (mainly property offences) as those who had zero positive tests. They reported committing more than twice as many offence types and reported having eight times the illegal income. They also reported twice as many experiences of arrest in the last 12 months (Bennett, 2000).

With regard to specific drug types, half of the arrestees held for burglary in a non-dwelling (e.g. commercial premises) tested positive for cocaine (including crack) and two-thirds tested positive for opiates (including heroin). A large proportion of arrestees held for shoplifting offences also tested positive for these drug types (41% for cocaine and 64% for opiates). Of the arrestees held for assault, one-quarter tested positive for opiates and one-eighth tested positive for cocaine. Nearly one-third, however, tested positive for alcohol (Bennett, 2000).

- drug supply-related crime (production, cultivation, money-laundering, corruption of officials,…)

Illicit cultivation
For many years, most cannabis was imported from outside the EU, but intensive indoor cultivation of cannabis has gradually increased in scale. No detailed centralised records are maintained of the total number of illicit cultivation sites discovered, but the examination of all Police seizures of cannabis now suggests that about half originate from the UK or other European countries.

Illicit production
The UK is not a major centre for the production of synthetic drugs. In 2001, only four laboratories were raided by Police. In one of these, over 60kg of amphetamine were recovered, but in the others there was little evidence that any substantial synthesis had taken place

Table 12: Persons found guilty, cautioned or given a fiscal fine, or dealt with by compounding by offence and year.

	1995	1996	1997	1998	1999	2000
Unlawful production – cannabis	5045	4196	3840	3214	2579	1960
- Other drugs	296	258	350	319	263	203
- All drugs	5337	4439	4182	3528	2834	2156
Unlawful supply	4301	5108	5966	7210	6936	5742
Possession with intent to supply unlawfully	6554	7572	8305	9480	8479	7296
Unlawful possession – cannabis	68598	65099	79088	91153	82131	70305
- Other drugs	19326	23671	28262	33290	32387	27375
- All drugs	82796	83992	102149	117710	108353	92877
Permitting premises to be used for unlawful purposes	669	714	805	826	819	584
Other Misuse of Drugs Act offences	755	726	952	892	852	676
All Misuse of Drugs Act Offences	**92184**	**93621**	**112860**	**129179**	**119408**	**102599**
Unlawful import or export	1492	1571	1741	1152	1234	1490
Other offences involving drugs	4	14	48	439	455	379
All drug offences	**93631**	**95199**	**114629**	**130643**	**121056**	**104390**

Source – Corkery (2002)

Methodological comments
'Compounding' is a payment of a compound settlement in lieu of prosecution for minor personal use drugs offences (Customs and Excise Management Act 1979, Section 152). A 'fiscal fine', available only in Scotland, is a financial penalty imposed by procurators fiscal in relatively minor cases where there is no formal admission of guilt.

Statistical unit: Totals refer to the number of persons found guilty, cautioned, given a fiscal fine or dealt with by compounding per year for: unlawful production, unlawful supply, possession with intent to supply, unlawful possession, permitting premises to be used for unlawful purposes, other Drugs Act offences, unlawful import or export, or other drug offences. Although a person may be officially processed more than once per year, each processing event is recorded separately (as if in respect of a separate person). Persons with more than one offence (dealt with at the same processing event) are counted as a single

offender in the totals but are counted once for each separate type of offence. A person who has committed cannabis possession and trafficking offences will therefore be included once for each offence type but only once in the total.

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

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

As can be seen from Table 12 there was a decline of 24% from 1999 to 2000 in the total number of persons found guilty, cautioned or given a fiscal fine for the unlawful production of all drugs. There was an increase of 20% between 1999 and 2000 in the number of persons found guilty, cautioned or given a fiscal fine for the unlawful import or export of drugs. The data on all offences from 2000 continues the downward trend in drugs offences from 1998 (Corkery, 2002).

The proportion of offenders dealt with for 'trafficking' was 14% in 2000 (Corkery, 2002).

Standard Table 11 Arrests for drug law offences provides a breakdown of illicit drugs and figures related to each drug for persons who have been found guilty of or cautioned for drug-related trafficking offences and drug-related use offences. From this table it is possible to see a continuation in trends from 1999. For each drug type there were substantially more possession offences officially recorded than drug trafficking offences. In 2000, there were six times as many possession offences recorded than trafficking offences. In relation to cannabis there were eight times as many possession offences as trafficking offences and for amphetamines, there were four times as many possession offences as trafficking offences. In relation to remaining drug types, possession offences were more than twice as common as trafficking offences (Corkery, 2002).

In 2000, more than 104,000 were found guilty, cautioned or given a fiscal fine or dealt with by compounding for all drug offences. Of these, the majority (73%) had been processed for cannabis related offences. Twelve percent had been processed for offences relating to heroin and less than 7% were processed for cocaine, crack, amphetamine, ecstasy, LSD or methadone-related offences (Corkery, 2002).

In the five years preceeding, the majority of drug offenders were found guilty, cautioned, given a fiscal fine or dealt with by compounding for cannabis-related offences. The second most frequently processed drug offences from 1995 to 1998 were in relation to amphetamines. In 1999 the rank order of heroin and amphetamines reversed and this trend has continued in 2000. The number of offences involving amphetamines has declined considerably between 1999 and 2000 by 46%. The number of offences involving amphetamines (6637) in 2000 is almost level with that of ecstasy (6630). Offences involving ecstasy have continued to rise at a steady rate since 1998 (Corkery, 2002).

The decreasing trend in the overall total of drug offences between 1998 and 1999 has continued in 2000. This is a result of a reduction in the number of people processed for offences relating to cannabis, amphetamines, heroin, LSD and (to a lesser extent) methadone. Over the same period there were increases in the number of persons found guilty, cautioned, given a fiscal fine or dealt with by compounding for offences relating to cocaine, ecstasy and crack (Corkery, 2002).

4.3 Social and Economic Costs of Drug Consumption

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

A study conducted into the social and economic costs of Class A drug use in England and Wales in 2000 (Godfrey et al., 2002) estimated that drug abuse costs society up to £18 billion (€ 28,260bn) a year. Problem drug users are responsible for 99% of these costs. Each problem drug user is estimated to cost the state around £10,400 (€ 16,328) a year compared to 'recreational' users who's costs are estimated to be under £20 (€ 31) a year because they commit little crime and do not overburden the health service. This comparison excludes the estimated £12bn (€ 18.8bn) annual bill for the social costs to the victims of crime.

The research puts the economic cost to the health service, criminal justice system and the welfare state, at between £2.9bn (€ 4.5bn) to £5.3bn (€ 8.3bn). Adding the "social costs" increases the figure to between £10.1bn (€ 15.8bn) and £17.4bn (€ 27.3bn), said the Home Office.

4.3 (b) Estimates of total consumption/demand/expenditure on drugs

Consumption
Estimates of the total consumption of illicit drugs in the UK can be taken from a recent study commissioned by the Home Office entitled 'Sizing the UK market for illicit drugs' (Bramley-Harker 2001). This study estimated the 'street/retail quantities' of the drugs rather than the 'pure quantities' because the authors did not have access to reliable information about street purities. Estimates of consumption (and expenditure) where taken from 'regular users'', defined as having used a particular drug at least once a week, or four times during the last month and also included prevalence of 'occasional users' derived from 1998 British Crime Survey and 1998/1999 Youth Lifestyles Survey plus data from prisons derived from Mandatory Drug Testing (MDT) in 1999/2000. Although the majority of data relates to England and Wales, final estimates of a UK perspective have been obtained by inflating, on a pro-rata basis, the original data. The data was derived from the NEW-ADAM programme (New English and Welsh Arrestee Drug Abuse Monitoring Programme) and therefore likely to be unrepresentative of the UK as a whole, but still provides some useful estimates and a basis for future work.

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

Table 13: Estimates of the size of the UK [retail] market for illicit drugs for 1998

Drug	Value of market	Street price	"Street quantity" (= value of market/street price) (converted to kg)
Amphetamines	£257.7million (€ 404.6m)	£10 per gram (€ 16)	25,772
Cannabis	£1577.9 million (€ 2,477.3m)	£92 per oz (28 grams) (€ 144)	486,224
Cocaine	£352.8 million (€ 553.9m)	£77 per gram (€ 121)	4,582
Crack	£1817.4 million (€ 2,853.3m)	£20 per dose (0.2 grams) (€ 31)	18,174
Ecstasy	£294.6 million (€ 462.5m)	£11 per dose (€ 17)	26,786 (000 tablets not kg)
Heroin	£2313.0 million (€ 3,631.4m)	£74 per gram (€ 116)	31,257

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

From Table 13, in terms of gross weight cannabis is estimated to be the most widely consumed illicit drug in the UK, at 486,224 kg. This corresponds with 1998 and 2000 BCS data which state that cannabis is the most commonly used drug. It has the lowest retail price and developments in attitudes towards the drug in the general public in recent years (see section 1.3) could have contributed to its wide consumption.

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

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

Expenditure

From the study 'Sizing the UK market for illicit drugs' (Bramley-Harker 2001), the estimated total value of the UK of the drug market in 1998 was around £6.6 billion (€10.4bn). There are uncertainties based around this estimate though which need to be highlighted. The data are taken from the NEW-ADAM survey and these data only cover metropolitan areas or large conurbations, not rural areas. In order to obtain an estimate for the whole of the UK, the data from England have been extrapolated. The information

from the ONS population trends (ONS 2000) suggests that only 30% of the population of England and Wales live in rural areas, this gives a broad indication of the level of over-estimation in the Bramley-Harker 2001 study. The actual market may be significantly lower than estimated.

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

Table 14: Estimating annual expenditures of regular users (England)

Drugs	Average no. of days used in last 30 days	Average expenditure per day used (£)	Average monthly expenditure (£)	Average annual expenditure (£)
Amphetamines	15.2	9.31 (€ 14.62)	141.2 (€ 221.68)	1,695 (€ 2661)
Heroin	24.6	28.8 (€ 45.22)	709.6 (€ 1,114.07)	8,516 (€ 13,370)
Cocaine	17.0	13.68 (€ 21.48)	231.9 (€ 364.08)	2,783 (€ 4369)
Crack	20.2	-	848.6 (€ 1332.30)	10,183 (€ 15,987)
Cannabis	20.6	6.4 (€ 10.05)	132.0 (€ 207.24)	1,583 (€ 2,485)
Ecstasy	9.0	29.94 (€ 47.01)	257.2 (€ 403.80)	3,086 (€ 4845)

Source: Sizing the UK market for illicit drugs (2001)
Notes: (i) Figures for cannabis and ecstasy are included for illustration only.
(ii) Numbers may not add due to rounding.

Table 15: Estimated total expenditures of regular users, England (£m)

Drug	Estimated no of regular users in the community	Annual average expenditure (£)	Total expenditure (£m)
Amphetamine	105,925	1,695 (€ 2661)	179.5 (€ 281.8m)
Heroin	225,954	8,516 (€ 13,370)	1,924.1 (€ 3,020.8m)
Cocaine	98,344	2,783 (€ 4369)	273.6 (€ 429.6m)
Crack	148,832	10,183 (€ 15,987)	1,515.6 (€ 2,379.5m)
Total	-	-	3,892.8 (€ 6,111.7m)
Cannabis	563,209	1,583 (€ 2,485)	891.6 (€ 1,399.8m)
Ecstasy	70,486	3,086 (€ 4845)	217.5 (€ 341.5m)

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

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

Table 15 shows that the estimated total expenditure for regular users in England for amphetamines, heroin, cocaine and crack is £3892.8 million (€ 6,111.7m). This figure would obviously increase if cannabis and ecstasy were included.

Individually, crack is estimated to have the highest average annual expenditure for regular users at £10,183 (€ 15,987). Heroin is estimated to be second at £8,516 (€ 13,370), followed by cocaine at £2,783 (€ 4369) and finally amphetamines at £1,695 (€ 2661). This may alter if cannabis and ecstasy are included, particularly as cannabis is the most widely consumed drug in the UK (but it is the least expensive).

The estimated total of monthly expenditure on all drugs (see Table 14) is consistent with estimates from other sources (Parker and Bottomley 1996; Edmunds et al. 1998). Crack is estimated to have the highest monthly expenditure for regular users, followed by heroin, amphetamines then cocaine.

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

5 Drug Markets

5.1 Availability and Supply

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

There is still, as with last year's report, a lack of useful data concerning availability of drugs in the UK. The National Criminal Intelligence Service does provide estimates of the amounts of Class A drugs smuggled into the UK on a yearly basis. They estimate for 2002 that heroin remains in the region of about 30 tonnes whilst cocaine has risen to 40 tonnes. NCIS state that they have reason to believe that the figure for cocaine may be underestimated. Class A synthetic drugs are more difficult to estimate but it is likely to be a matter of tonnes or many millions of tablets. In addition, reports from police forces and published sources indicate that most drugs, including heroin, cocaine, crack and Ecstasy are widely available in most parts of the UK (NCIS, 2002).

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

A study by Lupton et al (2002) investigated retail drug markets in eight deprived residential neighbourhoods in six different regions of England in late 2001/early 2002. Heroin was found to be easily available in all markets and crack in six of the eight neighbourhoods. It was reported by the respondents that the availability and use of both heroin and crack appeared to be increasing, with crack rising more quickly from a lower base. There also seemed to be a high degree of market separation for heroin and crack and those for other drugs.

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

The National Criminal Intelligence Service state that Class A drug trafficking can be seen as the most significant threat to the UK in terms of serious and organized crime. The crack cocaine market appears to be growing and spreading to new areas with West Indian organized criminals, specifically Jamaicans and British criminals of Jamaican descent targeting established heroin markets with crack cocaine (NCIS, 2002).

Over 90% of heroin imported into the UK originates from Afghanistan-grown opium (Corkery, 2002). However, the events of September 11th and after-effects such as war and upheaval in Afghanistan, removal of the Taliban, a ban on opium poppy cultivation and general tightening of security at ports and airports will have an effect on the heroin trade but it is to early to predict (NCIS, 2002). Conversion to morphine and heroin mainly takes place in neighbouring countries in South West Asia and increasingly in Afghanistan itself. For these countries the drugs are transported via Iran, Pakistan, Turkey to Europe (Corkery, 2002). From Western Europe heroin then enters UK in freight and vehicles, predominantly through ports in Southern and Eastern England (Corkery, 2002).

The North London Turkish heroin traffickers' dominance of large-scale heroin importation into the UK has diminished and there is evidence of increasing involvement of British Caucasian groups in heroin smuggling. Distribution continues to be mostly from London, but Merseyside, Birmingham and Manchester are significant distribution points. Merseyside supplies most Class A drugs in Scotland and dealers from Northern Ireland send couriers to mainland via ferry to obtain small quantities of heroin (NCIS, 2002).

90% of cocaine seized originates in Colombia. HM Customs estimates that 65% of cocaine arrives in UK on cross-channel transport, 15% by ship, 15% by air, 4% by rail and 1% by mail (Corkery, 2002). However, estimates of cocaine production in the Andean region and Peru have been increasing (NCIS, 2002)

Synthetic drugs are produced in UK as well as countries such as Netherlands, France, Belgium and Spain (Corkery, 2002). There has been an increasing number in the last year or two of ecstasy type substance manufactured in Netherlands being smuggled into UK (Corkery, 2002).

Morocco is the primary source of cannabis resin for the UK market. Main routes for transshipment are by road through Iberian Peninsula, France and Belgium (Corkery, 2002).

5.2 Seizures
Trends in quantities and number of seizures (if possible, distinguish police and Customs)

The number of drug seizures fell in 2000 from 1999 by 7% to 124,345, continuing a declining trend from 1998. The number of seizures involving cannabis declined by 7% from 1999, but continued to represent the majority of all seizures (73%). Amphetamine seizures decreased considerably by 47% from 1999 to 2000. The number of seizures of ecstasy-type substances increased by 46% from 1999 to 2000 and the seizures involving heroin, cocaine and crack also increased slightly by 5%, 1% and 8% respectively. It was the second highest level ever of heroin seizures in the UK and the amounts of cocaine seized by Customs were at their highest ever levels in 1998 to 2000. There was an increase in seizures within the UK involving Class A drugs between 1999 and 2000 from 30,900 to 34,100, an increase of 10.3%. The police make the majority of seizures although Customs seizures constituted a higher quantity of drugs (Corkery, 2002).

Cannabis
In 2000, the number of seizures of cannabis overall (by all enforcement agencies) was down from 1999. The number of seizures fell from 98,450 to 91,306. However, the quantity of seizures (excluding cannabis plants) rose from 70,737kg to 73,668kg (Corkery, 2002). Police seized 37,648kg and Customs seized 36,020kg. The number and quantity of Customs seizures was down on 1999, but the quantity of police seizures rose by 169% from 14,016kg to 37,648kg.

Heroin
In 2000, there were 16,295 seizures of heroin which is an increase of 776 on the 1999 figure. The quantity of heroin seized in 2000 was 3,382kg, an increase of 44% on 1999. The police again made the majority of the heroin seizures in terms of both number and quantity. The police made 16,122 seizures totaling 1,990kg while Customs made 173 seizures totaling 1,392kg. The number of heroin seizures carried out by both police and Customs had increased from 1999 (a 5% increase by police and a 9% increase by Customs). The quantity of Customs seizures increased by 64% from 1999 and the quantity of police seizures increased by 33% (Corkery, 2002)

Cocaine
Overall 5,898 seizures of cocaine were made in 2000. Seizures involving cocaine accounted for 17% of all seizures involving Class A drugs. 3,945kg of cocaine were seized, which was a rise of 33% on the previous year. The police made 4,750 seizures while Customs made 1,148. Although, Customs made more seizures in terms of quantity (2,371kg) than the police (1,574kg) and cocaine was the Class A drug most frequently seized by Customs. There was a decrease of 5% from 1999 in the quantity of cocaine seized by Customs but an increase of 32% in the number of seizures. The quantity of seizures made by the police rose by 230% from 1999 to 2000 but there was a 5% decrease in the number of seizures

Ecstasy
Overall, 9,664 seizures of ecstasy were made and 6,534,813 doses were seized in 2000. The quantity of ecstasy doses seized reached a new peak in 2000. The police (9,518) made the vast majority of seizures in terms of numbers with Customs only making 146, while the majority of seizures in terms of quantity was made by Customs, 3,862,200 doses compared to 2,672,613 doses by the police. The overall number and

quantity of seizures by both police and Customs increased between 1999 and 2000. The number of police seizures rose by 46% while the quantity increased by 78%. The number of Customs seizures rose by 147% and the quantity decreased by 20% (Corkery, 2002)

Amphetamines
7,032 seizures of amphetamines were made overall in 2000. The quantity of seizures decreased by 13% from the previous year. The police made the majority of seizures in terms of both number (6,935 in comparison to Customs 97) and quantity (1,047kg compared to Customs 718kg). The number of seizures by both police and Customs fell from 1999 (by 48% and 5% respectively) and the quantity of seizures rose by 146% for police and decreased by 36% for Customs (Corkery, 2002).

5.3 Price/purity

5.3 (a) Distinguish trends at retail (street) level and trafficking level if possible

Price
Information on the average price of drugs is provided by the National Criminal Intelligence Service (NCIS) who collect data from police test purchase operations. The average price of heroin in 2001 was 104 euros which is 6 euros cheaper than in 2000 and 2 euros more expensive than the average price in 1999. A gram of cocaine was 98 euros on average in 2001. This is 4 euros cheaper than in 2000. A rock of crack cost 31 euros on average in 2001 which is 5 euros cheaper than 2000 but the same as the unchanged price from 1996 to 1999. Cannabis (leaves and resin) cost 5 euros per gram on average in 2001 which is consistent with prices for 2000. The average price on an ecstasy tablet was 13 euros on average in 2001, which is slightly cheaper than 2000 and the unchanged price from 1996 to 1999 (17 euros). On an inflation-corrected basis all drug prices in the UK have continued to fall.

Information on average prices can also be gained from the 2001 Independent Drug Monitoring Unit Drug Users Survey. According to this survey, the average price of heroin in 2001 was 85 euros, this is a decrease of nearly 10 euros from 2000 and 4 euros from 1999. A gram of cocaine was 72 euros on average in 2001, which is 6 euros cheaper than in 2000. The average price for cocaine between 1997 and 1999 fluctuated between 80 euros (1997) up to 82 euros (1998) and back to 80 euros in 1999. A rock of crack cost 30 euros on average in 2001. This is similar to figures from NCIS. However, data from previous years on crack are not consistent with data from NCIS with the average price being 32 euros in 2000, 37 euros in 1999. Cannabis resin cost 2 euros per gram in 2001 which is similar to the average price in 2000. The average cost of cannabis leaves in 2001 was 5 euros. This price however is based on ‘skunk’, a more potent and expensive form of cannabis. The price of ‘skunk’ has remained stable since 1997. The average price of an ecstasy tablet was 10 euros in 2001, 1 euro cheaper on average than 2000.

Purity
Information on the average purity at street level of certain drugs is provided by the Forensic Science Service, which analyses seizures made by the police and customs. This information relates to the data provided in Standard Table 14 Purity at Street Level

of Some Illegal Substances and Standard Table 15 Composition of Tablets Sold as Illicit Drugs.

Brown heroin, on average, was 54.1% pure in 2001, which continues the increasing trend in purity of the last few years (in 2000 the average was 47%, in 1999, 43%, in 1998, 37% and in 1997, 35%).

In 2001, cocaine was, on average, 57.7% pure. This is higher than in 2000, when it was on average 52% pure. In 1999, the average purity was 62%, in 1998, 54% and in 1997, 52%. The purity of crack in 2001 was 72.8%. This is an increase from 2000, when it was at its lowest for the last 5 years at 66% average purity. The average purity ranged from 80 - 84% between 1996 and 1999.

The average purity of amphetamine has also increased, from 5% in 2000 to 10% in 2001. Again, amphetamine had the lowest average purity over the last five years in 2000. Between 1997 and 1999 the average purity was between 14% and 16%.

In 2001, the average MDMA drug content of tablets was 75mg. This is close to values found in the period 1997 to 2000.

The average MDEA drug content of tablets in 2001 was 39mg, although the sample size consisted of only 3 tablets. The average MDA drug content of tablets was 37mg and the sample size consisted of 2 tablets. There are no data from previous years with which to compare this information.

The average amphetamine drug content in tablets in 2001 was 7mg compared to 10mg in 2000.

6. Trends per Drug

6 (a) Information from different indicators and other sources plus comments on possible reasons and factors that may be associated to reported trends for each substance.

See sections 2 and 3 above.

6 (b) Analysis for the following substances

Cannabis
In England and Wales for respondents aged 16-59 cannabis use ‘ever’ has increased slightly from 21% in 1994, 22% in 1996, 25% in 1998, 27% in 2000 to 29% in 2001. Use in the last 12 months of cannabis was 8% in 1994, remained stable at 9% from 1996 to 2000 and increased to 11% in 2001(BCS, 2002, in press). 35% of males has used cannabis ‘ever’ in 2001 compared to 23% of females. In 1998, 31% of males had used cannabis ever compared to 20% of females.

Cannabis use for respondents aged 16-24 has remained stable at 44% in 1998 and 2001 for use ‘ever’ of the substance and 27% in 1998 and 2001 for cannabis use in last 12 months (BCS, 2002, in press). In 2001, 33% of males aged 16-24 had used cannabis in the last 12 months compared to 21% of females. In 1998, 32% of males aged 16-24

had used cannabis in the last 12 months compared to 22% of females in the same age group.

Synthetic drugs (amphetamine, ecstasy, LSD, other/new)
In England and Wales respondents aged 16-59 ecstasy use 'ever' has increased from 2% in 1994, 3% in 1996, 4% in 1998, 5% in 2000 to 6% in 2001. Use in the last 12 months remained stable at 1% in 1994, 1996, 1998 to 2% in 2000 and 2001 (BCS, 2002, in press). 8% of males had ever used ecstasy in 2001 compared to 4% of females. In 1998, 5% of males had ever used ecstasy compared to 3% of females.

Ecstasy use 'ever' for respondents aged 16-24 was 11% in 1998 and 12% in 2001 and use in last 12 months was 5% in 1998 and 6% in 2001 (BCS, 2002, in press). 10% of males aged 16-24 had used ecstasy in the last 12 months compared to 3% of females in 2001. In 1998, 6% of males had used ecstasy in the last 12 months compared to 4% of females.

Respondents aged 16-59 amphetamines 'ever' use was 8% in 1994, 9% in 1996, 10% in 1998, 11% in 2000 and 12% in 2001. Use in the last 12 months was 2% in 1994, 3% in 1996 and 1998, dropping again to 2% in 2000 and 2001 (BCS, 2002, in press). 15% of males had ever used amphetamines in 2001 compared to 9% of females. In 1998, 13% of males had ever used amphetamine compared to 8% of females

Amphetamine use 'ever' for respondents aged 16-24 was 10% in 1998 increasing to 16% in 2001. However, use in the last 12 months for those aged 16-24 has decreased from 10% in 1998 to 5% in 2001 (BCS, 2002, in press). 7% of males had used amphetamines in the last 12 months in 2001 compared to 2% of females. In 1998, 12% of males had used amphetamines in last 12 months compared to 8% of females.

Heroin/opiates
In England and Wales for respondents aged 16-59 heroin use 'ever' was around 1% from 1994 to 1998, increased to 2% in 2000 and dropped to 1% again in 2001. Use of heroin in the last 12 months was 1% in 1994, under 1% in 1996 and 1998, 1% in 2000 and under 1% again in 2001 (BCS, 2002, in press).

Heroin was most frequently reported as the main drug of use for 67% of users in the period ending 31st March 2001 in the RDMD (Department of Health, 2002b).

Cocaine/crack
In England and Wales cocaine (including crack) use 'ever' was 8% in 1998 and 9% in 2001 for respondents aged 16-24 (BCS, 2002, in press).

In 2001, 7% of males aged 16-59 had ever used cocaine compared to 3% of females. In 1998, for respondents belonging to the same age group, 6% of males had ever used cocaine compared to 3% of females.

For respondents aged 16-24, 7% of males had used cocaine in the last 12 months compared to 2% of females. In 1998, 4% of males had used cocaine in the last 12 months compared to 3% of females.

Multiple use (including alcohol, pharmaceutical products, solvents)

Data from the RDMD ending March 2001shows that subsidiary use accounted for 47% of drugs used. 8% of the 24,458 users reported misusing heroin, were using heroin as a subsidiary drug. Drugs reported mostly as subsidiary drugs were benzodiazepines (89% of users), cannabis (66% of users) cocaine (70% of users) and ecstasy (75% of users).

7 Discussion

7.1 Consistency between Indicators

Analysis of relationship between different indicators (consistencies and inconsistencies) on major trends

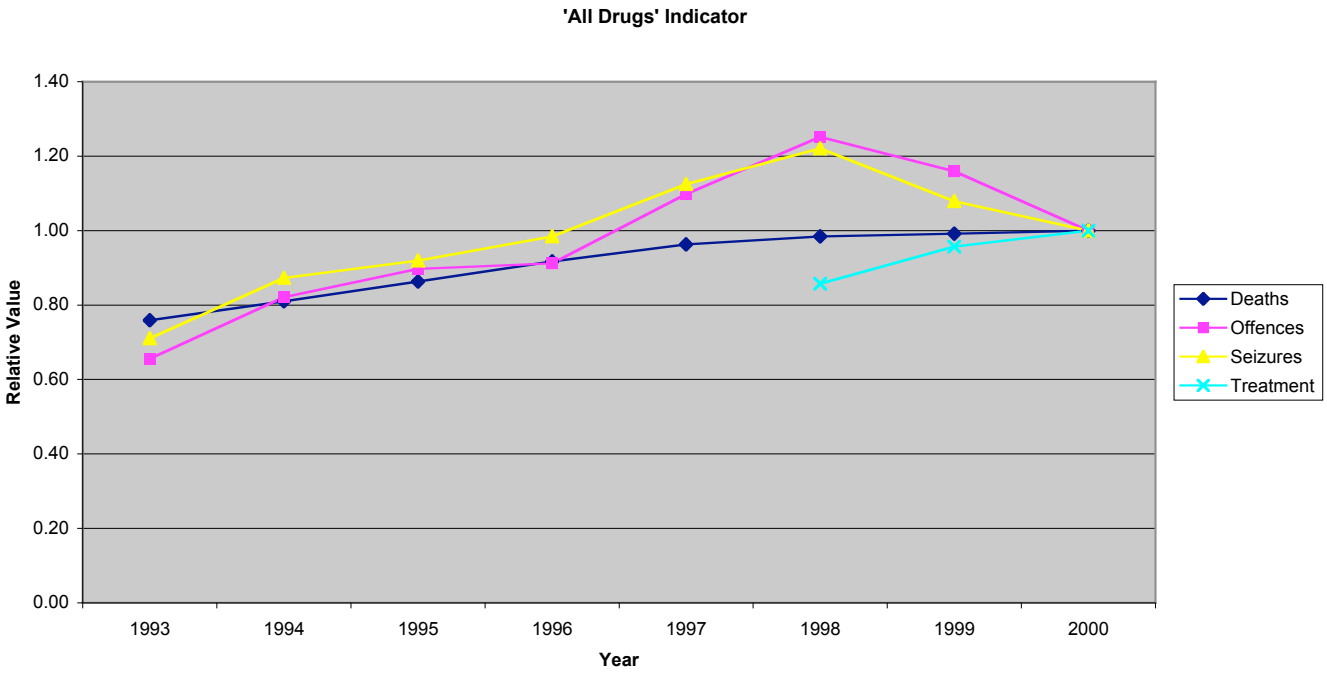
In 2000, an increase in the number of drug related deaths where cocaine was identified was mirrored in the amount of crack cocaine seized. It should be noted that it is not possible to differentiate between cocaine and crack cocaine in drug related deaths. Increases in the use of cocaine by young people were found in successive sweeps of the BCS and the numbers of users citing cocaine as their main drug within the treatment demand indicator has increased (at least in England).

Figure 7 describes the changes in four of the indicators – the number of drug related deaths, the number of seizures, the number of people found guilty of drug offences (or dealt with by compounding) which we label in the chart as ‘offences’ and the number of users starting agency contact. The first four of these indicators are derived from yearly totals, but for this limited comparative exercise, the treatment demand indicator is taken from the six-month period at the end of a given year. Thus the treatment demand figure for 2000 is derived from the number of users starting agency contact between 1st October 2000 and 31st March 2002.

Clearly the different indicators have different scales, for example the number of drug related deaths each year is far less than the number of users starting agency contact. Therefore in an attempt to provide more meaningful comparisons between the various indicators, some form of standardisation is required. In the following charts, the value of the indicator in 2000 is taken as a benchmark figure from which the values from previous years are compared against. For example, the relative value for any given indicator in the year 1999 will be the actual value of the indicator that year divided by the value of the indicator in 2000. While one effect of this is to make the indicators all appear to converge at one point in 2000, using relative values makes it more easier to examine similar trends in the indicators.

Figure 7 presents the changes in the indicators from 1993 to 2000, relative to the values in 2000. This chart, as with the following charts, only uses the readily available published data, therefore only includes 3 points of the treatment demand indicator.

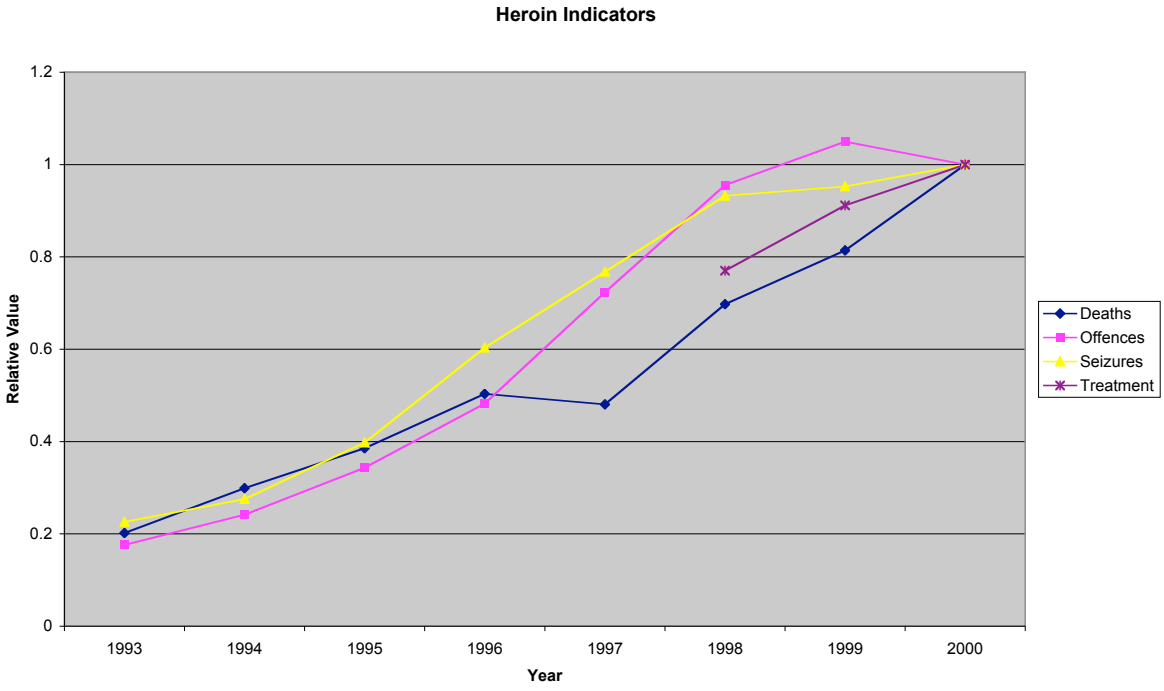
Figure 7: Relative changes in values of the indicators, 1993-2000



From Figure 7, there appears to be a steady increase in the deaths, seizures and offences indicators from 1993 to 1998, but while the treatment demand indicator has increased and the deaths indicator has levelled off between 1998 and 2000, the seizures and offences indicator has decreased.

The indicators combine information from a range of drugs, including cannabis, ecstasy, amphetamines, cocaine and heroin. Therefore examining changes in the 'all drugs' indicator may mask changes in the individual drug indicators. Figure 8 presents changes in the indicators relating to heroin.

Figure 8: Relative changes in values of the heroin indicators, 1993-2000



It is clear from Figure 8 that over the period 1993 to 2000, the heroin indicators have all shown a marked increase, with perhaps a slight decrease from 1999 to 2000 in the offences (but not the seizures) indicator.

There has been increasing concern throughout the United Kingdom about rises in the levels of cocaine and crack cocaine use. Figure 9 below, charts the increase in the indicators for cocaine. This figure is followed by the corresponding chart for amphetamines (Figure 10) which shows that in the previous few years, levels of amphetamine use have decreased. While indicator data such as these may not be directly linked to drug use prevalence, there is merit in the argument that while cocaine use has been increasing, amphetamine use has been decreasing and that people may be switching from amphetamine to cocaine use.

Figure 9: Relative changes in values of the cocaine indicators, 1993-2000

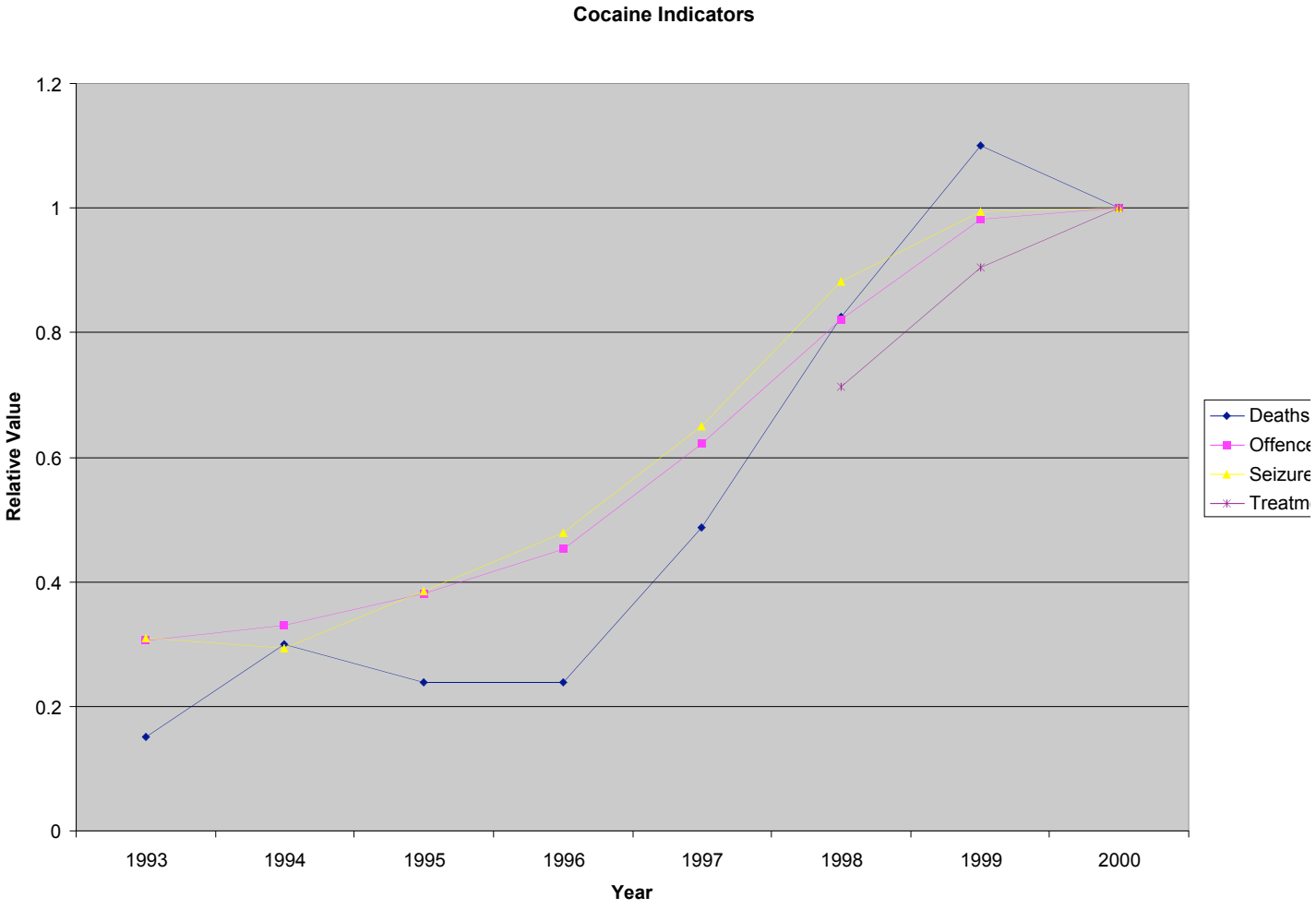
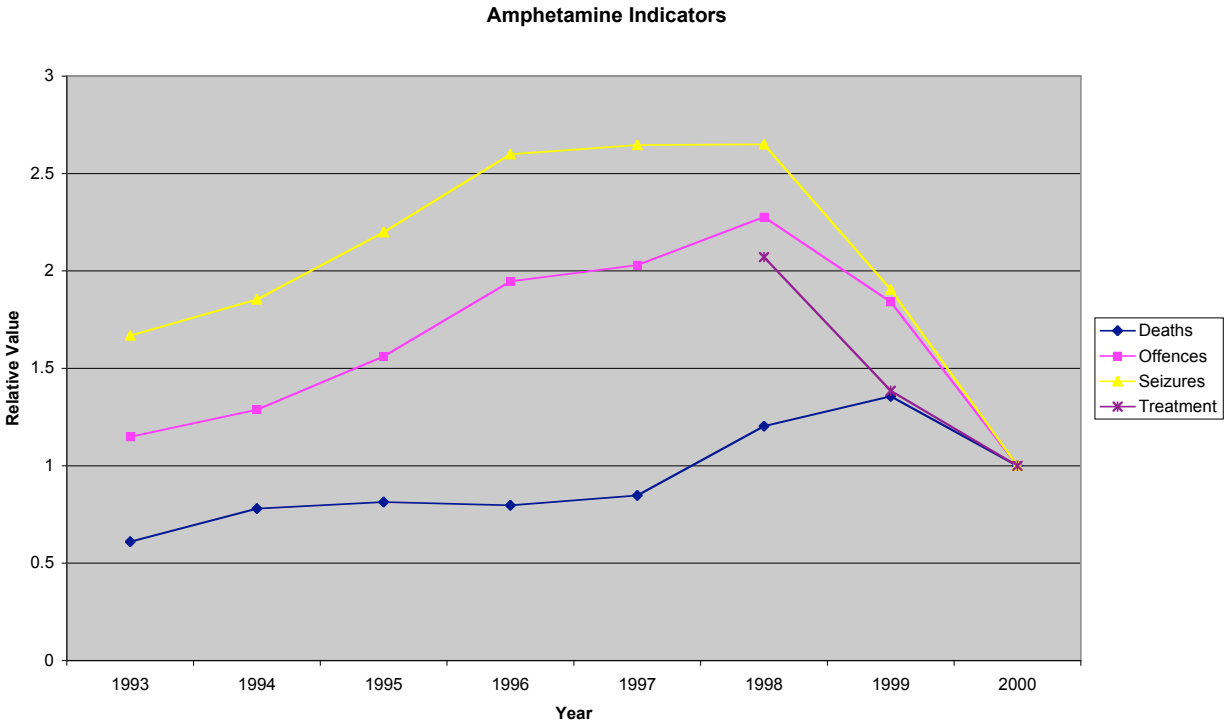


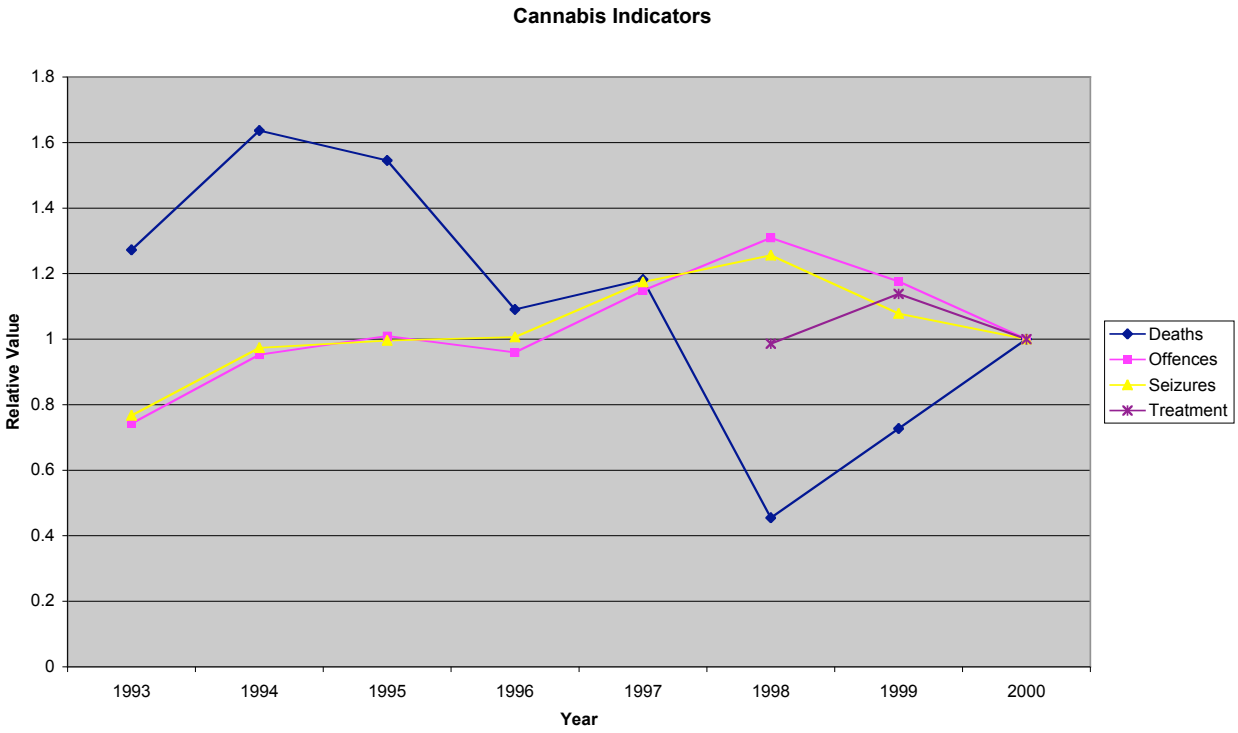
Figure 10: Relative changes in values of the amphetamine indicators, 1993-2000


Amphetamine Indicators
Relative Value
3
2.5
2
1.5
1
0.5
0
1993
1994
1995
1996
1997
1998
1999
2000
Year
Deaths
Offences
Seizures
Treatment

Finally, for completeness, trends in the cannabis indicators are shown in Figure 10 below.

Figure 11: Relative changes in values of the cannabis indicators, 1993-2000

The interpretation of Figure 11 is less straightforward, particularly in the shift in emphasis



within the Police towards Class A drugs. As cannabis is implicated in very few deaths each year, there will be increased variation in relation to a given time point as shown above.

So to summarise, it is clear that over the past decade, the different drug indicators have shown, in general, a steady increase. When examining specific drugs, there appears to have been recent decreases in the amphetamine indicators which, however, have been countered by increases in the cocaine indicators. Consideration has been taken into the reasons why indicators such as these are, in general, increasing in the United Kingdom. Increases in any given indicator may be reflecting changes in policies or data collection procedures rather than changes in drug use prevalence. It may therefore be difficult to consider under what circumstances some of the indicators, such as drug treatment demand, would decrease to such an extent that would suggest substantial changes in drug use prevalence in the United Kingdom.

7.2 Methodological Limitations and Data Quality

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

PART 3 DEMAND REDUCTION INTERVENTIONS

8 Strategies in Demand Reduction at National Level

8.1 Major Strategies and Activities

With regard to young people, delivery of integrated approaches to drug education, prevention, early detection and treatment will be planned locally through Young Peoples Substance Misuse Plans. Credible messages about the level of harm posed by different drugs are delivered through schools as part of a planned programme of Personal, Health and Social Education (PHSE and awareness campaigns)

The National Treatment Agency (NTA) was created by the Government on 1 April 2001 with a remit to increase the capacity, quality and effectiveness of drug treatment in England. The NTA will promote practice which is evidence-based, appropriately delivered, outcome focused, and integrated into a system of co-ordinated drug treatment and care. To equip DATs and service providers to meet this agenda the NTA will:

- distil and disseminate best practice drawn from research;
- collaborate with others to initiate research into effectiveness;
- support the development of quality systems of treatment promoting and building on existing good practice;
- develop systems of standards and accreditation for services, individuals and programmes of interventions;
- enhance the competence of managers and staff across the treatment sector; and
- develop and implement a human resources strategy to attract and retain high quality staff with drug treatment as a career.

The Government has announced plans to reclassify cannabis from class B to class C. This is intended to make a clear distinction between cannabis use and more dangerous Class A drugs and to encourage a more honest debate about the dangers associated with cannabis use, particularly frequent use.

8.2 Approaches and New Developments

8.2 (a) <u>New and innovative approaches</u>

An ‘Integrated Young People’s Substance Misuse Plan’ is intended to promote effective strategic planning at local level in line with Government’s national priorities.

The Scottish Executive Final Report of the School Drug Safety Team recommends developing drug education programmes and recognizing and dealing with incidents of drug use in schools. The report is available at http://www.scotland.gov.uk/library3/health/sdst_final_report.pdf

8.2 (b) Socio-cultural developments relevant to demand reduction

The Department of Health and the Department for Education and Skills announced in June 2002 new measures to tackle drugs in schools. The Education Minister, Ivan Lewis promised zero tolerance for those caught supplying drugs within the school gates; all new teachers will undertake training in drugs education by September 2002; new powers for OFSTED, which will be tasked to formally assess the standard of drugs education in secondary schools; practical guidance and a new website for teachers will be launched; a new look at how shock tactics can be effectively used when targeted at certain age groups and within a wider educational framework; discussions with the Home Office to look at new measures to tackle drug dealing in the vicinity of schools and which is targeted at young people of school age; new guidance for parents with emphasis on supporting head teachers in behaviour and drug policies and alcohol education will be given a higher priority, tackling the issue of underage drinking which can often contribute to anti-social behaviour. For further information see: http://www.dfes.gov.uk/pns/DisplayPN.cgi?pn_id=2002_0103

8.2 (c) Developments in public opinion

See section 1.3 above

8.2 (d) New research findings

An evaluation of a drugs prevention advisory programme, published by Drugs Prevention and Advisory Service (DPAS) has concluded that young people who are at risk of exclusion, need drugs education earlier.

8.2 (e) Specific events during the reporting year

See section 1.2 above - In June 2001 Government amended to Section 8(d) of Misuse of Drugs Act so that premises owners can be prosecuted for allowing the use of any controlled drug on their premises. This could have major implications for drug agencies.

9 Prevention

9 (a) National strategy

The United Kingdom Government's White Paper, 'Tackling Drugs to Build a Better Britain' sets out a ten-year strategy for tackling drug misuse in the United Kingdom. There are 4 main elements of the strategy, focusing on Young People, Communities, Treatment and Availability. The aim for Young People focuses primarily on Class A drug use and frequent use of any drug (HMSO, 1998).

Scotland, Wales and Northern Ireland have all embraced the 4 overarching elements of the UK drugs strategy. Each country has however adopted objectives within the elements that are relevant to the their specific circumstances (Tackling Drugs in Scotland: Action in Partnership, 1999; Tackling Substance Misuse in Wales, 2000; Northern Ireland Drug Strategy, 1999).

9 (b) Organisation and co-ordination within national structures

Three government departments share the responsibility of drug prevention in England. These are the Home Office, the Department for Education and Skills (DfES) and the Department of Health (DH). The Drug Prevention Advisory Service (DPAS) works at national, regional and local levels to implement the 10-year strategy (HMSO, 1998). At a local level they provide support for the Drug (and Alcohol) Action Teams (DA(A)Ts) which are local level multi agency groups.

Scotland, Wales and Northern Ireland have similar but separate strategies, as mentioned in section 9(a) above, and also similar local coordinating groups.

Young People's Substance Misuse Plans underpin the Governments vision/idea for an integrated approach to drug education, prevention and treatment services for children and young people which is incorporated into the wider framework for children's service planning. The operational outputs which all local DA(A)Ts must achieve by 2004 include all young people (and their parents/carers) receiving education, advice, information and support on substance misuse both in and out of school settings.

9 (c) Expenditures on prevention in Member States (specify expenditures on institutions working in the field of prevention)

Funding for drug education and prevention is increasingly being devolved to a local level for distribution for local initiatives and projects.

The Department of Health allocated £4 million (€ 6.3m) for drug education for the 2001/2002 financial year. With a further £4.12 million (€ 6.47m) allocated for the 2002/2003 financial year to support drug education in primary schools through nationally recognised local Healthy School Programmes (http://www.doh.gov.uk/drugs/standardsfund308.pdf). The Department for Education and Skills funding with reference to drug, alcohol and tobacco education, for the same period is £14.5 million (€ 22.8m). This breaks down to £7.5 (€11.8m) Standards Fund for drug, alcohol and tobacco education, £5.7 (€ 8.9m) for school drug, alcohol and tobacco advisers and £1.3 (€ 2m) for the training/resource package. There is also £1 million (€ 1.6m) for Connexions Advisers.

The Home Office has recently conducted a large consultation on the creation and use of Pooled Budgets, this is still under consideration, however the idea would mean all identifiable substance misuse funds for children and young people being channeled through one department to act as banker for local services with a joint commissioning body (with representatives of all departments) allocating funding to local services.

The Home Office allocated £4.5 million (€ 7.1m) to support the implementation of an integrated local plan for young people's substance misuse services.

The Youth Justice Board allocated £7 million (€ 11m) to ensure that each Youth Offending Team could employ a designated drugs worker and a further £1 million (€ 1.6m) for young people's substance misuse treatment.

9.1 School Programmes

9.1 (a) Specifities of policies

The role of schools is integral in delivering the government's 10-year strategy. They are required to teach a comprehensive drug education programme to Children and Young People. Drug education also has an important role in the implementation of the government's Public Health strategy, to improve health and reduce health inequalities (Department of Health, 1999).

The key policy documents around school drug education are;

- Protecting Young People; Good practice in drug education in schools and the youth service (DfEE[1] 1998).
- Circular 4/95 Drug Prevention in Schools (DfEE 1995).

The Qualifications and Curriculum Authority (QCA) produces the National Curriculum documents which all schools in the state sector must follow. Schools outside the state sector are not compelled to follow the National Curriculum, however most do. Drug education is a statutory requirement as part of science orders in the National Curriculum (QCA 1999a,b). There is also a non-statutory framework for Personal, Social, Health Education & Citizenship (PSHE&C) (QCA 2000), which includes drug, alcohol and tobacco education from Key Stage 2[2]. This provides opportunities for drug education in a broader context. The National Curriculum document states that the school curriculum should aim to provide opportunities for all pupils to learn and achieve. In terms of drug and alcohol education it should 'develop (pupils') physical skills and encourage them to recognise the importance of pursuing a healthy lifestyle and keeping themselves and others safe….' (Alcohol Concern/DrugScope 2001).

9.1 (b) Models of school interventions

Drug education in the UK generally follows a life-skills approach which offers opportunities for developing skills alongside knowledge and attitude testing.

Each Local Education Authority (LEA) is responsible for the drug education programmes in their region schools. All LEAs employ someone responsible to taking drug education forward such as a School Drugs Adviser.

9.1 (c) Prevention programmes available in the country

National Healthy Schools Standard (NHSS) forms a key part of a programme led by the and the Department for Education and Skills (DfES) and Department of Health (DH), the National Healthy Schools Programme. With support from other agencies a healthy

[1] Department for Education and Skills (DfES) formerly Department for Education and Employment (DfEE).

[2] Key Stage Ages; Key Stage 1 – 5-7yrs, Key Stage 2 – 7-11yrs, Key Stage 3 – 11-14yrs Key Stage 4 – 14-16 yrs

school is in a key position to improve children's health educational achievement as drug, alcohol and tobacco education is a key theme in the standard. This national programme involves an accreditation process for local health and education partnerships. There has been no national evaluation of this scheme but there is guidance for programme evaluation at a local level.

The Department of Health (DH) National Drug Prevention Development Team (incorporating the DH Drug Prevention Projects Programme) supports the work of over 50 Primary Schools / Primary Care Health Links Projects throughout England in a diverse range of localities. They aim is to establish links between primary and community health care professionals and primary schools to support teachers in delivering health education with the National Healthy Schools Programme including substance misuse issues.

57 Positive Futures projects have been established to engage vulnerable young people in high crime areas within sport activities. Promising evidence is emerging of reductions in substance misuse and other positive impacts (evaluation underway)

9.1 (d) Evaluation studies and results

The Office for Standards in Education (OFSTED) monitor schools' policies and practice in drug education and management of drug related incidents as part of a regular programme of inspections. In their report on drug education in schools in September 2000 they found that there were 75% of primary schools and 93% of secondary schools that had a drug education policy. Results from the most recent survey indicate that in the majority of lessons which featured drug education, pupils achieved adequate levels of 'knowledge and understanding' of drugs and their effects. Some lessons however, were found to be too short for effective learning to take place. Forty two (42%) of primary schools and 95% of secondary schools had a policy covering drug-related incidents (OFSTED, 2000).

Drug Action Team datasets record how many schools in their local areas that have quality drug education programmes.

The 'Drug Education in Schools, 2000/01' survey was published by the Scottish Executive Education Department in July 2001 and showed that 97% of schools in provided drug education in Scotland. Virtually all secondary schools reported providing drug education while 98% and 80% of responding primary and special schools, respectively, said they did so (Scottish Executive, 2001).

Results from the a survey of pupils in Northern Ireland conducted in October and November 2000 showed that in the previous school year almost three quarters (73%) have had some form of drug education (Department of Finance and Personnel, 2002).

The National Drug Prevention Development Team at the Department of Health are currently accepting tenders for the evaluation of the Primary Schools/Primary Care Health Links Project. This is expected to begin in September 2002.

DPAS published an evaluation of drugs prevention delivered through a 'Family of Schools' structure. This structure was implemented in two school 'Families', two secondary schools and a number of primary feeder schools. The aim was to bring about

greater consistency in the provision of drugs education between primary and secondary schools and to promote a co-ordinated educational approach with other agencies such as the police and youth workers as well as schools. The evaluation found that drugs information and education needs to be supported by other agencies more closely involved in drugs work to assist in awareness-raising. The teachers greatly valued the external guidance on providing effective drugs education and multi-agency working needs to link institutions not only on an individual basis but also at policy and management levels (Harris, 2001)

The outcome evaluation of Project Charlie demonstrated that children who had received drug education at early age were more knowledgeable about drugs and their decision making and ability to resist negative peer pressure was superior (for more information see EDDRA database at http://www.emcdda.org/responses/methods_tools/eddra.shtml)

9.1 (e) Research projects

Blueprint is a Home Office and DfES research programme set up to evaluate the development of a multi-component approach to school based drug education, targeting youth aged 11-13. The (including parent education programme and a media strategy) approach to school based drug education. The research will assess the programme in terms of its impact on, alcohol use, tobacco use, solvent use and use of any drug. It will also examine pupil involvement in, and satisfaction from, drug education and parents communications with children. Implementation and evaluation will commence in 2003 and the findings will be reported in 2007.

9.2 **Youth** Programmes **outside School**

The key policy document mentioned in section 9.1(a) 'Protecting Young People' also provides policy guidance for drug education outside the school setting and in particular in the youth service.

9.2 (a) Definitions used

It is difficult to draw a clear line between definitions of young people, adolescents and children as lower age distinctions vary widely between departments and services. The term 'children' refers to all those individuals who are under the age of 18, in accordance with the UN Convention on the Rights of the Child. Local authorities acting under certain provisions within the Children Act 1989, Courts and the Prison Service may also consider the term 'young people' to refer to those up to the age of 21 (SCODA, 1998)

9.2 (b) Types and characteristics of interventions with youth outside school.

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

variety of sources within the voluntary and statutory sectors. The schemes mentioned here are national programmes designed to have an impact on vulnerable young people.

Connexions, established in April 2001, is a support and advice service for young people aged 13-19 that incorporates the screening of young people at risk and makes referrals to specialist drug services. 27 partnerships are now operational and the remaining 20 coming on stream by 2003. This service is primarily delivered through a network of personal advisers who co-ordinate with specialist support services (Drugs Prevention Advisory Service, 2000). As mentioned in section 9(c) the budget allocation for Connexions Advisers in 2002 – 2003 is £1 million (€ 1.6m).

Positive Futures is now operating in 57 deprived areas to divert vulnerable young people away from drugs and crime through involvement in sport. Initial results are very encouraging, showing reductions in criminal activity and truancy and improved community awareness.

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

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

9.2 (c) Statistics and evaluation results

The National Drug Prevention Development Team at the Department of Health has commissioned a research team at the University of Glasgow to conduct a national evaluation of pump-priming drug prevention projects in Health Action Zones. The evaluation began in January 2002 and is funded until June 2003. The main aims of the project are: to establish whether the pump-priming initiative has resulted in an expansion of effective and sustainable services; to strengthen the evidence base about drug prevention services for vulnerable young people; and to contribute to the development of guidance about best-practice models of intervention.

OFSTED is also now responsible for the inspection of the Connexions Strategy. Local Connexions Partnerships will include the Careers Service and other services (e.g. youth, probation) with the intention of encouraging young people up to the age of 19 to continue in education, training or employment (www.ofsted.gov.uk/inspect/index.htm).

DPAS conducted an evaluation of a drugs prevention programme for young people who have been excluded from school. The programme was part of the Pupil Referral Units who provide education for young people excluded from school. The programmes consisted of an assessment exercise to discover the pupils' needs; a drugs education course; a life-skills exercise and a range of diversionary activities. The evaluation found that drugs education programmes are clearly needed, but short drugs education

programmes are insufficient to deal with the problems that young people who are excluded from school face. Many of the young people were already taking drugs implying that this group needs programmes implemented earlier which identify and deal with problems (Powis & Griffiths, 2001)

9.2 (d) Specific training for professionals and peers in these fields

The range of organisations and individuals which have a key role to play in educating, protecting and supporting young people and families and the lack of both specialist and trained generalist workers represents a serious threat to the delivery of the drug strategy.

Drugs and Alcohol National Standards which have already been adopted across the UK for adult treatment provision, and are being extending to include young people's services.

9.3 Family and Childhood

9.3 (a) Definitions used

The term children refers to all those individuals who are under the age of 18, in accordance with the Children Act of 1989 and the UN Convention of the Rights of the Child (1989).

Local authorities acting under certain provisions of the Children Act 1989, use the term 'young person to refer to those up to the age of 21.

9.3 (b) Types and characteristics of intervention with family and childhood

The programmes mentioned in this section are not specific drug prevention programmes however they address a range of measures which aim to ensure that vulnerable children get the best start in life (Sure Start), remain on track on their early years (On Track), flourish in secondary school and choose to stay on in education and training at 16 (Connexions Service).

Sure Start aims to work with parents and children to promote the physical, intellectual and social development of pre-school children, particularly those who are disadvantaged. The programme links with other government initiatives and works in partnership with parents and professionals from the voluntary and statutory sectors to improve the life chances of children under 4 in areas of need by improving access to health, family and educational services.

The Children's Fund, managed by the Children and Young Persons Unit, a cross departmental team, will primarily target 5-13 year olds at risk of social exclusion, bridging the gap between Sure Start for pre-school children and the new Connexions Service for the over 13s, delivering preventative services over and above those provided through mainstream statutory services and specific programmes. The Children's Fund has now absorbed the Home Office's On Track project, which aims to prevent crime by supporting 4-12 year olds and their families. The preventive element of the Children's Fund amounts to £380 million (€ 596.6m) (over 3 years 2001-4). Funding for the 22 On Track

projects (£450,000 pa) (€ 706,500) was initially agreed in August 2000 and was expected to continue for 7 years.

9.3 (c) Research projects and evaluation results

9.4 Other Programmes

9.4 (a) Description of the following interventions:

- Peer-to-peer approaches

Young People as Peer Educators in Drug Misuse is a project running in Manchester. It aims to increase young people's knowledge of drugs and to develop their communication and peer-education skills. Young people have drugs education session and then undertake a drugs project using the drugs knowledge they gained from the education sessions eg) they wrote and acted a short play and performed it to younger pupils who then asked pre-prepared questions. For more information access the EDDRA database at http://www.reitox.emcdda.org:8008/eddra/

INVOLVE is peer education on drugs provided in a classroom by young people selected from school and trained on a residential course. Young people are encouraged to participate, explore and openly discuss their own experiences. They deliver two sessions of drugs education to pupils at school. For more information access the EDDRA database at http://www.reitox.emcdda.org:8008/eddra/

- Telephone helplines

On a national level the 'National Drugs Helpline' provides a 24 hour information and advice service. The webpage also provides extensive information http://www.ndh.org.uk/facts.html.

- Community programmes

DrugScope is currently administering a grant scheme, Millennium Awards, which will award between £1,500 to £3,000 (€ 2355 – € 4710) to individuals and small groups to address drug issues in their communities. This scheme is for England only and in March 2002 was expanded from the original three pilot regions to cover all regions in England.

Cheshire 'Insight' Drugs Awareness/Education Programme is a multi-agency initiative which aims to provide basic drug awareness to diverse adult audiences (aged 17+), improve people's confidence in dealing with drug-related problems and to enable members of the community to seek further advice from helping agencies. . For more information access the EDDRA database at http://www.reitox.emcdda.org:8008/eddra/

- Mass media campaigns

Mass media approaches seem not to be used to great extent, although there have recently been two information campaigns as a result of government policy change or government comment. Firstly, the release of the 'Rachel's Story' video along with the DfES minister calling for a tougher approach to drug education. This resulted in the extensive media coverage and public discussion on drug education. The video will make up part of an education package for schools, however this won't be released until the autumn.

Secondly, a joint government initiative which coincided with the Home Secretary announcing plans to reclassify cannabis was the release of a 'Cannabis Credit Card' designed to provide information on Cannabis and the reclassification. A Cannabis fact sheet was also published on the government website www.drugs.gov.uk to support the distribution of the 'Credit card'.

The Health Promotion Agency in Northern Ireland launched a new campaign in February 2002 aimed at young people aged between 14 and 17. The campaign, Drugs, Your Body, Your Life, Your Choice provides factual information about ecstasy, speed and LSD and includes a series of TV advertisements and distribution of 100,000 information booklets to post-primary schools.
http://www.healthpromotionagency.org.uk/frameset.htm?pressreleases/dangerdrugs.htm~mainpage

- Internet

There are currently many regional and local helplines and drug prevention projects focusing on specific areas and target groups. The Drug Education and Prevention Information Service (DEPIS) is managed by DrugScope and funded by the Department of Health. This website has searchable information about drug education and prevention projects and resources for those working with children and young people and their carers (www.doh.gov.uk/drugs/depis). This includes material that is local or regionally based as well as national organisation also working in this area.

A new website was launched in March 2002 which provides young people with harm minimization information around drug and alcohol use. Basic drug information and further sources of information are provided http://www.drugslife.info/

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

The Know the Score web site is a drugs information gateway that provides information for young people, parents, relatives, friends and communities in Scotland (www.knowthescore.info). They also have a telephone information and advice service.

The Drugs Prevention website has been created by the Health Promotion Agency for Northern Ireland as part of the Northern Ireland Drugs Campaign.
www.drugsprevention.net

There are numerous other websites for those working in schools and with young people. Generally these tend to cover not only drug education but other social issues such as sexual health and mental health. www.wiredforhealth.gov.uk is a collaboration between Department of Health and DfES. It is specifically for professionals in schools and provides teaching material for the key stages 1- 4. This site also has sections for young people, one for each of the 4 Key Stages. The drug, alcohol and tobacco information pages have recently been updated and re-written.

Another site developed specifically for teachers is www.educari.com/SNADE. This offers specific drug education teaching materials & resources for special needs pupils.

9.4 (b) Research projects and evaluation results

An evaluation of the 'Know the Score' campaign in Scotland found that the campaign was successful in increasing enforcement activity. During the campaign period there was about a 12% increase in the number of recorded drug offences and a threefold increase in the number of drugs seized compared to the previous year.

The campaign was also successful in raising drug awareness with nearly 1200 separate activities or events taking place. The campaign strengthened existing partnerships between participating organizations such as the police, DATs, health and other organizations both locally and nationally and assisted in the development of new partnerships and increased inter-agency communication and understanding of respective roles (Maclean et al, 2002)

9.4 (c) Specific training

In February 2001, DPAS published a study of different approaches to training professionals in drug prevention. The findings suggest that to ensure a long-term impact, organizations need a strategic approach to training and active management involvement to deliver the strategy.

Training was found to have clear sustainable effects on working practices of individuals and agencies in around half of cases. The greatest impact arose from training which was single-disciplinary, extended over a longer period of time, with highly enthusiastic trainees, working within a small geographical area (Velleman et al., 2001).

10 Reduction of Drug-related Harm

10 (a) Role of harm reduction within the national drug policy/strategy:

- Definition and priority

- Recent policy trends (past 3 years)

Needle exchange programmes were introduced in NI in 2001 (McElrath, 2001)

- Current public/professional discussion

The National Needle Exchange Forum (NNEF), the UK Harm Reduction Alliance (UKHRA) and Action on Hepatitis C (AHC) raised concerns about the introduction of 'difficult to reuse syringes' (DTRS). Originally developed for use in hospitals, their introduction at Mainliners and other organisations, with the intention of reducing needle sharing, proved to be disaster for harm reduction. Users identified a number of problems with the DTRS and refused to take them, preferring to go without until supplies of 'traditional' syringes were arranged. The NNEF, UKHRA and AHC have advised needle exchanges not to introduce DTRS (Druglink 2001)

10 (b) Harm reduction practice:

- Key-objectives

.

- Targets: groups, drugs, risk behaviours

- Staffing

Programme dependent.

10 (c) Range of services

10 (d) Networking between HR professionals

10 (e) Co-ordination of national policies and local practice

10 (f) Expenditures on specific harm reduction projects (health rooms, pill testing, heroin trial, needle exchange, etc)

N/A

10.1 Description of Interventions

10.1 (a) Outreach work in recreational settings (definitions and delivery of services)

Outreach work attempts to bring the service to the user. Detached work involves workers going into the users own environment. Examples include support and needle exchange workers going into user's homes and support workers operating at raves and in clubs. Institutional work is where a service operates on the site of other agencies such as in a health centre, college or school.

'Decubed' is a safer dancing service which operates in dance clubs in Leeds. It aims to provide drug education for 13-16 age group and harm minimization for 17 and over target group.

- It was developed by Leeds Health Education.
- Workers deliver 8-10 all-night sessions per month
- They establish a presence in clubs and festivals to provide oppourtunities for clubbers to enhance their understanding about the risks associated with drug use.
- They provide leaflets, support and information.
- They let the clubbers approach them.

Crimestoppers' first nationwide campaign SNAP (Say No And Phone), launched in October 1995, was developed to target the problem of drugs and associated crime. Targeted at young, vulnerable people from 13 to 25, the campaign has harnessed

innovative ways to publicise its message through pop groups at dance nights for young clubbers and in school tours.

10.1 (b) Prevention of infectious diseases (delivery of services, at city level/in urban environment)

- Dissemination of information/education material
- Safer use training
- Outreach to problem drug users, groups at risk

In Northern Ireland organized street outreach drug services that assist drug users or injectors are yet to be implemented (McElrath, 2001)

- Peer-outreach
- Secondary NX through user networks
- Others (specify)

10.1 (c) Prevention of drug related overdoses

- Examples of 'policies' in overdose-prevention
- Examples of specific projects (heroin/other opiates, stimulants)
- Projects in high-risk settings (eg. Release from prison)
- Documentation, evaluation results, research

10.1 (d) Users rooms/ safe injection rooms (definitions and delivery of services)

- State of the situation
  The HASC report recommended that safe injecting rooms should be introduced. In the governments response to the report the Home Secretary stated that he did not support the introduction of safer injecting rooms saying that at present this kind of initiative would be available only to those who were prescribed heroin.
- List all services – N/A
- Key-objectives – N/A
- User profile – N/A
- Staffing, budgets – N/A
- Documentation, evaluation results, research studies – N/A

10.2 Standards and evaluations

10.2 (a) Existence of professional standards on HR interventions

10.2 (b) Evaluation studies on HR measures (if not already covered under 10.1), give references.

10.2 (c) Training for staff in HR techniques: organization, access, target groups for training

10.2 (d) Major research projects on HR topics carried out in past five years; amount of public research funding available in 2002.

11 Treatment

The National Treatment Agency was launched in April 2001. It oversees the process of establishing and disseminating national standards for commissioning, delivery and monitoring of drug treatment services.

11.1 "Drug-free" treatment and health care at national level

11.1 (a) Objectives and definitions of drug-free treatment

Drug free treatment services are abstinence based and have relapse prevention as their major service outcome goal. The existing network within services consists of a combination of early intervention practices, advice and counseling and out-patient services. Clients are referred to these type of services on an assessment of their drug dependence and needs (DoH, 2002a).

The Department of Health has acknowledged drug dependence 'as a chronic relapsing condition' requiring several attempts at overcoming dependence (HAS 1996).

11.1 (b) Criteria of admission to drug-free treatment

Individuals who have drug-related problems and meet the ICD-10/DSM-IV dependent criteria (ICD-10 - failure to take responsibility for actions, with subordination of personal needs to those of others, DSM-IV - persistent dependent and submissive behaviour). The majority of residential rehabilitation programmes require clients to either be 'drug free' on entry and/or have achieved a state of abstinence from their main problem drug (or all drugs), or to undertake an on-site detoxification from drugs and medication (DoH, 2002a). Admission is voluntary (self-referral; GP referral; criminal justice referral) and there are no priority groups for drug free treatment as there is for substitution treatment programmes. Co-financing may be required by some treatment agencies.

11.1 (c) Availability, financing, organization and delivery of drug-free treatment services

Drug treatment is financed locally with central Government money, which is used to develop drug treatment for both statutory and non-statutory organisations. This year the Government's Comprehensive Spending Review (SR2000) allocated extra money for drug treatment. Locally Drug Action Team Co-ordinators are responsible for drug services in their area. They hold pooled treatment budgets, overseen by the National Treatment Agency with funding from health (including social services) and the Home Office. The pooled budgets and NTA do not apply in Wales, Scotland or Northern Ireland.

Programmes usually run from immediately after the completion of detoxification and last between 3 and 12 months. To accomplish relapse prevention they provide a safe living environment supported by staff and peers and a therapeutic programme comprising of groups, lectures, individual counseling and family involvement. Residential services are usually registered under Registered Care Homes Act (1984). For low-intensity Residential Rehabilitation and Halfway House Rehabilitation, clients maintain their drug-free status and live in a semi-independent context (DoH, 2002a).

11.1 (d) Evaluation results, statistics, research and training

The Audit Commission 'Changing Habits: the commissioning and management of community drug treatment services for adults' investigated the UK's drug treatment system and the absence of reliable management information was acknowledged as a significant barrier to the development of appropriate effective and accessible drug treatment services across England (Audit Commission, 2002). As a response to the above conclusion NTA 'Four Key Performance Indicators for Drug Misuse Services' (Waiting times, New referrals – incidence, Treatment completion/planned discharge rates, Unit Costs) were developed and introduced to DATs (April 2002) with the aim to improve the information available to commissioners, service providers, and service users/carers.

A report to the Home Affairs Select Committee by an NHS Alliance special advisor states that drug addicts are being treated by GP's who lack training, resources and remuneration

Most treatment evaluation is conducted internally by the services involved.

11.2 Substitution and Maintenance Programmes

Inpatient prescribing and inpatient substance misuse treatment programmes are units specially for people with substance misuse disorders. They provide medically supervised withdrawal (DoH, 2002a).

11.2 (a) Objectives for substitution treatment

The overall aims of substitute prescribing are (DoH, 1999):

- to assist the service user to remain healthy, until, with appropriate support, he or she can achieve a drug-free life
- stabilize the service users, where appropriate, on substitute medication to alleviate withdrawal
- reduce the use of illicit or non-prescribed drugs
- deal with problems related to drug misuse
- reduce the dangers associated with misuse, particularly the risks of HIV, hepatitis B and C and other blood-borne infections
- reduce the duration of episodes of drug misuse
- reduce the need for criminal activity to finance drugs, reduce the risk of prescribed drugs being diverted onto the illegal drug market
- improve the overall personal, social and family functioning

11.2 (b) Criteria of admission to substitution treatment

Individuals who have drug-related problems and meet the ICD-10/DSM-IV dependent criteria (ICD-10 - failure to take responsibility for actions, with subordination of personal needs to those of others, DSM-IV - persistent dependent and submissive behaviour). The majority of clients entering prescribing programmes are dependent opioid users who present with additional polydrug use (DoH, 2002a). Admission is voluntary (self-referral; GP referral; criminal justice referral)

Priority groups are (DoH, 2002a):

- those who are HIV symptomatic or with other severe physical co-morbidity
- those with mental health co-morbidity
- pregnant women
- young people, particularly those identified as vulnerable.
- Other locally defined groups

11.2 (c) Availability, financing, organization and delivery of substitution treatment services

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

Once type of admission (routine/priority/emergency) has been decided and the client admitted there is an assessment and a risk assessment of the client. A care plan is developed and a care-coordinator is identified. Practical social support and counseling is then provided. A review of treatment and care plan then occurs. Clients on methadone maintenance programmes must also be reviewed every three months. HIV and hepatitis testing were appropriate and hepatitis B vaccinations occur. Relapse prevention is a component part of all treatment programmes. Clients who have successfully detoxified then move onto aftercare programmes (DoH, 2002a).

Inpatient programmes are usually based in general hospital psychiatric units, general hospitals themselves or dedicated inpatient units. These services are also provided by voluntary sector.

Methadone maintenance programs have not been implemented in Northern Ireland and methadone prescribing is strongly discouraged (McElrath, 2001)

11.2 (d) Substitution drugs and mode of application

Most prescribing in the UK is for oral methadone, although research in 1995 showed that 10% of all methadone prescriptions were issued for injecting. No outcome study in the UK has been carried out on injectable methadone prescribing.

Diamorphine is only rarely prescribed in the UK as a maintenance regime for people who have not been stabilised through methadone. Codeine-based substitutes, particularly dihydrocodeine, are used by some clinicians. Buprenorphine has recently been licensed for substitution treatment. Lofexidine is prescribed for community detoxification programmes. Those who have completed opiate withdrawal but need pharmaceutical assistance to remain drug free can have maintenance treatment with the opiate antagonist naltrexone. Benzodiazepine prescribing is only recommended for withdrawal. Dexamphetamine sulphate is often currently prescribed in England and Wales for treatment of primary amphetamine use (DoH, 2002a).

11.2 (e) Psycho-social counseling (requirements and practice)

There is the provision of counseling for all clients entering treatment. It is usually offered as part of a package of care. For opiate or benzodiazepine dependent drug misusers counseling may take place in conjunction with substitute prescribing. For other service

users, particularly stimulant users, counseling may be part of a range of treatment options. A number of theoretical approaches may be employed including brief interventions, cognitive-behavioural and motivational interviewing.

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

Using the QuADS standards 'counseling and psychotherapy services are based on written procedures and demonstrate staff competence'. They should:

- employ staff who are accredited by the British Association of Counseling with a National Vocational Qualification or equivalent.
- adhere to relevant codes of practice.
- Have supervision protocols
- Employ appropriately skilled supervisors
- Clear outcome and output measures
- Monitor and report on outcome measures
- Skills which cross a range of counseling modalities such as motivational interviewing, brief interventions, cognitive-behavioural, gestalt, person-centred, humanistic

11.2 (f) Diversion of substitution drugs

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

11.2 (g) Evaluation results, statistics, research and training

The NTORS 5 year follow-up showed that overall significant improvements were made in drug-related problems, health and social functioning among those in specialist drug services (Gossop et al., 2001). Reduction rates of non-fatal overdose were found for clients treated in both residential and community treatment settings. Reductions were linked to improvements of frequency in drug use and lower rates of injecting (Stewart et al, 2002). Injecting, sharing and having unprotected sex were substantially reduced among clients admitted to methadone programmes and among those admitted to residential treatment (Gossop et al, 2002)

Although the National Confidential Enquiry into Methadone Related Deaths in Scotland in 2000 (Squires et al., 2002), see section 3.2(b), was a clinical audit rather than a research project, the report shows that the introduction of supervised consumption in one Health Board area in Scotland (Lothian) was a contributing factor to the reduction in the number of methadone deaths in the area. Similarly, the low methadone death rate by methadone prescription in another Health Board area (Glasgow) has also been attributed to the high level of supervised consumption. Within the report, no GP reported the death of a patient who had commenced a methadone prescription less than one month prior to death. This suggests that the initial titration, assessment and monitoring procedures are effective (Squires et al., 2002).

Recommendations from the survey include educational sessions for all new patients starting on methadone, supportive ongoing updates and training to ensure good practice

from GPs, an extension of supervised consumption that addresses the patients autonomy within the community to take methadone in a private place, flexible prescribing regimes particularly for times of crisis such as access to a chemist seven days a week, provision and access to specialist addiction services which offer a range of treatment options to assist and support GPs and patients and an awareness of the limits of naxolone treatment in methadone overdose for doctors and paramedics (Squires et al., 2002).

QuADs: the organizational standards for drug and alcohol treatment services provide standards on the management of service prescribing.

11.3 After-care and Reintegration

11.3 (a) Links with national strategy and legislation (new developments)

The reintegration of chronic drug users was an essential component of the 1998 Drug Strategy. Drug Action Teams were tasked to increase the take-up rate of further education and employment for former addicted criminals through Welfare to Work, New Deal and other means. The New Deal programme provides financial support, promoting an "active labour market policy" to increase equality and opportunity and, via the Gateway stage, aiming to "support participants in gaining the self-confidence, experience and skills which will increase their employability" (Fletcher).

The 2001 budget promised to refocus the New Deal on the hardest to help and the most disadvantaged areas, including low employment inner city neighbourhoods where addiction is most concentrated. Designating these as Employment Zones should encourage and fund innovative and locally tailored solutions. For the 30,000 unemployed claimants the Chancellor said "a new three year budget of £40 million will mean they can receive the mentoring and training they need, but to get on the programme they will have to get off drugs." (HM Treasury, Chancellor's Budget Statement, 7 March 2001,

11.3 (b) Objectives, definitions and concepts of reintergration (such as education and training, employment, housing)

Reintegration in the UK is used synonymously with residential treatment. Structured day programmes used by former residents of residential services as after-care

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

Clients of residential rehabilitation programmes are either dependent drug users who have drug-related problems and meet dependence criteria ICD-10/DSM-IV (defined in 11.1b) or drug users in recovery. Drug users in recovery include individuals who have achieved a state of abstinence from their main problem drug.

11.3 (d) Organisation, financing, managing, availability and delivery of services

Residential rehabilitation services make up the majority of after-care and reintegration programmes. They have been pioneered and sustained mainly in the voluntary sector and be independent services on a non-for-profit basis. There are about 70 programmes

operating in England with approximately 1200 beds available. There are three types of programmes – short-term residential rehabilitation for 3 months, long-term residential rehabilitation for up to six months plus and primary/secondary treatment split.

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

11.3 (e) Statistics, research and evaluation results

Research by the Joseph Rowntree Foundation has shown that drugs users were often disadvantaged when seeking employment because the majority of them came from deprived backgrounds and because of the negative stereotype that preceeds them. The research, which was carried out in the North-West of England between March 2000 and October 2001, also found that Educational Training and Employment (ETE) schemes had a number of barriers set up within the system that worked against people with drug problems applying for employment. ETE workers were not equipped to deal with the multiple disadvantages experienced by the drug users interviewed and the workers also criticized the system of referral and the lack of co-ordination between systems (Klee et al, 2002)

11.3 (f) Training

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

12 Interventions in the Criminal Justice System

General framework of interventions in Criminal Justice System and links with the national strategy and legislation.

The Prison Service Drug Strategy aims to offer support and treatment to any prisoner with a drug problem.

The key components of the strategy are:

- improving the availability and quality of treatment
- improving the availability of voluntary testing places
- continuing the MDT programme
- reducing the supply of drugs into prison
- improving the training of staff
- using research to measure effectiveness and needs of specific groups of offenders
- establishing management information systems to monitor performance
- integrate the work of different departments within prisons and the different agencies involved in working with prisoners

It is an integrated overall strategy focusing on the needs of the majority of prisoners.

http://www.hmprisonservice.gov.uk/corporate/dynpage.asp?Page=317

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

12.1 Assistance to drug users in prisons

12.1 (a) Abstinence orientated treatments (detoxification, drug free units, therapeutic communities in prisons)

Since the mid-nineties there has been an increase in drug-free areas in prisons by 400% (Turnbull, 2000). Access to these programmes is voluntary under certain conditions, sometimes contracts for behavioural change. The central objective is abstinence, so urine testing is central to ensure drug-free status. Programmes mostly run in separate sections of the prison with no direct contact with other inmates and a high control standard (EMCDDA, 2001)

In England 'post Detox Centres' run eg) Holloway is a community where residents and staff work together to create a supportive and confidential environment in which inmates can explore drug and alcohol related problems. Post Detox Centres aim to help inmates become drug free and cope with staying drug-free. The inmates may stay in the centre for up to 3 weeks. Topics of group work include drug and alcohol awareness; harm minimization; sexual health; CARAT assessment and social skills (EMCDDA, 2001)

The new Prison Service Order (PSO 3630, Counselling, Assessment, Referral, Advice and Throughcare services) guidelines suggest that each prison will have a detoxification service for opiate misusers, developed in conjunction with the NHS (EMCDDA, 2001). There is no PSO on treatment, but one is planned by September 2003.

CARAT (Counselling, Assessment, Referral, Advice and Throughcare) services run in prisons throughout the country. CARATs provide a low threshold, low intensity, multi-disciplinary drug misuse intervention service that meets the needs of most prisoners with drug problems. CARAT workers create care plans based on prisoners' specific needs and ensure that links are made between the various departments within prisons including healthcare, education and sentence planning. CARAT workers can refer prisoners to detoxification, intensive treatment programmes and to external drug agencies on release. CARAT services are commissioned by the Prison Service and provided by external drug agencies, probation staff, health care staff and prison officers.

The number of therapeutic communities has increased from 4 to 6 prisons in England and Wales (EMCDDA, 2001). Therapeutic communities are intensive treatment programmes for prisoners with severe drug dependency (EMCDDA, 2001).

There has been a promotion of 35 detoxification programmes and an increase in the number of rehabilitation programmes to 51 in prisons across England, alongside the 6 Therapeutic communities (EMCDDA, 2001).

New rehabilitation programmes have been launched which include relapse prevention, cognitive behavioural and abstinence based 12-step programmes. These programmes

are mostly aimed at prisoners who have a history of drug dependence and drug-related offending (EMCDDA, 2001).

There has been a development and delivery of accredited treatment programmes – in line with the National Treatment Agency Models of Care that follow a tiered approach to providing a range of treatment services. The range of services currently provided within prisons meet the multi-dimensional needs of substance misusers from low threshold interventions, such as CARATs advice and information, to intensive Therapeutic Communities. Under rehabilitation programmes, Cognitive Behavioural Treatments, '12 Step' programmes and Therapeutic Communities cater for different levels of drug misuse or dependence.

12.1 (b) Substitution treatment

Provision of methadone treatment in UK prisons is minimal apart from the purposes of detoxification. It is estimated that a third of those who are receiving methadone treatment before entering prison also receive it in prison. There has been a considerable expansion in the growth of methadone detoxification for prisoners in England and Wales, but only a limited amount of methadone maintenance (EMCDDA, 2001).

Substitute prescribing is one of the most common forms of treatment delivered by community treatment agencies. There is a low level of continuity between community methadone treatment and prison methadone treatment (EMCDDA, 2001).

Methadone is used mostly as a substitution substance, but also Lofexidine and Dihydrocodeine are used in some prisons (EMCDDA, 2001).

Data indicate that, for those who are sentenced, there is reasonable contact with outside specialist agencies (EMCDDA, 2001).

In the women and juvenile prison HMP Holloway' in London 1,500 withdrawal treatments are carried out annually (EMCDDA, 2001).

In Scotland, methadone maintenance programmes are implemented according to the prisoners specific conditions. There is contact with a community prescriber to confirm dosage, compliance and willingness to continue prescription on liberation. The maximum dose is 60mgs daily (EMCDDA, 2001).

12.1 (c) Harm reduction measures (blood screening, vaccinations, provision of disinfections, needle exchange, provision of condoms)

In Scotland sexual relations are prohibited in prison and, consequently, condoms or lubricants are not available for prisoners. They are partly handed out for home-leavers and/or part of the release pack (EMCDDA, 2001).

In England and Wales prisoners can get condoms on prescription if the prison doctor believes there is risk of STD transmission. A Report by McKerrow (1997) found that 24% of prison establishments (76 replied of 126) had not taken any steps to ensure that prisoners who may be at risk of HIV were aware that condoms could be prescribed and 28% didn't monitor the prescribing of condoms.

Blood screening and HIV testing is conducted at the admission phase and on a voluntary basis. HIV tests are generally available for all prisoners. Vaccinations against hepatitis and tuberculosis are undertaken in prisons (EMCDDA, 2001).

A study by Branigan et al (2000) looked into the feasibility of making available disinfectant tablets for the purpose of cleaning injecting equipment in 11 prisons in England and Wales. They found that tablets were used for a variety of purposes by the prisoners, mostly related to hygiene. Both inmates and staff reported that tablets were being used for cleaning drug injecting equipment. The authors of the project support the provision of disinfectant tablets.

Needle exchange services are not implemented in prisons in England and Wales and are explicitly rejected in prisons in Scotland (EMCDDA, 2001).

12.1 (d) Community links (pre-release units and release, working with families, throughcare, therapeutic communities for offenders outside the prisons, involvement of community health structures)

CARATS provide:

- links with the prisoner and agencies within the community
- Health liaison with community upon prisoners release
- Liaison with and referral to community agencies to enable effective resettlement

Throughcare in English and Welsh prisons is described as 'the quality of care delivered to the offender from initial reception through to preparation for release establishing a smooth transition to community care after release' (EMCDDA, 2001).

As stated in section 4.1 (a) Progress2Work initiative prioritises prisoners with a history of drug misuse as a group of potential clients to be assisted in finding employment.

In Scotland the need for co-ordinated throughcare is apparent as 28% of Glasgow's Barlinnie prisoners surveyed had been to prison more than 15 times. 60% of prisons said they were addicted to drugs before prison. Scotland has special 'Family Contact Development Officers' that are employed to help families to keep or initiate contact with prisoners' relatives, to help work on relatives' drug problems, to inform families about drug problems in prison and outside (EMCDDA, 2001).

12.2 Alternatives to prison for drug dependent offenders

12.2 (a) Objectives, organization, funding and professional resources

The Drug Treatment and Testing Order was rolled out to courts in England and Wales on 1st October 2001. The main aim of the DTTO is to prevent re-offending, with the longer term aim of getting them off drugs for good. The Order is usually a stand-alone but a Community Rehabilitation Order can be imposed alongside the order (where a residence requirement is required, other than for residential treatment). The DTTO obliges the offender to undergo treatment at a specified place (residential centre or while continuing to reside in the community) for a set period which can be anything between

six months and three years. The offender must also be tested regularly for drug use and this together with the treatment provider's reports provides a clear indication of how well the offender is responding to treatment. Finally, and uniquely in English/Welsh law, the courts have a formal role in the reviewing progress. These reviews are designed both to motivate the offender and give the court confidence that the treatment is being complied with. Treatment services to support DTTOs are purchased by the probation service and provided by a mixed economy of specialist substance misuse treatment and probation services

12.2 (b) Accessibility to alternative measures: principles, criteria for admission

There is emerging evidence that a few drug misusers are responsible for a huge amount of crime. The DTTO is, therefore, targeted at problem drug misusers aged 16 or over who commit crime to fund their drugs habit, show a willingness to co-operate with treatment and are before the court for an offence that is sufficiently serious to attract a community sentence.

12.2 (c) Information strategies

Scottish Ministerial Group on Women's Offending report which looked at the make up of Scotland's female prison population; prevention and early intervention; community disposals and aftercare, stressed the importance of treatment for drugs, alcohol and other substance misuse problems.

12.3 Evaluation and training

12.3 (a) Evaluation results

The Home Office funded evaluation of the DTTO concluded that the evidence on treatment effectiveness suggests that at least three months is needed to effect any lasting change. This makes it imperative that people are retained in treatment for this period. The evidence from the evaluation and from previous research suggests that drug dependent offenders can be successfully coerced into treatment as they pass through the criminal process. But it is equally clear that the best schemes rely for their effectiveness on local champions who are heavily committed to the enterprise (Home Office 2000).

An evaluation of the Edinburgh Prison Drug Reduction Programme found that those prisoners who had completed the Programme's educational and group work sessions as part of the Drug Reduction Programme had used a significantly lower number of drugs during their current sentence than the control group. They were also less likely or less frequently to have used cannabis, dihydrocodeine, temazepan, diazepam, LSD, and buprenorphine (Shewan et al., 1996)

A study conducted by Branigan et al (2000) evaluated the effectiveness of making disinfectant tablets available for cleaning injecting equipment in prisons in England and Wales. The researchers found that the tablets were used by prisoners for a variety of purposes, mostly related to hygiene and it was reported by both inmates and staff that that the tablets were being used for cleaning injecting equipment.

12.3 (b) Statistics and research

No information available.

12.3 (c) Training

The NTA document Models of Care recognises the impact of drug use in prison but Training manuals are yet to be developed.

Health Promoting Prisons: A Shared Approach (Department of health, 2002d) is a publication prepared by the Prison Health Policy Unit (PHPU) and Prison Health Task Force (PHTF) which offers advice in support of the staff who work in prisons, NHS and voluntary organizations that have a role in promoting health in prisons. The publication includes a strategy and an Action Plan which aims to build the physical, mental and social health of prisoners, help prevent the deterioration of prisoners' health whilst in custody and help prisoners adopt healthy behaviours. Drug use is included in this strategy and providing support for drug using prisoners is a major specific health promotion intervention

13 Quality Assurance

13 (a) Description of new trends and developments

The national drug strategy recognized the need for an increased focus on the provision of effective drug treatment services that will work effectively with other health, social care and criminal justice service providers in order to provide seamless treatment and care to substance misusers. This has resulted in the development of a range of guidance documents on 'what works' based on a review of research evidence, including:

- Commissioning Standards: Drug and Alcohol Treatment and Care (SMAS 1999)
- QuADS: Organisational Standards for Alcohol and Drug Treatment Services (DrugScope and Alcohol Concern 1999)
- Prison Health Care Standards 8 (Prison Health Care Directorate 2000).

Due to the diversity of the substance misuse field, interventions have been characterized by substantial geographical variations in the availability, processes, structure and outcomes. There has been limited consensus on the essential components of specialist substance misuse services and of the importance of links with other agencies.

The National Treatment Agency is drawing up a treatment framework from these guidelines. The objective is to provide a Model of Care document outlining the framework and the processes. This should allow for the delivery of higher quality and more effective services which are closely informed by research evidence.

In addition there is a statutory duty for local authorities to deliver services by the most cost effective means. To this end the Audit Commission has prepared guidelines on Best Value, and conducts inspections. 'Changing Habits', the findings of an inspection into the commissioning and management of community drug treatment services for adults were published in 2002.

The Drug Prevention Advisory Service developed a Partnership Standard for Drug Action Team, which was published in 2002. It is designed to provide a basis for understanding the processes and effectiveness of arrangements at local level concerned with delivery of the National Drugs Strategy. It is intended that local arrangements can be assessed against the processes described in the Standard.

13 (b) Formal requirements for quality assurance

By April 2002 the NTA issued a provisional timetable for the introduction of standards and accreditation hoping by September 204 to implement the accreditation system, and by 2008 for all drug services to be accredited.

Drug Action Teams are already under an obligation to set out detailed plans of objectives and activities, and to subsequently report against these. In addition the Standard sets out in detail the core activities of a Drug Action Team, the tasks of the DAT chair and coordinator, and the Joint Working process of the different DAT partners. It sets out the process involved in preparing the Annual Plan, in the implementation of the Action Programme, in Performance Monitoring and Communication.

13 (c) Criteria and instruments applied in quality assurance

In the treatment field the key indicators include number of clients, waiting times, new referrals, treatment completion/planned discharge rates, and unit costs. In addition to these quantitative measures, a range of qualitative measures are being developed, referring to the appropriateness of the treatment.

DATs have to apply quality standards across core activities, including organisational arrangements; planning process, implementation, performance monitoring, and communication with stakeholders. These have to be included in the DAT Plan and reported on.

13 (d) Application of quality assurance procedures and results

The best developed quality assurance procedure is the Quality in Alcohol and Drug Services consultancy service. Within less than a year and half, the service was contracted by over 55 DAT to provide a quality assurance package to the treatment services within a Drug Action Team area. The service provides information on quality systems, guidance on managing change, on self assessment and self audits. It has been commended by the outgoing UK Anti Drugs Coordinator as one of the notable achievements during his time in office.

The implementation of the DAT standards has been thrown off course by the decision to merge DATs with the Crime and Disorder Reduction Partnerships. As the content of the Standard is largely generic, it is expected that it will be applied to the working of the new partnership,

NOTES ON PART 3

As already mentioned drug education is a statutory requirement as part of the science orders in all key stages. The following points detail the specific points for each key stage.

- Key Stage 1 – pupils should be taught about the role of drugs as medicines
- Key Stage 2 - pupils should be taught about the effects of tobacco, alcohol and other drugs, and how these relate to their personal health
- Key Stage 3 – pupils should be taught that the abuse of alcohol, solvents, and other drugs affects health……
- Key Stage 4 – the effects of solvents, alcohol, tobacco and other drugs on body functions (QCA 1999a,b)

Non-statutory framework for Personal, Social & Health Education and Citizenship, includes drug, alcohol and tobacco education from Key Stage 2 (Age 7-11). This provides opportunities for broader context for drug education.

- Key Stage 2 – which commonly available substances and drugs are legal and illegal, their effects and risks.
- Key Stage 3 – Basic facts and laws, including school rules about alcohol and tobacco, illegal substances and the risks of misusing prescribed drugs.
- Key Stage 4 – About the health risks of alcohol, tobacco and other drug use….and about safer choices they can make (QCA 1999a,b).

There is no statutory requirement for post 16 year olds in the United Kingdom.

In Scotland the leadership and coordination of drug prevention work lies with the Scottish Drugs Minister and they are advised by the Scottish Advisory Committee on Drug Misuse (Scottish Executive, 1999). At a local level DATs lead and coordinate on implementation and report annually to the government.

Wales has five regional Drug and Alcohol Action Teams set up as partnerships in planning to coordinate and support substance misuse action across a defined geographic area. Local Action Teams (LAT) act to implement this action and plan specifically for their local areas (National Assembly for Wales, 2002).

In Northern Ireland the responsibility for addressing drug misuse lies with the Department of Health, Social Services and Public Safety. A ministerial Group on Drugs, chaired by the Minister of this Department acts to facilitate involvement of relevant ministers from the Executive. These include Education; Further and Higher Education, Training and Employment; and Social Development and also involves liaison with the minister responsible for law and order to ensure coordination.

*****The ‘Strategic Prevention Action Plan for Drugs and Alcohol in Wales’ (YEAR) details good practice guidance for organisations in the statutory, voluntary and independent sectors that offer educational opportunities to children and young people. The Personal and Social Education Framework for Wales (YEAR) underpins this guidance.*******

****Young people are far more likely to die from the indirect effects of alcohol than from its direct effects. Indirect deaths include things such as accidents, suicide and violence (Alcohol Concern factsheet, 2002)*****

PART 4 KEY ISSUES

14 Demand reduction expenditures on drugs in 1999

14 (a) Focus on: direct expenditures in the field of drug demand reduction

Of the four strands of the UK drugs strategy (see section 1.1(a)), two (i.e. drug treatment and protecting young people) are primarily concerned with demand reduction. We apply here the notion of secondary and tertiary demand reduction. The total expenditure under these sub-heads was € 475.2 million in the financial year 2000/2001 and € 668.8 in 2002/2002.

14 (b) Short introduction to the topic

14.1 Concepts and definitions

Definitions and categories used in the country

The National Strategy recognizes that because of the complexity of drug problems a collaborative cross-government approach is needed. Partnerships between government departments, voluntary agencies and local communities are key to the impact of the strategy. The underlying principles, including evidence based policies, effective communication and accountability of the strategy apply equally to all aspects of the strategy.

Two of the four main elements of the strategy, suppression of availability and increase in treatment, provision can be divided according to the traditional distinction of supply and demand reduction. The other two elements, helping young people resist drug use and protecting communities contain elements of both.

There is an ongoing discussion over how appropriate the term Demand Reduction is, when the evidence base remains weak. Some practitioners and academics propose the replacement by the term Harm Reduction, which describes clear and measurable outcomes. Since Harm Reduction implicitly accepts a level of drug use, it is regarded as collusive by some, and remains subject to controversy.

14.2 Financial mechanism, responsibilities and accountability

14.2 (a) Organisation and delivery of drugs demand reduction expenditures during the year at
- central level
- regional/local level

Government has set out objectives for action against illegal drugs in the Action Against Illegal Drugs Public Service Agreement. These include a range of targets in accordance with the four strands of the drug strategy. The responsibility for these targets and the delivery is shared by the Home Office, the Department of Health and the Department for Education and Employment. The Home Office contributions is through the effective management of the Drug Prevention Advisory Service and support for Drug Action Teams, and the measures specific to drugs set out in the Service delivery agreement. (www.hm-treasury.gov.uk/psa)

In the devolved nations the executive may supplement these funding streams with extra money for particular projects.

In the field of treatment the Audit Commission conducted a study reviewing the existing provision of community based drug treatment services for adults. Findings with suggestions for improvements were published and have been taken up and are being further developed by the NTA.

In the field of drug education the setting up of the Drug Education and Prevention Service has created a data bank of evaluated projects. The hope is to engender an evaluation culture in the drugs field. Evaluations of individual projects have been undertaken by DPAS. There are several initiatives underway to expand the number of evaluation of programmes and the overall policy.

14.2 (b) Interaction between public and private expenditures

There are an increasing number of private sector initiatives in the drugs field. The JRF has made a Euro 1,570, 000 funding line available for research activities with the aims to increasing our understanding of drug and alcohol related problems and informing policy and practice. This is designed to complement the Euro 3,925,000 – 4,710,000 spent on research by the government. The trust part-funded the inquiries carried out by the Police Foundation and by the Royal Colleges of Psychiatrists and Physicians. These played a significant role in the subsequent reclassification of cannabis, and a reopening of the debate over different drug policies.

An even more active role is being played by the charity Transform, which is advocating the legalisation of all substances prohibited by the Misuse of Drugs Act. With a substantial following among academics and practitioners, it is a major contributor to the discussion on drug issues.
http://www.transform-drugs.org.uk/

At local level NGOs and community organizations are increasingly involved in the delivery of community drug services. The Millennium Award scheme is financed by the National Lottery and administered by DrugScope. It makes out small grants between £ 1,000 and £ 3,500 to small groups to develop materials, organize an event or deliver an activity.

There is also a clear distinction between statutory and non-statutory treatment services. The latter may have developed from low threshold or outreach services, and often still work in these areas. They may also be providing treatment and rehabilitation in a structured and high threshold format. While they are organizationally independent and registered charities much of their funding is sourced from government departments, which points towards an excellent working relationship among the practitioners, but complicates the distinction of sectors.

14.2 (c) Financial sources and responsibilities

Ultimate responsibility for all public finance lies with the treasury. The treasury concludes Public Service Agreements with government ministries and departments which specify performance targets.

Charities working in the drugs field are subject to the provisions of the 1993 Charities Act and are being monitored by the Charity Commission.

14.3 Expenditures at national level (geographical extension)

Funds allocated at/from

- central level
- regional/local level

14.4 Expenditures of specialized drug treatment centres

Inpatient/outpatient distinguishing among:

- Private and public; professionals/medicines/equipment/buildings/others

14.5 Conclusions

14.5 (a) Problems on information and research related to drug expenditures, gaps and suggestions for future developments in your country

The information on funding by central government is transparent. At local government level also, the allocation of funds to specific projects is clear. The main problem at present is one of definition – does the visit of a police officer to a school fall into the category of demand or supply reduction? The provision of arrest referral screening to arrestees in police stations is part of treatment, yet paid out of police budgets. Many community safety activities, including the refusal by local authorities to offer housing to known drug dealers, can be characterized as supply reduction without law enforcement.

It may therefore be better reflection of ongoing activities and operational objectives to distinguish not between demand and supply, but between harm reduction and interdiction. This would enable policy makers and academics to co-classify activities by different organizations under the same rubric, and further the cross-agency approach to drug policy. Given the definitional limitations of the term demand reduction, it would also be semantically more accurate.

14.5 (b) Global estimation of 'demand reduction expenditure on drugs'

14.6 Methodological information

14.6 (a) Limits in data available

14.6 (b) Main studies and research

The work by the Audit Commission into commissioning and management of community drug treatment services for adults.

A number of evaluations of prevention and education programmes published by DPAS.

14.6 (c) Bibliographical references

See Bibliography section

15 Drug and alcohol use among young people aged 12-18

15.1 Prevalence, trends and patterns of use

Focus on: - young people 12-18 years old (the age group should be considered divided into two groups: 12-14 and 15-17 (below 18)

- use of illegal Drugs.
- use of illegal drugs combined with alcohol

15.1 (a) General population surveys and special surveys on people 12-18 (military conscripts, care institutions, homeless etc)

A survey of illicit drug use among 15 - 16 year olds attending schools across Europe was conducted in 1995 and then repeated in 1999 (Hibell et al., 2000). Results for the United Kingdom showed a decline in most forms of drug use with heroin being the exception. Although heroin use among this group is low, figures for both males and females had increased over this time period (Plant & Miller, 2000).

In a Department of Health (2001) study the proportion of pupils who had used drugs in the last month increased from 7% in 1998 to 9% in 2000, while the proportion who had used drugs in the last year increased from 11% to 14% over the same time period. In the most recent Department of Health survey conducted in 2001, 12% of pupils had used drugs in the last month, while 20% had used drugs in the last year.

Figures from a survey of secondary school pupils aged 12 – 15 in Scotland (from Smoking, drinking & drug use among young people in Scotland in 2000 in Information and Statistics Division, 2001) carried out in 1998 and again in 2000 found that the measures of drug taking in the last month remained the same at 10%, while the proportion that had taken drugs in the last year seemed to decrease slightly from 15% to 14%.

As with tobacco and alcohol, drug use by young people increases sharply with age. With 3% of 11 year olds increasing to 29% of 15 year olds reported having used drugs (Department of Health, 2001). This same pattern was also found with pupils in Scotland with only 1% of 12 year olds reporting having used drugs in the last month and 22% of 15 year olds (from Smoking, drinking & drug use among young people in Scotland in 2000 in Information and Statistics Division, 2001).

Cannabis remains the drug most commonly used by young people. Twelve percent (12%) of pupils aged 11-15 reported they had used cannabis in the last year (Department of Health, 2001). In 2001 Balding found 23% of year 10 (14-15 yr old) students had tried cannabis and fewer year 10 students than year 8 (12-13 yr old) students, when asked about drugs, thought cannabis was always unsafe[3]. These figures are likely to be effected by the students experience with cannabis, that is, by year 10 a bigger proportion have tried cannabis. The perceived safety of other drugs generally decreased with an increase in age (Balding, 2001).

[3] Students were asked about drugs including solvents used as drugs. The response options were *never heard of them, know nothing about them, safe if used properly and always unsafe.*

In Scotland (ISD Scotland, 2001) and Northern Ireland (Department of Finance and Personnel, 2002) too, cannabis was by far the most likely drug to have been used. For both countries 13% of pupils reported using/trying cannabis at some stage in the last year.

In a study commissioned by the Youth Justice Board (2001), cannabis was also reported as being the most commonly offered drug, with pupils excluded from school (63%) more than twice as likely to have been offered drugs than those attending school (25%). Of the excludees that had tried cannabis 53% had used the drug in the last month. In the most recent survey conducted but the Youth Justice Board (2002) 53% percent of children excluded from school reported being offered cannabis. This figure is significantly lower than in 2001, however this figure is largely attributable to the change in questionnaire design. Pupils excluded from school remained more likely to have been offered cannabis than school children.

Although significantly lower than cannabis, figures for other drugs and children excluded from school remain considerably higher than for those attending school. Twenty nine percent (29%) were offered, and 21% took ecstasy, 18% were offered, and 13% took cocaine or crack and 10% were offered, and 8% took heroin (Youth Justice Board, 2001). Generally children excluded from school were far more likely to have been offered drugs when compared to those attending school.

Plant & Miller (2000) reported the following figures for the proportion of 15 – 16 year old students that had taken drugs. Cannabis was used by 41% in 1995 and 37% in 1999, amphetamines had been used by 13% in 1995 and almost 9% in 1999, ecstasy had been used by 8% in 1995 and 5% in 1999 and heroin had been used by 1.6% in 1995 and 2.5% in 1999.

15.1 (b) Qualitative research on patterns of use, set and setting, types of combinations, route of administration

Current and recent qualitative research covers a range of aspects of drug prevention including specific set and settings and patterns of use. There are a number of examples of work being undertaken in the UK in the EMCDDA's QED website (http://qed.emcdda.eu.int/resources/projects/uk.shtml). The examples given below are by no means an exhaustive list and are given to reflect the range of this type of research being undertaken.

- Ward J, Newburn T & Pearson G' Patterns of drug use among Young People being 'looked after' in care
- Henderson S, Protecting and Promoting the health of club-goers in Merseyside: an evaluation of two multi-component communication interventions
- Fitzgerald N et al., Drug education in secondary schools in North-East Scotland – A qualitative study of policy, planning and practice

15.1 (c) Perceptions about risks, benefits and image of specific drugs

Balding (2001) found that the drugs perceived generally across the sample as being the most unsafe are ecstasy, cocaine, crack, heroin along with solvents used as drugs.

Goddard & Higgins (2000) reported that the earlier the age of experimentation, the less likely children are to have tried cannabis. One reason suggested for this difference might be that few children aged 11 or younger are smokers and they may therefore be more likely to be attracted to drugs other than cannabis. Solvents, for example, possibly because they are easier to obtain.

It is thought that the knowledge of other drug users is a key to obtaining drugs. Balding (2001) reported up to 55% of 14 and 15 year olds are fairly sure or certain that they know a drug user. Forty percent (40%) of year 10 males and 41% of year 10 females are certain they know a drug user. Concerning for the future behaviour of young people is data collected from the year 6 (10-11yr olds) students, showing 15% of year 6 males and 10% of year 6 females are certain they know a drug user.

15.1 (d) Trends in recent years

Anecdotal evidence suggests that ecstasy use is stable, with decreasing uptake by younger people coming onto the scene. There are also changes in the club scene itself, with new music genres and new clubs emerging. Most noticeable is the trend away from the large super clubs, which could accommodate several thousand guests, and towards smaller, more intimate venues.

15.1 (e) New/alternative information sources (eg youth media)

15.2 Health and social consequences

Acute and long term harm to health (situation and recent trends) on drug use and drug and alcohol use

There appear to be few national figures available that relate specifically to the health and social consequences of drug misuse for young people. There are more figures available relating simply to alcohol misuse, for example the European School Survey Project on Alcohol and Drugs (ESPAD) report indicated that 13% of 15-16 year olds had been involved in an accident or had been injured as a result of drinking alcohol (Hibell, 2001).

15.2(a) Deaths and overdoses

'Drug-related deaths in Scotland, 2001' details the deaths over the period 1996-2001, however they use a new definitions to categorise deaths and therefore produce baseline figures. This baseline is now used across all countries in the UK[4]. Figures for drug

[4] 1. Deaths coded to mental and behavioural disorders due to the use of alcohol, tobacco and volatile substances have been excluded. 2. Deaths coded to opioid abuse, which resulted from the injection of contaminated heroin have been excluded. Also excluded are deaths from AIDS where the risk factor was believed to be the sharing of needles and road traffic and other accidents which occurred under the influence of drugs. 3. Specific rules were adopted for dealing with compound analgesics, which contain relatively small quantities of drugs, listed under the Misuse of Drugs Act eg co-proxamol, which contains dextropropoxyphene.

related deaths in Scotland were 332 in 2001, 40 more than 2000 (292) and 88 more than in 1996. Unfortunately the age groupings are large. The age bands are large and therefore we are unable to provide specific information for young people. Twenty-four percent (24%) of deaths in 2001 were persons under the age of 25 (Jackson, 2002). Also see comments in section 15.4.

15.2(b) Hospital emergencies

No information available

15.2(c) Driving accidents

Figures available for offences of driving after consuming alcohol and/or taking drugs in England and Wales in 2000 (Home Office, 2001) show that the number of under 17 year old drivers found to be 'unfit to drive through drink or drugs (impairment)' was 26. For the next age category (17 to 21 year olds) there were 248.

15.2(d) Demand for treatment

No information available

15.3. Demand and harm reduction responses

15.3(a) Prevention programmes and campaigns

See section 9.1 and 9.2

15.3(b) Specific harm reduction interventions in parties, techno scene, including pill testing

'Decubed' safer dancing service – see section 10.1 (a)

15.3(c) Other demand reduction responses

Peer-to-peer approaches - see section 9.4
Internet – see section 9.4

15.4. Methodological information

15.4(a) Limits in data available

There are some key methodological points to take into consideration regarding the Section 15 of this report. Please see the first paragraph of section 15.1.

Also the survey conducted by Balding (2001) is not a random sample, questionnaires are completed by schools who then pay to receive their schools results in a reports. Although this methodology has been questioned the sample size is very large (over 40,000 pupils) and therefore makes a useful contribution to the evidence base.

Reports on the figures for drug related deaths in England and Wales do not include a breakdown for different age groups, we are therefore unable to report on figures specific for young people.

15.4 (b) Bibliographical references

See references section

16 Social exclusion and re-integration

16.1 Definitions and concepts

16.1 (a) Concepts and definitions used in your country

All people have equal rights to accessing government provided information on drugs and to drug treatment. It is recognized that in practice many actual or potential clients experience difficulty in accessing these educational and/or treatment services. The high statistical correlation between under utilization of services, and other social factors suggests that these barriers are structural. Moreover, drug and substance misuse is interlocked with other processes of social deprivation. This leads to a special need for intervention, both in terms of providing equal access to drug services and to therefore extend the agenda of social inclusion, and for the mitigation of general social inequality, in the strategy of tackling social exclusion.

16.1 (b) Issues arise or discussed in your country regarding social exclusion/inclusion in relation to drugs.

Discussion in two directions: socially excluded groups and their relationship with substance misuse. Black and minority ethnic groups, for example, are known to be under-represented in treatment services. This under-representation is a reflection of the general marginalisation experienced by these groups. Ensuring that access if provided by ensuring services are culturally aware is therefore an extension of equality and an active form of social inclusion.

There are other groups and social contexts where drug use is interwoven with issues of social exclusion/inclusion. Drug and substance misuse is reported to be particularly high among groups which suffer other forms of deprivation, including rough sleepers and vulnerable young people. Developing suitable interventions and targeting tailor made drug services at such groups is therefore an extension of equality

On a different level there are discussions over the impact of drug use and drug control responses on equity and social inclusion. There are concerns over the introduction of drug testing in the workplace, for example. The roll out of such testing would – given current prevalence levels – identify a number of drug using employees who may face dismissal, especially after repeatedly testing positive. Such a policy would systematically exclude drug users from the job market, when the right to work is a prime definition of social inclusion/exclusion.

The provisions of the Misuse of Drugs Act regarding drug users and suppliers also creates issues of inclusion and exclusion. The law, by declaring a certain set of consumption habits and economic practices as unlawful, notwithstanding their widespread occurrence and popularity, sets into train processes that by determining the status of individuals are definitive, and in their implementation selective. The process known as criminalisation of drug users creates a form of social exclusion by punishing and stigmatising offenders. Drug offenders do suffer social exclusion because their criminal record is detrimental to their future careers, prospects of finding employment and by increasing their social vulnerability.

The implementation of the legal provisions also means that certain drug offenders are more vulnerable to becoming involved with the criminal justice system than others. There are different levels of equality issues at work, as the implementation of the law varies between different parts of the country, and is decided at local policy level.

There are issues over the selection of particular policy approaches to the communities in that area, with reference to of targeting, victimisation and constructed social exclusion.

At a different level, the question of discretion in implementation is important for the social inclusion discussion, because the law may impact differently on members of different communities, and can therefore become an instrument of structural exclusion.

The discussion over social inclusion/exclusion in the drugs field ranges therefore over specific questions of service provision to the primary basis of the drug laws and drug policy.

16.1 (c) Groups seen as particularly vulnerable regarding drug use

Vulnerability is used here not to define drug use, but to experiencing drug related harm occurring through substance use, whether through intoxication, illegality or health.

- Rough Sleepers and Homeless
- vulnerable young people, including**:** looked after children, young offenders, young homeless, young people excluded from school and children of drug using parents
- People in prison
- Black and minority ethnic groups

16.2 Drug use patterns and consequences observed among socially excluded population

16.2 (a) Prevalence of drug use and problematic drug use amongst specific socially excluded populations

Vulnerable young people
Past studies of certain groups of socially excluded young people have shown that they have high levels of drug use (Goulden & Sondhi, 2001). Research has shown that substance use was a contributory factor in 37% of cases of those over 10 years old presenting to local authority care. They found considerable variations in the perception of foster carers, care home staff and social workers about the substance taking of young people (Hamilton et al. 2000). Research also shows that drug use among young people in care is higher and starts at a younger age than for young people in the general population (Ward 1998).

Rough Sleepers and Homeless
Studies have reported levels of drug use among homeless people between 66% and 76% (Carlen 1996; DrugScope 2000). There is also a higher incidence of alcohol misuse than among the general population.

16.2 (b) Patterns of use (drugs used, route of administration, frequency)

Patterns of drug use are determined by interrelated factors of culture, availability and financial means. Different Black and ethnic minority groups display preferences for particular substances. Examples include the prevalence of heroin smoking among drug users of Bangladeshi extraction; the preference for cannabis (marijuana, as opposed to cannabis resin) among drug users of Caribbean extraction; the preference for khat among the Somali community.

Routes of administration

Among homeless people there is a high incidence of injecting. Over a third of the sample had injected heroin, and a fifth had injected crack. In the last month over 10% had used someone else's syringe, or passed their own syringe on.

Vulnerable young people had a high incidence of volatile substance use. This was particularly true of young people who had been excluded from school, committed offences, or were looked after. The earliest experimentation with volatile substances was recorded among the excluded.

There are reports that the introduction of mandatory drug testing in prison is leading to a switch from cannabis to opiates. This is explained by cannabis staying longer in the system than opiates (DrugLink, September/October 2002).

16.3 Relationship between social exclusion and drug use

16.3 (a) Indicators of social exclusion amongst specific populations of drug users, in comparison with the general population (eg. Unemployment…)

There is a high correlation between social vulnerability, including unemployment, offending and chronic drug use. The causal linkages are not understood, however, and remain a matter of speculation. Studies into particular cohorts of drug users suggest that there is a strong overlap between chronic use of some drugs and social exclusion. While this would apply to heroin and crack cocaine, the data for powder cocaine, MDMA and cannabis does not support this.

16.3 (b) Data from research on social exclusion and drug use (as a risk and/or consequences for drug use)

Research into hidden heroin users showed that 67% were reliant on social security benefits. There was an increasing resort to acquisitive crime during the course of a heroin user's career (Egginton and Parker 2000).

The perceived relationship between drug use and homelessness is also established, with 63% of respondents associating their homelessness with their drug use. While nearly half the sample had been continuously homeless, drug use was by far the most common reason for episodic homelessness with 42% viewing it as the reasons why they still experienced homelessness (Fountain and Howes 2002).

A possible precursor to drug use and social exclusion was picked up by a different research exercise among young homeless people, which established a high degree of school exclusions, up to 30% in one study site (Adamczuk 2000).

Interestingly, no causal relation between social exclusion and drug use was made by the young people interviewed in one study (Melrose and Brodie 2000). None had been excluded because of their drug us, none were looked after because of drug use but some had drug related convictions.

Most of these young people began using drugs with friends and found drugs easy to access. Many felt that nothing would have prevented them from taking drugs when they did, as they would not have listened to anyone at that time. Moreover, there was a widespread sense that no outside agencies were required to help them stop taking drugs – they felt that their drug taking was not a problem and that they could stop at any time.

16.4 Political issues and reintegration programmes

16.4 (a) Policies around social exclusion issues and implications for responses to social exclusion (eg. Policies of social inclusion)

According to the government, social exclusion is a shorthand term for what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime, bad health and family breakdowns.

The Social Exclusion Unit was set up by the Prime Minister to help improve Government action to reduce social exclusion by producing 'joined up solutions to joined up problems.'

Drugs and drug markets have been identified as impeding the regeneration of communities and neighbourhoods. Drug use has also been diagnosed as a contributory factor in the social exclusion of particular groups, including vulnerable young people, homeless people and prison inmates. The drugs strategy and the commitment to neighbourhood renewal pursue similar objectives, and the £ 900 million Neighbourhood Renewal Fund can be accessed by Drug Action Team for drug related initiatives

16.4 (b) Elements of treatment focusing on reintegration within general drug services

Homelessness services are beginning to work with drug services to provide a low threshold drug intervention service and act as a referral point. They can also have an important role to play in supporting clients with alcohol and mental health problems and should develop close contacts with drug, alcohol and psychiatric services (DrugScope 2001).

Guidelines have also been published to ensure that drug services can deal with diversity issues. The steps recommended include the recognition of diversity within ethnic groups; the provision of translation and culturally relevant materials, and even the employment of minority ethnic staff reflecting the target group.

With regard to young people, there is a growing integration with local child and adolescent services, while the drug services are separate and distinct from adult services (SCODA 1997).

16.4 (c) Specific regeneration programmes targeting former drug users

The government's reported success at removing a large number of rough sleepers from the street has raised fears among service providers that those left were the people with the most chaotic lifestyles. Drug use was part of that, and hence a close cooperation of hostels and drug services was recognized as essential. The RSU has since funded the publication of guidelines for practitioners.

16.4 (d) Results from outcome evaluation

The studies of drug use among homeless people found that nine out of ten currently dependent on any drug had used a drug service in the last year. However, over two in five who wanted help had not used a general support service in the last year, and over three in five had not accesses a clinical service. One way or another, a significant number of people who know that they need help are not receiving it.

16.5 Methodological information

16.5 (a) Limits in data available

Information on drug use is always difficult to obtain, but in the case of marginal groups this challenge is compounded. As much of this work is new there are additional problems, including definitions: the RSU definition on sleeping rough which was tightened over the course of the project until it referred precisely to being bedded down with blankets in a place not normally used for sleeping. According to some researchers this definition was in danger of excluding a number of homeless people.

16.5 (b) Main studies and research

Research into the impact of drug use on rough sleepers and the homeless, was commissioned by the Rough Sleepers Unit and by the charity Crisis. The Crisis study entitled *Home and Dry? Homelessness and Substance Use*, was published in 2002. A number of different studies have looked at the particular needs of vulnerable young people. The 2000 publication by DrugScope provides an overview of the literature and summarises the basic findings.

16.5 (c) Bibliographical references

See bibliography

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Database and software used

(a) Alphabetical List of relevant databases/software used for National Report indicating:

The database used was DrugScope's information system – Inmagic database/DBTextworks version 4. It is a bibliographic database of more than 80,000 items relating to misuse of prescribed, illicit and over-the-counter drugs. The database covers literature on all aspects of drug misuse that has been written in the English language world-wide and is one of the foremost and most comprehensive collections of literature on drug use in Europe. It's available to anyone worldwide. The contributing experts used a variety of systems and databases which are centred around the institution from which they are from.

(b) Relevant internet address

This is open to all in the UK via http://www.drugscope.org.uk/library/home.asp

ANNEX

Drug monitoring system and sources of information

Synthetic description of monitoring systems at national level regional level and local level (changes since last report)

Broadly speaking there are three forms of information within the drug strategy
(i) information about progress towards targets/objectives of the drug strategy, this information being reported in the annual reports on the drug strategies of England, Wales, Scotland and Northern Ireland;
(ii) information about performance in relation to Public Service Agreements which HM Treasury has agreed with specific Departments;
(iii) research projects which develop new systems and sources to the point at which they may be used for either of the two.

On (i), the objectives/targets of the UK drug strategies were not changed in late 1999 nor during 2000 (to our reporting date, November 2001). The relevant reports have been mentioned in Section XX, above and electronic addresses are supplied in Section XX.
On (iii), research, we list current research in section (d) below.

a) Procedures for collecting information and processing

Varies with the particular target/objective or the particular research project. See list below.

b) Documentation centres

DrugScope remains the UK's specialist drug information documentation centre, with an interdisciplinary scope and customer base (see section above on References and Databases. However, four factors - the increasing number of research specialisms relevant to drug strategies; the increasing involvement of larger numbers of contractors in projects; political devolution; and the increasing use of the internet for research purposes - mean that information sources are widening beyond the traditional and specialised documentation centre.

c) Reporting system

Apart for the setting up of the Drug Strategy Directorate within the Home Office in the spring of 2001, there was no major change in the system of upward reporting from information/research specialists to government.

d) Drug strategy research in England, Wales, Scotland and Northern Ireland

Drug strategy research in England

Key research project in 2001

Vulnerable groups research programme: Six projects looking at levels of drug use among young people at risk of developing drug problems in later life. Groups being researched include: young sex workers, young offenders, and young people in care.

Drug use and criminal offending: a programme of urine testing and interviews with arrestees across 16 police stations. The objective of this programme is to provide some insight into the links between drugs and criminal activity.

Estimates of problem drug users: two 'capture-recapture' studies providing local and national estimates of problem drug users in England. Study sites include: London, Liverpool, Brighton and Manchester.

Evaluation of Arrest Referral Schemes: a series of projects assessing the impact of drugs outreach work based in police custody areas. The studies will assess the impact of referral into treatment on drug use and offending behaviour.

Evaluation of activities targeting drug markets: local initiatives seeking to reduce or eradicate drug markets in three sites across England will be appraised over a three year period. Initiatives include extra policing, changes in housing management and redesigning of buildings.

Drug strategy research in Wales

A substance misuse research and information strategy is under development. This strategy will outline arrangements for the monitoring of progress against key targets, the handling of information and the generation of research studies. It will guide the direction and commissioning of studies and information initiatives to support the Welsh substance misuse strategy. There will be common ground with the research programme devised for the UK drug strategy by the cross-departmental Research & Information (Working) Group and the information strategy work that has been developed in Scotland.

The finalised R&I strategy will be informed by the context, culture and priorities in Wales, as well as by the vision for health improvement described in the *Better Health-Better Wales* strategy.

Current or recently completed activities by strategic aims

Aim 1: to help children, young people and adults resist substance misuse in order to achieve their full potential in society, and to promote sensible drinking in the context of a healthy lifestyle. Research projects include: the Schools Drugs Survey and drugs component of the British Crime Survey which covers Wales; the Youth Lifestyles Survey; analysis of the 1998/99 Youth Lifestyles Survey. The Initial results of this show higher rates of drug use across vulnerable groups, increasing with degrees of vulnerability and having potentially important interactions with gender. There is research examining the service needs of young people in the lower Teifi valley and the Institute of Rural Health is conducting a study examining adolescent substance misuse and focusing on geographical/spatial issues. There is also a local effectiveness study on peer education.

Aim II: to protect families and communities from antisocial and criminal behaviour and health risks associated with substance misuse. Research projects include the NEW-ADAM which covers England & Wales. The Dyfed Powys DAAT commissioned a hospital study in which Accident & Emergency staff are monitoring the nature of drug & alcohol related admissions. The Tackling Alcohol Related Street Crime (TASC) initiative in Cardiff has been subject to Home Office evaluation. The Substance Misuse Intervention Branch at the National Assembly has reviewed the progress of DTTOs in Wales and there is a study of substance misuse and homelessness (University of Wales Cardiff and University of Kent Canterbury) being conducted and also in-house work by North Wales DAAF (DAAT) into monitoring drug related deaths

Aim III: to enable people with substance misuse problems to overcome them and live healthy and fulfilling lives and in the case of offenders, crime free lives. Research projects include; the National Drug Treatment Monitoring System in which Welsh data is collected by the Substance Misuse Intervention Branch at the National Assembly; Welsh participation in UKATT. There is a two centre randomised controlled pilot study, led from Manchester University, one of the pilot sites being in South Wales regarding Dexamphetamine Substitution as a Treatment of Amphetamine Dependence. There is monitoring and evaluation of projects commissioned through the Welsh Drug & Alcohol Treatment Fund of which evaluation is conducted at both a national and local level; an audit/review of alcohol treatment services by University of Wales Cardiff & the Substance Misuse Intervention Branch, National Assembly; a project to develop rapid screening procedures for alcohol problems; research into needle fixation by Cardiff Community Addictions Unit; an assessment the prevalence of HCV and HBV amongst IDUs hidden to drug treatment services (University of Wales) Bangor; Iechyd Morgannwg Health commissioned a mapping exercise of treatment agencies to inform future service structure and development; a current Audit Commission study of the commissioning and management of drug treatment services includes one DAAT area in Wales;

Aim IV: to stifle the availability of illegal drugs on our streets and inappropriate availability of other substances. The Sizing the UK Drug Market & Drug Seizures and Offenders Statistical Series covers Wales.

Research cutting across more than one strategic aim includes needs assessment by Gwent DAAT and University of Glamorgan; training needs analysis commissioned by Gwent DAAT; Gwent DAAT conducting in-house research into evaluation methodology; needs assessment of minority ethnic groups in Cardiff (NewLink South Wales)

Drug Strategy research in Scotland

Scottish Executive – key research projects in drug misuse 2001

Training and Employment Review
A review of how best to support recovering drug users into employment, training and education has recently been completed. The report is now available at:
www.drugmisuse.isdscotland.org/goodpractice/EIU_movingOn.pdf

International Review of Treatment Effectiveness

A systematic review of the international research literature on the effectiveness of drug treatment is underway using the methods employed by the Cochrane Collaboration. This review was completed by May 2002.

Survey of opioid treatments in Scotland
A national survey of treatments for opiate dependents in Scotland began in October 2001. Telephone interviews will be conducted with key personnel in each DAT and Health Board area. This work was completed in March 2001.

Review of treatment services for young people
This project includes a literature review, an examination of service provision across Scotland and qualitative work with young people. The work was completed March 2002.

Prison transitional care evaluation
Prison transitional care arrangements will begin in Scotland later this year. The Scottish Executive are now working with the Scottish Prison Service (SPS) to design the evaluation of this initiative.

Estimating the current prevalence of problematic drug use across Scotland
A prevalence study using the capture-recapture methodology has just been completed in Scotland that allows results to be disaggregated by Drug Action Team area. The report was published in November 2001.

Evaluation of Drug Testing and Treatment Orders
An evaluation of Drug Testing and Treatment Orders (DTTOs) has recently been completed in two pilot sites in Scotland.

Randomised controlled trial of methadone and dihydrocodeine
This RCT comparing methadone and dihydrocodeine began earlier this year and will be completed in 2003.

Follow-up of 1996 Glasgow cohort of methadone users
This project is systematically following-up individuals who were part of the Glasgow methadone evaluation in 1996. The project will be completed in 2003.

Drug Strategy research in Northern Ireland

Research and Information Programme

The drug and alcohol research unit is in the process of commissioning a researcher to undertake an analysis of the drug and alcohol data from the NISRA Omnibus Survey and the Young Person's Behaviour and Attitudes Survey. The report was published in March/April 2002.

The drug and alcohol research unit have appointed a researcher from the Queens University Belfast to review evidence and provide an assessment of the need for substitute prescribing for heroin users in Northern Ireland. The research will also provide an estimate of the number of heroin users in Northern Ireland. The final report was published June 2002.

The drug and alcohol research unit are also taking forward a proposal to extend a UK survey of salivary antibodies to HIV, Hepatitis B and C in injecting drug users to Northern Ireland.

In October, the drug and alcohol research unit published a report entitled 'Heroin Use in Northern Ireland: A Qualitative Study into Heroin Users' Lifestyles, Experiences and Risk Behaviours'. The report is available on the departmental website at dhsspsni.gov.uk

In August, a report entitled 'Drinking, Smoking and Illicit Drug Use Amongst 15 and 16 year old School Students in Northern Ireland' was published. This report is also available on the departmental website.

List of tables used in the text

List of maps used in the text

No maps were used in the text

List of graphics used in the text

Source: Personal communication with Gordon Hay, Patsy Bailey, Tom Bucke, John Corkery, Ali Judd

Figure 8: Relative changes in value of the heroin indicators, 1993-2000.
Source: Personal communication with Gordon Hay, Patsy Bailey, Tom Bucke, John Corkery, Ali Judd

Figure 9 : Relative changes in values of the cocaine indicators, 1993-2000
Source: Personal communication with Gordon Hay, Patsy Bailey, Tom Bucke, John Corkery, Ali Judd

Figure 10 : Relative changes in values of the amphetamine indicators, 1993-2000
Source: Personal communication with Gordon Hay, Patsy Bailey, Tom Bucke, John Corkery, Ali Judd

Figure 11 : Relative changes in values of the cannabis indicators, 1993-2000.
Source: Personal communication with Gordon Hay, Patsy Bailey, Tom Bucke, John Corkery, Ali Judd

List of abbreviations used in the text

ACMD	Advisory Council on Misuse of Drugs
ASRO	Addressing Substance Related Offending
BCS	British Crime Survey
CARA	Criminal Assets Recovery Fund
CARATS	Counselling, Assessment, Referral, Advice and Throughcare Service
CCTV	Closed-Circuit Television.
CDSC	Communicable Disease Surveillance Centre
CITA	Council for Involuntary Tranquilliser Addiction
CNS	Central Nervous System
CPR	Cardiopulmonary Resuscitation
DAATs	Drug and Alcohol Action Teams
DAFT	Drug and Alcohol Treatment Fund
DASG	Drug and Alcohol Specific Grants
DATs	Drug Action Teams
DfES	Department for Education and Skills
DH	Department of Health
DPAS	Drugs Prevention Advisory Service
DPAS	Drugs Prevention Advisory Service
DRD	Drug-Related Deaths
DRG	Drug Reference Groups
DTTOs	Drug Treatment and Testing Orders
EIU	Effective Interventions Unit
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESPAD	European School survey Project on Alcohol and other Drugs
GHB	Gammahydroxybutyrate
GMR	General Mortality Register
GP	General Practitioners
GROS	General Register Office Scotland
HAS	Health Advisory Service
HAZ	Health Action Zone
HDA	Health Development Agency
HMSO	Her Majesty's Stationary Office
HOAI	Home Office Addicts Index
IDU	Injecting Drug Users
LEA	Local Education Authority
LTR	Long-Term Rehabilitation
MDT	Mandatory Drug Testing
MSGD	Ministerial Steering Group on Drugs
N/A	Not applicable
NCIS	National Crime Intelligence Service
NDTMS	National Drug Treatment Monitoring System
NEW-ADAM	New English and Welsh Arrestee Drug Abuse Monitoring
NGO	Non Government Organisation
NHSS	National Healthy Schools Standard
NI	Northern Ireland
NPSAD	National Programme on Substance Abuse Deaths
NTA	National Treatment Agency

NTORS	National Treatment Outcome Research Survey
OFSTED	Office for Standards in Education
ONS	Office of National Statistics
PHLS	Public Health Laboratory Service
PSHE	Personal Social and Health Education
QuADs	Quality Standards in Alcohol and Drug Treatment
RAPT	Rehabilitation Addicted Prisoners Trust
RDMD	Regional Drug Misuse Databases
RSU	Rough Sleepers Unit
RTA	Road Traffic Accident
SCIEH	Scottish Centre for Infection and Environmental Health
SCS	Scottish Crime Survey
SMAS	Substance Misuse Advisory Service
SMR	Special Mortality Register
STI	Sexually Transmitted Infection
STR	Short-Term Rehabilitation
TB	Tuberculosis
TDI	Treatment Demand Indicator
TPU	Teenage Pregnancy Unit
TRL	Transport Research Laboratory
UAPMP	Unlinked Anonymous Prevalence Monitoring Programme
UK	United Kingdom
UKADCU	United Kingdom Anti-Drugs Coordination Unit
UN	United Nations
VSA	Volatile Substance Abuse
YOT	Youth Action Teams