



European Monitoring Centre
for Drugs and Drug Addiction



UK Focal Point
On Drugs

**2011 NATIONAL REPORT (2010 data)
TO THE EMCDDA
by the Reitox National Focal Point**

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

REITOX

United Kingdom drug situation: annual report to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2011

Editors

Charlotte Davies*, Layla English[§], Claire Stewart*, Alan Lodwick*, Jim McVeigh[§], Mark A. Bellis[§]

* *United Kingdom Focal Point at the Department of Health*

7th floor, Wellington House, 133 -155 Waterloo Road, London, SE1 8UG, UK

[§] *United Kingdom Focal Point at the North West Public Health Observatory*

The Centre for Public Health, Research Directorate, Faculty of Health and Applied Social Sciences, Liverpool John Moores University, 2nd Floor Henry Cotton Campus, 15-21 Webster Street, Liverpool, L3 2ET, UK

Report submitted to the EMCDDA: 27th October 2011

The United Kingdom Focal Point on Drugs

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

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

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

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

The Head of the United Kingdom Focal Point on Drugs is Alan Lodwick at the Department of Health (alan.lodwick@dh.gsi.gov.uk).

The structure and content of this report

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

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

The remainder of each chapter is concerned with **New Developments and Trends** that have not been included in previous annual reports. Generally, this covers developments that have occurred in the second half of 2010 or the first half of 2011. Relevant data that have become available during this period will also be discussed although these will often refer to earlier time periods.

This report, and the reports from the other European countries, will be used in the compilation of the EMCDDA's annual report of the drug situation in the European Union and Norway to be published in 2012.

National Contributors – Scotland, Wales and Northern Ireland

Welsh Government	Gareth Hewitt
Department of Health, Social Services and Public Safety, Northern Ireland	Kieron Moore Caroline Hickey
Scottish Government	Nicola Paterson Julie Carr
Information Services Division, National Health Service, Scotland	Laura Wood

Experts on the EMCDDA Key Epidemiological Indicators

Population prevalence	Nicola Singleton	United Kingdom Drug Policy Commission
Problem prevalence	Gordon Hay	University of Glasgow
Treatment demand	Michael Donmall	National Drug Evidence Centre, University of Manchester
Drug-related deaths	John Corkery	International Centre for Drug Policy, St George's, University of London
Infectious diseases	Vivian Hope	Centre for Research on Drugs and Health Behaviour, London

Other Focal Point Experts and Partners

Home Office	Holly Clark Anna Richardson
Crime and supply data	David Povey (Home Office), John Marais (Ministry of Justice)
New Psychoactive Substances	Michael Evans-Brown

Main Contributors for Individual Chapters

Chapter One	Charlotte Davies	UK Focal Point
Chapter Two	Charlotte Davies Alan Lodwick	UK Focal Point UK Focal Point
Chapter Three	Layla English	UK Focal Point
Chapter Four	Layla English Gordon Hay	UK Focal Point Centre for Drug Misuse Research, Glasgow University
Chapter Five	Charlotte Davies Michael Donmall Claire Stewart	UK Focal Point National Drug Evidence Centre, University of Manchester UK Focal Point
Chapter Six	Layla English John Corkery Vivian Hope Claire Stewart	UK Focal Point International Centre for Drug Policy, St George's, University of London Centre for Research on Drugs and Health Behaviour, London School of Hygiene and Tropical Medicine UK Focal Point
Chapter Seven	Layla English Vivian Hope	UK Focal Point Centre for Research on Drugs and Health Behaviour, London School of Hygiene and Tropical Medicine
Chapter Eight	Layla English	UK Focal Point
Chapter Nine	Charlotte Davies	UK Focal Point
Chapter Ten	Charlotte Davies	UK Focal Point
Chapter Eleven	Charlotte Davies Dave Marteau	UK Focal Point Department of Health
Chapter Twelve	Layla English	UK Focal Point

In addition to those already mentioned thanks are extended to:

John McCracken, Mark Prunty, Sara Mason, and Mark Edgington at the **Department of Health**;

the large number of staff who contributed to this report at the **Home Office** including Andrew Britton, Angela Scrutton and Cyrille Marcel in addition to those mentioned overleaf;

Robert Stanbury and Stella Francoise at the **National Offender Management Service**;

Tristan McAlpine and Anna Starling at the **Ministry of Justice**;

representatives of **SOCA**;

Kenny Simpson from the **Scottish Crime and Drug Enforcement Agency**;

Sharon Thandi from the **Information Centre for Health and Social Care**;

staff who contributed from the **Scottish Government** including Stuart King, Paul Bennett, Naureen Ahmed and Kathleen Glazik in addition to those mentioned overleaf;

staff at the **Welsh Government** including Chris Roberts and Fiona Cunnah;

staff at **Public Health Wales** and **Health Solutions Wales** including Josie Smith and Elizabeth Walsh;

Gary Maxwell and Rob Phipps from the **Department of Health, Social Services and Public Safety, Northern Ireland**;

David Chater from the **Department for Education**;

Neil Hodgson at **DWP**;

Ann Gledson, Therese Sheppard, Andrew Jones and Tim Millar from the **National Drugs Evidence Centre**;

Scott Parrott of the **Forensic Science Service**; and

Lisa Jones, Ellie McCoy, Amy Luxton, Harry Sumnall and David Seddon at the **Centre for Public Health at Liverpool John Moores University**.

Table of Contents	Page
Summary	11
Trend by individual drug	17
PART A: New Developments and Trends	
1. Drug policy: legislation, strategies and economic analysis	24
1.1 Introduction	26
1.2 Legal framework	27
1.3 National action plan, strategy, evaluation and coordination	31
1.4 Economic analysis	34
2. Drug use in the general population and specific sub-groups	37
2.1 Introduction	37
2.2 Drug use in the general population	38
2.3 Drug use amongst young adults	41
2.4 Drug use in the school and youth population	44
2.5 Drug use among specific groups in the adult population	50
2.6 Drug use among specific groups in the school age population	53
2.7 Attitude surveys on the use of illegal drugs	54
3. Prevention	55
3.1 Introduction	55
3.2 Universal prevention	56
3.3 Selective prevention in at-risks groups and settings	60
3.4 Indicated prevention	62
4. Problem Drug Use	64
4.1 Introduction	64
4.2 Indirect estimates of problem drug users	69
4.3 Data on PDUs from non-treatment sources	69
4.4 Intensive, frequent, long-term and other problematic forms of use	70
4.5 Research	63
5. Drug-related treatment: treatment demand and treatment availability	71
5.1 Introduction	71
5.2 Strategy and policy	71
5.3 Treatment systems	73
5.4 Characteristics of treated clients (TDI)	80
5.5 Trends of clients in treatment	86
5.6 Treatment outcomes	90
6. Health correlates and consequences	92
6.1 Introduction	92
6.2 Drug-related infectious diseases	92
6.3 Other drug-related health correlates and consequences	97
6.4 Drug-related deaths and mortality of drug users	108
7. Responses to health correlates and consequences	116
7.1 Introduction	116
7.2 Prevention of drug-related emergencies and reduction of drug-related deaths	116
7.3 Prevention and treatment of drug-related infectious diseases	119
7.4 Responses to other health correlates among drug users	125
8. Social correlates and social reintegration	128
8.1 Introduction	128
8.2 Social exclusion and drug use	128
8.3 Social reintegration	133
9. Drug-related crime, prevention of drug-related crime and, prison	138
9.1 Introduction	138

9.2 Drug-related crime	139
9.3 Prevention of drug-related crime	142
9.4 Interventions in the criminal justice system	145
9.5 Drug use in prisons and responses	150
10. Drug markets	151
10.1 Introduction	151
10.2 Availability and supply	151
10.3 Seizures	153
10.4 Price/purity	157
PART B: Selected Issues	
11. Drug-related health policies and services in prison	163
11.1 Prison systems and prison populations: contextual information	163
11.2 Organisation of prison health policies and service delivery	166
11.3 Provision of drug-related health services in prison	171
11.4 Service quality	180
12. Drug users with children	182
12.1 Size of the problem	182
12.2 Physical, mental and other risks to drug using parents and their children	186
12.3 Policy and legal frameworks	190
12.4 Responses addressing drug using parents/pregnant women and their children	197
PART C: Bibliography and annexes	
Bibliography	209
List of tables used in the text	245
List of figures used in the text	247
List of abbreviations used in the text	250
List of standard tables and structured questionnaires	255
Appendix A: United Kingdom prevalence estimates from population surveys	257
Appendix B: United Kingdom treatment presentations by primary drug	260

Technical Notes

Standard Tables

References in the text to Standard Tables (sometimes abbreviated to ST01, ST02 etc) are to standardised reporting formats specified by the EMCDDA. All National Focal Points provide data using these Standard Tables in order to facilitate the collection of information in a consistent and comparable format across Europe. The tables provided to the EMCDDA by the UK Focal Point are available on the Focal Point website (www.ukfocalpoint.org.uk).

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

Exchange Rates

All monetary values in this report are provided in both Euros (€) and Pounds Sterling (£). Euro values have been derived using the annual average spot exchange rate published by the Bank of England for the most appropriate calendar year (for example, for 2007/08 financial year values, the exchange rate for 2007 has been used). For 2011, the annual rate has been estimated from the first three quarterly average rates published at the time of writing and by assuming that the fourth quarter rate is the same as that prevailing in the third quarter. The 2011 rate has been calculated as the average of these four quarterly rates.

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

Year	Euro rate (£1 =)
2003	1.4456
2004	1.4739
2005	1.4629
2006	1.467
2007	1.4619
2008	1.2588
2009	1.1233
2010	1.1752
2011	1.1664

After 2007 there were considerable changes in the Sterling/Euro exchange rate. This means that care must be taken when interpreting trends in values given in Euros

References to Specific Drugs

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

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

Use of term 'significant'

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

The United Kingdom and its constituent countries



The United Kingdom population was estimated to be 62.3 million in the middle of 2010. 84% (52.2 million) live in England, eight per cent (5.2 million) in Scotland, five per cent (3.0 million) in Wales and three per cent (1.8 million) in Northern Ireland.

Summary

PART A: New Developments and trends

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

Drug Classification

The *Police Reform and Social Responsibility Act 2011* makes provision for the power to invoke a temporary class drug order to control new psychoactive substances that raise sufficient concern to justify a faster legislative response.

National action plans and strategies

A new drug strategy, *Reducing Demand, Restricting Supply, Building Recovery* was published by the Coalition Government in December 2010. The strategy emphasises recovery and supporting people to become drug free.

A revised national strategy document for Northern Ireland, entitled *The New Strategic Direction for Alcohol and Drugs Phase 2 – 2011-2016* will be published later in 2011.

Public expenditure

Labelled public expenditure in the United Kingdom during 2010/11 was estimated to be around £1.1 billion.

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

Results from the 2010/11 British Crime Survey (BCS) and the 2009/10 Scottish Crime and Justice Survey (SCJS) have been published. After decreases in previous years, reported drug use remained stable although there has been a decrease in the use of cocaine powder in both surveys. In the 2010/11 BCS, last year use of mephedrone amongst 16 to 24 year olds was at the same level as cocaine powder use.

School pupils

After a general decline in drug use since 2003 amongst schoolchildren in England, recent drug use fell sharply between 2009 and 2010 from 14.8% to 12.5% although questions on mephedrone were not asked. Recent drug use was lower amongst Welsh schoolchildren at 7.9%.

Drug use amongst club goers

Ecstasy (75%) remains the most recently used stimulant drug amongst young club goers responding to the Mixmag survey with use of mephedrone at 51%. Other research carried out in gay dance clubs in London, found that mephedrone was the drug most commonly used on the survey night and second most used drug in the last month and last year after cocaine powder.

Attitudes to drug use

While the majority of adults in the 2010/11 BCS believed it was acceptable to get drunk frequently or occasionally (80%), most thought it was never acceptable to use cannabis (65%), cocaine (91%) or heroin (98%).

Chapter 3. Prevention

Universal prevention

In England a review of PSHE education, which includes drug education, is underway and revised guidance on drug issues is due for publication in late 2011. In Wales, revised

guidance on substance misuse is under consultation and guidance on VSA education has been published.

Mass media and campaigns

In England the FRANK campaign continues. In Scotland, Know the Score continues to focus on the message 'cocaine: you don't know what you're getting'. The Dan 24/7 website was launched in Wales to complement the existing telephone helpline.

Community

In England and Wales the 'Positive Futures' diversionary activity programme for young people in deprived areas continues for the tenth year and has secured £10million of funding over the next two years. Also in England and Wales, the 'Choices' targeted drug prevention/early intervention programme has been developed jointly by the voluntary sector (VCSE) and the Government and has £4million funding for 2011/12. It is aimed at vulnerable 10 to 19 year olds who are at higher risk of drug use/ offending.

Chapter 4. Problem drug use

Estimate of problematic drug use (EMCDDA definition)

New estimates for 2009/10 of the number of opiate and/or crack cocaine users (OCU) in England were published in 2011. The results showed a significant decrease in OCU between 2008/09 and 2009/10 (321,229 compared to 306,150 respectively). Separate estimates for crack users (184,247) and opiate users (264,072) showed no significant change from the previous estimate. A significant decrease in the number of injectors of opiates and/or crack cocaine between 2006/07 to 2009/10 was reported (116,809 compared to 103,185 respectively), and this was particularly apparent in London. In Wales, estimates for 2009/10 were published, and reported around 16,389 problematic opioid and/or cocaine powder and/or crack cocaine users.

Combining the new estimates for England and Wales with the most recent estimates for Northern Ireland and Scotland, it is estimated that there are around 380,000 problematic drug users in the UK, equivalent to a rate of 9.31 per 1,000 population aged 15 to 64.

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

Strategy and policy

Pilot Payment by Results schemes, an initiative contained in the 2010 Drug Strategy, have been announced. Treatment providers in England will receive financial payment for outcomes related to a client's recovery from drug dependence.

Data show that Scotland's performance target on waiting times was met in 2010.

Treatment system

A number of treatment guidance documents have been published in Wales. Work is underway in England to develop a new service framework to replace the existing framework, *Models of Care*, placing recovery at the centre of the treatment system.

Treatment demand indicator

The number of treatment presentations decreased by eight per cent in 2009/10 although the number of first ever presentations remained stable. There were decreases in the number of opiate, crack cocaine and cocaine powder presentations but the number of cannabis presentations continued to increase. Current injecting amongst primary heroin presentations has decreased in the past two years.

Substitution treatment

The number of opioid users in prescribing treatment in England increased by three per cent between 2008/09 and 2009/10 with a 43% increase since 2005/06. Around one-quarter have been in prescribing treatment for more than four years.

Chapter 6. Health correlates and consequences

Drug-related deaths (DRD)

Using the EMCDDA definition, drug-related deaths in the UK decreased by 7.7% from the previous year (1,930 in 2010 compared to 2,092 in 2009). There were decreases across all three DRD definitions (DSD -5.9% and ONS -4.4%). Apart from Northern Ireland where there are a comparatively low number of drug-related deaths (n=35 in 2009; n= 42 in 2010) there were decreases across the UK. The average age of death continues to rise (from 32 in 1996 to 39 in 2010).

As in the past 10 years, opiates were the main drugs mentioned on death certificates. Between 2009 and 2010 there was a sharp fall in ecstasy related deaths (72%) and cocaine mentions fell by nearly one quarter.

Drug-related infectious disease

HIV amongst IDUs was 1.1 per cent in 2010 in England, Wales and Northern Ireland, a decrease from 2009 (1.5%), but still higher than in 2000 (0.8%). HIV prevalence was higher in London at 4.3%.

Amongst IDUs in 2010, HCV prevalence was 47% in England, Wales and Northern Ireland, the same as in 2009, but higher than in previous years (43% in 2008 and 2007, and 38% in 2000). There were marked regional differences across the UK. HCB prevalence was 16% in England, Wales and Northern Ireland, a decrease from 29% in 2002.

Chapter 7. Responses to health correlates and consequences

Information provision

In England the Department of Health published *A summary of the health harms of drugs*, a systematic review of the evidence on acute and chronic harms of legal and illegal substances.

In Scotland the National DRD database (NDRDD) published its first year of data, reporting on the circumstances and wider context of a cohort of 432 deaths in 2009. In Wales, a report on the systematic review into a sample of 55 DRDs was published.

Naloxone

Pilot take home naloxone and overdose awareness training schemes have been operating across the UK in the past 12 months. The implementation of national programmes has begun in Scotland and Wales.

Strategy and guidance

In Scotland, a multi-agency *Sexual health and BBV framework 2011 to 2015* has been published. In Wales a Harm Reduction Database (HRD) has been established in 46 Needle and Syringe Programmes (NSP) and a service framework for NSPs has been published.

The Department of Health has published a cross-government mental health strategy, action plan and supporting documents. NICE published a clinical guideline for adults and young people entitled *Psychosis and co-existing substance misuse: assessment and management*.

Chapter 8. Social correlates and social reintegration

Housing

Sixteen per cent of clients entering treatment in Scotland in 2009/10 reported being homeless and 17% lived with other drug users. Nine per cent of new clients entering treatment in England during 2010/11 reported an urgent housing problem. In Wales, Drug Interventions Programme (DIP) caseloads for 2009/10 showed that 24% of individuals lived in temporary accommodation and seven per cent had no fixed abode.

Employment

Data show that 13% of clients presenting to treatment in England, Scotland and Northern Ireland during 2009/10 were employed (a decrease from 15% in the previous year) and two-thirds were unemployed. Males were more likely to be in employment than females (14% compared to 9%). In Scotland, 72% reported funding drug use from welfare benefits.

Families

In 2009/10 in Scotland, 42% of new clients reporting to Scottish Drug Misuse Database reported having dependent children under the age of 16. In Northern Ireland, 20% of those presenting to treatment reported living with a child. One-third of these individuals lived alone with a child.

Reintegration

The NTA published a housing/ employment resource pack to accompany the needs assessment and treatment planning process.

The Government's Welfare to Work programme will streamline welfare payments, including to substance users, into one Universal Credit.

A peer mentoring scheme was established in Wales, with €14.0 million (£12 million) funding available until September 2013. It aims to involve 13,000 individuals and 210 peer mentors. Integrated Family Support Services (IFSS) were set up in four pilot sites in Wales and will be evaluated in 2011.

The final evaluation of UK's first Family Drug and Alcohol Court was published. The UKDPC published a series of reports around the stigmatisation of drug users and family members. A review of social work provision was conducted in Scotland.

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

Drug offences

While the number of recorded drug crimes decreased in 2009/10, the number of arrests increased although this may be due to an increase in drug trafficking crimes. The number found guilty at court or cautioned for drug offences remained stable between 2008 and 2009 with a decrease for all individual drugs except cannabis. For the first time since 2001, cocaine powder offences did not increase.

Prevention of drug-related crime

Around 60,000 individuals were helped into drug treatment and recovery services in England and Wales through the Drug Interventions Programme in 2009/10. Updated guidance on the programme has been published.

Interventions in the criminal justice system

A monetary penalty remains the most common disposal for those found guilty of drug possession offences at court with imprisonment the most common disposal for import/export

offences and trafficking offences. A consultation on proposals for a drug offence sentencing guideline ran in 2011.

The number of individuals starting a Drug Rehabilitation Requirement (DRR) in England and Wales or a Drug Treatment and Testing Order (DTTO) in Scotland as part of a community sentence decreased. However, the proportion of orders successfully completed increased.

Chapter 10. Drug markets

Availability

There has been a further decrease in the proportion of schoolchildren in England having ever being offered drugs from 33% in 2009 to 28% in 2010. In Scotland, 13% of adults reported being offered drugs in the last year. Most areas reported a heroin shortage between spring 2010 and spring 2011.

Seizures

The number of seizures in England and Wales decreased by seven per cent in 2009/10, the first decrease since the introduction of the cannabis warning. Across individual drugs only the number of cannabis plant seizures increased. Similarly the quantity of drugs seized decreased for all drugs except cannabis plants and crack cocaine.

Price/purity

Data from law enforcement agencies show that street-level drug prices remained stable in 2010 although there was a reduction in crack cocaine prices. The purity-adjusted price of cocaine powder has fluctuated in recent years and the purity-adjusted price of heroin increased in 2010, due wholly to a decrease in heroin purity.

PART B: Selected Issues

Chapter 11. Drug-related health policies and services in prison

Drug use amongst prisoners is explicitly mentioned in drug strategies in the UK and there are specific prison drug strategies. Responsibility for health in prisons has been transferred to health services from prison services and a wide range of interventions for drug users is provided. Interventions include information provision, BBV services, prescribing programmes, and psychosocial programmes. There is increasing availability of naloxone programmes on release from prison. A number of guidelines, prison service instructions and prison service orders exist to ensure quality and consistency of service.

Chapter 12. Drug users with children

Prevalence estimates

Treatment data suggest around half of clients have children. Estimates indicate that just over half of OCUs are in treatment. Research has suggested that between 240,000 and 360,000 children are affected by parental drug use but this is commonly considered to be an underestimate.

Physical, mental and other risks to drug using parents and their children

Genetic, developmental, psychological, physical, environmental and social harms can have an impact on the children of drug users. Harm results from the interaction of a complex range of factors and drug use alone does not necessarily imply harm to children. It is reported that having one or both parents in treatment can be a protective factor for the child(ren).

Responses addressing drug using parents/pregnant women and their children

There is a raft of legislation, policy and guidance regarding drug using parents and their children in the UK, with a focus on safeguarding the needs of the child(ren).

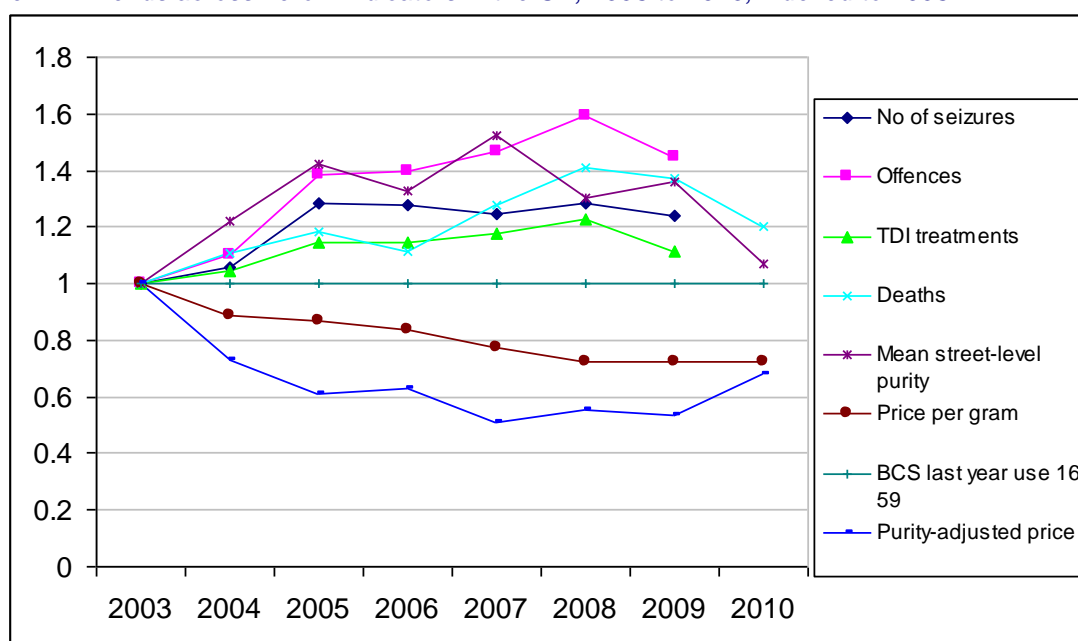
Trends by individual drug

Methodology

Data presented in the figures below are taken from a number of standard tables including numbers 1; 11; 13; 14; 16; and 34. Data are also drawn from the relevant sections of this report. Since the UK only has continuous treatment data from 2003/04, all indicators are indexed to 2003. Where data are for financial years e.g. 2003/04, they are labelled as the first year covered by the financial year, i.e. 2003. Data on seizures, offences, TDI treatments, deaths, and price are for the UK; those for purity and for prevalence of use are for England and Wales. Where mentioned the correlation coefficient used is Pearson's r , computed using the Excel data analysis tool.

Heroin

Figure T.1: Trends across heroin indicators in the UK, 2003 to 2010; indexed to 2003



The only indicators below 2003 levels are price and purity-adjusted price while use has remained stable. All other indicators are higher than 2003 but have fluctuated and there is no clear trend. Street-level purity and presentations to treatment seem to be heading back towards 2003 levels. While deaths have increased since 2003, there is a decrease since 2008 although it remains unclear what the cause of these changes may be given the stable levels of use. When deaths increased between 2006 and 2008, it was suggested that this was due to an ageing cohort of heroin users.

Data from the TDI show that the proportion of individuals presenting to treatment for primary heroin use who are over the age of 40 continues to increase from 10.3% in 2003/04 to 19.2% in 2008/09 and 21.9% in 2009/10. It may be that treatment is a protective factor against risk behaviours and the decrease in current injecting amongst heroin users presenting to treatment (from 34.3% in 2007/08 to 26.7% in 2009/10) may support this. Despite a lack of breakdown by individual drug and age, the mean age of drug-related deaths increased from 36.2 years old in 2003 to 39.7 years old in 2010. Older injecting drug users (the majority of whom are heroin users) have higher levels of morbidity than their younger counterparts with increased prevalence of blood-borne viruses; 60% of those aged 35 and over tested positive for Hepatitis C in 2010 compared to 26% of those aged under 25

years old. Prevalence of HIV infection was 1.6% amongst those aged over 34 and 0.6% amongst those aged under 25 years old.

The decrease in purity and associated rise in purity-adjusted prices in 2010 is the result of a heroin shortage in the UK during 2010. In 2010, the wholesale price of heroin increased by around 25% although reported street-level prices remained stable. It remains to be seen what the impact of this shortage is on treatment demand, deaths and other indicators.

Crack cocaine

Figure T.2: Trends across crack cocaine indicators in the UK, 2003 to 2010; indexed to 2003

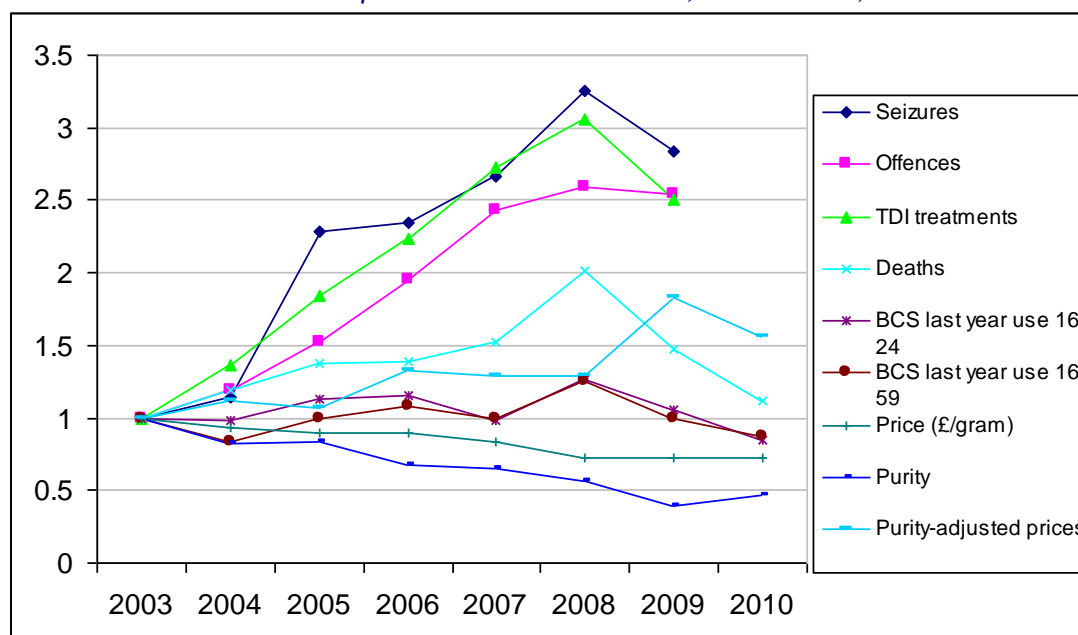


*Crack cocaine prices before 2007 were based on price per rock (0.2g) not per gram. Prices after 2007 cannot be compared to previous years.

Indicators for crack cocaine decreased after 2008 with a more substantial fall than for cocaine powder. As with cocaine powder, the three indicators below 2003 levels are price, purity and use. The number of treatment presentations for primary crack cocaine use has fallen as has the number of primary heroin presentations reporting secondary use of crack cocaine. Overall the number of treatment presentations reporting any use of crack cocaine decreased by 19% from 34,994 in 2008/09 to 28,318 in 2009/10. The number of treatment presentations for primary crack cocaine use is now almost at 2003 levels as is the number of seizures. Out of all the indicators, only the number of offences remains substantially higher than in 2003.

Cocaine powder

Figure T.3: Trends across cocaine powder indicators in the UK, 2003 to 2010; indexed to 2003



Indexed to 2003, the purity and price of cocaine powder are lower than in 2003 while prevalence of use for both 16 to 59 year olds and 16 to 24 year olds decreased in 2010/11 to below 2003/04 levels. The graph shows a fall in almost all cocaine powder indicators (apart from price) in 2009, at which point the mean purity of cocaine powder was less than half of what it was in 2003. There is a strong correlation between TDI treatments and offences ($r=0.97$) perhaps reflecting the role of the criminal justice system in channelling problematic cocaine powder users into treatment. Other data indicating a decrease in cocaine powder use and related problems are the fall in the proportion of positive mandatory drug tests for cocaine in the British Army between 2008 and 2010 from 67.8% to 53.9% and a decrease in the number of inpatient hospital discharges for cocaine poisoning in the UK from 2,627 in 2008/09 to 1,986 in 2009/10.

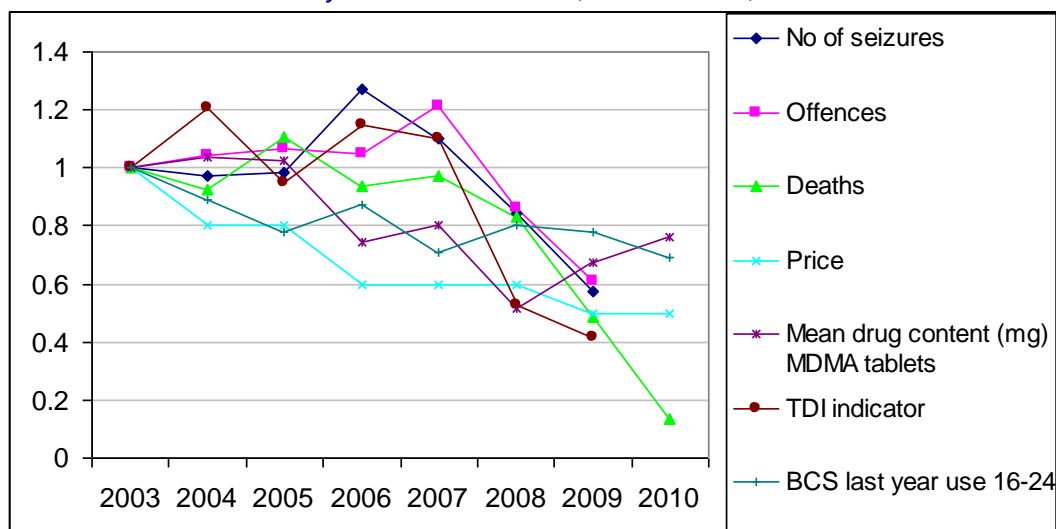
Most strikingly, there has been a large decrease since 2008 in the number of deaths mentioning cocaine¹ from 325 to 180. Although purity decreased between 2008 and 2009, it is difficult to attribute the decrease in deaths to this since purity has been falling since 2003 and the number of deaths increased until 2008.

SOCA partly attributes the decrease in cocaine powder purity to the success of upstream interdiction efforts (SOCA 2009). There are suggestions that the fall in the purity of cocaine powder may be due to a lack of availability, resulting in an increase in wholesale prices and the need to cut the product to maintain profit margins. The proportion of schoolchildren reporting being offered cocaine or that cocaine is easy to obtain has fallen and the quantity of cocaine powder seized by law enforcement agencies in England and Wales decreased in 2008/09 (from 3,453 in 2007/08 to 2,916 in 2008/09) and 2009/10 (to 2,642). For the first time since 2001, the number of cocaine powder seizures also decreased in England and Wales, by 13% from the previous year ($n=21,337$).

Ecstasy

¹ It is not possible to distinguish between cocaine powder and crack cocaine in toxicology tests.

Figure T.4: Trends across ecstasy indicators in the UK, 2003 to 2010; indexed to 2003



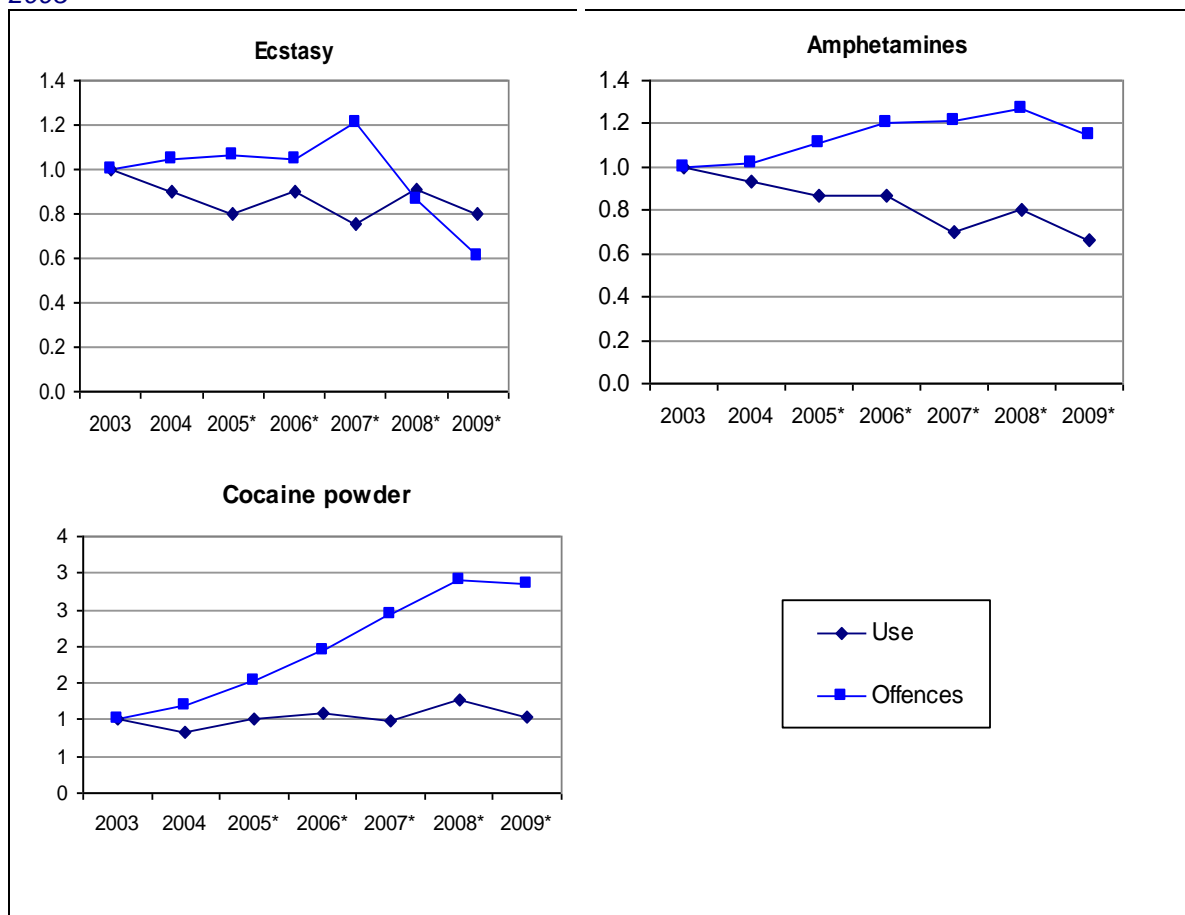
All indicators for ecstasy are well below 2003 levels. The most striking decrease is in the number of deaths, which has fallen from 66 in 2003 to nine in 2010. The biggest decrease has been in the past two years with a decrease from 55 in 2008 to 32 in 2009 and nine in 2010. This is despite the mean drug content of ecstasy increasing over this period back to levels detected in 2006 and 2007. However, these data only cover the content of tablets that are found to contain MDMA and it may be that there is less ecstasy available. Indeed, between the first quarter of 2006 and the final quarter of 2009 the number of ecstasy seizure records analysed by the Forensic Science Service (FSS) decreased from 1,126 to 68 while the number of piperazine and cathinone records increased substantially. At the end of 2009, MDMA accounted for 7.7% of all tablet seizures compared to 99.3% at the beginning of 2006. While reported recent use amongst 16 to 24 year olds has been relatively stable since 2005 at around four per cent, it is likely that what users believe is ecstasy is in fact another substance. It has been mooted that the fall in ecstasy and cocaine deaths since 2008 may be as a result of users switching to 'legal highs' with the suggestion that this may have had an unintended harm reduction effect.²

Alongside the decrease in deaths mentioning ecstasy, there has been a decrease in the number of ecstasy-related offences since 2007 with the fall in offences greater than the fall in reported use. This is in contrast with other stimulant drugs like cocaine powder and amphetamines where there has been a large increase in possession offences since 2003 in England and Wales despite stable or falling use (Figure T.4). This may be due to both an over-estimation of use by survey respondents and the decrease in the availability of ecstasy as shown by the large fall in the number of seizures and in the FSS data. Between the first quarter of 2007 and the third quarter of 2009 the number of FSS records analysed and found to be piperazines increased from 72 to 1,061 accounting for 84% of all records compared to seven per cent in the first quarter of 2007. Research with young club goers suggests that most drug users had never even heard of piperazines (Fiona Measham – personal communication) and recent use of piperazines is relatively low amongst young people (Hoare and Moon 2010) supporting the view that would-be ecstasy users may have been inadvertently using piperazines.

Similar to other indicators the number of people presenting to treatment for primary ecstasy use has decreased substantially since 2007/08 from 857 to 325 in 2009/10.

² See: <http://www.straightstatistics.org/article/banned-drug-may-have-saved-lives-not-cost-them>

Figure T.5: Drug possession offences and drug use in England and Wales, 2003 to 2009; indexed to 2003



*Data since 2005 are on an all offence basis; previous data were based on principal drug offence

Mephedrone

Data from the British Crime Survey in England and Wales show that recent use of mephedrone amongst adults aged 16 to 59 was 1.4% in 2010/11. Amongst young people aged 16 to 24 years old recent use was 4.4%, a similar level to the second most commonly used drug, cocaine powder. While analysis of BCS data suggests that mephedrone users also use other drugs, it is not clear to what extent users of other stimulants such as ecstasy and cocaine powder have substituted mephedrone for these drugs.

In 2010 1.7% of schoolchildren in Northern Ireland reported recent use of mephedrone, around the same level as ecstasy use. Six per cent of pupils reported ever being offered mephedrone.

A survey of mephedrone users (Carhart-Harris et al. 2011) found that only 20% had used mephedrone before 2009. Data from the FSS show that seizures of cathinone tablets were first noticeable in the first quarter of 2009. Despite the classification of mephedrone in April 2010, at the end of 2010 cathinone tablets still accounted for around half of the tablets analysed by the FSS. A study looking at mephedrone pre- and post- legislation found that even pre-classification many mephedrone users had never bought the drug from the internet with most obtaining it through friends as with other drugs (McElrath and O'Neill 2010). A further study amongst school and college/university students carried out before the legislative changes supports this finding (Dargan et al. 2010). It found that almost half of respondents sourced mephedrone through a dealer with only 11% sourcing it through the

internet. The authors suggest this is due to younger people not having access to a debit/credit card.

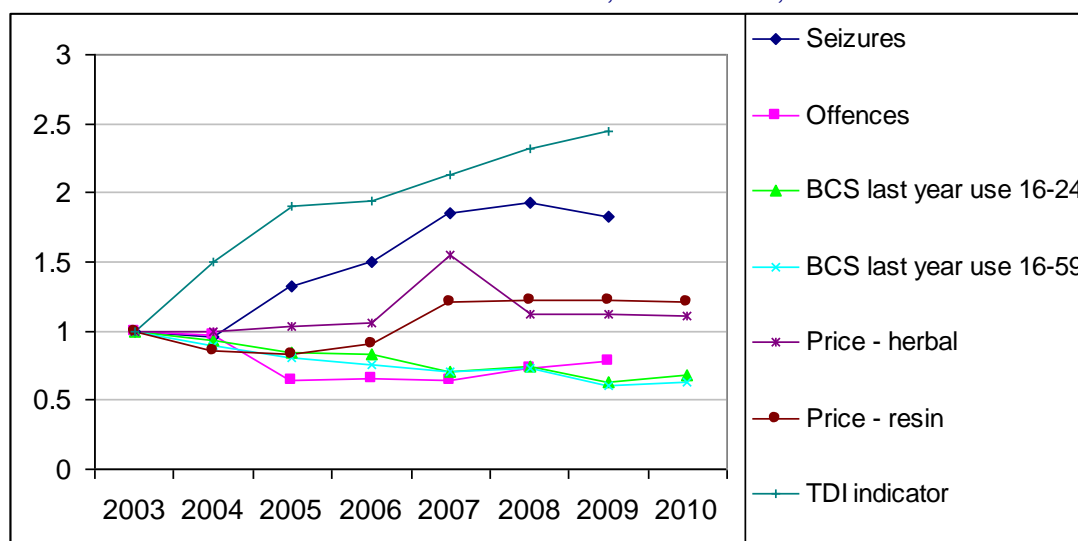
Since classification the price of mephedrone has increased but surveys show that it remains a popular stimulant drug and is second only to cocaine powder in popularity (Measham et al. 2010).

There has been less published about the health effects of mephedrone use than on the prevalence of use and sources of supply. In a small qualitative study, users reported physical effects similar to other stimulants. The authors suggested that the dependence potential of mephedrone may be quite high as almost one-third of participants reported three or more dependence symptoms using the DSM-IV scale (Winstock et al. 2011). TDI data show an increase in treatment presentations for 'other stimulants' in 2009/10, many (36%) of which are for primary mephedrone use.³ The number of presentations to treatment for mephedrone use is higher than for ecstasy use.

Data from England and Wales show that there were six drug-related deaths in 2010 where mephedrone was mentioned on the death certificate. In two deaths mephedrone was the only drug mentioned. In Scotland, mephedrone was mentioned on three death certificates.

Cannabis

Figure T.6: Trends across cannabis indicators in the UK, 2003 to 2010; indexed to 2003



While use of cannabis has decreased since 2003 driving the fall in any drug use, the number of seizures and the number of treatment presentations for primary cannabis use have increased substantially. Analysis shows that use is negatively correlated with seizures ($r = -0.93$) and TDI presentations ($r = -0.96$). However, this shows the difficulty in gaining an insight into the drug situation using the indicators alone and shows the importance of contextual information in interpreting the data. The increase in treatment presentations, which is mainly amongst young people aged under 20 years old is likely to reflect the expansion of young people's treatment services. There is, however, a lack of information about the referral and treatment pathways of young cannabis users and there is no consensus around the concept of problematic cannabis use. Therefore, it is not possible to determine whether there has been an increase in problematic cannabis use despite a decrease in overall cannabis use. However, the proportion of cannabis users reporting daily use has not increased and data

³ The individual drug was not recorded in almost half of 'other stimulant' cases.

from the 2010/11 BCS suggest that it is older cannabis users rather than younger cannabis users who are more likely to be daily cannabis users.

Similarly the increase in seizures is due to the introduction of the cannabis warning which allows police to deal with cannabis possession offences using administrative sanctions. This has led to a divergence in the trend data for seizures and offences, with the latter decreasing resulting in a negative correlation between the two indicators. This compares with other drugs where there are strong positive correlations between seizures and offences. However, while cannabis offences dealt with by the court or caution have fallen, the number of cannabis offences dealt with⁴ by the police has almost doubled to 154,345 in 2009. This may be due to the increased use of stop and search powers by police, which increased by 69% since the introduction of the cannabis warning.

⁴ This includes formal warnings for cannabis and penalty notices for disorder (PND)

New developments and trends

PART A

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

1.1 Introduction

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

The *Misuse of Drugs Act 1971* is the principal legislation in the United Kingdom with respect to the control and supply of drugs that are considered dangerous or otherwise harmful when misused. This Act divides such drugs into three Classes (A, B and C) to broadly reflect their relative harms and sets maximum criminal penalties for possession, supply and production in relation to each class. Drugs in Class A include cocaine, ecstasy, LSD, magic mushrooms, heroin, methadone, methylamphetamine and injectable amphetamine. Class B drugs include amphetamine, barbiturates, cannabis and, since April 2010, cathinones including mephedrone. Class C drugs include anabolic steroids, tranquillisers, ketamine, and since December 2009, BZP and GBL. The *Drugs Act 2005* amended sections of The *Misuse of Drugs Act 1971* and *The Police and Criminal Evidence Act 1984*, strengthening police powers in relation to the supply of drugs. The *Police Reform and Social Responsibility Act 2011* added provisions for 12-month temporary class drug orders enabling enforcement activity against the traffickers and suppliers of new psychoactive substances.

The United Kingdom Government is responsible for setting the overall strategy and for its delivery in the devolved administrations only in matters where it has reserved power (SQ32). A new drug strategy was launched in December 2010 (HM Government 2010a) replacing that of the previous Government, which was published in 2008 (HM Government 2008a). Within the strategy, policies concerning health, education, housing and social care are confined to England; those for policing and the criminal justice system cover England and Wales.

The Scottish Government and Welsh Government's national drug strategies were published in 2008, the latter combining drugs, alcohol and addiction to prescription drugs and over-the-counter medicines. All three strategies aim to make further progress on reducing harm and each focuses on recovery. The Scottish and Welsh strategy documents are also accompanied by an action or implementation plan, providing a detailed set of objectives; actions and responsibilities; expected outcomes; and a corresponding time scale (Scottish Government 2008a; WAG 2008a; WAG 2008b). Each plan reflects the devolution of responsibilities to the national government.

Northern Ireland's strategy for reducing the harm related to alcohol and drug misuse, the *New Strategic Direction for Alcohol and Drugs (NSD)*, was launched in 2006. The NSD contains actions and outcomes, at both the regional and local level, to achieve its overarching aims (DHSSPSNI 2006). A review of the NSD was conducted in 2010, and a revised document was issued for public consultation in March 2011. It is anticipated that the revised document, entitled *The New Strategic Direction for Alcohol and Drugs Phase 2 – 2011-2016* will be published later in 2011.

After the change in Government in 2010, performance targets in England were abolished. However, elsewhere in the UK, drug strategies are underpinned by performance management frameworks, including Public Service Agreements (PSAs) and associated sets of performance indicators, which progress is measured against.

Labelled public expenditure on drugs is about €1.3 billion (£1.1 billion) per annum. The economic and social costs of Class A drug use in England and Wales combined are estimated to have been around €22.2 billion (£15.4 billion) in 2003/04 (Gordon et al. 2006). Using a similar methodology, it is estimated that the economic and social costs of illicit drug use in Scotland was €5.1 billion (£3.5 billion) in 2006 (Casey et al. 2009).

1.2 Legal Framework

Drugs controlled under the *Misuse of Drugs Act 1971*⁵ are listed as Class A, B or C under Schedule 2 of the Act. The ABC classification system of drugs is based on a broad assessment of the comparative health and social harms of controlled drugs and their misuse. It also provides the criminal justice system with a legal framework within which maximum criminal penalties are determined.

1.2.1 Classification of drugs

This section represents the situation as at 30 September 2011.

Temporary Class Drug Orders

The introduction of a new power extending the remit of the *Misuse of Drugs Act 1971* to control new psychoactive substances which raise sufficient concern to justify a faster legislative response forms part of the Government's Drug Strategy published in December 2010 (see section 1.3.1). The *Police Reform and Social Responsibility Act 2011*⁶ was given Royal Assent on 15 September 2011. Section 151 and Schedule 17 make provision for the power to invoke a temporary class drug order. It is expected that the power will be available to the Secretary of State by the end of 2011. The importation, exportation, production and supply of a temporary class drug will be prohibited, although simple possession will not be unlawful. Under Schedule 17 of the 2011 Act, the Secretary of State must consult the Advisory Council on the Misuse of Drugs (ACMD)⁷ before invoking a temporary class drug order. The ACMD is also able, of its own volition, to recommend to the Secretary of State that a substance be subject to a temporary class drug order. Temporary class drug orders will be in force for up to 12 months, subject to parliamentary approval being given within forty days of the order being laid under the 'made affirmative' resolution procedure,⁸ or less if revoked or the temporary class drug is brought under permanent control within this timeframe. This will allow the ACMD to collate and make a full assessment of harm to provide full advice to Government on control under the 1971 Act.

A new joint Working Protocol agreed between the Home Secretary and the ACMD will also be placed in the Houses of Parliament Libraries – a draft of this document is currently available in Parliament.⁹ The Working Protocol is a shared document which sets out how Government and ACMD interact, and the framework within which the ACMD is to provide advice concerning temporary class drug orders.

⁵ See: <http://www.legislation.gov.uk/ukpga/1971/38/contents>

⁶ See: <http://www.legislation.gov.uk/ukpga/2011/13/contents/enacted/data.htm>

⁷ The Advisory Council on the Misuse of Drugs (ACMD) is the statutory body of independent experts appointed to provide advice to Government on drug-related issues and measures, including legislative alterations, to tackle them based on available evidence. Ministers are required to consult the ACMD and consider all available evidence prior to making an Order in Council to control a drug or amend its classification under Schedule 2 of the 1971 Act, subject to Parliament's approval through the affirmative resolution procedure.

⁸ See: <http://www.publications.parliament.uk/pa/ld200809/ldselect/ldconst/116/11607.htm>

⁹ See: <http://deposits.parliament.uk/>

Tapentadol and amineptine

The ACMD provided advice to government, which was accepted, on the control and classification of tapentadol and amineptine under the *Misuse of Drugs Act 1971*.¹⁰ These were approved by Parliament so tapentadol and amineptine became controlled Class A and C drugs, respectively, on 18 March 2011.

Phenazepam

In July 2011, the government also accepted the ACMD's advice to add phenazepam to the list of benzodiazepines which are controlled Class C drugs under the 1971 Act. Pending control, the Home Office imposed a ban on the importation of phenazepam which is being sold as a 'legal high' on the internet. The ACMD's advice summarised the health harms of phenazepam and highlighted concerns that, as a potent member of the benzodiazepine family (with a potency five times that of diazepam), the risk of overdose is high.¹¹

Desoxypipradrol and related compounds

In September 2011, the ACMD provided further advice to Government on desoxypipradrol (2-DPMP), the importation of which was banned in November 2010 following initial advice.¹² The ACMD's advice also identified structurally related compounds, such as diphenylprolinol (diphenyl-2-pyrrolidinylmethanol or D2PM) and 2-diphenylmethylpyrrolidine, and formulated a generic definition to capture them along with 2-DPMP under the 1971 Act. Ministers accepted the ACMD's assessment of evidence on 2-DPMP and structurally related compounds, identified in some 'legal high' branded samples of 'Ivory Wave' in 2010, including its recommendation to control them as Class B drugs under the 1971 Act on the basis of harm they pose.

The Government is expected to seek parliamentary approval to ban phenazepam as a Class C drug and 2-DPMP and related compounds by generic definition as Class B drugs under the *Misuse of Drugs Act 1971* by the end of 2011.

1.2.2 Advisory Council on the Misuse of Drugs

Constitution of the ACMD

The *Police Reform and Social Responsibility Act 2011* amended Schedule 1 of the *Misuse of Drugs Act 1971* regarding the constitution of the ACMD. Section 152 removes the requirement to have at least one member with expertise in each of six areas of scientific practice: medicine; dentistry; veterinary medicine; pharmacy; the pharmaceutical industry; and chemistry. It also removes the requirement to have members who have experience of social problems connected with drug misuse. These stipulations are intended to allow for greater flexibility in the ACMD's membership to respond to changes in the drugs landscape, particularly in dealing with new psychoactive substances. The list of statutory areas of members' expertise has been replaced by a more detailed, non-statutory list of likely relevant areas of expertise from which the ACMD's membership should be drawn. This list is published in the Working Protocol agreed between the ACMD and the Government (see section 1.2.1) and will be kept under review, as a joint exercise, by both parties.

¹⁰ See: Home Office Circular at <http://www.homeoffice.gov.uk/about-us/corporate-publications-strategy/home-office-circulars/circulars-2011/005-2011/>

¹¹ See: <http://www.homeoffice.gov.uk/publications/agencies-public-bodies/acmd1/acmd-advice-phenazepam?view=Binary>

¹² See: <http://webarchive.nationalarchives.gov.uk/20101208201547/http://www.homeoffice.gov.uk/publications/drugs/drug-licences/desoxypipradrol/>

Review of the ACMD

Findings from a review of the ACMD by Sir David Omand were published in 2010 (Omand 2010).¹³ The review aimed to discover whether the ACMD is able to discharge the function it was set up to deliver and whether it represents continuing value for money. It was concluded that the ACMD has been effective within the resources given and represents excellent value for money. The review recommended that the ACMD should continue to provide advice on its own initiative, in addition to meeting the requirements of the government, and that Ministers should respond to advice within six weeks. It was also recommended that the ACMD should agree a three-year rolling programme annually and that the Government should provide the ACMD with a co-ordinated set of priorities (see section 1.3.1). The Government and ACMD have embedded a number of Sir Omand's recommendations in the Working Protocol.

1.2.3 Proposed revisions to legal framework

Drug driving law

The House of Commons Transport Committee (2010) published a report on its inquiry into drink and drug driving law. Announced in July 2010, the inquiry focused on the more high profile and controversial recommendations from the North Review (North 2010; see 2010 UK Focal Point Report). The Committee recommended that the Government develop a five-year strategy for tackling drug driving and welcomed the Government's commitment to install drug screening devices in every police station by 2012. It also recommended the adoption of a 'zero tolerance' approach to illegal drugs known to impair driving.

The Government published its response to the reports of the North Review and House of Commons Transport Committee (HM Government 2011). It proposes implementing recommendations to amend the *Road Traffic Act 1988* to allow nurses to assess whether a drug driving suspect 'has a condition which might be due to a drug' in addition to Forensic Physicians who currently undertake that role. Other recommendations to be implemented include the provision of training to health professionals involved in assessing those suspected of drug driving and type approval of preliminary drug screening devices to police stations within two years. A specification for a station-based device¹⁴ has been approved and manufacturers have submitted devices for type approval. The Government intends to continue exploring the issues around the creation of a new offence and to research the possibility of either introducing threshold limits for drugs or adopting a zero tolerance approach.

Provision of foil

A report into the use of foil, as a harm reduction measure for heroin users (see section 7.3.1), explored the legal status of providing foil to users (ACMD 2010). After reviewing international evidence, the ACMD report concludes that there is no evidence of any harmful effect from the provision of foil. Given the potential harm reduction benefits, the ACMD recommends that foil be exempt from Section 9A of the *Misuse of Drugs Act 1971*, which makes it an offence to supply any article for the purpose of administering a controlled drug illegally.

Anabolic steroids

The ACMD has provided advice to the Government recommending that the importation of anabolic steroids be restricted to personal custody and the term 'medicinal product' be removed from the *Misuse of Drugs Regulations 2001*. The Government has accepted the

¹³ See: <http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/acmd1/2010-ndpb-review-acmd?view=Binary>

¹⁴ See: <http://www.homeoffice.gov.uk/publications/police/road-traffic-documents/drug-testing-devices/>

ACMD's advice. The Government intends to implement the ACMD's recommendations by December 2011.

'Sativex'

The ACMD also reviewed its advice to Government on the scheduling of the medicinal product 'Sativex' oromucosal spray under the *Misuse of Drugs Regulations 2001*, following the grant by the Medicines and Healthcare products Regulatory Agency (MHRA) of its Marketing Authorisation in June 2010.

Forthcoming advice

The ACMD will publish its thematic advice to government on tackling new psychoactive substances and the so called 'legal high' market in October 2011. It is also working on a review of cocaine and advice on polysubstance use, and its working group on treatment is now on the Recovery standing committee to enable the delivery of the recovery agenda in the Government's Drug Strategy. Its review of khat, another work priority agreed between the Home Secretary and the ACMD, will begin in autumn 2011.

1.2.4 Commentary and research

Drug control legislation and legal highs

A joint report published by the United Kingdom Drug Policy Commission (UKDPC) and Demos¹⁵ explored whether current drug control legislation is appropriate for today's drug market, specifically focusing on the issue of 'legal highs' (Birdwell et al. 2011). The authors view drug policy as a 'wicked issue' where there is no right or wrong and no simple solution. By using a framework that seeks consensus and avoids polarising the debate, the authors believe progress in drug policy can be made. The report states that there is a 'fundamental and growing bias in the political and regulatory system towards prohibition as a default option'. This, the authors claim, may actually increase harms and have large financial implications. The report provides a number of recommendations within three broad principles:

- focus on achieving outcomes on which there is a consensus;
- ensure a more balanced decision making process and debate including conducting more rigorous research on the impacts of drug control and giving greater consideration of the benefits as well as harms of drugs; and
- consider other regulatory options for control including the use of consumer protection legislation and consider an integrated framework for controlling harmful substances (including alcohol and tobacco) possibly through a *Harmful Substances Control Act*.

Drug harms in the UK

Nutt et al. (2010) used a multicriteria decision analysis to assess the harms caused by the misuse of drugs. Of the 16 harm criteria, nine related to individual harms and seven were associated with harms to others. The authors concluded that heroin, crack cocaine and methamphetamine were the most harmful substances to users while alcohol, heroin and crack cocaine were most harmful to others. Alcohol was found to be the most harmful drug overall followed by heroin and crack cocaine. The authors found no correlation between the overall harm scores and the classification of drugs within the *Misuse of Drugs Act 1971*. They conclude that the findings support previous work in the UK and the Netherlands on drug harms. Rolles and Measham (2011) suggest that the methodology used by Nutt et al. (2010) is "highly vulnerable to subjective judgements" and that the model does not disaggregate the harms related to the drug itself from the harms related to the policy environment.

¹⁵ An independent think tank. See: <http://www.demos.co.uk/>

1.3 National action plan, strategy, evaluation and coordination

1.3.1 National action plans and strategies

Advisory Council on the Misuse of Drugs

The Home Secretary wrote to the ACMD in February 2011 setting out her priorities for the ACMD during 2011-12.¹⁶ The letter asks for the issue of 'legal highs' to be prioritised in the ACMD's work programme and for a review of cocaine harms to begin immediately with a review of khat undertaken at the next available opportunity. Other strands of work for the ACMD include a polysubstance working group and an inquiry into treatment effectiveness to drive the delivery of the 'recovery' focus in the Government's Drug Strategy.

Drug Strategy 2010

A new drug strategy, *Reducing Demand, Restricting Supply, Building Recovery* was published by the Coalition Government in December 2010 (HM Government 2010a). The strategy emphasises recovery and supporting people to become drug free. It also aims to restrict supply by cracking down on internet sales, reducing supply in prisons, developing an approach to stop criminals profiting from the trade in cutting agents and strengthening international partnerships. Some of the key initiatives of the strategy are to:

- introduce a system of temporary bans on new psychoactive substances;
- pilot wing-based, abstinence focused, drug recovery services in prisons;
- pilot Payment by Results (PbR) schemes for drug recovery; and
- develop and evaluate alternative forms of treatment-based accommodation for offenders.

For the first time, the strategy includes dependence on all drugs including prescription and over-the-counter drugs and, where appropriate, severe alcohol dependency.

This strategy is for the period 2010-11 to 2014-15. The Government is putting in place the infrastructure and mechanisms that will enable delivery on its commitments. This is supported by strong governance arrangements to monitor, drive implementation, and review the outcomes of the strategy led through an Inter Ministerial Group of cross-Government Ministers. In addition to this, the Government will conduct an Annual Review of the progress and outcomes made for each of the four years of the strategy.

The Government are working with a newly formed Recovery Partnership bringing together the Substance Misuse Skills Consortium,¹⁷ the Recovery Group UK¹⁸ and DrugScope.¹⁹ The aim of this is to facilitate change within the sector away from a treatment to a recovery focus.

A summary of the responses to the consultation on the drug strategy, carried out in 2010 (see 2010 UK Focal Point Report) was published alongside the strategy document (HM Government 2010b).

Scotland

Scotland's national drugs strategy, the *Road to Recovery* (Scottish Government 2008a) published in May 2008, continues with the implementation and delivery of its person-centred approach to tackling drug misuse.

¹⁶ See: <http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/hs-acmd-priorities-2011-2012?view=Binary>

¹⁷ See: <http://www.skillsconsortium.org.uk/>

¹⁸ See: <http://www.therecoverygroupuk.org/Home.aspx>

¹⁹ See: <http://www.drugscope.org.uk/>

Scottish Drugs Recovery Consortium (SDRC)

The Scottish Drugs Recovery Consortium (SDRC)²⁰ is a national membership organisation and independent charity funded by the Scottish Government to support the delivery of the national drugs strategy. It has over 650 members, including partners from the voluntary, statutory, policy and academic fields, in addition to individuals who are in recovery. The ethos behind SDRC is that recovery from drug problems and addiction are achievable. The SDRC is leading a programme of work, in collaboration with the UKDPC, focused on stigma associated with drug users and their families in Scotland. *Getting Serious About Stigma in Scotland: The problem with stigmatising drug users* (Singleton 2011a) was published in February 2011 (see section 8.2.5). The SDRC are also developing 'Recovery Guides' which will aim to provide a clear understanding of recovery, and which will be circulated widely across Scotland

Report of the Independent Enquiry

The report of an independent enquiry into Scotland's substance misuse problem was published in 2010 (Matthew 2010). The report recognises the need for a range of measures to help prevent people being drawn into misusing drugs and alcohol. The enquiry team suggest a new dynamic with two main strands: the first using a holistic approach to address wider social problems and achieve a cultural shift in people's attitudes towards drugs; and the second, a personalised approach with a 'circle of care' supporting those in need of drug treatment. The former is in line with the aims and principles of the *Road to Recovery* (Scottish Government 2008a) and the latter is currently being explored further in collaboration with the Scottish Government as it fits well with the holistic and person-centred approach to recovery outlined in the national strategy. Finally, the enquiry team call for the end of, what is described as, cynical media reporting, which can stigmatise drug users and stifle cultural change.

Wales

The current implementation plan for the Welsh Drug Strategy, *Working together to reduce harm* (WAG 2008a), runs until the end of 2011. A new implementation plan is under development and will be published in autumn 2011.

Northern Ireland

Northern Ireland's strategy for reducing the harm related to alcohol and drug misuse, the *New Strategic Direction for Alcohol and Drugs* (NSD), was launched in 2006. The NSD contains actions and outcomes, at both the regional and local level, to achieve its overarching aims (DHSSPSNI 2006). A review of the NSD was conducted in 2010, and a revised document was issued for public consultation in March 2011. It is anticipated that the revised document, entitled *The New Strategic Direction for Alcohol and Drugs Phase 2 – 2011-2016* will be published later in 2011.

1.3.2 Implementation and evaluation of national action plan and/or strategy

England

The Government has committed to evaluating the effectiveness and value for money of the Strategy. It is currently developing an evaluation framework which will include an assessment of the evidence currently underpinning the Drugs Strategy, the gaps where better evaluation is required, as well as promoting a consistent approach to new evaluation.

Scotland

Scotland has an NHS Health Improvement, Efficiency, Access and Treatment (HEAT) Target, that has been agreed with local authorities to reduce waiting times for drugs (and alcohol) treatment across NHS, local authority and voluntary sector services,. Data shows

²⁰ See: <http://www.sdrconsortium.org/>

that between April and June 2011, services are well on track for achieving the target (see section 5.2).

Drug Strategy Delivery Commission

The Scottish Drugs Strategy Delivery Commission has established task groups to investigate further the delivery of four priority areas in Scotland's drugs strategy *the Road to Recovery*. The task groups are: Children Affected by Parental Substance Misuse; Prevention; Enforcement; and Delivering Recovery Outcomes. Each Task Group is chaired by a member of the Commission and an update on progress will be provided at the full Commission meetings.

Wales

Implementation of the Substance Misuse Strategy

The *Substance Misuse Annual Report 2010* (WAG 2010a) sets out the progress made in implementing the Welsh Assembly's 10-year substance misuse strategy. An annex to the report sets out progress against the Key Performance Indicators (KPIs).²¹ Data show a 12% decrease in reported serious acquisitive crime since the previous year and a 19% decrease since baseline. Other achievements include an increase in the proportion of clients waiting no more than 10 working days between treatment referral and assessment, from 55% at baseline to 65% in 2009/10 and the creation of 1,794 additional treatment places in 2009/10. However, drug-related deaths increased from 96 in 2008 to 132 in 2009 and there has been an increase in the proportion of clients waiting more than 10 working days between assessment and the beginning of treatment.

Northern Ireland

The *New Strategic Direction for Alcohol and Drugs Update 2011* (DHSSPSNI 2010) provided a review of the outcomes contained in the NSD and an update on the performance indicators to highlight progress on delivery. This document was used to inform the development of the NSD Phase 2.

1.3.3 Research

The findings of a 2010 review of the drugs evidence base commissioned by the Scottish Government (Best et al. 2010a; see 2010 UK Focal Point Report) were published in 2010. These findings continue to be used to help inform the commissioning and delivery of services in Scotland, the establishment of recovery-focused outcomes and indicators, and the involvement of service users and communities in developing knowledge about recovery and service provision.

Further research and commentary.

MacGregor (2011) explored the impact of research on policy in the drugs field. The paper provides a historical review of drugs research in the UK between 1980 and 2010, and discusses the interplay between research and policy.

Seddon (2011a) analysed changes in UK drug policy using a 'historical sociology' approach. This approach, the author argues, allows drug policy to be viewed as a component of politics and social change and helps identify the levers required for change and allow us to see that change is possible.

Askew et al. (2010) reported on the application of the design experiment methodology²² to a local drugs policy intervention and how this methodology influenced implementation.

²¹ See: <http://wales.gov.uk/dsjlg/publications/communitysafety/submisusekpi/kpis.pdf?lang=en>

²² A qualitative form of policy evaluation using feedback from intensive observations of an intervention to improve its implementation.

1.4 Economic analysis

1.4.1 Budget and public expenditure

Data provided in this section refer to labelled expenditure only and are drawn from Government accounting and administrative systems. Previous research has shown that the majority of public expenditure on drugs is unlabelled (see 2007 UK Focal Point Report). Changes over time should be interpreted with caution as this may be due to the mainstreaming of drug specific monies rather than a reduction in funding.

England

Labelled public expenditure in England during 2010/11 was €1.1 billion (£971 million), a five per cent reduction on the previous year (Table 1.1). This reflects a decrease across all COFOG categories except for social protection. For general public services, the decrease is predominantly in overseas assistance and drug-related capacity building projects with a 23% reduction in funding for Afghanistan counter narcotics work. For public order and safety, there was a decrease of €16.5 million (£14 million) for the Drug Interventions Programme (DIP) and a €7.1 million (£6 million) increase in prison clinical services funding. The remaining difference is due to an inability to separate expenditure on drug supply reduction in prisons and regional support for substance misuse services in prisons from wider budgets during 2010/11. The reduction in total DIP funding is a result of several changes. Changes to the DIP Main Grant were due to a new funding model being introduced in 2010/11 and, in addition, the costs for Prolific and Priority offenders (PP0), integrated offender management and administration costs were removed from the overall DIP Programme budget. For health, the pooled treatment budget (PTB) remained stable but there was a reduction in funding for capital development of drug misuse services after large investment in the previous two years. The reduction in education spending was due to a large decrease in the FRANK budget borne out of a government-wide freeze on communications spend.

Table 1.1: Labelled public expenditure on drugs by COFOG category in England, 2006/07 to 2010/11

COFOG category	2006/07 (£/€ million)	2007/08 (£/€ million)	2008/09 (£/€ million)	2009/10 (£/€ million)	2010/11 (£/€ million)
01 – General public services	83.1	74.6	76.1	62.2	50.6
	121.9	109.1	95.8	69.9	59.0
03 – Public order and safety	276.7	255.9	269.6	287.9	270.9
	405.9	374.1	339.4	323.4	316.0
07 – Health	601.6	611.2	644.9	657.0	637.6
	882.5	893.5	811.9	738.0	743.7
09 – Education	5.4	4.2	4.1	3.9	0.5
	7.9	6.1	5.2	4.4	0.6
10 – Social protection	49.8	31.0	7.6	11.4	11.4
	73.1	45.3	9.6	12.8	13.3
Total	1,016.6	977.0	1,002.3	1,022.5	971.0
	1,491.3	1,428.1	1,261.9	1,148.6	1,132.6

Source: Government Departments

Northern Ireland

Labelled expenditure on drugs increased by nine per cent in 2010/11 to €10.8 million (£9.2 million). The majority of this increase was an increase in the amount allocated for implementation of the national strategy across Drug and Alcohol Co-ordination Teams (DACTs) from €5.8 million (£5.2 million) in 2009/10 to €7.6 million (£6.5 million) in 2010/11 (Table 1.2).

Table 1.2: Labelled public expenditure in Northern Ireland, 2008/09 to 2010/11

	£/€m 2008/09	£/€m 2009/10	£/€m 2010/11
Allocation to DACTs	£0.74	£0.74	£0.74
	€0.93	€0.83	€0.87
Allocation to implement the national strategy across DACTs	£5.04	£5.20	£6.50
	€6.34	€5.84	€7.64
Substitute prescribing allocation to Health Boards	£1.03	£1.04	£1.10
	€1.30	€1.17	€1.50
Policy development/research	£0.20	£0.30	£0.17
	€0.25	€0.34	€0.20
Public information campaigns	£0.44	£0.45	£0.45
	€0.55	€0.51	€0.53
Needle and Syringe Exchange Scheme	£0.14	£0.15	£0.16
	€0.18	€0.17	€0.19
National Strategy implementation expenditure	£0.60	£0.53	£0.05
	€0.76	€0.60	€0.06
Total	£8.19	£8.41	£9.17
	€10.31	€9.45	€10.78

Source: Government departments

Wales

The amount of labelled expenditure continued to increase in Wales with an 18% increase between 2009/10 and 2010/11 and a 68% increase since 2006/07. The majority of the increase came from Local Health Board allocations from their general health budget but there were also increases in the Substance Misuse Action Fund, which funds local Community Safety Partnerships (CSPs) and in the amount allocated for various policy initiatives (Table 1.3).

Table 1.3: Labelled public expenditure in Wales, 2006/07 to 2010/11

Expenditure item	2006/07 (£/€ million)	2007/08 (£/€ million)	2008/09 (£/€ million)	2009/10 (£/€ million)	2010/11 (£/€ million)
Substance Misuse Action Fund (SMAF)	10.30	14.78	18.17	20.13	21.94
	15.10	21.61	22.87	22.61	25.78
SMAF Capital	4.31	3.69	6.43	5.95	6.47
	6.32	5.39	8.09	6.68	7.60
Local Health Board*	9.70	10.36	10.87	11.09	17.13
	14.20	15.15	13.68	12.46	20.13
Drug Interventions Programme (DIP)**	5.65	5.65	6.47	6.47	5.98
	8.29	8.26	8.06	7.27	7.03
Drug Testing on Charge (DIOC)**	0.82	0.82	-	-	-
	1.20	1.20	-	-	-
Operation Tarian	0.64	0.64	0.64	0.64	0.64
	0.94	0.94	0.81	0.72	0.75
Policy Initiatives	2.40	2.75	3.22	3.98	4.71
	3.52	4.02	4.05	4.47	5.54
Total	33.82	38.69	45.80	48.26	56.87
	49.57	56.57	57.65	54.21	66.83

*Expenditure relates to 0.4% ring-fenced LHB allocation

** DIP and DIOC budgets aggregated from 2008/09

Source: Welsh Assembly Government

Scotland

The Scottish Government drug misuse budget for 2010-11 was €38.4 million (£32.645 million). This included record funding for drug treatment of €33.6 million (£28.6 million) to Health Boards for frontline drug services, in line with the national drugs strategy, to help

people to recover from drug problems. Funding of €587,600 (£500,000) has been provided over 2010/11 and 2011/12 for the rollout of the national naloxone programme.

Ring-fenced funding for frontline drugs services in 2011-12 has been protected and will be maintained at €33.4 million (£28.6 million). In addition, €3.7 million (£3.2 million) is provided to Health Boards to support the operation of Alcohol and Drug Partnerships (ADPs). Also €583,300 (£500,000) has been provided by the Scottish Government to deliver the national roll out of the naloxone programme for the period 2010 to 2012.

These figures refer only to the ring-fenced funding provided to Health Boards and are not the complete picture of Scottish Government spend on drug misuse, i.e. in 2011-12 the Scottish Government also provided €10.6 million (£9.1 million) to Community Justice Authorities (CJAs) for drug-related criminal justice interventions, comprised of €8.4 million (£7.2 million) nationwide for the Drug Treatment and testing Order (DTTO) programme (inclusive of €699,840 (£600,000) specifically allocated for a DTTO II pilot scheme based in Edinburgh) and €2.2 million (£1.9 million) for two dedicated drugs courts, one based in Glasgow and one in Fife. This represents a continuation of the levels of funding for 2010-11. In addition, the Scottish Government also provided €26.5 million (£22.7 million) from the Justice portfolio to support the Scottish Crime and Drug Enforcement Agency (SCDEA) in 2011/12.

Health Boards also provide funding from their unified budget, and funding from local government in the past has been significant, and at least comparable to the ring-fenced funding provided by central government.

2. Drug use in the general population and specific groups

2.1 Introduction

The *British Crime Survey* (BCS) provides estimates of the prevalence of drug use in the general population in England and Wales²³. Scotland²⁴ and Northern Ireland²⁵ also undertake similar surveys. Combining data from the crime surveys undertaken in 2009/10,²⁶ the UK Focal Point estimates that 36% of the adult population in the United Kingdom, aged between 16 and 59, had used an illicit drug at some point in their lifetime. In England and Wales, for which the most complete time series data are available, prevalence of last year use of any illicit drug had been fairly stable at around 12% from 1996 to 2003/04, decreasing year on year to 9.6% in 2007/08; and then falling again to 8.6% in 2009/10. In 2010/11, drug use remained stable at 8.8%.

As in previous years, young adults under 35 are much more likely than older adults to use drugs, and amongst those who are under 25 years old, recent (last year) and current (last month) prevalence is higher still. Amongst young people in England and Wales, there has been a steady decline in drug use since 1998 (excluding a non-significant increase in 2008/09).

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

Amongst the school age population, surveys of drug use prevalence have been undertaken in each of the four administrations of the United Kingdom.²⁷ In England, for which the longest time series are available, drug use increased between 1998 and 2003, but has fallen since then.

²³ The BCS is an annual survey, which gathers information about experience of crime in England and Wales, and is designed to provide a complementary measure of crime to police recorded crime statistics. It was first carried out in 1982 and since 2001/02 it has become a continuous survey. Since 1996, it has also asked respondents aged 16 to 59 about their use of illicit drugs in a self-completion module.

²⁴ The *Scottish Crime and Justice Survey* (SCJS) (previously the *Scottish Crime and Victimisation Survey* (SCVS) and the *Scottish Crime Survey*) is similar in scope and aims to the BCS. The latest published results are for 2009/10. Surveys were carried out as part of the BCS in 1982 and 1988; as the independent *Scottish Crime Survey* in 1993, 1996, 2000, 2003; as the SCVS in 2004, 2006; and as the SCJS in 2008/09 and 2009/10. Findings from the 2010/11 Survey are due to be published in 2012.

²⁵ The *Northern Ireland Crime Survey* (NICS) is also similar to the BCS. Surveys were carried out in 1994/95, 1998, 2001 and 2003/04 and the survey was continuous between January 2005 and March 2009 with the drugs module being dropped thereafter. The last published results are for 2008/09. In addition, a *Drug Prevalence Survey*, based on the EMCDDA model questionnaire, was carried out in Northern Ireland in 2002/03 and 2006/07 and 2010/11. Results from the latest survey are expected at the end of 2011.

²⁶ Data from Northern Ireland are for 2008/09.

²⁷ Amongst the school age population, the main sources of information on drug use prevalence are surveys undertaken in schools. In England, a survey of the prevalence of drug use, smoking and drinking amongst young people (11 to 15 year old school children), has been undertaken annually since 1998. The *Young Person's Behaviour and Attitudes Survey* was undertaken in Northern Ireland in 2000 for the first time and repeated in 2003 and 2007. In Scotland, the *Scottish Schools Adolescent Lifestyle and Substance Use Survey* (SALSUS) is undertaken every two years, the most recently published data are for 2008 - 2010 findings are due to be published by ISD Scotland later in 2011. The *Health Behaviour in School Age Children Survey* (HBSC) provides data from Wales and is undertaken every four years with a two-year interim survey. The most recent survey was conducted in 2009.

Cannabis continues to be the most commonly used drug throughout the UK with prevalence rates close to those of any drug. The use of other drugs is considerably lower. Since the mid 1990s the *British Crime Survey* shows that the use of cocaine powder increased substantially with a corresponding decline in amphetamines over the same period. The most recent BCS included questions on new psychoactive substances and shows prevalence of mephedrone use amongst 16 to 24 year olds at similar levels to cocaine powder.

2.2 Drug use in the general population

2.2.1 UK estimate

By combining data from the 2009/10 BCS (Hoare and Moon 2010), the 2009/10 Scottish Crime and Justice Survey (SCJS)²⁸ (MacLeod and Page 2011) and the 2008/09 Northern Ireland Crime Survey (NICS) (Toner and Freel 2010), the Focal Point has produced a United Kingdom estimate for 16 to 59 year olds (Table A.1, Appendix A) showing that:

- 35.9% had used drugs in their lifetime (ever);
- 8.7% had used drugs in the last year (recent use); and
- 5.0% had used drugs in the last month (current use).

Drug use is lowest in Northern Ireland and highest in England and Wales for lifetime use and Scotland for current and recent use.

2.2.2 England and Wales: the British Crime Survey

The latest findings from the *2010/11 British Crime Survey*²⁹ (Smith and Flatley 2011) show that, for adults aged 16 to 59 years, 36.3 % had used drugs at least once in the lifetime (ever use); 8.8% had used drugs at least once in the last year (recent use); and 4.8% had used drugs at least once in the last month (current use) (Table 2.1).

Cannabis remains the most commonly used drug across all recall periods followed by cocaine and ecstasy for recent and current use. Amphetamines remain the second most common drug ever taken due to high prevalence in the late 1990s. This is demonstrated by relatively high prevalence of lifetime amphetamine use amongst the older age groups; lifetime amphetamine use is more than double the prevalence of lifetime cocaine use in people aged 45 years and over compared to similar levels in those aged 15 to 34 years old (ST01).

Table 2.1: Percentage of 16 to 59 year olds reporting lifetime, last year and last month use of individual drugs in England and Wales, 2010/11

	Lifetime use			Last Year use			Last Month use		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug	42.6	30.1	36.3	12.0	5.7	8.8	6.9	2.8	4.8
Amphetamines	14.7	8.4	11.6	1.4	0.8	1.1	0.4	0.3	0.4
Cannabis	36.6	24.8	30.7	9.3	4.4	6.8	5.6	2.1	3.8
Cocaine	11.8	6.1	8.9	3.0	1.3	2.2	1.2	0.5	0.8
Ecstasy	11.3	5.3	8.3	1.9	0.9	1.4	0.6	0.3	0.4
LSD	7.7	2.8	5.3	0.4	0.1	0.2	0.1	0.0	0.1
Magic mushrooms	10.0	4.3	7.2	0.6	0.3	0.4	0.1	0.1	0.1
Opiates	1.3	0.6	0.9	0.3	0.1	0.2	0.1	0.1	0.1
Base	12,407	14,920	27,327	12,407	14,920	27,327	12,407	14,920	27,327

Source: Standard Table 01

²⁸ Data used for the UK estimate are for ages 16 to 59 years old.

²⁹ The fieldwork for the survey was carried out between April 2010 and March 2011. 27,327 individuals completed the drugs module of the 2010/11 BCS. The overall response rate for the survey was 76% and the response rate for the self-completion drugs module was 92%.

For all individual drugs, recent drug use amongst males is around twice as high as that amongst females increasing to three times as high in the 35 to 44 and 45 to 54 years age group (ST01).

New psychoactive substances

Questions on some new psychoactive substances were included in the 2010/11 BCS adding to the ones introduced in the previous survey year. Many of these drugs are newly classified and the recall period in the survey would cover these drugs pre- as well as post-classification. Amongst adults aged 16 to 59, 1.4% reported using mephedrone in the previous year, a similar proportion to those taking ecstasy. Use of Spice, Khat (both 0.2%), BZP (0.1%) and GBL/GHB (0.0%) were very low. Analysis shows that 91% of those taking mephedrone had also taken another illegal drug in the last year with 72% using cannabis, 53% cocaine and 48% using ecstasy. This suggests that those taking mephedrone are existing users of drugs rather than new users.

Factors related to drug use

Analysis of the 2010/11 BCS showed a relationship between drug use and certain personal and lifestyle factors. For example:

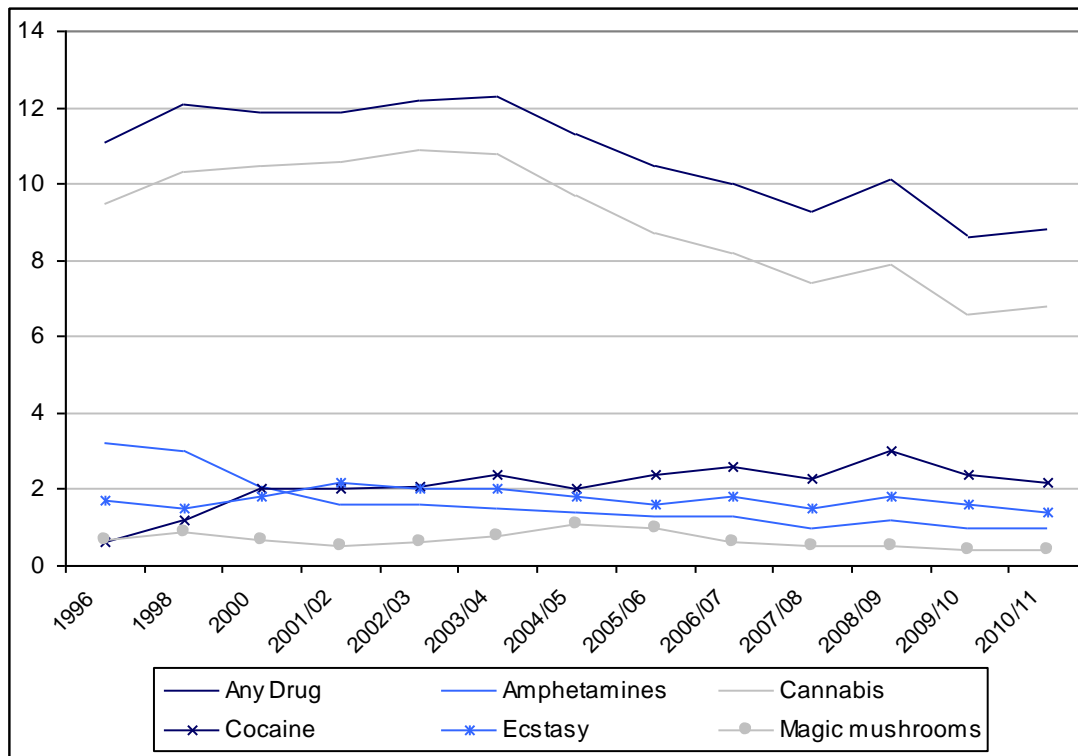
- single adults had higher levels of recent drug use than other marital groups (18.1% of single adults had used drugs recently compared to 2.7% of married adults);
- those who consumed alcohol frequently had higher levels of recent drug use than those who consumed alcohol less frequently (12.3% of adults who had drunk alcohol more than three times a week in the past month compared to 6.1% who drank alcohol less than one day a week);
- those who visit nightclubs and pubs frequently are more likely to be recent drug users (32.8% of those visiting a nightclub four or more times in the last month compared to 6.0% of those who had not visited a nightclub in the last month); and
- recent drug use was higher amongst those who were unemployed (17.7%) than those who were employed (7.7%).

Whilst these simple comparisons provide useful information it should be noted that many of these factors are interrelated or relate to other factors, such as age or sex, which are also related to the likelihood of drug use and may be responsible for the observed associations.

Trends in drug use

Data show that, compared with 1996, lifetime use of almost all individual drugs was higher in 2010/11 (except anabolic steroids where reported use is lower and heroin, LSD and tranquilisers which have been stable). However, when recent and current drug use is considered there has been a steady fall since 2003/04, driven mostly by a decrease in cannabis use (recent use fell from 10.8% in 2003/04 to 6.8% in 2010/11). The trend in stimulant use is less clear. In the late 1990s and early 2000s there was a large decrease in recent amphetamine use (from 3.2% in 1996 to 1.5% in 2003/04) and a corresponding increase in recent cocaine powder use (from 0.6% in 1996 to 2.5% in 2003/04). While amphetamine use continued to fall slowly to one per cent in 2007/08, remaining stable since, cocaine powder use has fluctuated with changes in opposing directions each year since 2007/08. Since the beginning of the century, prevalence of recent ecstasy use has decreased from 2.2% in 2001/02 to 1.4% in 2010/11. BCS analysis also shows a statistically significant decrease in recent use of any stimulants between 1996 and 2010/11 although this decrease has mostly occurred in the last two years, during which time a number of stimulant-type 'legal highs' have been available (the use of which is not included in the BCS measure of stimulant use).

Figure 2.1: Percentage of 16 to 59 year olds reporting last year drug use of individual drugs in England and Wales, 1996 to 2010/11



Source: Standard Table 01

Recent use of magic mushrooms increased between 2003/04 and 2005/06 (although at its peak it was still only being reported by 1.1% of the population), when a recognition of a legal loophole which allowed headshops and similar outlets to sell fresh mushrooms increased their availability. However, since the legislation was amended, use has fallen and prevalence is now at its lowest level since the survey began.

2.2.3 Scottish Crime and Justice Survey: Drug Use 2009/10

Latest survey data from the *Scottish Crime and Justice Survey (SCJS) 2009/10*³⁰ show that, amongst adults aged 16 to 64 years old in Scotland:

- 31.1% reported that they had taken illicit drugs at some point in their lives;
- 9.0% reported recent drug use; and
- 5.3% reported current drug use.

Cannabis continues to be the most commonly used drug across all recall periods followed by cocaine for recent and current use. However, for lifetime use, the prevalence rates for amphetamines and ecstasy are higher than for cocaine (Table 2.2).

³⁰ The survey fieldwork for the SCJS was conducted between 1st April 2009 and 31st March 2010. The final sample size for the survey was 16,036 with a response rate of 70%. Of those who participated in the full survey, 84% answered the self-completion section, including questions on drug use. Results reported here have been taken from ST01 provided on an EMCDDA basis and refer to 16 to 64 year olds so data differ slightly from the published SCJS report (Macleod and Page 2011) as this gives data for adults aged 16 and over. A technical report is available: <http://www.scotland.gov.uk/Resource/Doc/933/0115491.pdf>. It is also worth noting that this age range is slightly different from that covered by the BCS (which only asks the drugs questions of those aged 16 to 59). Comparable data for the 16 to 59 age range were used in the UK estimate and are shown in Appendix A.

Table 2.2: Percentage of 16 to 64 year olds reporting lifetime, last year and last month use of individual drugs in Scotland, 2009/10, by gender

	Lifetime use			Last Year use			Last Month use		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug	37.7	24.8	31.1	12.3	5.8	9.0	7.3	3.4	5.3
Amphetamines	12.0	7.2	9.5	1.7	0.7	1.2	0.6	0.3	0.4
Cannabis	34.7	22.2	28.3	10.4	4.8	7.6	6.4	2.6	4.5
Cocaine	11.1	5.8	8.4	3.9	1.5	2.7	1.3	0.7	1.0
Ecstasy	12.0	6.7	9.3	3.5	1.3	2.4	1.3	0.4	0.8
LSD	8.3	3.4	5.8	0.6	0.0	0.3	0.2	0.0	0.1
Magic mushrooms	10.5	4.1	7.2	1.1	0.3	0.7	0.7	0.2	0.4
Opiates	1.6	1.0	1.3	0.6	0.4	0.5	0.5	0.3	0.4
Base	4,478	5,659	10,137	4,478	5,659	10,137	4,478	5,659	10,137

Source: Standard Table 01

Results from the 2009/10 SCJS self-completion drug use module are summarised below and refer to all adults aged 16 years and over living in private households in Scotland (Macleod and Page 2011).

Factors related to drug use

Associations between drug use and socio-economic, experiential and area factors were investigated using simple one-to-one relationships.³¹ Those working in routine and manual occupations (9.8%) were significantly more likely to report using illicit drugs in the last year than those in managerial and professional occupations (5.5%). Those living in private rented accommodation (16.6%) were significantly more likely to report having used drugs in the last year compared with those who were owner-occupiers (3.8%). Respondents living in urban areas (8.0%) were significantly more likely to be recent drug users than those living in rural areas (3.5%).

Polydrug use

Around one-third of current drug users (32.7% of those who reported drug use in the last month) reported simultaneous use of one or more other drugs together with the drug they had used most often in the last month (simultaneous polydrug³² use) at some point in their lives. The majority of current users (83.1%) also reported having mixed the drug they had used most often in the last month with alcohol at some point in their life.

Trends in drug use

Data show that there has been a slight, non-statistically significant, decrease in the proportion of respondents reporting recent drug use from 9.4% in 2008/09 to 9.0% in 2009/10. The prevalence of most individual drugs remained stable although there was a decrease in reported recent cocaine use from 3.5% in 2008/09 to 2.7% in 2009/10.

2.3 Drug use amongst young adults

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

2.3.1 UK Estimate

By combining data from surveys undertaken in 2009/10 and 2008/09 (as described in section 2.2.1), it is estimated that in the United Kingdom:

- 44.1% of 16 to 34 year olds and 40.3% of 16 to 24 year olds have ever used drugs;

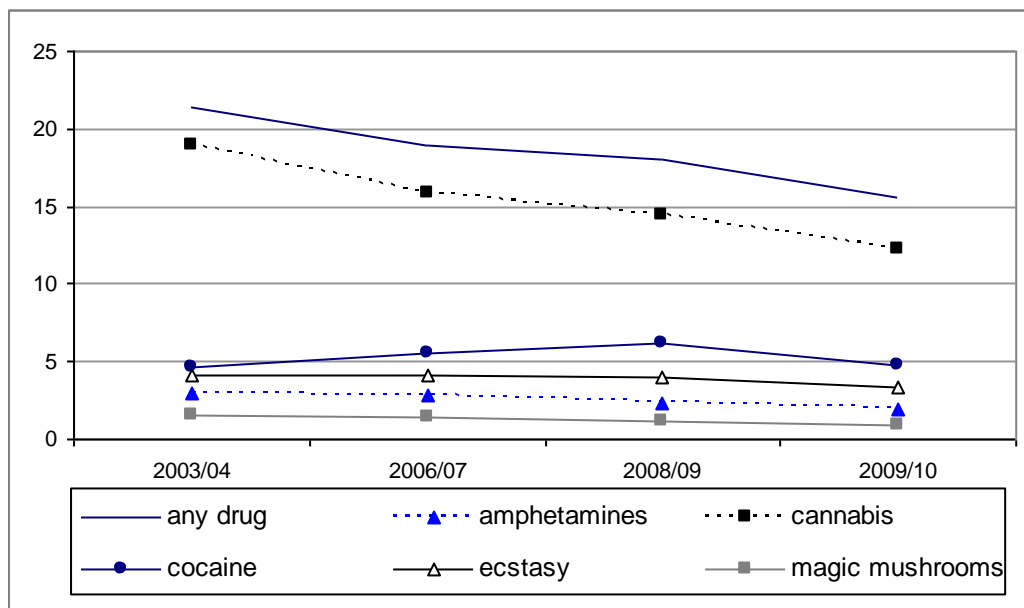
³¹ Results should be interpreted with caution since it is not possible to determine the role of additional factors like the age or sex profiles of different groups using simple one-to-one relationships.

³² Polydrug use refers to the use of more than one drug at the same time, often with the intention of enhancing or countering the effect of another drug.

- 15.6% of 16 to 34 year olds and 20.0% of 16 to 24 year olds have used drugs recently; and
- 9.0% of 16 to 34 year olds and 11.6% of 16 to 24 year olds are current drug users (Table A.2, Appendix A)

These rates are lower than the corresponding figures in the UK estimate from 2008/09 (see UK Focal Point Report 2010). Prevalence of recent drug use amongst 16 to 34 year olds decreased between the four estimates published by the UK Focal Point mainly due to decreases in cannabis use (Figure 2.2). While use of cocaine increased until the 2008/09 estimate, it has fallen in the most recent estimate.

Figure 2.2: Percentage of 16 to 34 year olds reporting last year use of individual drugs in the UK from 2003/04 to 2009/10



Source: UK Focal Point Report 2005; 2008; 2010

Whilst Scotland has the highest prevalence of drug use amongst 16 to 34 year olds for recent and current use, prevalence of drug use for 16 to 24 year olds is similar to that reported in England and Wales. Given that lifetime use amongst both age groups is lower in Scotland than in England and Wales, this may suggest that young adults in England and Wales cease taking drugs at a younger age than their counterparts in Scotland (Table A.2, Appendix A). Consequently, there is less difference in prevalence of drug use between 16 to 34 year olds and 16 to 24 year olds in Scotland than there is between those same age groups in England and Wales (Table 2.5).

2.3.2 England and Wales: the British Crime Survey 2010/11

Whilst lifetime drug use is higher amongst 16 to 34 year olds than 16 to 24 year olds, both recent and current use is higher amongst 16 to 24 year olds (Table 2.3). Recent cannabis use amongst 16 to 24 year olds is twice as high as amongst those aged 25 to 34 years old and this is more pronounced amongst females (ST01). For all individual drugs, 16 to 24 year olds are more likely to be recent users although the difference is not as large for cocaine use. When looking at current use, prevalence of cocaine use is the same level for both age groups (ST01).

Table 2.3: Percentage of 16 to 24 year olds and 16 to 34 year olds reporting last year use of individual drugs in England and Wales, 2010/11 by gender

	16-24 year olds			16-34 year olds		
	Male	Female	Total	Male	Female	Total
Any drug	25.4	15.2	20.4	20.5	10.8	15.7
Amphetamines	3.2	1.9	2.6	2.4	1.5	2.0
Cannabis	21.6	12.5	17.1	16.3	8.6	12.5
Cocaine	5.8	3.1	4.5	5.6	2.8	4.2
Ecstasy	4.8	2.7	3.8	4.0	1.9	3.0
LSD	1.0	0.1	0.6	0.7	0.2	0.5
Magic mushrooms	1.9	0.8	1.3	1.2	0.6	0.9
Base	1,694	1,952	3,665	4,269	5,268	9,589

Source: Standard Table 01

Frequency of drug use

The BCS asks a question on the frequency of cannabis use for those who have used cannabis in the last year. In 2010/11, 14.6% of recent cannabis users aged 16 to 34 years old and 11.5% of recent cannabis users aged 16 to 24 years old reported being daily or almost daily cannabis users. Whilst young people aged 16 to 24 years old are more likely to be recent cannabis users than older people, they are less likely to be daily or almost daily users (Table 2.4). Those aged 25 to 34 years old are most likely to be daily or almost daily users (20.0%). Particularly interesting is that although males aged 25 to 34 years old are more than twice as likely than females of the same age to be recent cannabis users, among those are recent users men are only slightly more likely than women to be daily or almost daily users (20.5% compared to 18.7%).

Table 2.4: Percentage of recent cannabis users reporting daily or almost daily use in England and Wales 2010/11 by age and gender

Age	Male	Female	Total
15 to 24 years	13.2	7.8	11.5
25 to 34 years	20.5	18.7	20.0
35 to 44 years	21.1	9.8	19.0
45 to 54 years	19.1	12.2	17.1
55 to 59 years	12.6	31.3	17.0

Source: Standard Table 01

Trends in drug use

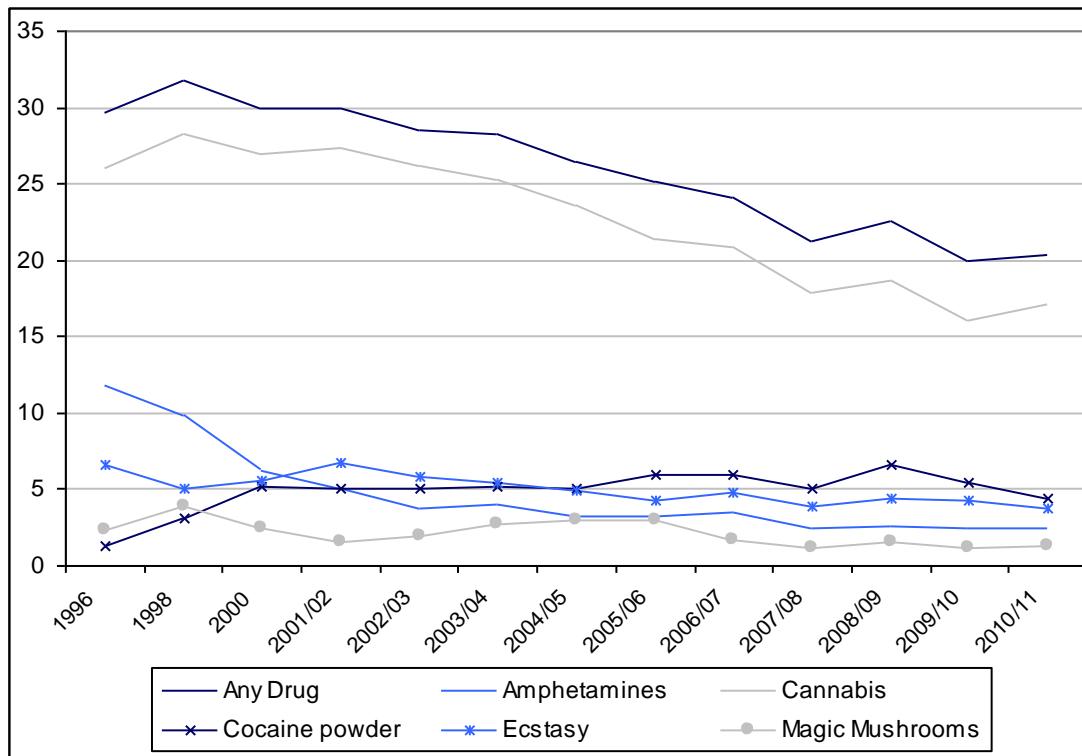
Recent drug use amongst 16 to 24 year olds remained stable in 2010/11 after a long-term downward trend (Figure 2.3). Since 1996, there has been a statistically significant decrease in prevalence of use of cannabis, ecstasy, LSD, and amphetamines. Despite recent cannabis use increasing slightly from 16.1% to 17.1% in 2010/11, this was not statistically significant. Since 1996, the only drug for which prevalence of use has significantly increased is cocaine powder from 1.4% to 4.5% in 2010/11. Data show that reported use decreased between 2009/10 and 2010/11 although this was not statistically significant. There has however, been a statistically significant decrease from levels reported in 2008/09 and cocaine powder use is at the lowest level this century.

In addition to the drugs reported separately for the EMCDDA, data from the 2010/11 BCS show relatively high prevalence of mephedrone use amongst young people aged 16 to 24 years old, the same level as cocaine powder use (4.4%). Analysis shows that the majority of mephedrone users of all ages (91%) also use other drugs, but it is not possible to identify if the use of mephedrone has led to a reduction in cocaine powder and ecstasy use.³³

³³ Around half of mephedrone users report using either cocaine powder (53%) or ecstasy (48%) in the last year.

Ketamine was added to the BCS in 2006/07 and recent use amongst young people aged 16 to 24 years old has increased significantly since then from 0.8% to 2.1%.

Figure 2.3: Percentage of 16 to 24 year olds reporting last year use of individual drugs in England and Wales, 1996 to 2010/11



Source: Standard Table 01

2.3.3 Scottish Crime and Justice Survey

In 2009/10 cannabis was again the most commonly used drug amongst young adults followed by cocaine then ecstasy (Table 2.5). Similar to the results reported for adults aged 16 to 64 years old, females are much less likely to be drug users.

Table 2.5: Percentage of 16 to 24 year olds and 16 to 34 year olds reporting last year use of individual drugs in Scotland, 2009/10 by gender

	16-24 year olds			16-34 year olds		
	Male	Female	Total	Male	Female	Total
Any drug	24.7	15.5	20.2	22.3	12.5	17.5
Amphetamines	2.8	1.8	2.3	3.4	1.8	2.6
Cannabis	21.7	13.1	17.4	19.3	10.5	14.9
Cocaine	8.8	4.4	6.6	8.2	3.6	5.9
Ecstasy	9.6	2.8	6.3	8.0	2.9	5.5
LSD	1.1	0.1	0.6	1.3	0.0	0.7
Magic mushrooms	2.7	1.0	1.9	2.4	0.7	1.6
Base	518	639	1,157	1,262	1,608	2,870

Source: Standard Table 01

Trends in drug use

While reported recent drug use amongst adults aged 16 to 64 years old remained stable between 2008/09 and 2009/10, prevalence of recent drug use amongst young adults decreased for both 16 to 24 year olds (23.5% in 2008/09 to 20.2% in 2009/10) and 16 to 34 year olds (19.0% in 2008/09 to 17.5% in 2009/10). The decrease is largest amongst 16 to 24 year olds and for the most commonly used drugs: cannabis and cocaine. The prevalence of

recent ecstasy use has remained stable although amongst males it increased from 7.9% in 2008/09 to 9.6% in 2009/10 and fell from 4.3% to 2.3% amongst females.

2.3.4 Other studies on drug use amongst adults

Polydrug use in Great Britain

Smith et al. (2010) explored patterns of polydrug use in Great Britain using data from a national household survey carried out in 2000.³⁴ They found that hazardous alcohol use and tobacco use were strongly associated with illicit polydrug use and that polydrug use was significantly associated with mental health issues.

Magic mushrooms

Riley et al. (2010) used focus groups to explore how magic mushroom users accounted for their drug use and the political and cultural discourses surrounding this use.³⁵ They found two types of discourses structured participants' thoughts; one emphasising the right to exercise personal freedom and the other emphasising the spiritual aspect of mushroom taking. Their research pre-dates a change in legislation during 2005 making the possession and supply of fresh mushrooms a Class A drug offence.

2.4 Drug use in the school and youth population

2.4.1 England

Since submission of the 2010 United Kingdom Focal Point report, results have been published from *Smoking, Drinking and Drug Use amongst Young People in England 2010* (Fuller 2011).

Data show that in 2010, 17.1% of pupils aged 11 to 15 years old had ever taken drugs, 12.0% had used drugs recently, and 6.4% had used drugs in the last month (Table 2.6). Cannabis is the most prevalent drug with 7.9% using it in the last year although volatile substance use is also highly prevalent for lifetime use. Unlike in the general population, after cannabis and volatile substances, magic mushrooms are the next most prevalent drug with one per cent reporting use in the last year (not shown, see Fuller 2011). This is followed by cocaine powder and ecstasy (both 0.9%) and amphetamines and opiates (both 0.8%).

³⁴ Latent class analysis was performed on past year use of nine illicit drug groups. Analysis was based on data from a large multi-stage probability sample of the Great Britain population collected in 2000 for the Psychiatric Morbidity Survey (Singleton et al. 2001). The sample size was 8,538.

³⁵ Four focus groups were held in 2004 with 20 participants recruited via 'head shops' in South West England and a drugs information centre in Scotland. Participants initially completed a short questionnaire on their drug use. Data from the focus groups were analysed using discourse analysis.

Table 2.6: Percentage of pupils aged 11 to 15 years reporting lifetime, last year and last month use of individual drugs in England in 2010 by gender

	Lifetime use			Last Year use			Last Month use		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug	17.3	16.9	17.1	12.6	11.4	12.0	7.2	5.7	6.4
Amphetamines	0.9	1.0	0.9	0.7	0.9	0.8	0.3	0.4	0.3
Cannabis	9.9	8.4	9.2	8.6	7.2	7.9	5.0	3.7	4.3
Cocaine powder	1.1	1.2	1.2	0.9	0.8	0.9	0.4	0.2	0.3
Crack cocaine	0.7	0.4	0.6	0.4	0.3	0.3	0.2	0.1	0.2
Ecstasy	1.0	1.2	1.1	0.8	1.0	0.9	0.4	0.3	0.4
LSD	0.7	0.5	0.6	0.5	0.4	0.4	0.3	0.2	0.2
Other hallucinogens (magic mushrooms and ketamine)	2.0	1.7	1.9	1.5	1.4	1.5	0.6	0.4	0.5
Opiates	0.8	1.1	0.9	0.7	0.9	0.8	0.4	0.3	0.4
Volatile substances	7.0	8.9	8.0	3.0	4.1	3.6	1.3	1.9	1.6
Base	3,418	3,433	6,851	3,401	3,424	6,825	3,383	3,410	6,793

Source: Fuller 2011

Prevalence rates amongst boys and girls are similar for lifetime use but boys are more likely to be recent drug users particularly at older ages (Table 2.7). However, this is largely due to differential rates of cannabis use with girls more likely than boys to have used stimulants in the last year (2.9% compared to 2.5% for all pupils and 6.8% compared to 5.9% for those aged 15 years).

Table 2.7: Percentage of pupils reporting last year use of drugs in England, 2010 by age and gender

	11 yrs	12 yrs	13yrs	14yrs	15yrs	Total
Boys	4	4	9	16	27	13
Girls	5	5	8	13	24	12
Total	5	4	8	14	25	12
Base (boys)	511	692	674	669	870	3,416
Base (girls)	517	675	650	704	858	3,404
Base (total)	1,029	1,366	1,324	1,373	1,728	6,820

Source: Fuller 2011

Type of drug by age

At younger ages, pupils are more likely to have taken volatile substances and poppers than cannabis. However, at age 13, despite the prevalence of recent volatile substance use being similar to younger pupils, the use of cannabis increases substantially from 0.7% at age 12 to 4.5% at age 13. Prevalence then doubles for each added year of age with 9.1% reporting cannabis use at age 14 and 21.1% at age 15. Volatile substances are the second most popular drug used at older ages with ecstasy (2.3%), cocaine powder and magic mushrooms (both 2.1%) the next most commonly reported drugs at age 15.

Frequency of use

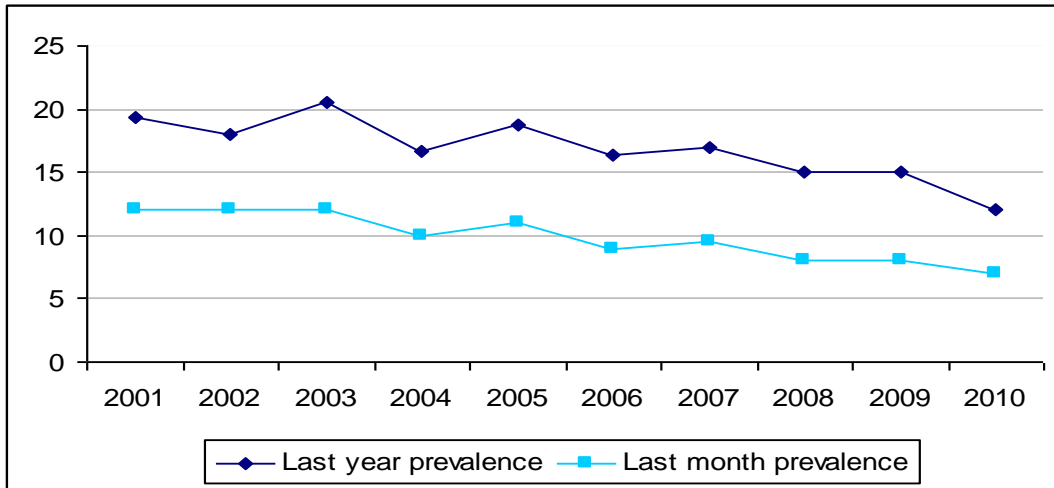
Five per cent of recent drug users reported using drugs on most days with one quarter using drugs at least once a month. Around one quarter of recent drug users had only ever taken drugs once. Recent Class A drug users were least likely to have only ever taken drugs once (9%) and more likely to report taking drugs most days (11%) and at least once a month (46%).³⁶ Four per cent of pupils who had used cannabis only in the last year reported using most days with 24% using at least once a month (Fuller 2011).

³⁶ Frequency of drug use refers to all drugs not just Class A drugs.

Trends in drug use

Since 2003, there had been a general decline in recent and current drug use amongst the school population in England (Figure 2.4) with a large decrease in recent use between 2009 and 2010 from 14.8% to 12.5%. However, it should be noted that the survey did not ask about new psychoactive drugs such as mephedrone, which was the second most commonly used drug amongst young people aged 16 to 24 in the BCS 2010/11 alongside cocaine powder. While analysis from this survey found that most mephedrone users had used other drugs in the last year (see section 2.2.2), there is the possibility that the pattern of use is different amongst the school age population.

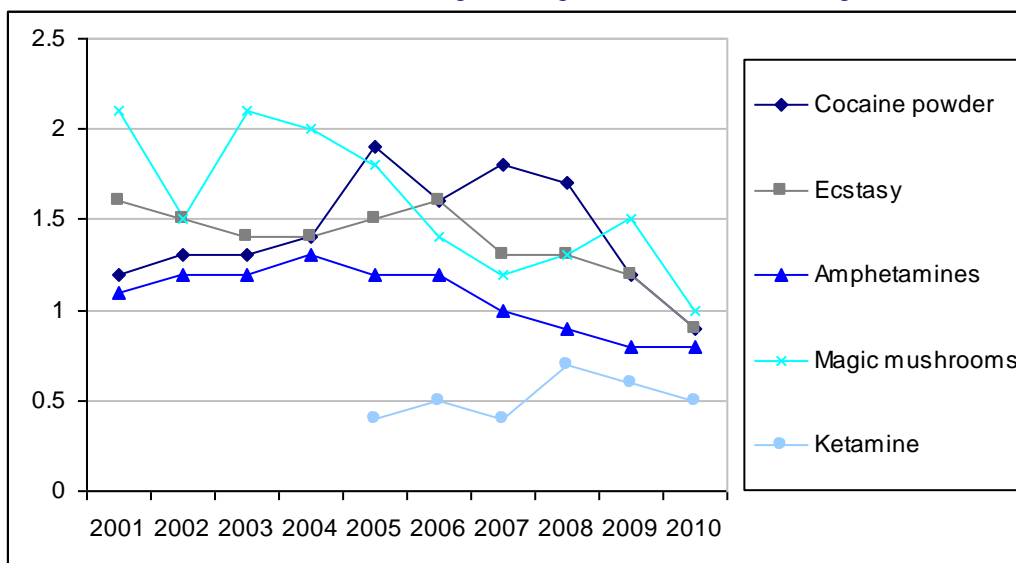
Figure 2.4: Drug use amongst schoolchildren in England, 2001 to 2010



Source: Standard Table 02

The long-term downward trend is largely accounted for by a decline in the most commonly used drug, cannabis, with recent use falling from 13.3% in 2003 to 8.2% in 2010. However, there has also been a decrease in use of all other drugs particularly stimulants (from 6.1% in 2003 to 2.7% in 2010) with use of poppers falling from 4.0% in 2003 to 1.5% in 2010. While recent cocaine powder use increased in the mid-2000s, it has now fallen to below 2001 levels (Figure 2.5).

Figure 2.5: Recent use of some individual drugs amongst schoolchildren in England, 2001 to 2010



Source: Fuller 2011

2.4.2 Wales

Additional drug use questions were included in the 2009 Health Behaviour in School-aged Children (HBSC) survey in Wales.³⁷ Results show that amongst pupils aged 11 to 15 years old 9.7% reported ever using drugs, 7.9% reported recent drug use and 4.6% reported current drug use (Table 2.8). Drug use amongst female pupils is at similar levels or slightly higher than males, unlike in England where females are less likely to be recent and current drug users (Table 2.8). Apart from cannabis, use of illegal drugs is low at one per cent or under for all recall periods.

Table 2.8: Percentage of pupils aged 11 to 15 years reporting lifetime, last year and last month use of individual drugs in Wales in 2009/10 by gender

	Lifetime use			Last Year use			Last Month use		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug	9.6	9.9	9.7	7.8	8.1	7.9	4.6	4.6	4.6
Amphetamines	0.9	0.9	0.9	0.8	0.7	0.7	0.2	0.3	0.2
Cannabis	8.1	8.1	8.1	6.7	6.9	6.8	3.7	3.6	3.6
Cocaine powder	0.9	1.2	1.0	0.6	0.8	0.7	0.2	0.2	0.2
Crack cocaine	0.3	0.5	0.4	0.2	0.3	0.2	0.1	0.0	0.1
Ecstasy	0.8	1.2	1.0	0.5	0.6	0.6	0.2	0.1	0.2
LSD	0.2	0.4	0.3	0.2	0.2	0.2	0.0	0.0	0.0
Magic mushrooms	1.2	0.9	1.0	0.8	0.6	0.7	0.3	0.1	0.2
Opiates	0.4	0.1	0.5	0.3	0.2	0.3	0.0	0.1	0.1
Volatile substances	2.4	3.0	2.7	1.6	1.9	1.7	0.6	0.8	0.7
Base	4,415	4,409	8,824	4,415	4,409	8,824	4,415	4,409	8,824

Source: Standard Table 01

At the youngest age (11 years old), girls are less likely to be recent drug users (Table 2.9). This is largely due to higher levels of volatile substance use amongst boys with cannabis use prevalence at the same level. The largest increase in drug use occurs between the ages of 12 and 13 years old. In Wales, the difference in drug use prevalence between those aged 14 years and 15 years is not as large as in England (Table 2.7).

Table 2.9: Percentage of pupils reporting last year use of drugs in Wales, 2009/10 by age and gender

	11 yrs	12 yrs	13yrs	14yrs	15yrs	Total
Boys	2.0	1.7	3.7	10.0	16.4	7.8
Girls	0.8	1.3	6.3	11.1	16.3	8.1
Total	1.4	1.5	5.0	10.6	16.4	7.9
Base (boys)	678	951	928	807	1,051	4,415
Base (girls)	669	955	966	857	962	4,409
Base (total)	1,347	1,906	1,894	1,664	2,013	8,824

Source: Standard Table 02

2.4.3 Northern Ireland

Topline results from the Young Person's Behaviour and Attitudes Survey (YPBAS) in Northern Ireland were published in August (NISRA 2011).³⁸ Data below are for pupils aged

³⁷ HBSC is a cross-national research study into the health and wellbeing of young people, <http://www.hbsc.org/index.html>. Surveys are carried out every four years with the last being carried out in 2009/10. The survey fieldwork took place between October and December 2009. All secondary schools in Wales were included in the sample frame with schools randomly selected. The school response rate was 61%. In each school, a class was randomly selected and a individual student response rate of 91% was achieved. The overall sample size was 8,824.

³⁸ The survey fieldwork took place between 18th October and 19th November 2010. Forty-four per cent of schools agreed to take part. 3,546 pupils completed the survey, a pupil response rate of 88%. The majority of pupils (96.5%) were aged between 12 and 16 years old. Further analysis is required for completion of standard table 02, which will be carried out in late 2011/early 2012 and provided to the

12 to 16 years old so differ slightly from the published survey, which includes some 11 and 17 year olds. Key findings are that in 2010:

- 15% of pupils had ever used drugs³⁹;
- 11% had used drugs recently; and
- seven per cent were current drug users.

There was a decrease in the lifetime and last year prevalence rates for any drug between 2007 and 2010; lifetime use decreased from 19% to 15%, last year use decreased from 14% to 11%, and last month use remained fairly unchanged (8% and 7% respectively) (Table 2.10). It is important to note when making comparisons between 2007 and 2010 that changes were made to the questionnaire in 2010 to include questions on mephedrone and legal high use and thus the any drug category in 2010 includes these drugs while the 2007 any drug category does not. Cannabis (6%) and solvents (4%) were the two most commonly reported drugs used in the last year, followed by 'legal highs' (3%), cocaine powder (2%), mephedrone (2%) and ecstasy (2%). As shown in the *British Crime Survey* in England and Wales, despite the recent emergence of mephedrone, its prevalence is at similar levels to more established stimulant drugs.

Table 2.10: Lifetime, last year and last month use of individual drugs amongst schoolchildren in Northern Ireland, 2007 and 2010

	Lifetime	Last year				Last month	
		2007	2010	2007	2010	2007	2010
Any drug	19.3	15.2	13.7	11.3	7.7	7.1	
Amphetamines	1.8	2.1	1.0	1.4	0.4	0.7	
Cannabis	9.3	7.5	6.9	5.8	3.9	3.3	
Cocaine	2.6	2.7	1.9	2.0	0.9	1.0	
Crack	1.6	1.5	1.1	0.9	0.6	0.6	
Ecstasy	2.9	2.3	2.3	1.7	1.2	0.8	
LSD	1.6	1.3	1.0	1.0	0.4	0.5	
Magic mushrooms	1.3	2.0	0.7	1.5	0.3	0.6	
Heroin	1.1	1.0	0.6	0.7	0.4	0.4	
Solvents	8.5	7.0	4.6	4.3	2.3	2.4	
Tranquillisers	1.1	1.3	0.8	0.9	0.4	0.5	
Poppers	6.1	1.5	4.1	0.9	1.8	0.6	
Anabolic Steroids	0.8	0.9	0.5	0.7	0.4	0.4	
Mephedrone	-	2.0	-	1.7	-	0.9	
Legal Highs	-	3.8	-	2.6	-	1.2	
Base		3,225	3,546	3,225	3,546	3,225	3,546

Source: NISRA 2008; 2011

2.4.4 Other studies on drug use in the school and youth population

A survey of pupils in schools, colleges and universities in Scotland⁴⁰ carried out before the classification of mephedrone found that 20.3% of respondents had ever used mephedrone (Dargan et al. 2010). Of these, almost one-quarter (23.4%) reported using mephedrone on only one occasion with 4.4% reporting daily use. The majority of users reported using mephedrone in capsule or powder form.

EMCDDA in 2012. A technical report including the full survey questionnaire is available at: <http://www.csu.nisra.gov.uk/YPBAS%202010%20Technical%20Report.pdf>

³⁹ Mephedrone and legal highs were added to the list of drugs included for 'any drug' in 2010 thus caution should be taken when comparing the results.

⁴⁰ A total of 1,006 individuals completed questionnaires from five schools, three colleges and two universities in Tayside, Scotland in February 2010. The authors state that all students were given the opportunity to participate in the survey although the methods used are not described. Mean age of pupils at school was 14.0 years and students at colleges/universities was 20.5 years.

McCrystal and Percy (2011) surveyed young people attending colleges of further education (FE) in Northern Ireland about their drug use.⁴¹ Comparing levels of drug use with a school sample drawn from the same area,⁴² the authors found that whilst lifetime use of substances was similar between the two settings, those attending FE colleges had slightly higher levels of recent use and current frequent use. However, these differences were only significant for cannabis and tobacco. The authors also found evidence to suggest that higher levels of educational attainment were associated with lower levels of substance misuse.

Smith et al. (2011) collected data on the leisure situations in which 15 to 16 year olds used drugs.⁴³ Approximately one-third (35%) of the participants reported ever using an illicit drug, 20% reported using drugs in the last month and just over one out of 10 reported using drugs weekly. Seven out of 10 participants who claimed to have used drugs in their lifetime, reported using cannabis at least once, making cannabis the most used drug amongst the sample. Data from focus groups identified cannabis use among 15 to 16 year olds as a safe and acceptable aspect of social situations among friends. The participants also used cannabis in search of pleasurable excitement to counter the routines set out by school. The authors characterised the participants' cannabis use as ranging from experimental and opportunistic for some participants to planned and deliberate for others. Generally, cannabis use was not described as a persistent feature of the participants' lives, but rather an activity under the participants' control and therefore could be stopped and started.

2.5 Drug use among specific groups in the adult population

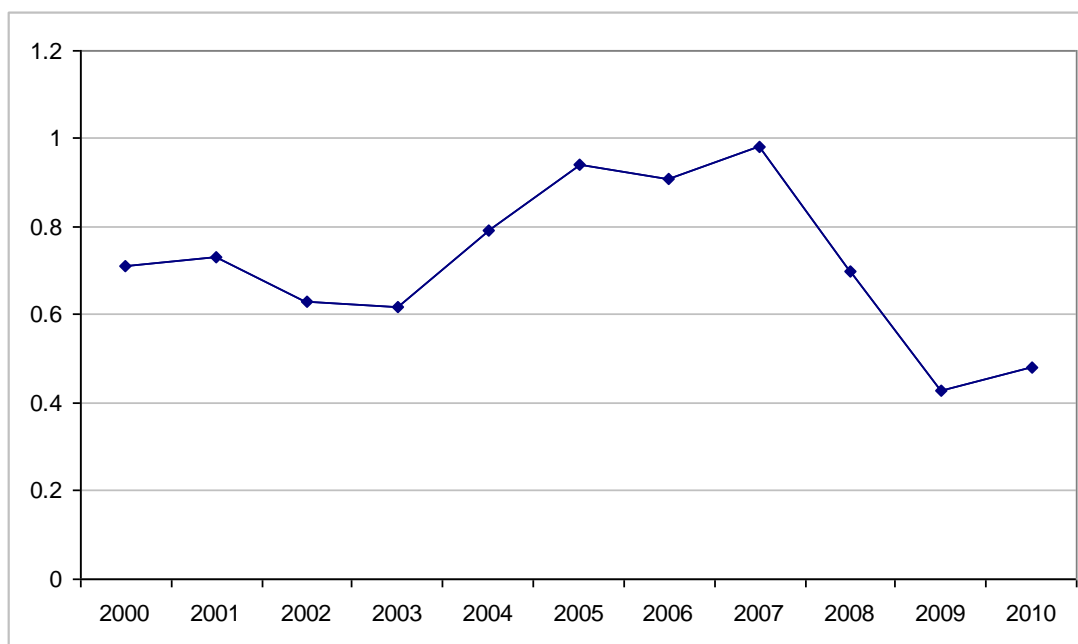
2.5.1 Armed Forces

With compulsory drug testing in the Armed Forces being introduced by the *Armed Forces Act 1996*, around 85% of servicemen and women are tested annually (HC Deb, 10 May 2006, c296W). Data show that there has been a large decrease recently in the proportion of individuals testing positive for illegal drugs from 0.98% of individuals tested in 2007 to 0.48% in 2010 (Figure 2.6).

⁴¹ A total of 283 young people attending the second year of a college course in two colleges in Northern Ireland aged 17 to 18 years old were surveyed representing 72% of all eligible students. The colleges were selected as they were located in two towns where schools participated in the Belfast Youth Development Study (BYDS), a longitudinal study of drug use amongst youth.

⁴² Data were taken from the sixth datasweep of the BYDS.

⁴³ A total of 1,010 questionnaires (The Young People, Sport and Leisure (YPSAL) Questionnaire) were completed by pupils in Year 11 from schools in north-west England and north-east Wales in December 2003 and between January and mid-May 2004 (response rate: 70%). The study also used focus groups consisting of sub-samples of between four and eight 15 to 16 year olds from the same schools, resulting in 24 single-sex focus groups.

Figure 2.6: Percentage of positive tests for illegal drugs in the British Armed Forces, 2000 to 2010

Source: Ministry of Defence - personal communication

The vast majority of positive tests are for cocaine and cannabis with the third most commonly detected drug, steroids, present in only 4% of cases. In the British Army (which accounts for 89% of positive tests in the Armed Forces), over half of positive tests (54.3%) were for cocaine a decrease from 67.8% in 2008 (Ministry of Defence – personal communication). Over the same period there has been an increase in the proportion positive for cannabis from 27.1% to 41.7%. It is possible that the overall decrease in positive tests and the decrease in the proportion of positive tests for cocaine, is due to the use of mephedrone, which was not screened for over this period.

2.5.2 Ethnic Minorities

An in-depth analysis of drug use amongst ethnic minorities was published in last year's BCS report (Hoare and Moon 2010; see 2010 UK Focal Point Report). Data from the 2010/11 BCS (Smith and Flatley 2011) show that recent drug use was higher amongst White ethnic groups (9.4%) than non-White groups (5.1%). Those describing themselves as from a Mixed ethnic group (n=282) were much more likely to report recent drug use (19.2%), mostly due to a high prevalence of cannabis use (17.7%). The prevalence of drug use amongst all other ethnic groups was half or less of the level amongst the White group.

2.5.3 Drug use amongst club goers

A survey of drug use amongst young club-goers,⁴⁴ found that the most commonly used illicit drug in the last year was cannabis (85%) (Table 2.11). The most commonly used stimulant drug was ecstasy (75%) followed by cocaine powder (63%), and mephedrone (51%). Use of other 'legal highs' was relatively low at less than 10% in the past year.

⁴⁴ The results came from a cross-sectional, self-reported, self-nominating survey of young people. Average age was 25 years old and three quarters were 18 to 27 years old. No sample size or further methodological information are available.

Table 2.11: Percentage of respondents in a clubbers' survey reporting lifetime, last year and last month use of certain individual drugs, 2010

Drug	Lifetime	Last year	Last month
Cannabis	86.5	85.0	52.0
Ecstasy	87.5	75.0	54.0
Cocaine powder	82.7	62.7	42.3
Ketamine	62.0	41.2	28.0
Mephedrone	61.0	51.0	25.0
Amphetamine	64.0	24.0	10.0
Magic mushrooms	49.4	15.9	6.0
BZP	17.2	5.0	<1

Source: Dr A Winstock, Global Drug Survey, personal communication

Mephedrone use amongst those associated with the dance music scene

Results from a self-selecting online survey of those associated with the dance music scene⁴⁵ (Winstock et al. 2010b) show that 41% of respondents had ever used mephedrone. Mephedrone was the sixth most frequently used drug in the last month after alcohol, tobacco, cannabis, MDMA, and cocaine powder. Mephedrone users were significantly more likely to be male (69%) and younger (mean age 23.8 years) than the larger survey sample. Fifteen per cent reported using mephedrone weekly or more often with a further 15% using every two weeks. Current users reported using mephedrone on an average of 4.3 days in the last 30 days with 0.4% reporting daily use. More than two-thirds of respondents reported using half a gram or more over a session with the most common route of administration, intranasally (66%). The majority of mephedrone users who had also used cocaine powder (n=857), reported that mephedrone provided a longer lasting (65%) and better high (55%) than cocaine powder. The authors suggest that while certain factors such as mephedrone's legal status and ease of availability online have played a role in its popularity, user dissatisfaction with the quality of drugs in the illicit drug market may also have contributed to its increased prevalence.

Measham et al. (2011) explored the use of illegal drugs and emerging psychoactive substances amongst those visiting gay dance clubs in South London.⁴⁶ Eighty-nine per cent of those surveyed reported lifetime illegal drug use, 78% last year use and 68% last month use. Half of all respondents reported that they had already taken drugs or were planning to do so that night. Mephedrone was the drug most commonly used on the survey night with 27% stating that they had already taken it or were planning to do so that night. This is despite the drug being controlled 10 weeks previously. Mephedrone was also the second most commonly used drug in the last month or last year after cocaine powder. While there was evidence of some use of 'second generation legal highs' such as naphyrone, the authors found no evidence to suggest displacement from mephedrone to unclassified drugs in the weeks following mephedrone's ban.

⁴⁵ The online questionnaire was promoted by the dance music magazine 'Mixmag' and posted on their associated website: <http://www.dontstayin.com>. Between 17th and 30th November 2009 a total of 2,295 responses from UK residents were received. The majority (65%) of respondents were male and the mean age was 25.0 years. This was a self-selected sample and is likely to represent a specific 'niche' group who have a disproportionately high drug use. In addition to drug use questions, questions on physiological effects were also included.

⁴⁶ The survey was carried out in two gay friendly clubs in South London over three nights on two consecutive weekends in July 2010 using opportunistic sampling. 308 customers took part, 82% of whom were male. The mean age was 29.8 years old. Researchers recorded information from participants on a two-page survey.

Web-based survey of mephedrone

An online survey of mephedrone⁴⁷ use found that the majority of users started using mephedrone in 2009 or 2010 with only 20% using before then (Carhart- Harris et al. 2010). Other illegal drug use was high with 98% of mephedrone users having ever used cannabis, 87% MDMA, 82% cocaine, 74% amphetamines and 59% ketamine. Around two-thirds of respondents (64%) reported using alcohol when taking mephedrone and almost half-used cannabis (48%). Simultaneous use of ecstasy and cocaine was reported by 11%. Fifty-seven per cent sniffed mephedrone and 28% usually took the drug orally.

2.5.4 Drug use amongst young holidaygoers

Hughes et al. (2011) carried out a cross-sectional comparative survey of young British and German holidaygoers' use of substances and how this relates to violence and unintentional injuries.⁴⁸ Findings for British holidaymakers showed that 20% reported recent use of illicit drugs in their home country with visitors to Cyprus most likely to be drug users (34%) and to use drugs other than cannabis (23%). Visitors to more traditional holiday destinations such as Italy had similar levels of drug use as visitors to more nightlife based destinations but were less likely to use drugs other than cannabis (3% compared to 8% of all British holidaygoers). Ten per cent of British participants reported using illicit drugs while on holiday with those visiting Cyprus reporting the highest level of drug use (19%) and use of drugs other than cannabis (13%).

Prescription drug misuse

A review of the literature and data on the extent of dependence and harm on over-the-counter and prescription medicines (benzodiazepines, z-drugs, and OTC codeine products) concluded that there was a knowledge gap in the prevalence of misuse of and dependence on these drugs (Reed et al. 2011). The review looked at international evidence, prescribing data, and carried out analysis on a sub-group of users in opiate substitution treatment who were also being prescribed benzodiazepines.

Holloway and Bennett (2011) surveyed university staff and students about their use of prescription drugs.⁴⁹ One-third of students (33%) and one-quarter (24%) of staff reported ever having used prescription drugs not prescribed to them. The most commonly misused prescription drugs were pain relievers (22% of students, 15% of staff) followed by sedatives (9% of students, 4% of staff). The majority of users reported obtaining prescription drugs from a family member or partner.

2.6 Drug use among specific groups in the school age population

Data from the 2010 survey of smoking, drinking and drug use in England (Fuller 2011; see section 2.4.1) show that pupils who had ever truanted or had been excluded from school were much more likely to have used Class A drugs in the last year than those who had not; nine per cent compared to one per cent. Truants/excludees were also more likely to report using drugs at least once a month (8% compared to 1%). However, the proportion of

⁴⁷ A total of 1,506 individuals responded to an online survey built using Bristol Online Survey. The survey was advertised on drug websites/forums and took place between May and September 2010. Eighty-four per cent of respondents were male, with a mean age of 26 years old and 80% lived in Britain.

⁴⁸ A short anonymous questionnaire was administered to young people checking in for UK or Germany bound flights at airports in Palma de Mallorca, Spain; Faro, Portugal; Venice, Italy; Crete, Greece; and Larnaca, Cyprus. Data collection took place in July and August 2009. 35% of those approached said they did not have time to complete the survey. Of those that did, 93% agreed to take part when further details were given. The final sample size was 6,502.

⁴⁹ An email survey of all staff and students at a large university in Wales resulted in 1,614 responses from students (11% response rate) and 489 responses from staff (19% response rate). The staff survey was distributed in July 2009 and the student survey in November 2009.

truants/excludees reporting Class A drug use and monthly drug use decreased from the previous year's survey when prevalence was 12% and 14% respectively.

2.7 Attitude surveys on the use of illegal drugs

Questions added to the 2010/11 BCS focussing on attitudes towards substance use found that the majority of adults aged 16 to 59 in England and Wales (80%) believed that it was acceptable to get drunk frequently or occasionally (Smith and Flatley 2011). However, the majority of respondents thought that it was never acceptable to use cannabis (65%), cocaine (91%) or heroin (98%). Those aged 30 to 34 years old were most likely to believe it is acceptable to take cannabis frequently or occasionally (44%) and those who had used drugs recently were more likely to find occasional or frequent use acceptable.

A study carried out by the UKDPC (Singleton 2010; see section 8.2.3) asked respondents to rate the acceptability of six different types of drug user. All types of drug user were generally viewed as not acceptable although users of cannabis were less likely to be rated as not acceptable (64% to 77%) than heroin users (86% to 89%). Very few respondents rated any drug user type as acceptable with the highest level of acceptability (13%) given to the scenario where a "35 year old adult uses cannabis a few times a week".

3. Prevention

3.1 Introduction

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

Policies have been embedded in, or complemented by, a much wider framework of social action to create the capacity of both individuals and communities to resist drugs, including policies for children and young people aimed at enabling them to reach their full potential. In England, the *Children's Plan* aimed to facilitate this (DCSF 2007). The devolved administrations take a similar approach, specifically through *Children and Young People: Rights to Action* (WAG 2004) in Wales. The GIRFEC (Getting It Right For Every Child) programme⁵⁰ provides the methodology for delivering the Scottish Government's three social policy frameworks: the *Early Years Framework*, *Achieving our Potential* and *Equally Well* (Scottish Government 2008b;c;d), which aim to develop the prevention and early intervention agenda. In Northern Ireland, *Our Children and Young People – Our Pledge: A 10 year strategy for children and young people in Northern Ireland, 2006-2016* (OFMDFMNI 2006) sets a framework for addressing the needs of young people. Improved education and early interventions for young people and families (especially those most at risk) and improved public information about drugs have been priority areas.

Universal drug prevention initiatives have been an important area of policy. Communication programmes, such as 'Talk to FRANK'⁵¹ in England and 'Know the Score'⁵² in Scotland, provide factual information and advice to young people and their families. In Northern Ireland, the Public Health Agency⁵³ develops public information campaigns for various target groups and settings, and in Wales a bilingual (Welsh and English) helpline, 'Dan 24/7'⁵⁴ is available. School-based drug education forms a central part of the United Kingdom's approach to universal drug prevention. Throughout most of the United Kingdom, drug prevention is part of the national curriculum and the majority of schools have a drug education policy and guidelines for dealing with drug incidents. Guidance on drug education recommends an approach that incorporates all psychoactive substances, including alcohol and tobacco, and places drug education within the wider health and social education agenda.

In England and Wales, all local areas have been expected to produce *Children and Young People's Plans* for all services for children and young people, including prevention and treatment. The *Common Assessment Framework (CAF)*⁵⁵ in England aims to facilitate early identification of problems and secure a network of required support services, linking into more targeted arrangements. The priorities within targeted prevention are to ensure young people have access to a range of core services to help keep them engaged in education, in stable housing and with a supportive family or care placement. Similarly, in Scotland, the *Integrated Children's Services Planning Framework* requires a single plan agreed with all relevant agencies to deliver integrated services for children and young people.

Communities are provided with assistance to build the capacity to resist drugs, through a range of initiatives which are delivered by local partnerships. There are specific interventions

⁵⁰ See: <http://www.scotland.gov.uk/Topics/People/Young-People/childrenservices/girfec>.

⁵¹ See: <http://www.talktofrank.com/>

⁵² See: <http://knowthescore.info/>

⁵³ See: <http://www.publichealth.hscni.net/>

⁵⁴ See: <http://www.dan247.org.uk>

⁵⁵ See: <http://www.cwdcouncil.org.uk/caf>

targeting young people in deprived communities such as Positive Futures⁵⁶ in England and Wales. In Scotland, a number of projects receive time limited funding from the Scottish Government in partnership with Lloyds TSB Partnership Drugs Initiative (PDI)⁵⁷, targeting children with, or at risk of, problem drug misuse as well as those affected by familial drug use. Increasingly, family interventions are being set up, more specifically for problem drug users, to help support parenting and therefore reduce the risk of drug use amongst their children but also with wider objectives.

3.2 Universal prevention

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

3.2.1 School

England

Substance misuse and other aspects of health inequalities are addressed in schools through Personal, Social, Health and Economic (PSHE) education. The Government stated in the *Importance of Teaching: the Schools White Paper* (DfE 2010) that an internal review of current PSHE delivery will be undertaken⁵⁸ and this commenced in July 2011.⁵⁹ It will examine PSHE content and its delivery in schools. The Government has pledged that the Department for Education (DfE) will publish revised guidance for schools on drug issues later in 2011⁶⁰ (HC Deb, 9th May 2011 c967W).

Whole-school intervention to improve school ethos

In a follow up to an earlier feasibility study (Bonnell et al 2010a; see 2010 UK Focal Point Report) it was reported that four schools in England took part in a pilot study to investigate the effects of a whole school intervention⁶¹ entitled 'Healthy Schools Ethos'⁶² (Bonnell et al. 2010b). The intervention aims to improve social inclusion in schools and thus reduce substance use. Qualitative data suggested that improved self-regard and relationships with teachers and other students were reported amongst students involved in the planning and/or delivery of the intervention. It was also reported that actions such as re-writing school rules may have a positive effect on the school as a whole. The authors were not able to report on changes to substance use in this study.

⁵⁶ See: <http://www.posfutures.org.uk/index.asp?m=793&t=Home>

⁵⁷ See: <http://www.ltsbfoundationforscotland.org.uk/index.asp?tm=16>

⁵⁸ See: <http://drugstrategyblog.homeoffice.gov.uk/?p=5>

⁵⁹ See:

<http://www.education.gov.uk/consultations/index.cfm?action=consultationDetails&consultationId=1759&external=no&menu=1>

⁶⁰ See: <http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/response-acmd-mdma-ecstasy?view=Binary>

⁶¹ A multi-method, matched-pair randomised trial was undertaken. Two pairs of schools, matched by achieving similar local authority inspection ratings and proportions of Black and Minority Ethnic (BME) and disadvantaged students, either took part in the intervention or were randomly assigned as a control during the school year 2007-2008. Semi-structured interviews were conducted with staff. Baseline surveys of Year 7 students were conducted at the start of the school year and followed up around nine months later. The aim was to investigate outcomes after the intervention relating to relationships with teachers, social support, self-regard, security, engagement, and substance use.

⁶² The intervention involved the delivery of various activities (such as changes to school policy and rules, development of 'safe-spaces' for younger pupils and peer-mediation by older pupils) by an 'action-team' (comprised of staff and students) to improve student/teacher relationships, social support, self-regard, security and engagement with the aim of reducing substance use.

Motivational Interviewing (MI) and cannabis use in college

McCambridge et al. (2011) reported on the results of an exploratory trial of Motivational Interviewing (MI)⁶³ with pupils in 12 further education colleges in London, England.⁶⁴ The aim of the study was to investigate the effectiveness of MI as a universal drug prevention intervention when compared to a typical drug education lesson which would be used in further education colleges (control). The authors examined initiation, prevalence and consumption levels of cannabis use (in addition to cigarette smoking and alcohol consumption) amongst two groups of students who had been exposed to either a standard drug education lesson or MI, at three month and 12 month follow-up. Their previous substance use history was not taken into account when they were assigned into groups and it was assumed that all students shared common risk factors in terms of smoking, drinking and drug use. Primary prevention effects (i.e. non-initiation) amongst those who did not already use cannabis and secondary prevention effects (i.e. reduced consumption levels) amongst those who had already begun using cannabis were examined. There were slightly lower levels of cannabis use in the control group at both follow ups, and also less initiation into cannabis use. Therefore, the authors conclude that motivational interviewing is not an effective universal prevention technique.

Research into delivery and recall of drug education

Research conducted in four English schools⁶⁵ found that the majority of pupils (70%) were unable to remember receiving drug education whilst in secondary school. Generally, pupils reported that the last time they received drug education was when they were in primary school⁶⁶ and some reported that they had never received any drug education (Fletcher et al. 2010). Delivery and content of drug education varied greatly between schools. The authors found that the teachers who were interviewed as part of the study reported that drug education was not a high priority, delivery was 'limited' and that there was often a gap between the schools' drug policy and what happened in practice. It was reported that the use of surveillance and searching of some pupils was employed to reduce drug use within schools and several pupils reported that they had been referred to a drugs counsellor.

Northern Ireland

Drugs education is delivered as part of the Personal Health strand of the revised curriculum that is now being taught to all pupils of compulsory school age in all grant-aided schools in Northern Ireland. It is a statutory component within Personal Development and Mutual Understanding (PDMU)⁶⁷ at Primary level and within the Personal Development strand of Learning for Life and Work (LLW)⁶⁸ at Key Stages 3 and 4. The Council for Curriculum, Examinations and Assessment (CCEA) has provided guidance and resource materials to all schools to support them in implementing PDMU/LLW and these include sections on drugs and alcohol awareness (CCEA 2011).

A survey of drug use amongst students at further education (FE) colleges in Northern Ireland (McCrystal and Percy 2011; see section 2.4.4) found higher levels of recent drug use and current frequent drug use than amongst school pupils of the same age. The authors note that prevention interventions in FE colleges have a limited evidence base and that the

⁶³ Motivational Interviewing (MI) aims to enable the participant to explore their own behaviour in order to perceive potential risks and reflect on changing their behaviour.

⁶⁴ A cluster randomised trial was conducted with 416 students aged between 16 and 19 years of age. They were recruited using opportunistic sampling and students were randomly grouped into 'clusters' according to their everyday college class. One cluster attended a standard one hour drug prevention class and the other cluster attended a MI class.

⁶⁵ Qualitative data were collected via semi-structured interviews with pupils aged 14 to 15 (n=50) and teachers (n=10) at four secondary schools in England in the school year 2006-2007 and in 2009.

⁶⁶ Primary education takes place between the ages of five to 11.

⁶⁷ See: http://www.nicurriculum.org.uk/key_stages_1_and_2/areas_of_learning/pdmu/

⁶⁸ See: http://www.nicurriculum.org.uk/key_stage_3/areas_of_learning/learning_for_life_and_work/

findings of their survey should help inform the debate on the establishment of effective drug education initiatives in the FE sector.

Scotland

Choices for Life (CFL)⁶⁹ is an interactive substance misuse education programme⁷⁰ for primary seven age⁷¹ pupils that has been running nationally in Scotland since 2005. The aim is to prepare pupils for secondary school and the choices they may face, using national concert-style events which combine multimedia, live drama and entertainment. To date, over 300,000 pupils across Scotland have participated. In November 2011, CFL is being redesigned and re-launched as an online, two-day programme of events broadcast to schools across Scotland via Glow (Scotland's schools intranet system) with a potential reach of around 400,000 schoolchildren, ranging from primary seven to sixth year secondary⁷² pupils. The event will be modular, tailored to different age groups and is being developed with input from a range of partners with all content aligned with the *Curriculum for Excellence*⁷³ framework (see 2010 UK Focal Point Report). Learning and supporting materials to complement the online conference will be made available to teachers, parents/carers and pupils on an accompanying CFL website.

Wales

In Wales, guidance on substance misuse which is issued to schools has been reviewed by the substance misuse education steering group.⁷⁴ Following this review, new guidance has been developed and will be issued for consultation with schools and other education providers in 2011 (WAG 2010b).

*The All Wales School Liaison Core Programme*⁷⁵

The All Wales School Liaison Core Programme (AWSLCP) programme has expanded further. In addition to the majority of mainstream schools, a further 115 non-mainstream education units also receive the core programme: an increase of 43 on the previous year (WAG 2010c). A third evaluation of the programme was conducted between December 2008 and December 2010 using qualitative and quantitative research methods. This focused on whether the messages contained in the AWSLCP lessons and the supportive police role undertaken by the School Community Police Officers were feeding through to a reduction in anti-social behaviour in schools and communities, a greater sense of personal safety for

⁶⁹ CFL is funded by the Scottish Government and managed by Scottish Crime and Drug Enforcement Agency.

⁷⁰ Including illicit drugs, alcohol and tobacco.

⁷¹ Aged between 10 and 11 at the start of the school year.

⁷² Aged 18.

⁷³ Curriculum for Excellence provides the framework for learning for all children and young people in Scotland aged three to 18. It requires schools to increase children and young people's understanding of the use and misuse of a variety of substances including over the counter and prescribed medicines, alcohol tobacco, illegal drugs and solvents. As part of substance use education pupils explore the impact of risk taking behaviour on their life choices and health.

See:

<http://www.ltscotland.org.uk/curriculumforexcellence/healthandwellbeing/outcomes/substancemisuse/index.asp>

⁷⁴ The steering group was set up to review and oversee the further development of substance misuse education and prevention programmes in schools and other educational settings. The group includes education experts and key stakeholders.

⁷⁵ The AWSLCP is a substance use education programme running in Wales since 2004. It is delivered across the majority of primary and secondary schools in Wales by a partnership between specialist police liaison officers and teachers. In addition to substance use it aims to reduce anti-social behaviour and problems associated with personal safety. See 2008, 2009, and 2010 UK Focal Point Reports and

<http://wales.gov.uk/about/aboutresearch/social/forthcoming/awslcpevaluationreport/?jsessionid=19KyNfNFdfm3GL5ZjTL8mzhzh2hB24Cq1ZPtBfGLvFcnrGdLQX2!1989468226?lang=en> .

pupils and a reduction in substance misuse. The evaluation identified a number of issues and implications for the Police, for schools and local education authorities, for the programme itself, and for the Welsh Government. The Welsh Government has developed an action plan with the AWSLCP to address these areas and to monitor the implementation of the report's recommendations (Stead et al. 2011).

Prevention and education of volatile substance abuse (VSA) in Wales

The Welsh Government has published guidance on best practice for the prevention of and education around volatile substance abuse (VSA). The guidance provides advice and information to parents, schools, youth services, the police and retailers and details different intervention approaches for young people. It provides good practice guidance for substance misuse education for young people as part of a whole organisation approach within schools, colleges and youth services (Welsh Government 2011a).

3.2.2 Community

England: Positive Futures⁷⁶

In 2010/11, over 57,000 young people participated in Positive Futures and over 38,000 positive outcomes were recorded, including over 9,800 qualifications; improved behaviour, self-esteem and confidence; and gaining employment. The UK Government has agreed funding of €11.7 million (£10 million) for the two years of the programme in 2011/12 and 2012/13 and has set a number of high-level priorities for the programme to work to including: reducing drug (and alcohol) misuse; reducing crime; preventing serious youth violence; and delivering a positive social impact through community engagement and cohesion.

Scotland: CashBack for Communities⁷⁷

The Cashback for Communities programme continues in Scotland. Since 2008 over €49 million (£42 million), recovered through the *Proceeds of Crime Act 2002*, have been invested in a wide range of diversionary, participative and intervention activities by the Scottish Government, with over 600,000 young people having participated in the programme (see 2010 UK Focal Point Report).

Evaluating interventions: a review of outcome measures

In a review of outcome measures used for evaluating interventions aimed at substance using parents and their children, the authors posit that there is currently a lack of such measures utilised in evaluations in the UK (Woolfall and Sumnall 2010). The authors suggest that this is because evaluations are often small-scale, poorly designed or focus merely on formative process and monitoring data. They carried out a review of outcome measures for use in future evaluations and put forward a range of outcomes which they felt would be most suitable. Seventeen outcome measures were deemed most appropriate for use with children and seven were selected for parental use. These measures relate to health; substance use; safety; school; child behaviour; self-esteem and self-efficacy. It is recommended that further research should be carried out using these specific outcome measures and the results should be used in tandem with formative process and monitoring data to provide a fuller

⁷⁶ Positive Futures is a community based prevention programme that targets and supports 10 to 19 year olds on the cusp of, or who have desisted from offending. The programme has been running since 2001 and provides sports and arts based activities through 91 projects in deprived communities across England and Wales. The activities are used to engage young people and build relationships whereby attitudes and behaviour can be challenged and young people supported to change. Positive Futures provides long term support and is focused on progression and helping participants access education, training and employment opportunities. It is funded by the Home Office and managed by a young people's charity, Catch22. See: <http://www.catch-22.org.uk/>

⁷⁷ See: <http://www.scotland.gov.uk/Topics/Justice/public-safety/17141/cashback>

picture of the impact of parental substance use and highlight examples of effective interventions.

3.2.3 Sources of information

England: school survey

In 2010, similar to previous years, 61% of school pupils in England age 11 to 15 reported having received drug education in school in the previous year (Fuller 2011) (see section 2.4.1). Older pupils were more likely to remember these lessons than their younger counterparts (66% of Year 11 pupils compared to 44% of Year 7 pupils).⁷⁸ Pupils were most likely to cite teachers as a source of information on drugs (67%) with television (64%), parents (62%) and the police (52%) the next most common sources. The internet and magazines/newspapers were mentioned by just under half of pupils (49% and 45% respectively). Other adults at school, relatives and friends were also key sources of information (mentioned by 39%, 37% and 36% respectively). The FRANK campaign was mentioned by just under one-third of all pupils (31%) with older pupils more likely to mention it than younger pupils (43% of 15 year olds compared to 15% of 11 year olds) and boys (33%) more likely to mention it than girls (29%). Of the options provided, telephone helplines were the least likely source of information to be mentioned by participants (16%).

Northern Ireland: Young Person's Behaviour and Attitudes Survey

In Northern Ireland, results from the 2010 *Young Person's Behaviour and Attitudes Survey* (NISRA 2011)⁷⁹ (see section 2.4.3) showed that 73% of pupils reported receiving drugs education in schools in the previous 12 months with 18% reporting that they had received it in a youth facility.⁸⁰ Seventeen per cent of respondents stated that they had not received any drugs education in the previous 12 months. Ninety per cent of respondents reported that the education they received has made them less likely to take drugs or solvents (n= 2,512). The majority of respondents reported that they get information about drugs or solvents from school (82%). Other common sources of information included: television (62%); parents (57%); the internet (43%); books/magazines (35%); and friends (32%). Eight per cent of respondents cited helplines as a source of information.

3.3 Selective prevention in at-risk groups and settings

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

3.3.1 At-risk groups

England and Wales: Choices

In 2011/12 the Government provided €4.7 million (£4 million) in funding to the Choices programme, which has been co-designed with the voluntary and community sector (VCS). Its aim is to prevent and reduce substance misuse (and related offending) by vulnerable groups of young people aged 10 to 19 years who are most likely to be at risk, or already starting to become involved. Targeted prevention and early intervention programmes will be delivered at a local level by VCS organisations. A key objective of the programme is to encourage the national VCS to support local VCS organisations through the transfer of skills, expertise and knowledge, to help local VCS organisations to develop effective local approaches and practices. The programmes will cover a wide geographical area and aim to work with around 160 local VCS organisations and engage with around 10,000 young people.

⁷⁸ Year 7 pupils are aged 11 and 12. Year 11 pupils are aged 15 and 16.

⁷⁹ The sample size was 3,546. See section 2.4.3 for methodology.

⁸⁰ Such as a youth club or a community centre.

Scotland: Inspiring Scotland

Inspiring Scotland⁸¹ has been running for three years with investment of €15.6 million (£13.4 million) from the Scottish Government alongside additional contributions from a range of public and private sources. It has a number of 'themes' of investment, including the '14 to 19 Fund'.⁸² In 2010, 4,577 young people took part in '14 to 19 Fund' programmes⁸³ which focus on supporting vulnerable young people, including those with issues associated with drugs misuse, into learning or employment. A total of 2,267 young people completed programmes and were supported into employment, education and training.

Outreach drug education in nightclub environment

A novel drug education outreach service, called 'Drug Idle', aimed at recreational drug users who go to nightclubs was developed with the aim of improving their knowledge about the potential toxicity of drugs (Wood et al. 2010a). Three events were held at nightclubs in London and participants took part in an interactive quiz and attended workshops discussing how to deal with someone who is unwell due to drug taking, harm minimisation and door searching and personal safety.⁸⁴ A question and answer session with a team of drug experts was held during the final event. A final version of the intervention was developed using feedback from participants. The authors reported that participants who had attended all three parts of the finalised intervention said that they had found it useful, 96% thought it was the right length and 99% would recommend such an event to a friend. The study was limited in that the authors were unable to measure any changes in knowledge about drugs after the intervention due to the anonymous nature of the feedback surveys that were completed by participants, and have suggested that a further study to assess this may be conducted in the future.

3.3.2 At-risk families

Early intervention report

An independent review of early intervention, commissioned by the UK Government, highlighted the importance of providing social and emotional support to children in the early years of life. Evidence has shown that early intervention can delay or prevent future problems (including substance misuse), and the review compared this to the more expensive, and often ineffective nature of, late intervention (Allen 2011). It made several recommendations including:

- the role of early intervention in policy and practice should be increased;
- evidence of best practice in early intervention programmes should be brought together and promoted to encourage its adoption; and
- early intervention programmes should be pioneered by local pilot schemes.

Wales: Strengthening Families programme 10-14

The Strengthening Families 10-14 Programme⁸⁵ (see 2009 and 2010 UK Focal Point Reports) continues to operate in eight areas across Wales and a national training centre has

⁸¹ Inspiring Scotland uses a model of venture philanthropy whereby investment is made in third sector organisations to fund the provision of services (rather than receiving donations or grants).

⁸² This fund offers £10 million per year over ten years and is aligned to the Scottish Government's *More Choices, More Chances* strategy (Scottish Executive 2006a).

⁸³ These are delivered by 22 different providers, ranging from large national bodies to local programmes. Organisations involved include 'Aberdeen Foyer'; 'Action for Children Scotland'; 'Move On'; 'Tomorrow's People'; and the 'Venture Trust'.

⁸⁴ A total of 149 participants attended three 'Drug Idle' events at a nightclub in London.

⁸⁵ This programme aims to strengthen protective factors (parenting, communication, and young people's resilience skills) and also reduce key risk factors within families. The intervention typically lasts for about seven weeks and involves weekly sessions where the young person and family

been established in order to increase the number of programme facilitators. Some areas are participating in a Randomised Controlled Trial (RCT),⁸⁶ which will explore project outcomes including drug use and anti-social behaviour amongst young people. Results of the RCT are expected in March 2014 (WAG 2010a).

3.4 National and local media campaigns

England: Talk to FRANK⁸⁷

In England, the Government has confirmed that the FRANK campaign will continue to provide information and advice on drugs aimed at young people.⁸⁸ A new campaign aimed at 11 to 18 year olds was launched in autumn 2011 and included radio and internet advertising. In the adverts, a series of drug-related questions were posed to teenagers and they were encouraged to reconsider what they know about drugs and where to find reliable information about the risks.

Scotland: Know the Score

In Scotland, the Know the Score Cocaine Awareness Campaign, targeted at 18-24 year olds, was re-launched in November 2010.⁸⁹ The aim was to raise awareness of the range of risks associated with cocaine use, with the message 'you don't know what you are getting with cocaine.' The campaign included around two months of cinema, radio and online advertisements, reinforced through Cocaine Awareness Weekends in around 140 bars and clubs across Scotland. The campaign received a Gold Award 2010⁹⁰ from the Chartered Institute of Public Relations. In common with previous years, Know the Score also had an information point at Scotland's biggest music festival, 'T in the Park', in 2011.

Wales: The Welsh Drug and Alcohol Helpline DAN 24/7⁹¹

In 2009 in Wales around 2,500 calls were made to DAN 24/7. This number has doubled since 2008. The service is promoted through drug services and other agencies that drug users may have contact with. The image of the service has been updated and posters, leaflets and cards displaying its new logo have been distributed at targeted local and regional events. The helpline has a related website⁹² which received around 9,500 hits in the last year and which now includes an interactive search facility listing local drug services (WAG 2010a).

members meet separately with a project worker for the first hour and as a family with the project worker in the second hour.

⁸⁶ Funded by the National Prevention Research Initiative (NPRI) See:

<http://www.mrc.ac.uk/Ourresearch/ResearchInitiatives/NPRI/index.htm>

⁸⁷ The Talk to FRANK drugs internet information and advice service funded by the Department of Health, the Home Office and the Department for Education has been running in England for eight years. See: <http://www.talktofrank.com> and <http://www.homeoffice.gov.uk/media-centre/news/frank-campaign>.

⁸⁸ See: <http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/response-acmd-mdma-ecstasy?view=Binary>

⁸⁹ The campaign also ran in 2009.

⁹⁰ See: <http://www.scotland.gov.uk/News/Releases/2010/11/08103633> and <http://www.cipr.co.uk/content/events-awards/scotland-pride-awards-2010-results>

⁹¹ Drug and Alcohol Helpline, 'DAN 24/7' is a bilingual (Welsh and English) telephone help line funded by the Welsh Assembly Government and operated by Betsi Cadwaladr University Health Board. It provides a 24 hour gateway service, designed to provide substance use information, guidance, advice and sign post callers to local relevant services.

⁹² See: <http://dan247.org.uk/>

Northern Ireland

In Northern Ireland the Department of Health Social Services and Public Safety (DHSSPS) funds a National Drug Helpline which is linked to the FRANK helpline and website in England. Information, education and training on issues related to substance use are provided to young people via public information campaigns and support programmes provided by the Public Health Agency (PHA)⁹³ and through various local organisations. Following a needs assessment, the PHA recently set up four pilot⁹⁴ 'one stop shop services' across the country. The services provide information, education, signposting and referrals particularly in relation to alcohol and drug misuse. As substance misuse is often one outcome of a range of underlying issues, the services also provide information advice and signposting for a range of related issues including (but not exclusively) suicide and self harm; mental health and wellbeing; sexual health; relationship issues; resilience; and coping with school/ employment. An evaluation has been carried out on the pilot services and consideration is being given to rolling them out across Northern Ireland.

Research

Review of prevention guidance development

In a review of young people's drug prevention guidance development⁹⁵ in the UK, some of the disadvantages of using a formal systematic review as part of the development process are discussed (Pearson and Coomber 2010). The authors suggest that the use of this approach and the prioritising of internal validity may have led to some valuable 'real world' evidence being overlooked if it did not fulfil the strict methodological criteria demanded by the systematic review search strategy. They suggest that future evidence reviews could also consider the use of different methods such as meta-ethnography or realist synthesis.

Information-seeking amongst vulnerable young people

In a small qualitative study⁹⁶ of vulnerable young people aged 13 to 18 years of age, participants were asked about their experiences of seeking information regarding substance use (Notley et al. 2011). The authors reported that the young people in the study accessed a wide variety of information sources and attached varying degrees of credibility to them. Family members were perceived to be the most credible sources, with mothers and siblings cited as the most credible within the family. Other sources identified included peers, youth workers, teachers, medical professionals and the internet. The levels of interaction with information sources and the methods of information seeking tended to depend on the personal circumstances of participants and further research in this particular area is recommended.

⁹³ See: <http://www.publichealth.hscni.net/>

⁹⁴ The four pilot organisations are: FASA (Forum for Action on Substance Abuse) in North Down and Ards; FUEL (Fermanagh Underage Entertainment Life) in Enniskillen; REACT Ltd in Banbridge; and CCDAAG (Carrickfergus Community Drug & Alcohol Advisory Group) in East Antrim.

⁹⁵ Using observational techniques the authors attended team meetings during the systematic review (SR) process which led to the development of drug prevention guidance and also interviewed individual reviewers and members of the SR management team.

⁹⁶ A total of 11 young people were interviewed following a semi-structured format and using an opportunistic sampling technique. Data were collected as part of their needs assessment interview at a drug treatment service.

4. Problem drug use

4.1 Introduction

The EMCDDA's definition of problem drug use is 'injecting drug use or long-duration/regular use of opioids, cocaine and/or amphetamines'. In England estimates are produced for opiate and/or crack cocaine users (OCUs) and injecting drug use.⁹⁷ In Scotland, problem drug use refers to opiates and/or the illicit use of benzodiazepines⁹⁸ and drug injecting, in Wales it is long duration or regular use of opioids, cocaine powder and/or crack cocaine and in Northern Ireland problem opiate and/or problem cocaine powder use. For the purpose of this chapter the term problem drug use (PDU) will be used to encompass all of these definitions from across the UK and to allow for comparisons across Europe to be made by the EMCDDA.

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

Latest national and regional estimates for England are for 2009/10 for opiate and/or crack cocaine use, with separate estimates available for opiate use, crack cocaine use, and injecting drug use.

In Scotland, 2006 national and regional estimates for opiate and/or benzodiazepine misuse, and injecting of these drugs, were published in October 2009. New estimates for 2009/10 are due to be published at the end of 2011. In Wales local and national estimates for 2006/07 and 2009/10 for long duration or regular use of opioids and/or crack cocaine/cocaine powder were published in 2009 and 2011 respectively (Welsh Government 2011b). Estimates for Northern Ireland for 2004 were published in 2006 and cover problem opiate and/or problem cocaine powder use.

Based on these, it is estimated that there are a total of 379,262 problem drug users in the United Kingdom, and 133,112 injecting drug users (primarily of opiates or crack cocaine).

4.2 Prevalence estimates of problem drug use

4.2.1 Prevalence estimates for England for 2009/10

In England, new national and local estimates of the prevalence of opiate and/or crack cocaine use (OCU)⁹⁹ have been published for 2009/10,¹⁰⁰ with separate estimates available for opiate use, crack cocaine use and injecting drug use (Hay et al. 2011a;b).

There were an estimated 306,150 opiate and/or crack cocaine users in England in 2009/10, a rate of 8.93 per thousand population aged 15 to 64; an estimated 264,072 opiate users, a rate of 7.70 per thousand population; an estimated 184,247 crack cocaine users, a rate of

⁹⁷ Injecting drug use refers to estimates of the numbers injecting out of those that are opiate and / or crack cocaine users. It does not include estimates of injectors of other drugs.

⁹⁸ Refers to estimates of the numbers injecting out of those that are opiate and/or benzodiazepine users.

⁹⁹ Problem drug users according to the EMCDDA definition.

¹⁰⁰ This is a follow up study to an earlier three-year Home Office project which provided prevalence estimates for 2004/05, 2005/06 and 2006/07 (Hay et al. 2006; 2007; 2008) ('sweeps' 1 to 3). A further study, commissioned by the National Treatment Agency (NTA), provided estimates for 2008/09 (Hay et al. 2010a;b) and was carried out two years after the final 'sweep' of the original project and was considered to be the fifth 'sweep'. The current study is a second follow-up, carried out three years after the original Home Office study and commissioned by the NTA. It is considered as 'sweep six'. Estimates for 2007/08 are not available as a study wasn't commissioned for that year.

5.37 per thousand population; and an estimated 103,185 injectors who use opiates and/or crack cocaine, a rate of 3.01 per thousand population (Table 4.1).

Table 4.1: Estimates of OCU, opiate use, crack cocaine use and drug injecting and rates per 1,000 population aged 15 to 64 in England, 2009/10

	Estimate	95% CI	Rate	95% CI
Opiate and/or crack cocaine users	306,150	299,094 -316,916	8.93	8.72 - 9.24
Opiate users	264,072	260,023-271,048	7.70	7.58 - 7.90
Crack cocaine users	184,247	177,534-195,526	5.37	5.18 - 5.70
Injectors of opiates and/or crack cocaine	103,185	100,085-107,544	3.01	2.92 - 3.14

Source: Hay et al. 2011a

There was a significant decrease in the estimated number of opiate and/or crack cocaine users in England between 2008/09 and 2009/10.¹⁰¹ A significant decrease in the number of injectors was reported between 2006/07 and 2009/10,¹⁰² which was particularly apparent in London (Hay et al. 2011b) (Table 4.2).

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

	2004/05	2005/06	2006/07	2008/09	2009/10
Opiate and/or crack cocaine users	327,466	332,090	328,767	321,229	306,150
Opiate users	281,320	286,566	273,123	262,428	264,072
Crack cocaine users	192,999	197,568	180,618	188,697	184,247
Injectors of opiates and/or crack cocaine	137,141	129,977	116,809	n/a	103,185

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

Regional differences

Similar to previous years, estimates show marked variation in prevalence rates for opiate and/or crack cocaine users across the nine Government Regions. The North West has the highest reported rate of opiate and/or crack cocaine users per 1,000 population (11.08 per 1,000) followed by the North East and Yorkshire and the Humber (10.84 and 10.75 per 1,000 respectively). The East of England and the South East have the lowest rates (6.44 and 6.56 per 1,000 respectively).

By Government Office region, the only area with a significant change in the number of opiate and/or crack cocaine users was London, with a significant decrease in numbers from 62,769 in 2008/09 to 51,445 users in 2009/10.

Age

In the latest sweep of estimates of opiate and/or crack cocaine use in England, the highest prevalence rate continues to be amongst those in the 25 to 34 age group (Table 4.3).

¹⁰¹ Sweeps five and six of the research study period.

¹⁰² Sweeps three and six of the research. Data regarding drug injecting are not available for 2008/09 (sweep 5).

Table 4.3: Prevalence rate per 1,000 population of opiate and/or crack cocaine users by age group in England, 2009/10

Rate	15 to 24 years		25 to 34 years			35 to 64 years		
	95% CI		Rate	95% CI		Rate	95% CI	
6.87	6.84	7.40	17.95	17.41	18.52	6.65	6.46	6.85

Source: Hay et al. 2011a

The estimated numbers of OCUs amongst the 15 to 24 and the 25 to 34 age groups decreased significantly between 2008/09 and 2009/10 (Table 4.4) (Hay et al. 2011a). This is similar to the findings of earlier 'sweeps' of this research; significant decreases in the estimated numbers of OCUs in both age groups were also reported between 2006/07 and 2008/09 (Hay et al. 2010b; see 2010 UK Focal Point Report). Between 2008/09 and 2009/10 there were significant decreases in the estimated number of 15 to 24 year old OCUs in five out of the nine Government Regions (Hay et al. 2011a)

Table 4.4: Estimated number of opiate and/or crack cocaine users by age group in England, 2006/07, 2008/09 and 2009/10

Year	15 to 24 years		25 to 34 years		35 to 64 years	
	Estimate	95% CI	Estimate	95% CI	Estimate	95% CI
2006/07	60,672	59,245-63,598	139,284	136,139-144,344	128,810	125,982-133,641
2008/09	55,145	55,104-58,618	129,141	126,101-131,926	136,943	134,091-140,083
2009/10	47,173	46,944-50,798	121,636	117,920-125,442	137,341	133,424-141,512

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

4.2.2 Estimates of problem drug use in Wales

PDU estimates for Wales for the period 2009/10 were published in the Welsh Government's *Substance Misuse Annual Report 2010-11* in October 2011. There were an estimated 16,389 problematic opioid and/or crack cocaine/ cocaine powder users in Wales in 2009/10, a rate of 8.46 per thousand population aged 15 to 64. The rate for primary stimulant users only (of crack cocaine and/or cocaine powder) was 1.7 per thousand population aged 15 to 64; for primary opioid users only the rate was 6.2 per thousand population aged 15 to 64; and for users of both stimulants and opioids it was 0.6 per thousand population aged 15 to 64 (Welsh Government 2011b).

4.2.3 Estimates of problem drug use in Scotland

Information Services Division (ISD) Scotland is currently undertaking work to produce national and local PDU estimates for 2009/10.¹⁰³ It is expected that the estimates will be published in late 2011.

4.2.4 Estimates of problem drug use in the United Kingdom

Combining the new estimates for England (Hay et al. 2011a) and Wales (Welsh Government 2011b) and the most recent estimates for Northern Ireland (Centre for Drug Misuse Research 2006) and Scotland (Hay et al. 2009) it is estimated that there are 379,262 problem drug users in the United Kingdom, a rate of 9.31 per thousand population aged 15 to 64 (Table 4.5).

¹⁰³ See: http://www.drugmisuse.isdscotland.org/publications/abstracts/prevalence_projectupdate.htm

Table 4.5: Estimates of problem drug use in the United Kingdom: number and rate¹⁰⁴ per 1,000 population aged 15 to 64

Country	Estimate	95% CI		Rate	95% CI	
England	306,150	299,094	316,916	8.93	8.72	9.24
Northern Ireland	1,395	1,316	1,910	1.28	1.21	1.75
Scotland	55,328	54,451	57,234	16.16	15.91	16.72
Wales	16,389	13,850	23,580	8.46	7.14	10.33
United Kingdom ¹⁰⁵	379,262	368,711	402,640	9.31	9.05	9.88

Source: Centre for Drug Misuse Research 2006; Hay et al. 2009; 2011a; Welsh Government 2011b

The latest available estimate for the number of injecting¹⁰⁶ PDUs (predominantly of opiates and crack cocaine) in the UK is 133,112, a rate of 3.27 per thousand population aged 15 to 64 (Table 4.6).

Table 4.6: Estimates of injecting drug use in the United Kingdom: number and rate¹⁰⁷ per 1,000 population aged 15 to 64

Country	Estimate	95% CI		Rate	95% CI	
England	103,185	100,085	107,544	3.01	2.92	3.14
Northern Ireland	470	444	644	0.43	0.41	0.59
Scotland	23,933	21,655	27,143	6.99	6.33	7.93
Wales	5,524	4,668	7,947	2.85	2.41	4.10
United Kingdom	133,112	126,852	143,278	3.27	3.11	3.52

Source: Centre for Drug Misuse Research 2006; Hay et al. 2009; 2011a; Welsh Government 2011b

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

Table 4.7 shows estimates provided over time by the UK Focal Point; the dates refer to the year the estimate was produced rather than the year the estimate refers to.¹⁰⁸ There has been a decrease in the estimated number of problem drug users from 398,845 in the 2007 estimate to 379,262 in the 2011 estimate. However, the decrease is not statistically significant.

¹⁰⁴ Calculated using the following population estimates for 15 to 64 year olds: England 34,299,600; Northern Ireland 1,090,990; Scotland 3,422,900; Wales 1,937,063; United Kingdom 40,750,553.

¹⁰⁵ Based on estimates of opiate use in Northern Ireland for 2004; opiate and/or benzodiazepine misuse in Scotland for 2006; opiates and/or crack cocaine use in England for 2009/10; and long duration or regular use of opioids and/or crack cocaine/ cocaine powder in Wales for 2009/10 (Centre for Drug Misuse Research 2006; Hay et al. 2009; Hay et al. 2011a; Welsh Government 2011).

¹⁰⁶ Based on estimates of injecting of any drug by opiate and/or problem cocaine powder users in Northern Ireland for 2004; injecting of opiates and/or benzodiazepines in Scotland for 2006; injecting of any drug by users of opiates and/or crack cocaine in England for 2009/10; and injecting of any drug by users of opioids and/or crack cocaine/ cocaine powder in Wales for 2009/10. Injecting estimates for Northern Ireland and Wales assume the same proportion of injecting as England (Centre for Drug Misuse Research 2006; Hay et al. 2009; Hay et al. 2011a; Welsh Government 2011b).

¹⁰⁷ Calculated using the following population estimates for 15 to 64 year olds: England 34,299,600; Northern Ireland 1,090,990; Scotland 3,422,900; Wales 1,937,3063; United Kingdom 40,750,553.

¹⁰⁸ For more information on these estimates see previous UK Focal Point Reports.

Table 4.7: Estimates of problem drug use: number and rate per 1,000 population, aged 15 to 64 in the United Kingdom

Year of estimate	Estimate	95% CI		Rate	95% CI	
2007 ¹⁰⁹	398,845	397,033	421,012	10.15	10.11	10.72
2008 ¹¹⁰	403,547	395,378	423,907	10.19	9.98	10.70
2009 ¹¹¹	404,884	396,267	431,120	10.10	9.88	10.75
2010 ¹¹²	397,346	387,536	419,949	9.79	9.55	10.35
2011 ¹¹³	379,262	368,711	402,640	9.31	9.05	9.88

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

Estimates of injecting drug use in the UK by year of estimate are provided in Table 4.8. The 2011 estimate shows a significant decrease in injecting drug use since the 2009 estimate and a larger decrease since the 2007 estimate.

Table 4.8: Estimates of injecting drug use: number and rate per 1,000 population, aged 15 to 64 in the United Kingdom

Year of estimate	Estimate	95% CI		Rate	95% CI	
2007 ¹¹⁴	164,036	158,881	178,614	4.18	4.04	4.55
2008 ¹¹⁵	156,398	151,032	165,696	3.95	3.81	4.18
2009 ¹¹⁶	147,900	143,298	156,017	3.69	3.57	3.89
2011 ¹¹⁷	133,112	126,852	143,278	3.27	3.11	3.52

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

¹⁰⁹ 2007 estimate is based on estimates of opiates and/or crack cocaine use in England for 2004/05 (Hay et al. 2006), opiate use in Northern Ireland for 2004 (The Centre for Drug Misuse Research 2006), and problem drug use in Scotland, 2003 (Hay et al. 2004). Estimates for Wales are extrapolated from England estimates.

¹¹⁰ 2008 estimate is as 2007 above except for England for 2005/06 (Hay et al. 2007).

¹¹¹ 2009 estimate is based on estimates of opiates and/or crack cocaine use in England for 2006/07 (Hay et al. 2008), opiate use in Northern Ireland for 2004 (The Centre for Drug Misuse Research 2006), opiates and/or benzodiazepine use in Scotland, 2006 (Hay et al. 2009) and for long duration or regular use of opioids, cocaine powder and/or crack cocaine in Wales in 2006/07 (WAG 2009).

¹¹² 2010 estimate is based on estimates of opiates and/or crack cocaine use in England for 2008/09 (Hay et al. 2010a;b), opiate use in Northern Ireland for 2004 (The Centre for Drug Misuse Research 2006), opiates and/or benzodiazepine use in Scotland in 2006 (Hay et al. 2009) and for long duration or regular use of opioids, cocaine powder and/or crack cocaine in Wales in 2006/07 (WAG 2009).

¹¹³ Based on estimates of opiate use in Northern Ireland for 2004; opiates and/or benzodiazepines use in Scotland for 2006; opiate and/or crack cocaine use in England for 2009/10; and long duration or regular use of opioids, cocaine powder and/or crack cocaine in Wales for 2009/10 (Centre for Drug Misuse Research 2006; Hay et al. 2009; Hay et al. 2011a; Welsh Government 2011).

¹¹⁴ 2007 estimate is based on estimates of opiates and/or crack cocaine use in England for 2004/05 (Hay et al. 2006), injecting of any drug by opiate and/or problem cocaine powder users in Northern Ireland for 2004 (The Centre for Drug Misuse Research 2006), and problem drug use in Scotland, 2003 (Hay et al. 2004). Estimates for Wales are extrapolated from England estimates.

¹¹⁵ 2008 estimate is as 2007 above except for England for 2005/06 (Hay et al. 2007).

¹¹⁶ Based on estimates of injecting of any drug by opiate and/or problem cocaine powder users in Northern Ireland for 2004; injecting of any drug by users of opiates and/or crack cocaine in England for 2006/07; injecting of opiates and/or benzodiazepines in Scotland for 2006; and injecting of any drug by users of opioids, cocaine powder and/or crack cocaine in Wales for 2006/07. Injecting estimates for Northern Ireland and Wales assume the same proportion of injecting as England (Centre for Drug Misuse Research 2006; Hay et al. 2008; Hay et al. 2009; WAG 2009).

¹¹⁷ Based on estimates of injecting of any drug by opiate and/or problem cocaine powder users in Northern Ireland for 2004; injecting of opiates and/or benzodiazepines in Scotland for 2006; injecting of any drug by users of opiates and/or crack cocaine in England for 2009/10; and injecting of any drug by users of opioids, cocaine powder and/or crack cocaine in Wales for 2009/10. Injecting estimates for Northern Ireland and Wales assume the same proportion of injecting as England (Centre for Drug Misuse Research 2006; Hay et al. 2009; Hay et al. 2011a; Welsh Government 2011).

4.3 Data on PDUs from non-treatment sources

Statistics from the Northern Ireland Addicts Index 2010

The Northern Ireland Addicts Index provides information about individuals reported to be addicted to one or more of 14 specific drugs¹¹⁸ classified under the *Misuse of Drugs Act 1971* (PHIRB 2010). The index showed that at 31st December 2010:

- 315 individuals were registered on the Addicts Index, an increase of 27 from 288 in 2009;
- 79% of registered addicts were male in 2010 (81% in 2009);
- 24% of registered addicts were aged 29 years and under in 2010 (24% in 2009 and 25% in 2008);
- similar to the previous year, heroin was the most frequently used notifiable drug, reported by 83%;
- as in recent years, methadone (19%) and cocaine (5%) were the second and third most commonly reported drugs;
- in 2010, 54% of registered addicts whose injecting behaviour was known reported currently injecting, similar to 2009 (55%);
- of the 315 addicts on the Index, 60 were registered within the last year; 157 have been registered between one and five years; the remaining 98 addicts have been registered between six and 21 years; and
- there were 255 re-notifications in 2010 (compared to 228 in 2009) and 60 new notifications.

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

Dependence on prescription drugs in England

The Department of Health in England commissioned a report which investigated the extent of dependence and associated harms with over-the-counter codeine products and prescribed benzodiazepines (Reed et al. 2011). The authors reported that there is currently a dearth of UK literature regarding dependence on these drugs. The report discusses changes in trends in the prescribing of benzodiazepines and z-drugs¹¹⁹ in the past 20 years.

In a qualitative study¹²⁰ of over-the-counter medicine (OTC) abuse in the UK (Cooper 2011), participants (n=25) who had self-reported that they were addicted to OTC medicines typically

¹¹⁸ People are registered on the Index if they are known to be, or a medical practitioner considers them to be, addicted to one or more of 14 controlled drugs. *The Misuse of Drugs (Notification of and Supply to Addicts) (Northern Ireland) Regulations 1973* require any doctor to notify the Chief Medical Officer (CMO) of the Department of Health, Social Services and Public Safety in writing within seven days, if they attend to a patient who is considered to be, or the doctor has reasonable grounds to suspect is, addicted to any of the following controlled drugs: Cocaine, Methadone (Physeptone), Dextromoramide (Palfium), Morphine, Diamorphine (Heroin), Opium, Dipipanone (Constituent of Diconal), Oxycodone, Hydrocodone, Pethidine, Hydromorphone, Phenazocine, Levorphanol, Piritramide.

¹¹⁹ Z-drugs are a group of non-benzodiazepine drugs that have similar effects to benzodiazepines and whose names mainly start with a letter 'z'. They include zaleplon, zolpidem, zopiclone and eszopiclone. They are prescribed to treat conditions such as sleeping disorders.

¹²⁰ A total of 58 individuals were interviewed using a semi-structured telephone interview. Participants were purposively sampled, using the snowball method and were in three groups: those employed by or stakeholders of the OTC industry (n= 16); pharmacists and medicine counter assistants (n=10 and n=7 respectively); and individuals with a self-reported OTC addiction (n=25). Twenty-three participants with an OTC addiction had begun using OTC medicines to self-treat for genuine medical reasons and the remaining two had begun use to exploit some non-therapeutic side effect.

reported using codeine products.¹²¹ The authors identified three discrete patterns of 'respectable' addiction amongst these participants, which were defined by their typical dosage patterns. These were: individuals who never exceeded the recommended dose; those who sometimes took slightly higher than the recommended dose; and those who took significantly higher than the recommended dose. Participants from each group reported that they had used the product for reasons other than those 'clinically indicated' and had experienced withdrawal symptoms when they tried to stop using them. When interviewed, pharmacists identified a range of medicines with abuse potential but were often unaware of how or where to refer individuals with an addiction. They also suggested that there was a lack of communication between pharmacists employed at other outlets and therefore the supply of OTC medicines to individuals with an addiction could not be adequately monitored. Stakeholders from the industry were also interviewed and identified codeine as the main drug associated with OTC medicine abuse. The majority of participants were in favour of choice for individuals, with continued availability of codeine and other OTC medicines alongside increased information about potential risks and improved treatment and support options.

Looked after children

In 2006, the Department for Children, Schools and Families (DCSF) started collecting information on the number of looked after children identified as having a substance misuse problem. Of the 44,400 children looked after for at least 12 months in the year ending 30th March 2010, 4.4% were identified as having a substance misuse problem.¹²²

4.5 Research

In a review of the history and extent of usage of the term PDU, Seddon (2011b) charted its introduction into the drugs field and discussed how it replaced such terms as drug dependent, abuser and addict. He posits that the introduction of the term PDU has 'neutralised' the associations that individuals have with this population and has enabled policy makers and researchers to circumvent the more polarising and moral issues that surround drug use. He goes on to say that the use of the term PDU has gone hand in hand with a more pragmatic approach by policy makers and health and criminal justice professionals to managing problems related to drug use by focusing resources on 'problematic' users.

In an investigation into the attitudes of the UK public towards people with a history of drug dependence (Singleton 2010; see section 8.2.5), the author reported that the term 'drug dependence' was used throughout the research process and during interviews with the general public as it was thought that terms such as addict or problem drug user may be regarded as 'pejorative' by participants.

¹²¹ All used some form of opiate and pseudoephedrine and sedative antihistamines were also mentioned.

¹²² See: <http://www.education.gov.uk/rsgateway/DB/SFR/s000978/index.shtml>

Chapter 5: Drug-related treatment: treatment demand and treatment availability

5.1 Introduction

United Kingdom drug strategies identify treatment as being effective in tackling problem drug use and therefore, seek to improve its quality and effectiveness. *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (DH and the devolved administrations 2007) and in England, *Models of Care for Treatment of Adult Drug Misusers: Update 2006* (NTA 2006) provide the basic framework for drug treatment, offering guidance on the structure and range of services to be commissioned in each area, as well as guidelines on clinical practice. The National Institute for Health and Clinical Excellence (NICE) also provides guidance in a number of areas¹²³. Treatment interventions in any given area are expected to include advice and information, care planning, psychosocial interventions, community prescribing, inpatient drug treatment and residential rehabilitation. In addition, drug misusers should be offered relapse prevention and aftercare programmes; hepatitis B vaccinations; testing and counselling for hepatitis B and C and HIV; and needle exchange. Oral opiate substitution treatment with methadone is the most common pharmacological treatment used in treating heroin addiction; buprenorphine is also prescribed while injectable opiates, such as injectable methadone and injectable diamorphine, are also available but are not commonly used.

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

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

Treatment Demand Indicator (TDI) data are from four separate systems: the National Drug Treatment Monitoring System (NDTMS) in England, the Scottish Drug Misuse Database; the Welsh National Database for Substance Misuse; and the Northern Ireland Drug Misuse Database. For reporting to the EMCDDA, data are combined for the United Kingdom. Continuous national data are available from 2003/04. From 2003/04 to 2005/06, presentations to treatment increased substantially, levelling off in 2006/07 before rising in 2007/08 and 2008/09 and decreasing by eight per cent in 2009/10. The majority of presentations continue to be for opiate use, although the number has decreased. Cocaine powder presentations increased substantially between 2003/04 and 2008/09 before decreasing in 2009/10. Cannabis presentations continue to rise and now account for one-fifth of all treatment presentations and one-third of first ever presentations.

5.2 Strategy and policy

The 2010 Drug Strategy published by the coalition Government in December (HM Government 2010a; see section 1.3.1) contained proposals for a trial payment by results

¹²³ See 2010 UK Focal Point Report

scheme for drug treatment in England. Payment by Results (PbR) will see providers receive financial rewards for outcomes related to a client's recovery from drug and alcohol dependence. In April 2011, it was announced that eight areas had been selected to run the pilots, which will begin to use this approach to contracting services from October 2011.¹²⁴ A co-design group consisting of representatives from central government departments and local pilot sites was convened to develop a draft set of proposals to measure outcomes and set eligibility criteria.¹²⁵ A number of outcomes including free of dependence and offending were proposed with both initial and final outcome measures. Other proposed outcomes include health and wellbeing outcomes. The data sources for measurement and data time lags were considered. Organisations and individuals were invited to comment on the proposals in summer 2011. An evaluation of the PbR pilots will be undertaken with the work currently out for tender.

The Coalition Government announced in 2010 that a new organisation, Public Health England would be created and the National Treatment Agency (NTA) would be part of this (see 2010 UK Focal Point Report). After a 'pause' for reflection on proposed health reforms, the Secretary of State announced that Public Health England (PHE) will be established as an Executive Agency rather than as part of the Department of Health (DH). The full transfer of responsibilities to PHE, including the NTA's work, will now take place in April 2013.

The NTA Business Plan 2011/2012 focuses on supporting the development and delivery of effective and local recovery-oriented systems while preparing for its key functions to be absorbed by Public Health England (NTA 2011a). A key task is to publish final guidance and clinical protocols to shift the balance away from long-term maintenance treatment for opiate users to a greater focus on recovery and achievement of related recovery outcomes. The NTA is also working with the Department of Health (DH) to develop outcome indicators for the PbR pilots. Other methods of incentivising the delivery of recovery outcomes are to be developed including outcome indicators for the allocation of the pooled treatment budget and a more outcome based funding formula for DH Drug Interventions Programme (DIP) money from 2012/13.

UKDPC Payment by Results briefing

A briefing paper was published by the United Kingdom Drug Policy Commission (UKDPC) looking at payment by results and how this may be applied to recovery from drug use¹²⁶ (Roberts 2011). The paper describes existing forms of PbR in the UK for the purchasing of healthcare and for moving people on incapacity benefit into work. A number of issues and challenges were identified including the need to get the outcomes and tariffs right and for government and statutory agencies to maintain a regulatory role. Concerns were also raised about the potential for 'cherry-picking' of clients and the possible neglect of those with more complex needs, and the authors suggest that a move to PbR should be gradual and include an evaluative element so that any issues can be smoothed out and the intervention recalibrated. Other issues identified include the ability of smaller organisations to compete, the need to get the balance between payment for activity and payment for outcomes correct, and the need for investment in workforce development. The author concludes that there is broad support for a more outcome-based system of funding and for greater focus on recovery and social integration but a cautious approach should be taken since PbR "is effectively a social experiment with a particularly vulnerable group".

¹²⁴ See: http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_125929

¹²⁵ See: http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128332.pdf

¹²⁶ The briefing draws on the presentations given and discussions at an expert seminar on Payment by Results held in London in September 2010. See: <http://www.ukdpc.org.uk/publications.shtml#Localism>

Scotland

Scotland has a National Health Service (NHS) Health Improvement, Efficiency, Access and Treatment (HEAT) target that has been agreed with local authorities to reduce waiting times for drugs (and alcohol) treatment across NHS, local authority and voluntary sector services. The target was extended to include alcohol treatment in November 2010 and now states that, by March 2013, 90% of clients will wait no longer than three weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.

A new Drug and Alcohol Treatment Waiting Times Database was introduced in Scotland in April 2011 and began reporting in September 2011. For the first time, alcohol treatment waiting times are being monitored (as well as continuing to measure drug treatment waits). The database reports at Alcohol and Drug Partnership level, and measures the complete wait from referral to treatment in line with the HEAT Target. It also records up to five interventions offered to each client by a service.

Actual performance data published by NHS Information Services Division (ISD) Scotland in September 2011 found that, across Scotland between April and June 2011, 84% of clients waited no longer than three weeks from referral received to appropriate drug or alcohol treatment to support their recovery (NHS National Services Scotland 2011). Broken down by drugs and alcohol, 81% of clients waited no longer than three weeks for drug treatment and 86% of clients waited no longer than three weeks for alcohol treatment.

5.3 Treatment systems

5.3.1 Guidance

Building recovery in communities

The NTA in England launched a consultation in February 2011 to gather opinion on the update of the service framework for substance misuse (NTA 2011b). Under the working title of *Building Recovery in Communities* (BRiC), the new service framework will replace the *Models of Care* document (NTA 2006), placing recovery at the centre of the treatment system.¹²⁷ The consultation ran for three months until May 2011 and the new service framework is due to be published at the end of 2011. An interim report by Professor John Strang, chair of the expert group tasked with providing guidance on recovery-orientated treatment, was published in July 2011. It set out 12 immediate steps that treatment agencies can take to improve the recovery orientation of their services and highlighted areas of work requiring further attention (NTA 2011c).

Psychosocial drug treatment interventions in Wales

The Welsh Government produced guidance on psychosocial interventions as part of an integrated framework of substance misuse treatment (Welsh Government 2011c). Aimed at service providers and partners, the guidance details individual psychosocial interventions, supported by evidence, and outlines the appropriate selection of each intervention based on the client's needs and intervention intensity. Guidance on therapist skills and the role of the key worker are also covered.

Guidance for provision of Tier 4 services in Wales

The Welsh Government also published guidance for drug services involved in the provision of 24-hour care (Welsh Government 2011d). The guidance provides information on the current availability of, and criteria for admission to registered in-patient facilities for detoxification, stabilisation and rehabilitation. Guidance is also provided on the referral of clients and the assessment, management, and clinical governance of Tier 4 services.

¹²⁷ See: <http://www.nta.nhs.uk/recovery-consultation.aspx>

Guidance on Community Prescribing in Wales

Further guidance on the planning, management and delivery of community prescribing have been published, aimed at all service providers in order to benefit service users and their families in Wales (Welsh Government 2011e). Guidance outlines which prescribing regimes should be offered, the legal obligations associated with prescribing, and how to undertake comprehensive client assessment. The guidance encourages the creation of a single point of access and details the delivery of community prescribing and criteria for home and community detoxification. Specific details on delivery of maintenance programmes, supervised consumption, prescribing for vulnerable groups, and aftercare are also provided.

Guidance to reduce unplanned dropout from substance misuse services

Public Health Wales (2010) published guidance to reduce unplanned dropout from and promote re-engagement with substance misuse treatment services. Two questionnaires were used in gathering information for the guidance; a postal survey to substance misuse services, and a mixed-method questionnaire for service users. The guidance identifies factors influencing unplanned dropout at various stages of the treatment process and the impact that unplanned drop out has on problematic substance users. This includes an increase in levels of injecting, levels of drug use and an increase in criminal activity. A number of recommendations are made demonstrating good practice in keeping users retained in treatment.

Assessment and management of psychosis with coexisting substance misuse

NICE published a clinical guideline addressing psychosis with coexisting substance misuse (NICE 2011) including advice on how to ensure that evidence-based treatments for both conditions are offered and that treatment plans are tailored to the individual's needs (see section 7.4.1).

5.3.2 User involvement

User involvement in the drugs field

Chatwin (2011) explored user involvement in the drugs field and how the UK can learn from experiences elsewhere in Europe. The paper suggests that the NTA's requirement for user involvement in service provision could be viewed as coercive and highlights criticisms that user involvement can be merely a tick-box activity. In contrast, the author shows that autonomous user groups in the Netherlands were able to lobby for policy change and initiate the provision of controversial services such as syringe exchange. Using examples from the Netherlands, Denmark and Sweden, it is suggested that state-sponsored involvement of drug users is not the most effective way of eliciting meaningful user involvement in the development of drug policy and treatment services.

5.3.3 Substance misuse workforce

Management of drug misuse amongst GPs in Scotland

An independent follow-up survey looking at the management of drug misuse amongst Scottish General Practitioners (GPs) in 2008¹²⁸ found that 44% of those surveyed were currently treating drug misusers, a significant decrease from 62% in 2000 (Matheson et al. 2010). The majority of those not treating drug misusers (59%) stated that it was not 'practice policy' to do so. Over one-third (37%) had referred to national guidelines when treating drug

¹²⁸ A survey questionnaire based on a questionnaire used in 2000 (Matheson et al. 2003) was sent to a random sample of one in four Scottish GPs in May 2008. A shorter questionnaire was subsequently sent to non-responders in June and an overall response rate of 60% was achieved, representing 76% of sampled GP practices and almost 40% of all Scottish GP practices.

misusers, most commonly the UK clinical guidelines (DH et al. 2007). This is an increase from 22% in 2000. GPs were more comfortable prescribing methadone at or above the recommended minimum daily dose of 60mg than in 2000. Levels of training in drug dependency remained similar between the two surveys but those who provided an enhanced service were significantly more likely to have received training in the 2008 survey than in the 2000 survey. The authors suggest that the decrease in GP involvement may be a result of the new GP contract introduced in 2004, which encourages GPs to specialise; nevertheless, those who are involved in drug misuse treatment are more likely to have been trained in this area.

Alcohol and drugs workforce in Scotland

The Scottish Government and COSLA¹²⁹ issued a joint statement on supporting the development of Scotland's alcohol and drugs workforce.¹³⁰ The statement is addressed to anyone who has a role in improving outcomes for individuals, families or communities experiencing problematic drug and alcohol use. The purpose of the statement is to:

- set out why action is required to develop the alcohol and drug workforce and to outline the important roles and contributions of those directly involved in workforce development;
- acknowledge the need for strategic leadership and express the responsibilities of decision makers at national and local level; and
- set out learning priorities for all levels of the drug and alcohol workforce.

Data from Scotland show that by February 2010, 2,196 nurses and midwives had completed a non-medical independent prescribing programme allowing them to register as a prescriber. By November 2010, 390 pharmacists had completed the relevant programme (SP WA 24 February 2011, S3W-39212).

Staff characteristics and retention rates amongst clients with a dual diagnosis

Schulte et al. (2010) examined the relationship between characteristics of staff at outpatient addiction services and 90-day retention rates of dually diagnosed (DD) clients.¹³¹ Clients were mostly male (76%), with mood disorders the most common co-existing psychiatric diagnoses. The majority of practitioners were female (66%) and just over one-fifth (22%) stated that they were ex-substance users. Most respondents (93%) reported working with other professionals when treating DD clients. The median work experience with DD clients was seven years and 73% of practitioners had received basic DD training while only three practitioners had received advanced DD training. Level of training had no significant impact on self-ratings of DD competency but the length of work experience was moderately related. Overall, the 90-day retention rate of clients was 48% with a median length of stay of 58 days. Self-referrals and high levels of self-reported DD competency amongst staff significantly decreased the likelihood of treatment dropout. Conversely, alcohol misuse and low job satisfaction were both predictors of a higher risk of dropout.

¹²⁹ The Convention of Scottish Local Authorities. See: <http://www.cosla.gov.uk/>

¹³⁰ See: <http://www.scotland.gov.uk/Resource/Doc/254429/0110090.pdf>

¹³¹ All clients starting treatment in six outpatient treatment centres in North-West England between September 2006 and June 2007 were invited to take part in a formal mental health assessment. A total of 176 out of 187 clients agreed to take the assessment and 124 indicated coexisting mental health problems. The practitioner responsible for each client was approached (n=46) and all took part in the study. Client and staff assessments were carried out and dropout was defined as failure to attend at least two treatment sessions, which were scheduled fortnightly.

Relationship between therapists and substance using clients

Kothari et al. (2010) explored the experiences of therapists working with drug using clients.¹³² An interpretative phenomenological analysis resulted in five super-ordinate themes. The theme of 'finding hope' emerged as therapists often needed to feel hope for an individual in order to help them. Identifying the core meaning of clients' substance misuse was seen as necessary for therapists to understand their clients' addiction and it was vital to maintain a good therapeutic relationship with clients, through keeping connected, in order to achieve positive outcomes. Fear and responsibility emerged as an important theme, as the large amount of responsibility placed on therapists and the vulnerability of their clients often generated fear within them. Therapists also believed that possessing tolerance was beneficial when working with substance-using clients. The authors claim that the results highlight the importance of training and support for clinicians, including a commitment to regular clinical supervision, monitoring of caseloads and collaboration with members of other multidisciplinary teams.

5.3.4 Inpatient and residential treatment

Inpatient versus outpatient opioid detoxification

Day and Strang (2010) report on a randomised controlled trial looking at inpatient versus outpatient opioid detoxification. The study found that 51% of the inpatient group achieved the primary outcome measure, namely successful completion of the medicated detoxification process, compared to 36% of the outpatient group, although this was not statistically significant. There was no significant difference between the two groups for aftercare take-up, but outpatients rated their satisfaction with the treatment process significantly higher than the inpatients did. After one month 19% (n=13) of participants were heroin free although two of these had recommenced opioid substitution treatment. After six months, 16% were heroin free (n=11); 23% of inpatients and 15% of outpatients although these differences were not significant. The authors conclude that, while the study showed no advantages for inpatient rather than outpatient detoxification in medium term outcomes, a larger trial that is sufficiently powered to detect differences between the settings is needed.

5.3.5 Alternative types of treatment

Effectiveness of supported one-to-one model of community opiate detoxification

Shaw (2010) evaluated the effectiveness of a community detoxification intervention with one-to-one support.¹³³ The research highlighted the potential positive outcomes of a one-to-one supported opioid detoxification programme as an alternative to home-based or inpatient detoxification models, in that a comparison of successful completion rates (drug free at completion) were higher than traditional community detoxification models (65% compared to 20%) and almost as high as inpatient models (65% compared to 75%). While only two of the nine participants who were followed-up continued to be drug free one month after leaving the detoxification programme, a lower frequency of drug use after detoxification was observed in the majority of participants. Although participants were generally positive about the intervention, the research found little difference between the participant's desire, anxiety,

¹³² Eight clinical psychologists, who had worked therapeutically with at least three substance users in the last year, were interviewed using semi-structured interview schedules. Participants were recruited via clinical psychology training courses, as trainers or specialist placement providers.

¹³³ The programme involved participants (n=17) residing in a purpose designed, homely environment for the duration of the detoxification with 24 hour support and supervision. They were only permitted to interact with staff and mentors and had no contact with other participants. Post-detoxification, participants were given the opportunity for further support and aftercare. Seventeen participants resident at the programme were interviewed on entry to the programme (pre-detoxification), at the end of the programme (post-detoxification) and one month following. Data on participants' drug use, withdrawal, desire for drugs, anxiety, arousal and depression were collected and analysed, in addition to personal evaluations of the detoxification programme and an assessment of their experiences.

arousal and depression pre- and post- detoxification. The author suggests that the small sample size, high attrition rate and short period between post detoxification interview and the follow up interview are limitations in this study. However, the viability and initial effectiveness of this model of opioid detoxification is highlighted, alongside the need for further research into innovative approaches to drug treatment as an alternative to long-established methods.

Recovery and abstinence

The meaning of abstinence

A study by Neale et al. (2010) used qualitative information to explore drug users' meanings of abstinence.¹³⁴ The authors found that participants adopted "fluid, contingent and context specific interpretations of being drug free" and that they often expressed recovery in terms outside of their drug use such as rebuilding relationships. The concept of abstinence is poorly defined, the authors believe, and there are many strands to the concept within which harm reduction can play an important role.

UK Recovery Academy

A paper by Best et al. (2010b) reported on discussions from a meeting of the UK Recovery Academy.¹³⁵ The authors list and analyse the objections raised by participants about the move to recovery orientated addiction services in the UK.

Addiction careers of heroin and alcohol users

Best et al. (2010a) compared the addiction careers of heroin and alcohol users and the reasons for achieving abstinence.¹³⁶ Thirty-one individuals (12%) had recovered from addiction naturally having no history of contact with formal treatment services. Alcohol only users were significantly more likely to have never accessed formal treatment than drug users, and more females (20.8%) had never accessed formal treatment than males (8.7%). Heroin users reported a heroin career of, on average, 10.5 years with a first quit attempt occurring around 3.5 years after becoming dependent, and access to formal treatment service occurring a further five years later. Alcohol careers were slightly longer, lasting a mean of 16.8 years.

Breaking the habit

A report published by the Centre for Policy Studies¹³⁷ sought to provide evidence of the need to move from a policy of maintaining heroin users on methadone to abstinence based treatment and access to residential rehabilitation. The report used expenditure data to suggest a lack of cost-effectiveness in existing drug policy (Gyngell 2011). The media reported extensively on the report but its findings were criticised by a number of organisations, including DrugScope, for erroneously attributing the full costs of the treatment system to methadone maintenance only.¹³⁸

¹³⁴ The study was based on qualitative interviews with 30 drug users aged between 25 and 49, starting treatment in Southern England. Participants were prompted to expand on treatment goals and meanings of abstinence, being drug free, and recovery.

¹³⁵ See: <http://www.recoveryacademy.org/>

¹³⁶ The fieldwork was completed in two waves, the first gathered data opportunistically from three sites: an addiction conference; reunion meeting for residential rehabilitation centre; and through the magazine, *Addiction Today*. Individuals who had been dependent on alcohol or heroin at some point but had not used for one year were invited to complete a questionnaire. The second wave used an amended questionnaire to provide more detail and was launched at the same conference and distributed through the same magazine. A total of 256 responses were received across the two waves.

¹³⁷ A right of centre think tank that aims to limit the role of government, develop privatisation, ensure low tax and promote families.

¹³⁸ See: <http://www.drugscope.org.uk/ourwork/pressoffice/pressreleases/CPS-report>

5.3.6 Treatment of specific groups

Cost-benefit analysis of specialist substance misuse services for young people

A cost-benefit analysis of drug and alcohol treatment for young people found that, for every £1 spent on substance misuse treatment for young people in England during 2008/09, there was a benefit of £4.66-£8.33 (Frontier Economics 2011). Reductions in offending are largely responsible for the net short-term benefit and, by preventing the escalation of substance misuse, treatment can result in better educational and employment outcomes, increased earnings and provide other long-term benefits. The study utilised published data on trajectories of drug use, data from 24,000 young people in treatment using NDTMS, and previous studies on the social costs of substance misuse.

The treatment experience and needs of older drug users

Ayres et al. (2011) conducted qualitative research with older drug users in Bristol exploring their experiences of and needs for drug treatment.¹³⁹ Participants were interviewed, generating a number of themes: older drug users requiring a service that is clearly separate to younger drug users; older drug users self-medicating, appropriate pain relief for age-related illness and reduced tolerance to pain due to opiate dependency; continued and sustained illegal drug use in addition to prescribed medication; reluctance/apprehension towards detoxification through fear of relapse; and barriers to local drug treatment services outside of primary care because of feelings of anxiety, stigma and shame. The authors concluded that older people in drug treatment require age appropriate local treatment services to provide additional support to prescribing services and recommend that health professionals and staff should be trained in understanding the needs of older drug users. Furthermore, opioid detoxifications should be personalised and carried out at a slower paced regime in order to manage "age related metabolic changes".

A report by the Older Persons' Substance Misuse Working Group of the Royal College of Psychiatrists (RCP 2011) examined the barriers to identification of substance misuse in older people and provided key messages for screening and assessment. The authors conclude that there is a paucity of UK research and evidence on what works in the treatment of substance misuse for older people and that treatment should take into account co-existing physical and psychological conditions. The report provides a framework for the assessment of substance misuse amongst older people and an outline schedule of issues to be covered during the assessment process.

Sex workers

A study looking at the treatment outcomes of street sex workers who misuse heroin¹⁴⁰ found that all women were retained in treatment at one-year follow up (Litchfield et al. 2010). The treatment involved substitute prescribing followed by sexual health interventions, advice, keyworking and psychosocial interventions within a GP-led targeted sex workers' clinic. Only one-third of participants were still involved in sex work at follow-up, although 72% tested positive for heroin. Quality of life increased significantly between baseline and follow-up.¹⁴¹

¹³⁹ Twenty drug users aged between 55 and 66 years were recruited in Bristol between June and September 2009 via a Shared Care service based in GP surgeries, a needle and syringe programme and peers. Inclusion criteria were people aged over 55 who were in oral substitution treatment and/or had illegally bought drugs such as heroin, cocaine or benzodiazepines. Interviews were carried out with all participants and, post-analysis, six interviewees took part in a focus group.

¹⁴⁰ A total of 34 patients were recruited out of 42 patients satisfying the inclusion criteria (female heroin user with physiological addiction to heroin aged over 18 who had offered sex for money in the previous four weeks). All patients entered treatment in a street sex workers clinic in Derby, England between October 2006 and May 2007. An initial assessment was carried out and a follow-up at one year. Quality of life was measured using the Christo inventory, a clinical tool validated for people who misuse drugs.

¹⁴¹ A mean Christo score of 8.97 at one year compared to 12.05 at baseline.

The authors note that abstinence from heroin use is not a precondition for ceasing sex work and suggest that GP-led targeted primary care interventions can improve health and help women stop street sex working.

5.3.7 Addiction to over-the-counter and prescribed medicine

A study into the extent of misuse of prescription-only (POM) and over-the-counter medicines (OTC), and the availability of services to help those dependent on them, found that 9,920 new clients entering structured drug treatment services in England during 2009/10¹⁴² reported problems related to prescription only or OTC medicines (NTA 2011d). The majority of these used 'other opioids' or 'benzodiazepines' and 83% also reported problems with illegal drugs. In terms of age and gender, those who reported use of POM/OTC medicines only, were twice as likely to be female and over the age of 40 years old than those who also had problems with illegal drugs. Most partnerships surveyed reported having some local knowledge in relation to POM/OTC medicines and, where dedicated POM/OTC services existed, they were a valued aspect of the drug treatment system. The report states that the broadening of the *Drug Strategy 2010* (HM Government 2010) to include POM/OTC medicines puts a responsibility on local areas to develop services to assist POM/OTC dependent users to achieve recovery.

A study by Heather et al. (2011) looked at predictors of response to a brief intervention for patients on long-term benzodiazepine prescriptions.¹⁴³ They found that level of dependence did not predict response to the brief intervention but whether benzodiazepines were prescribed by a usual GP or other medical practitioner did, with patients more likely to both reduce and cease use if prescribed by their usual GP.

5.3.8 Further research

Experiences of treatment and care for heroin dependency amongst users, carers and professionals

In a preliminary study of drug users, carers and professionals in a Northern Ireland Healthcare Trust,¹⁴⁴ Braden et al. (2010) found that participants shared experiences of treatment and care for heroin dependency. Common issues reported from the focus group were the experience of stigmatisation, perceived judgemental responses from healthcare professionals and unpredictable and limited service availability. The following themes emerged from the research: treatment experiences; unhelpful and stigmatised care exposure; helpful experiences (drug treatment experiences, self help support groups, support for carers); treatment and care aspirations; influential advice; and professional training needs.

Theories of behavioural change

Webb et al. (2010) reviewed ten theories of behavioural change and assessed how applicable they are for the field of addiction. They suggest that theory can be used to identify targets for intervention and the authors encourage researchers and practitioners to recognise the value of behavioural change theory when developing interventions.

¹⁴² Data are from NDTMS.

¹⁴³ Patients who had been receiving prescriptions for benzodiazepines for over six months were identified in seven GP practices in one area in North England. Of the 591 eligible participants identified, 284 agreed to take part and were randomised to either a consultation group or letter group. The consultation group were invited to a GP consultation and provided with a self-help booklet and leaflet. The letter group were sent a letter asking them to consider gradually cutting down on their dose.

¹⁴⁴ Three separate purposive samples of seven ex/current heroin users, four family carers, and four health/social care professionals were selected via voluntary participation. A focus group methodology was used and data collection was carried out between May and August 2007.

Survey instrument for assessment of drug dependency

A prospective study¹⁴⁵ was conducted to determine the validity of a survey instrument designed to assess dependent drug use amongst clients seeking drug treatment (Uddin et al. 2010). The self-complete survey was constructed by adapting a five question instrument which has previously been used by the Office for National Statistics (ONS). It was reported that the survey could be used as a time-saving alternative to carrying out detailed interviews with clients and suggested that further research should be undertaken to determine its usefulness with non-opiate users.

5.4 Characteristics of treated clients (TDI)

The Treatment Demand Indicator (TDI) records the number of clients presenting to a treatment centre in a particular year but does not provide information on clients who remain in treatment without starting a new treatment episode.¹⁴⁶ Data presented are from the National Drug Treatment Monitoring System in England, the Scottish Drug Misuse Database, the Welsh National Database for Substance Misuse¹⁴⁷, and the Northern Ireland Drug Misuse Database. Data are presented for the UK as a whole unless otherwise stated.¹⁴⁸ Continuous national data are available from 2003/04.

5.4.1 Treatment centres

In 2009/10, 127,893 individuals presented to drug treatment in the United Kingdom, the majority of whom (93%) were seen in outpatient centres (Table 5.1). This is an eight per cent decrease on the previous year (n=139,390) and the lowest number since 2004/05.

Table 5.1: Presentations by centre type in the United Kingdom, 2003/04 to 2009/10

Centre type		2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Outpatient	n	91,659	111,434	121,202	120,226	123,850	131,532	119,065
	%	91.9	94.6	94.4	93.8	93.8	94.4	93.1
GP*	n	3,966	3,402	3,833	4,303	3,833	4,151	4,988
	%	4.0	2.9	3.0	3.6	2.7	3.0	3.9
Inpatient	n	4,038	2,945	3,411	3,679	4,320	3,707	3,840
	%	4.0	2.5	2.7	2.8	3.3	2.7	3.0
Total	n	99,663	117,781	128,446	128,208	132,003	139,390	127,893
	%	100	100	100	100	100	100	100

*Data for 2008/09 are for England only; data for other years include Scotland

Source: Standard Table 34

Previous treatment

Fifty-six per cent of those presenting to treatment had been previously treated. Those presenting to GP treatment were more likely to have been previously treated (75%) than those presenting to outpatient treatment (55%), reflecting the greater proportion of opiate users in the GP client base (Table 5.2). Indeed, data show that 71% of primary opiate users had been previously treated compared to 27% of primary cannabis users and 31% of primary cocaine powder users.

¹⁴⁵ This sub-study was carried out within a wider research project comparing methadone and buprenorphine (see section 5.5.2). Participants were recruited from the wider trial (n=47) and were asked to self-complete five yes or no questions on a quantitative survey, based on an ONS questionnaire, which was designed to measure drug dependence. The survey took five to ten minutes to complete. Participants were then interviewed on a one-to-one basis and asked quantitative questions about their drug dependence using a standard ONS interviewer-administered questionnaire. Participants were also screened for recent drug use through urine analysis.

¹⁴⁶ For further information about the TDI, please see the TDI Protocol document available at: <http://www.emcdda.europa.eu/html.cfm/index65315EN.html>

¹⁴⁷ Data from Wales include less structured treatments.

¹⁴⁸ Percentages quoted are valid percentages. Where missing data are substantial, this has been stated in the text.

5.4.2 Characteristics of treated clients (TDI)

Source of referral

Clients were most likely to be self-referred (30%) or referred from criminal justice agencies (28%). Clients who had never been previously treated were less likely to have been referred by criminal justice sources (24%). Females accounted for just over one-quarter (26%) of all treatment presentations but accounted for 46% of referrals from social services. Conversely, females accounted for only 17% of referrals from the criminal justice agencies and the proportion of female clients referred from criminal justice agencies was much lower than males (18% compared to 31%).

Age

The mean age of those presenting to treatment in 2009/10 was 32.9 years old and was lower amongst first ever treatments (31.6 years). One-fifth of all clients (19.8%) presenting to treatment were over the age of 40 years old, an increase from 18.0% in 2008/09, 17.0% in 2007/08 and 12.2% in 2003/04 representing an ageing PDU population (see section 4.2.1). Different drugs have different client age profiles (see 2010 UK Focal Point Report).

Primary cannabis users are much younger than other primary drug users with over two-thirds (69%) aged under 24 years old compared to 27% of all treatment presentations. However, the proportion of primary cannabis users in the youngest age group, under 15 years old, had decreased from 11.8% in 2008/09 to 10.2% in 2009/10, the lowest proportion since continuous national data have been available. Despite an overall increase in cannabis presentations to treatment in 2009/10 (see Table B.1, Appendix B), the number of clients aged under 15 years old decreased by eight per cent from 2,693 in 2008/09 to 2,469 in 2009/10.

Drugs used

The majority of clients (61%) presenting to drug treatment in 2009/10 were primary opiate users and this increases to 91% amongst GP clients. Twenty per cent of all clients were primary cannabis users, eight per cent primary cocaine powder users and five per cent primary crack cocaine users (Table 5.2).

Table 5.2: Presentations to treatment by primary drug and centre type in the United Kingdom, 2009/10

Drug	Outpatients		Inpatients		GP*		Total	
	n	%	n	%	n	%	n	%
Amphetamines	3,568	3.1	65	1.7	68	1.4	3,701	3.0
Benzodiazepines	2,324	2.0	59	1.6	70	1.4	2,453	2.0
Cannabis	23,860	20.8	78	2.1	174	3.6	24,112	19.6
Cocaine powder	9,159	8.0	162	4.3	41	0.8	9,362	7.6
Crack cocaine	5,106	4.5	324	8.7	87	1.8	5,517	4.5
Opiates	67,413	58.9	3,007	80.6	4,395	90.5	74,815	60.8
Other	3,094	2.7	37	1.0	21	0.4	3,152	2.6
<i>Sub Total</i>	<i>114,524</i>	<i>100.0</i>	<i>3,732</i>	<i>100.0</i>	<i>4,856</i>	<i>100.0</i>	<i>123,112</i>	<i>100.0</i>
Not Known	4,541		108		132		4,781	
Total	119,065		3,840		4,988		127,893	

Source: Standard Table 34

The proportion of presentations by primary drug differs between countries within the UK. While primary opiate users account for the majority of treatment presentations in England, Scotland and Wales, they account for only 12% of treatment presentations in Northern Ireland (Table 5.3). In Northern Ireland, cannabis users are the largest group accounting for 40% of treatment presentations in 2009/10 followed by benzodiazepine users (24%).

Benzodiazepines treatment presentations in Scotland (8%) account for a lower proportion of all treatment presentations than in Northern Ireland although more than in England (1%) or in Wales (3%). In Wales seven per cent of presentations are primary amphetamine users, higher than cocaine powder presentations and accounting for a larger proportion than elsewhere in the UK.

Table 5.3: Presentations to treatment by primary drug and country in the United Kingdom 2009/10

Drug	England		Northern Ireland		Scotland		Wales		UK	
	n	%	n	%	n	%	N	%	n	%
Amphetamines	2,626	2.6	13	0.7	115	1.4	947	7.1	3,701	3.0
Benzodiazepines	985	1.0	446	24.4	675	8.4	347	2.6	2,453	2.0
Cannabis	19,650	19.7	735	40.1	1,193	14.9	2,534	19.0	24,112	19.6
Cocaine powder	8,096	8.1	158	8.6	427	5.3	681	5.1	9,362	7.6
Crack cocaine	5,385	5.4	1	0.1	27	0.3	104	0.8	5,517	4.5
Opiates	61,232	61.3	215	11.7	5,423	67.5	7,945	59.5	74,815	60.8
Other	1,928	1.9	263	14.4	170	2.1	791	5.9	3,152	2.6
<i>Sub Total</i>	<i>99,902</i>	<i>100.0</i>	<i>1,831</i>	<i>100.0</i>	<i>8,030</i>	<i>100.0</i>	<i>13,349</i>	<i>100.0</i>	<i>123,112</i>	<i>100.0</i>
Not known	2,626		13		115		947		3,701	
Total	100,829		1,831		10,264		14,969		127,893	

Source: Standard Table 34

First ever treatment clients

While cannabis users account for 20% of all presentations to treatment in 2009/10 (Table 5.2), they account for one-third (33%) of first ever treatments. Similarly, primary cocaine users account for a higher proportion of first ever treatments than all treatments (12.4% compared to 7.6%). Only 40% of first ever treatment clients are primary opiate users compared to 61% of all treatment clients, although this still represents over 17,000 clients (Table B.2, Appendix B).

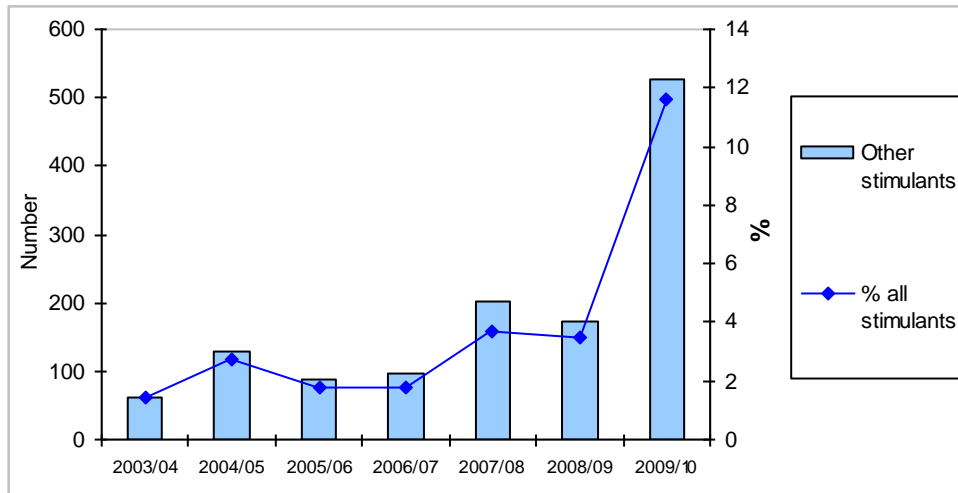
Other stimulant users

In 2009/10 there were 528 clients with primary use of 'other stimulants'. While this is only a small number, representing 0.4% of the total clients presenting for treatment, it is a large increase from 173 clients the previous year and accounts for 12% of all primary stimulant users,¹⁴⁹ up from four per cent the previous year (Figure 5.1). Eighty-four per cent of these clients had never been treated before and just over half (53%) were aged 19 years or under with 82% aged under 34 years old. Analysis of the 'other stimulant' group in England shows that 43% of presentations were for an unspecified stimulant. Of the presentations where an individual drug was identified, 47% were for khat use, 36% for mephedrone use, and 10% for methamphetamine use.

A further 358 clients were secondary users of 'other stimulants', a large increase from 145 the previous year. The majority (60%) of secondary users of other stimulants were primary cannabis users up from 40% in 2008/09 and representing a four-fold increase in number amongst primary cannabis users.

¹⁴⁹ The TDI stimulant group includes amphetamines, MDMA and other derivatives and other stimulants excluding cocaine.

Figure 5.1: Number of clients presenting to treatment with primary use of 'other stimulants' and percentage of all primary stimulants in the United Kingdom 2003/04 to 2009/10

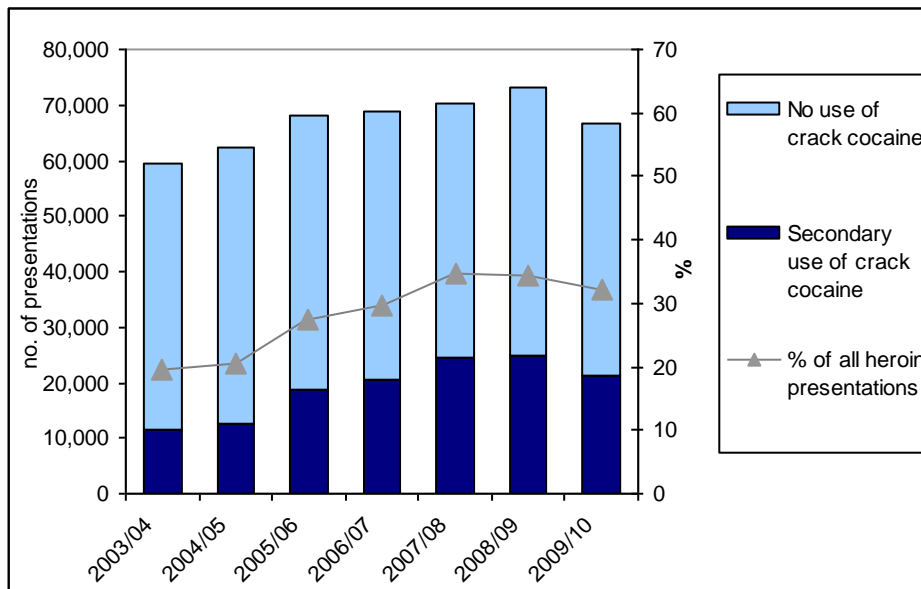


Source: Standard Table 34

Heroin users

In 2009/10 primary heroin users accounted for 89% of all presentations to treatment for primary opiate use. Clients aged over 40 years old now account for 21.9% of all heroin presentations up from 19.2% in 2008/09, 17.3% in 2007/08 and 10.3% in 2003/04. Around one-third (32.0%) of primary heroin clients report secondary use of crack cocaine. This proportion increased from 19.5% in 2003/04 to 34.6% in 2007/08, remaining stable in 2008/09 before decreasing slightly in 2009/10 (Figure 5.2).

Figure 5.2: Number and percentage of primary heroin presentations reporting secondary use of crack cocaine in the United Kingdom, 2003/04 to 2009/10



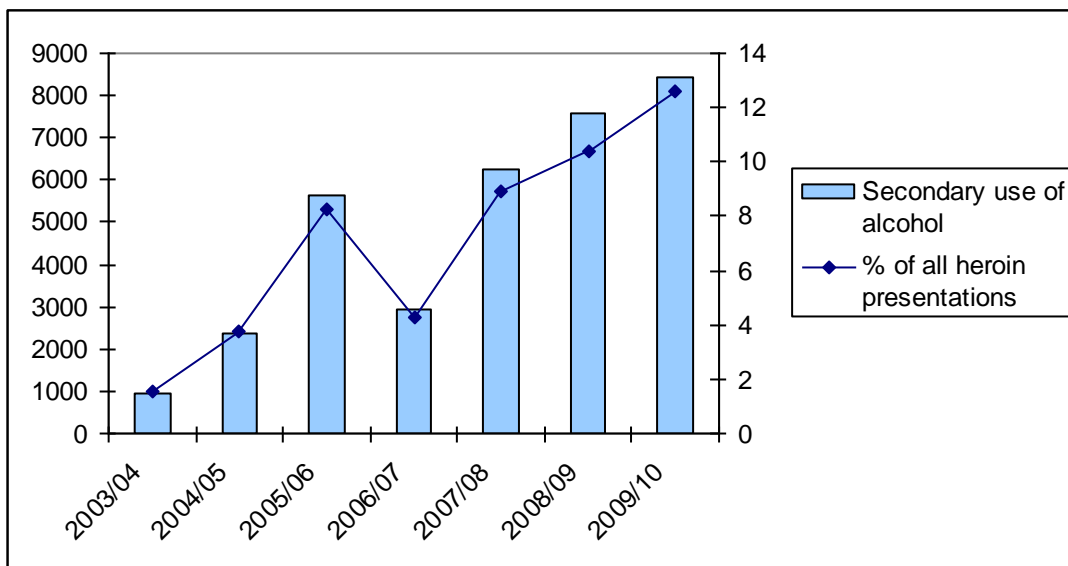
Source: Standard Table 34

There was also a decrease in the proportion of primary heroin users reporting current injecting (from 34.3% in 2007/08 and 31.8% in 2008/09 to 26.7% in 2009/10) and an increase in heroin users reporting that they have never injected (from 30.7% and 30.9% in 2007/08 and 2008/09 respectively to 34.5% in 2009/10). However, prevalence of current injecting is relatively stable for first ever treatments at around 28 to 29% and there has been

no change in the proportion of first ever primary heroin using clients reporting that they have never injected (43% in each of the last three years).

While the decrease in secondary crack cocaine use and current injecting amongst all heroin clients may suggest a reduction in risk behaviour, the increase in secondary alcohol use may cause concern, particularly given that alcohol is mentioned in one-third of all drug-related deaths in England and Wales (ONS 2011). Data show that 8,426 primary heroin clients reported problems with alcohol in 2009/10, an 11% increase on the previous year and representing 13% of all primary heroin presentations. This has increased from two per cent of all heroin presentations in 2003/04 (Figure 5.3). However, it is unclear whether this reflects a changing trend in poly-substance use and the growing prevalence of alcohol-related harm in the general population (NWPHO 2011) or whether there has been an increased focus by commissioners and treatment agencies to record and address problematic alcohol use amongst heroin users. Indeed the UK clinical guidelines for drug misuse and dependence (DH et al. 2007) highlighted the need to screen for and treat alcohol dependence amongst drug misusers and the increased prevalence of secondary alcohol use within treatment data occurs after publication of these guidelines in 2007. Furthermore a study referred to in the clinical guidelines, which was published in 2007 (Senbanjo et al. 2007) suggests that one-third of those receiving methadone had a current alcohol problem, higher than the levels recorded within TDI data and suggesting therefore that an increase in prevalence is not wholly responsible.

Figure 5.3: Number of reports of secondary alcohol use amongst primary heroin users and percentage of all heroin clients reporting secondary alcohol use in the United Kingdom, 2003/04 to 2009/10



Source: Standard Table 34

Amongst those presenting to treatment for primary opiate use in the United Kingdom during 2009/10, 11% reported secondary use of benzodiazepines. However, the proportion is much higher in Scotland where 37% of those presenting for primary opiate use reported secondary use of benzodiazepines. This compares to seven per cent of primary opiate presentations in Wales (ST34).

Crack cocaine users

A higher proportion of primary crack cocaine than primary heroin presentations are aged over 40 years old (29% compared to 22%, respectively). Sixty per cent of primary crack cocaine users presenting to treatment in 2009/10 had been treated previously and 36%

reported secondary heroin use. One-fifth (21%) of primary crack cocaine users reported ever injecting but only five per cent reported current injecting. Overall, 22% of all clients presenting to treatment (n=28,318) were crack cocaine users, of whom 19% were primary crack cocaine users.

Injecting status and route of administration

Fifty-two per cent of clients had never injected drugs, a similar proportion to the previous year (53%). Of the 18,646 clients reporting current injecting, 94% were primary opiate users and two per cent were primary amphetamine users. Females were less likely than males to report injecting as their usual route of administration; 29.6% of female primary opiate users and 15.2% of female primary amphetamine users reported injecting compared to 35.3% and 27.0% of males, respectively.

Living and labour status

Data on living and labour status of clients are reported in sections 8.2.1 and 8.2.2.

5.4.3 Trends in clients presenting for drug treatment

Opiate users

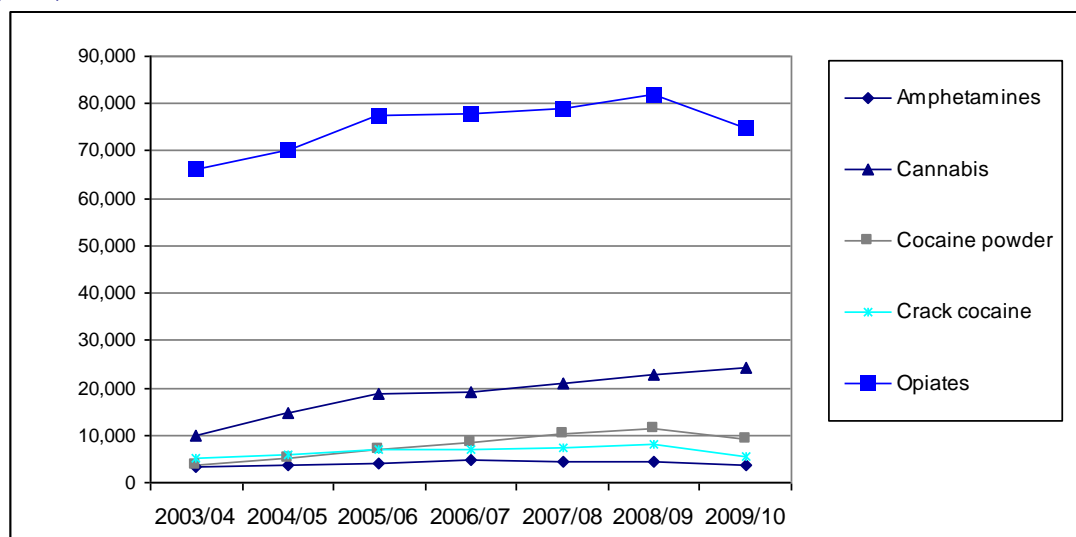
Data show that there was a large increase in the number of opiate clients presenting to treatment between 2003/04 and 2005/06 from 66,012 to 77,580 (18% increase) with numbers then remaining stable until a four per cent increase was reported in 2008/09. This was followed by a 14% decrease in 2009/10 to below 2005/06 levels (n=74,815). Nevertheless, the number of first ever clients who were primary opiate users remained stable between 2008/09 and 2009/10 suggesting that the incidence of those requiring help for opiate misuse remains similar to the previous year.

Cocaine powder users

For the first time since continuous national treatment data were available in 2003/04, primary cocaine powder presentations decreased from 11,446 in 2008/09 to 9,362 in 2009/10, representing a 22% decrease (Figure 5.4; Table B.1, Appendix B). There was a similar decrease amongst first ever presentations to treatment (19%) and data from England show that there was a 12% decrease in the number in treatment between 2008/09 and 2009/10 (NTA 2010b). Analysis by age group shows that the largest reduction in cocaine powder presentations was amongst the younger age groups (27% amongst those aged under 25 years, 15% amongst those aged 25 to 39 years and 4% amongst those aged over 40 years). Consequently, the proportion of all cocaine powder presentations that are aged under 25 years old decreased from 38% to 34%.

Presentations to treatment for primary crack cocaine use also decreased in 2009/10 by 31% from 7,985 in 2008/09 to 5,517 while first ever primary crack cocaine presentations decreased by a similar percentage (32%). Including secondary crack cocaine users, presentations to treatment decreased by 19%.

Figure 5.4: Trends in the number of clients presenting for treatment for individual drugs in the United Kingdom, 2003/04 to 2009/10



Source: Standard Table 34

As figure 5.4 shows, presentations to treatment for primary cannabis use continue to increase and now account for one-third of first ever presentations compared to just under one-fifth in 2003/04 (Table B.1, Appendix B). Over this time, the number of first ever and all primary cannabis presentations has more than doubled. This is despite a clear trend downwards in cannabis use over this period as measured by general population household surveys (see section 2.2).

5.5 Clients in treatment

5.5.1 Treatment prevalence

Data on clients in treatment are currently only available from England and Wales. Scotland has started collecting data on individuals in treatment through the Scottish Drug Misuse Database (SMR25b form) and it is anticipated that the first release of this follow-up data will be available in 2012.

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

In 2010/11 there were 204,473 individuals aged over 18 years in drug treatment in England (NTA 2011e), a one per cent decrease from the previous year ($n=206,889$) and a 16% increase since 2005/06 ($n=175,869$). The treatment system remains dominated by opiate and crack cocaine users; 49% of clients in treatment during 2010/11 were primary opiate only users, 32% primary opiate/crack cocaine users, and three per cent primary crack cocaine only users. Primary cannabis users accounted for seven per cent of all treatment clients, although this rises to 28% amongst those aged 18 to 24 years.

The number of over 40s in treatment increased by 80% between 2005/06 and 2010/11 and, in 2010/11, 29% per cent of all treatment clients were aged over 40 years old, 89% of whom were opiate and/or crack cocaine users. This compares to 18% and 83% respectively in 2005/06. The number of 18 to 24 year olds in treatment decreased by 25% over this period with a 46% decrease in the number of opiate and/or crack cocaine users of this age.

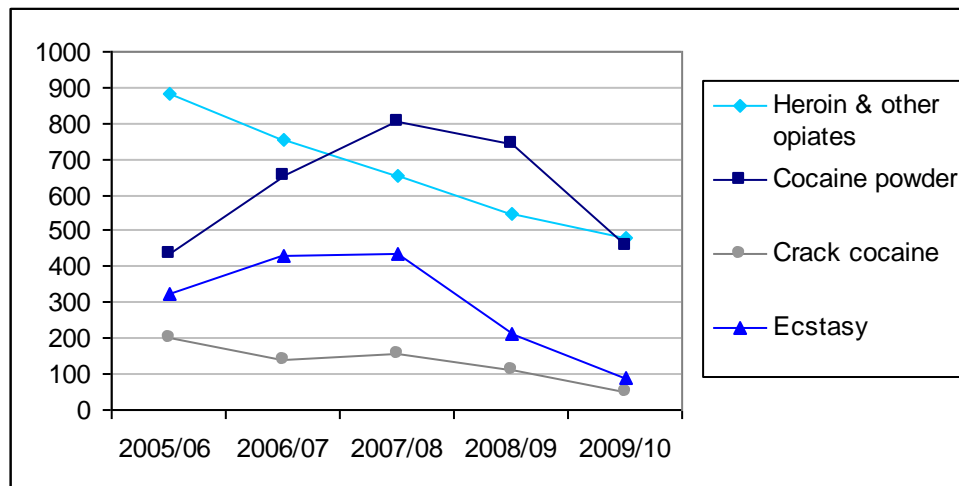
The most common treatment pathway for treatment clients in 2010/11 was prescribing only, which is defined to include basic psychosocial support through keyworking. Around one-half of clients in treatment ($n=100,822$) received this intervention. The next most common pathway was prescribing and psychosocial, received by 14% of clients.

An analysis of six years' data between 2005/06 and 2010/11 shows that of the 341,741 individuals receiving treatment over this period, 39% were still in treatment at the end of 2010/11, 36% had exited treatment without completing and 25% had successfully completed treatment. Primary cocaine powder users were most likely to have completed treatment over this period (48%) followed by primary cocaine powder users (44%). However, similar proportions had exited treatment without completing the programme. Those using opiates only (19%) and opiates and/or crack cocaine (15%) were least likely to have completed treatment. However, opiate users were less likely to have exited with treatment incomplete and more likely to be retained in treatment at the end of 2010/11 than other drug users.

Young people in treatment in England

NDTMS data show that 23,528 young people under the age of 18 were in treatment in England during 2009/10, a two per cent decrease from 2008/09 (n=24,053) (NTA 2010a). Cannabis continues to be the drug for which treatment is most commonly sought, 56% of those in treatment were primary cannabis users in 2009/10; the same proportion as in 2005/06. While the number in cannabis treatment continues to rise (4% increase in 2009/10), the number of under-18s receiving treatment for primary heroin or crack cocaine use has fallen each year for the last five years (Figure 5.5). After a large increase between 2005/06 and 2007/08, the number of under 18s seeking treatment for cocaine powder use has fallen back to 2005/06 levels.

Figure 5.5: Numbers of under 18s in treatment for individual Class A drugs in England, 2005/06 to 2009/10



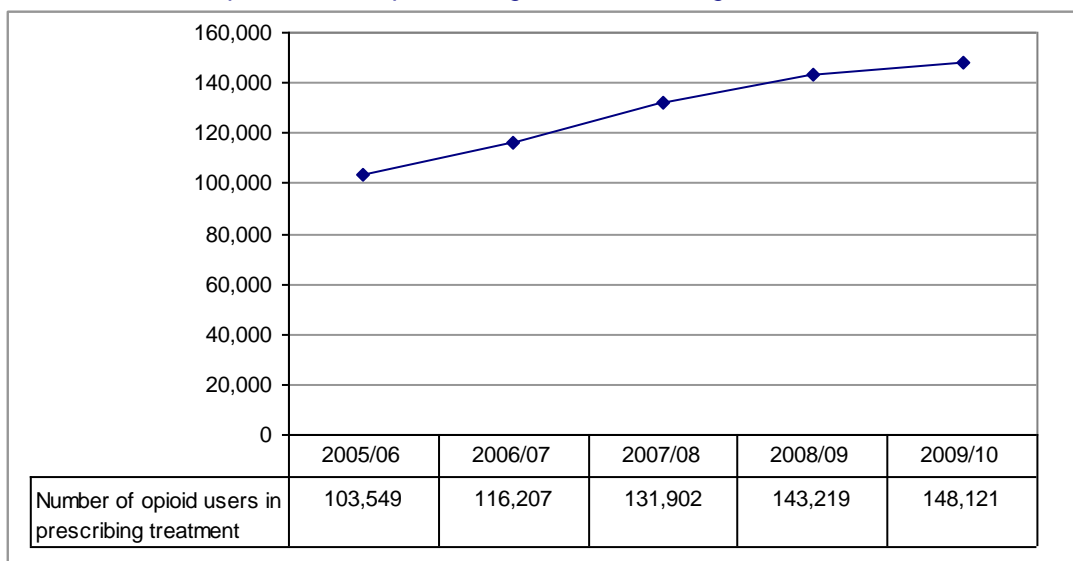
Source: NTA 2010a

5.5.2 Substitution treatment

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

Data from the NDTMS show that in 2009/10 there were 148,121 opioid users in prescribing treatment (ST24), an increase of three per cent from the previous year and a 43% increase since 2005/06 (Figure 5.6).

Figure 5.6: Number of opioid users in prescribing treatment in England, 2005/06 to 2009/10



Source: NDTMS

Analysis shows that 62% of those in prescribing treatment had been receiving treatment for over 12 months with almost one-quarter (23%) receiving prescribing treatment for over four years.¹⁵⁰

Data from the Welsh National Database for Substance Misuse

In Wales during 2009/10 there were 1,828 clients in opioid substitution treatment¹⁵¹ (OST). Data show that 81% of those in OST received methadone and 22% received buprenorphine (ST24).

Substitution treatment in Northern Ireland

Data from Northern Ireland show that in 2009/10, 543 clients received opioid substitution treatment, a 12% increase on the previous year (n=487). Half of the clients received methadone, with 48% receiving buprenorphine and two per cent receiving dihydrocodeine (ST24).

Research on opioid substitution treatment

A field comparison of buprenorphine versus methadone

Pinto et al. (2010) compared the effectiveness of buprenorphine (BMT) and methadone maintenance treatment (MMT) and examined the beliefs of clients about these drugs.¹⁵² They found that clients selecting BMT were significantly less likely than MMT clients to be retained in treatment or to have completed detoxification (primary outcome measure) at six

¹⁵⁰ See: <http://www.nta.nhs.uk/news-expertgroup-2010.aspx>. Data differ from that provided in Figure 5.6 as it includes all clients in prescribing services not just opiate users. Data provided to the EMCDDA are also based on an episode rather than journey definition.

¹⁵¹ As 2009 was the first year that opioid substitution treatment data started being collected, in some cases the data collection has not been complete. Therefore it is not possible to calculate the proportion of opiate users in opiate substitution treatment.

¹⁵² A total of 361 clients (89% of those eligible) presenting for maintenance treatment between October 2005 and October 2007 were recruited from three sites within a community drug service in Norfolk, England. Allocation to the two drugs was by patient preference with 63% choosing methadone and 37% choosing buprenorphine. Detailed baseline data were collected and a questionnaire regarding clients' knowledge and beliefs about the drugs was completed. The primary outcome was retention in treatment at six months or successful detoxification. Use of opioids was based on the first urine toxicology report each month.

months, 50% compared to 70%. However, BMT clients were more likely to have completed detoxification after six months (7.5% compared to 0.3%) and the odds of having opiate negative urine samples were significantly higher for the BMT group than for the MMT group. There was a relationship between methadone dose and retention in treatment, with higher doses yielding improved retention but the same effect was not detected for buprenorphine, with doses above 8mg not impacting on retention. Clients in both groups had similar beliefs about buprenorphine but differed in their views on methadone, with those choosing BMT stating that methadone would make them less clear-headed, more drowsy, more likely to crave heroin and be harder to stop use, therefore replacing one addiction with another. Ten per cent of the study participants stated that they would not have accessed treatment if methadone was the only option.

Comparison of methadone and Suboxone® in applied treatment settings

A study comparing the merits of methadone and Suboxone® in drug treatment¹⁵³ (Tanner et al. 2011) found that participants generally viewed Suboxone® more positively than methadone. Participants reported that Suboxone® enabled clearer thinking, increased personal confidence and had less stigmatisation attached to it than methadone. However, the negative consequences of clearer thinking were also evident, such as boredom and the inability to deal with thoughts; therefore, increased therapeutic services may be required to support clients. The authors conclude that switching clients to Suboxone® from methadone could be part of a recovery journey and may aid with the social reintegration process. However, any transition should be accompanied by psychosocial support.

UKCBTT study

Kouimtsidis et al. (2011) reported on process measures from the United Kingdom cognitive behavioural therapy study in methadone maintenance treatment (UKCBTMM),¹⁵⁴ which compared outcomes of clients receiving methadone maintenance treatment (MMT) only with those receiving MMT and cognitive behavioural therapy (CBT). Using tools to measure clients' ability to cope with problems, self-efficacy and outcome expectancies, the authors found differences between the two groups with those receiving CBT more likely to have increased problem solving skills in some but not all of the domains measured. However, many of the differences were not statistically significant and the authors suggest that no definite conclusions can be taken from the study.

Cognitive functioning amongst drug users in maintenance substitution treatment

King and Best (2011) conducted a study into levels of cognitive function and drug use history amongst problem drug users in Birmingham, England.¹⁵⁵ The study assessed the criminal thinking, impulsivity and IQ of offending drug users in treatment. The authors concluded that there was some evidence of higher methadone dose being linked to lower cognitive

¹⁵³The study was a service audit of treatment preferences using two opportunistic data sources: structured interviews with nine service users, six of whom had used both methadone and Suboxone®; and written narrative accounts of users' experience with both drugs and the transition between the two by a group of 12 individuals who had been switched from methadone to Suboxone® and were still in treatment. The study took place in Lanarkshire, Scotland.

¹⁵⁴ Sixty clients were randomised to methadone maintenance only (MMT) or methadone maintenance and cognitive behavioural therapy (CBT) after being stabilised on methadone (1 to 6 months in treatment). Participants were aged between 18 and 70 years old and had an ICD-10 diagnosis of opiate dependence. Outcomes were taken at one year with an interim assessment at six months (Drummond 2004). Treatment process measure tools used were the Coping Response Inventory, the Drug Taking Confidence Questionnaire and a tool measuring outcome expectancies from reduced heroin use using a 22 item scale.

¹⁵⁵ A sample of 30 problem drug users attending two community drug services in Birmingham, England was recruited opportunistically. A research questionnaire was administered by an interviewer followed by an intelligence test (Wechsler Abbreviated Scale of Intelligence).

functioning. This, they argue, may have implications for the delivery of structured psychosocial interventions to clients in treatment with lower cognitive functioning.

5.5.3 Treatment engagement

It is estimated that, in 2009/10, over half of opiate and crack cocaine users (57%) in England were in structured treatment, with the proportion rising to 63% for opiate users. Crack cocaine users (39%) are less likely to be in treatment than opiate users but the proportion has increased since 2005/06, when an estimated 25% of crack cocaine users were in treatment (Table 5.4).

Table 5.4: Opiate and crack cocaine users in drug treatment in England 2005/06, 2006/07, 2008/09 and 2009/10

	PDU estimates (2005/06)			PDU estimates (2006/07)			PDU estimates (2008/09)			PDU estimates (2009/10)		
	n	n	%	n	n	%	n	n	%	n	n	%
Opiate and/or crack cocaine users	332,090	146,981	44.3	328,767	167,396	50.9	321,229	175,673	54.7	306,150	173,760	56.8
Opiate users	286,566	139,544	48.7	273,123	158,988	58.2	262,428	167,256	63.7	264,072	167,200	63.3
Crack cocaine users	197,568	49,728	25.2	180,618	60,103	33.3	188,697	74,598	39.5	184,247	71,162	38.6

Source: Standard Table 07; NTA 2010b

5.6 Treatment outcomes

Measuring reliable change amongst those receiving substance use treatment

A paper by Marsden et al. (2011) compared the performance of the Jacobson and Truax (JT) reliable change index with three alternative methods for detecting clinical change in individuals receiving treatment for substance use.¹⁵⁶ The aim of the analysis was to find a way to report individual outcomes rather than grouped descriptive statistics. Results from the study suggested that the JT reliable change index was more conservative than the other methods in assigning clients to the 'improved' category and that there was no evidence of inferiority of the JT method when comparing effect size, level of agreement and classification performance. The authors conclude that treatment evaluators should go beyond effect size reporting and report on the pattern of individual change. They suggest that the JT reliable change index is appropriate for carrying this out.

Aftercare participation and treatment outcomes

An analysis of data from the Drug Outcome Research in Scotland (DORIS) study, undertaken between 2001 and 2004,¹⁵⁷ focussed on long-term outcomes of aftercare

¹⁵⁶ Using data from the NDTMS in England recorded using the Treatment Outcomes Profile (TOP), self-reported days of heroin, cocaine or alcohol use at admission and review were analysed using a multi-level, mixed-linear model. Differences in performance were assessed by the proportion assigned to an 'improved', 'unchanged' or 'deteriorated' category, level of agreement, difference in effect size for observed and true scores and receiver operating characteristic parameters.

¹⁵⁷ The DORIS study was a prospective follow-up study of a cohort of 1,007 clients from 33 treatment agencies starting a new episode of drug treatment in Scotland in 2001-02. Interviews using structured

participation amongst a cohort of drug users starting treatment in 2001/2002 in Scotland (Vanderplasschen et al. 2010). The authors found that aftercare participation following initial treatment appeared to be associated with having a completely drug-free period after eight months (48% compared to 27%) and 33 months (29% compared to 18%) but not after 16 months. The impact of aftercare was greatest amongst those who had started community treatment (other than methadone maintenance) and those who had received treatment in prison. Little additional value was reported after intense residential treatment. The authors conclude that aftercare should be an integrated part of treatment.

questionnaires were carried out at baseline, eight months, 16 months, and 33 months. Data analysed for the aftercare participation was taken from the 653 individuals who completed all four interviews. Seventy-one per cent were male, the mean age was 27 years and 99.5% were of White ethnic origin. Heroin was the primary drug for over 80% of the sample.

6. Health correlates and consequences

6.1 Introduction

HIV prevalence amongst injecting drug users (IDUs) in the United Kingdom was 1.1% in 2010, similar to levels seen in recent years, and higher than in the late 1990s. In London prevalence has been higher at, or near, four per cent. Prevalence of hepatitis C (HCV) is much higher at around 47% (in England, Wales and Northern Ireland).

Prevalence and attribution of dual diagnosis remain difficult to estimate. Depression, anxiety disorders, personality and psychotic disorders are commonly reported amongst drug users, although prevalence varies with setting and specific sub-populations. It has been suggested that from 1993 to 1998 there were at least 195,000 co-morbid patients and 3.5 million general practitioner (GP) consultations involving such patients in England and Wales.

The impact of maternal drug use on unborn children can be wide ranging and babies can be affected by withdrawal from maternal drug use. In the United Kingdom, there is little evidence of HIV transmission to babies through maternal infection associated with drugs. However, there is a risk of hepatitis transmission, particularly of HCV, where the risk of transmission amongst babies whose mothers test positive is six per cent.

Data on drug-related deaths (DRDs) submitted to the EMCDDA by the United Kingdom are based on three different definitions. The EMCDDA definition refers to deaths caused directly by the consumption of at least one illegal drug.¹⁵⁸ The definition used to measure deaths for the United Kingdom Drug Strategy is where the underlying cause is drug abuse, drug dependence, or poisonings where any of the substances scheduled under the *Misuse of Drugs Act 1971* are involved. The definition used by the Office for National Statistics (ONS) is much wider and includes legal drugs.¹⁵⁹

The Drug Strategy definition has been adopted by the General Mortality Registers (GMRs) across the UK and is a subset of the ONS definition. Information on deaths is also available from a Special Mortality Register (SMR).¹⁶⁰ In the United Kingdom, based on the EMCDDA definition, DRDs rose steadily from 1996, when 1,152 deaths were registered. Following a period of decline between 2001 and 2003, deaths increased again between 2004 and 2008 when they reached their highest level (2,231). Latest figures for 2010 show an eight per cent decrease from the previous year.

6.2 Drug-related infectious diseases

Information on infectious disease is based on that presented in *Shooting Up: Infections among injecting drug users in the United Kingdom 2010* (HPA et al. 2011) and provided to the EMCDDA in Standard Table 09.

6.2.1 HIV/AIDS

The overall prevalence of HIV seen among IDUs in 2010 was similar to that seen in recent years, and remains higher than that found in the late 1990s. The Unlinked Anonymous Monitoring (UAM)¹⁶¹ survey of current and former IDUs in England and Wales indicated an

¹⁵⁸ These deaths are known as 'overdoses', 'poisonings' or 'drug-induced deaths'. See: <http://www.emcdda.europa.eu/themes/key-indicators/drd>

¹⁵⁹ See: ONS (2011) <http://www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/2010/stb-deaths-related-to-drug-poisoning-2010.html#tab-background-notes>

¹⁶⁰ The National Programme on Substance Misuse Deaths (np-SAD) uses data from inquests into drug-related deaths reported by coroners in England, Wales, Northern Ireland, Guernsey, Jersey and the Isle of Man; Procurators Fiscal in Scotland and the Scottish Crime and Drug Enforcement Agency.

¹⁶¹ Data are taken from a voluntary self-reported surveillance questionnaire issued by drug agencies to participants who have ever injected drugs. Participants are also asked to provide an oral fluid

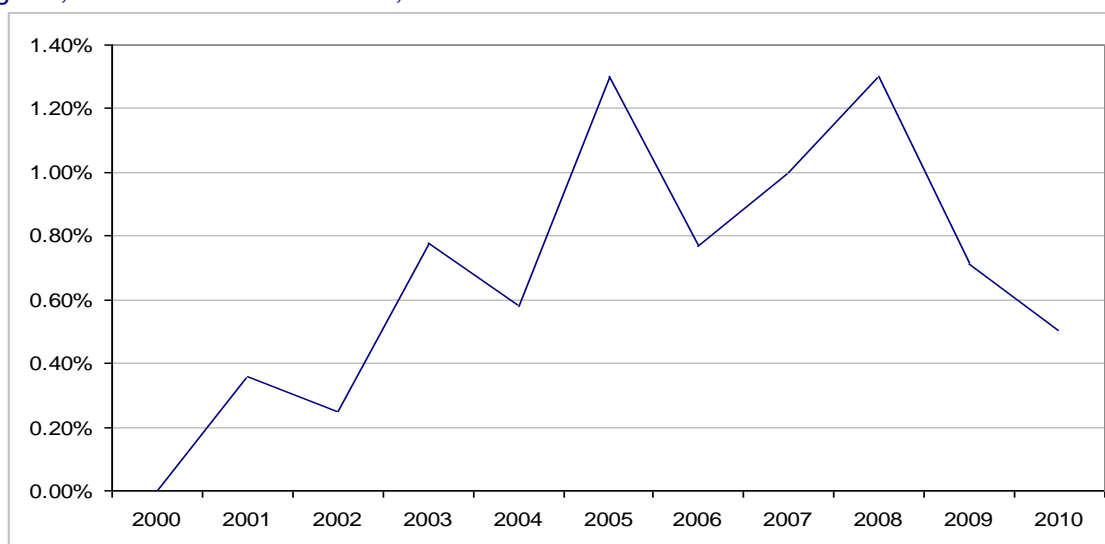
overall HIV prevalence of 1.1% in 2010 (ST09). In 2010 the prevalence was 1.2% among men and 0.8% among women, with prevalence increasing with age from 0.6% among those aged under 25 years to 1.6% among those aged 35 years and over (ST09).

The 2010 prevalence of HIV among the IDUs taking part in the UAM survey across England, Wales and Northern Ireland was 1.1%.¹⁶² Between 2000 and 2010, prevalence varied between 0.76% and 1.6% (HPA 2011a; HPA 2011b). In 2010, no HIV infections were detected in Wales (0%)¹⁶³ or Northern Ireland (0%).¹⁶⁴

In England the HIV prevalence was 1.2%¹⁶⁵ in 2010; this is significantly higher than in 2000 when the prevalence was 0.78%. HIV prevalence among the IDUs taking part in the survey in England was also significantly higher in 2005, 2008 and 2009 than in 2000 (HPA 2011b).

There is also evidence of ongoing HIV transmission amongst IDUs within the UK, and that this might be higher than a decade ago. In particular, the HIV prevalence amongst recent initiates to injecting in England, Wales and Northern Ireland (i.e. those who first injected during the preceding three years) has been elevated since 2003. The prevalence among the recent initiates participating in the UAM Survey in 2010 was 0.5% compared with no infections found among this group in 2000 (HPA 2011a; HPA 2011b; Figure 6.1).

Figure 6.1: Trends in the prevalence of HIV infection among recently initiated injecting drug users in England, Wales & Northern Ireland**, 2000 to 2010*



* Those who started injecting drugs during the three years prior to participating in the survey.

** Includes Northern Ireland from 2002.

Source: Data from UAM survey of IDUs in contact with specialist services.

In Scotland, the prevalence of HIV among IDUs is monitored through the surveillance of people undergoing voluntary confidential HIV testing. A HIV prevalence of 0.4% was found amongst IDUs undergoing testing in Scotland during 2009. This compares with a prevalence

and/or (since 2009) dried blood spot (DBS) sample which is tested for antibodies to HIV (anti-HIV), hepatitis C (anti-HCV) and hepatitis B core antigen (anti-HBc). It is a multi-site survey managed by the Health Protection Agency (HPA) and involving over 70 specialist drug agencies in England, Wales and Northern Ireland. Data on viral infections amongst current and former IDUs, including HCV, hepatitis B and HIV prevalence are collected, in addition to risk/protective behaviours and uptake of healthcare. Data have been collected since 1990 and are irreversibly anonymous.

¹⁶² 95% confidence interval (CI) 0.73%-1.4%

¹⁶³ 95% CI 0%-1.9%

¹⁶⁴ 95% CI 0%-1.9%

¹⁶⁵ 95% CI 0.81%-1.6%

of 1.4% to 3.2% in the early to mid-1990s and 0.3% to 0.9% during the period 1998 to 2008 (HPA et al. 2011; ST09).

The number of new HIV diagnoses in the UK associated with exposure through injecting drug use has been low and relatively stable in recent years, averaging 161 reports each year from 2000 to 2009. Up to the end of June 2011, 141 new HIV diagnoses had been reported in this group for 2010 (43 in London, 18 in Scotland and 80 elsewhere in the UK; HPA et al. 2011).

6.2.2 Viral hepatitis

Hepatitis C

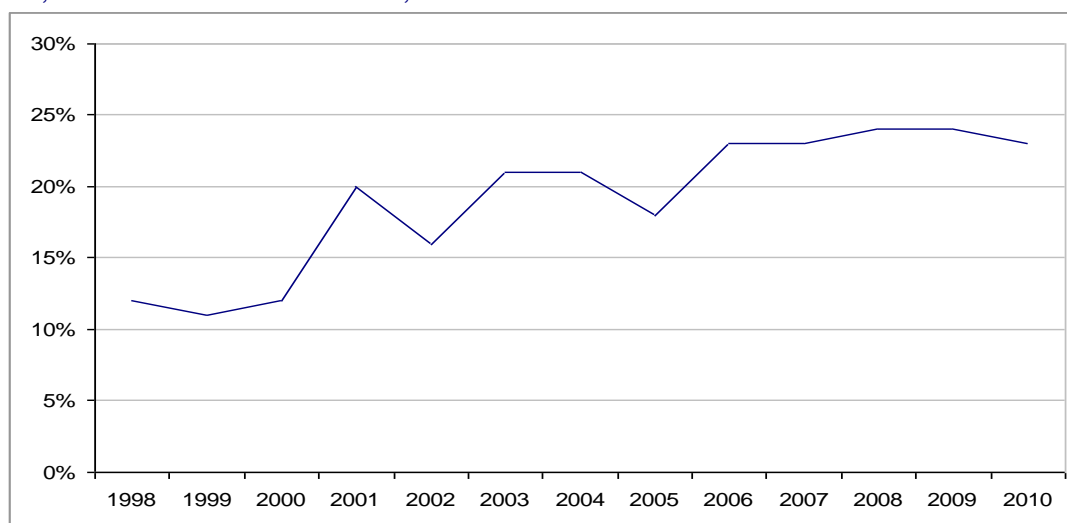
The prevalence of hepatitis C infection amongst IDUs remains high overall (HPA et al. 2010). In 2010, 48% of the (current and former) IDUs participating in the UAM Survey in England and Wales had antibodies to hepatitis C,¹⁶⁶ which is similar to the level seen in recent years (ST09). However, this is higher than the level found in 2000 when prevalence was 38% (ST09). The prevalence in 2010 was 49% among men and 43% among women, and increased with age from 27% among those aged under 25 years to 60% among those aged 35 years and over (ST09).

In 2010, the overall prevalence of antibodies to hepatitis C amongst the IDUs participating in the UAM Survey across England, Wales and Northern Ireland was 47%, this compares to 38% in 2000 (HPA 2011b). In England in 2010 the hepatitis C prevalence amongst the participants in the UAM survey was 49%, however, there were very marked regional variations from 28% in the West Midlands and 29% in the North East to 64% in London and 65% in the North West (HPA 2011b). The prevalence in Wales and Northern Ireland was lower than in many of the English regions; hepatitis C prevalence among the UAM survey participants in Wales was 26%, and in Northern Ireland it was 31% (HPA 2011a).

The prevalence of antibodies to hepatitis C amongst recent initiates in England, Wales and Northern Ireland (those injecting for less than three years) has been elevated in recent years. In 2010, the prevalence amongst recent initiates participating in the UAM Survey from England, Wales and Northern Ireland was 23%, similar to that seen between 2001 and 2009 (HPA 2011b). However, the prevalence among this group remains higher than found was in 2000 and earlier years; it was 12% in 2000 (HPA 2011a; Figure 6.2).

¹⁶⁶Prior to 2009 this survey only collected oral fluid samples, however in 2009 both oral fluid and dried blood spot (DBS) samples were collected from participants. The sensitivity of the test on DBS samples for antibodies to hepatitis C is almost 100%. However, the sensitivity of the oral fluid sample test for antibodies to hepatitis C is about 92%. Results presented are adjusted to allow for the poorer sensitivity of the tests on the oral fluids samples.

Figure 6.2: Percentage of recently initiated injecting drug users* with antibodies to hepatitis C in England, Wales and Northern Ireland**, 1998 to 2010



*Those who started injecting drugs during the three years prior to participating in the survey.

**Includes Northern Ireland from 2002.

Source: Data from UAM survey of IDUs in contact with specialist services.

In Scotland, the estimated prevalence of antibodies to hepatitis C was 57% among current and former IDUs surveyed at needle exchanges across the country as part of the Needle Exchange Surveillance Initiative (NESI) in 2010 (HPA et al. 2011). The prevalence amongst the recent initiates (those who had commenced injecting in the previous three years) was 25% (HPA et al. 2011). These are similar to the levels found in the previous NESI survey in 2008/09 (HPA et al. 2011).

The number of newly diagnosed hepatitis C infections in the UK are principally monitored through laboratory reports rather than through the use of statutory notifications. Whilst data from both of these types of systems have limitations, laboratory reports are regarded as being more useful, although risk factor information is often missing or incomplete. There has been a marked increase in the annual number of new diagnoses throughout the UK; reflecting increased availability and easier access to voluntary confidential testing (see section 7.3.2). In the UK, since reporting began, there have been well over 100,000 reported laboratory diagnoses of hepatitis C infection; with around 90% of these infections thought to be associated with injecting drug use. In 2010, there were 10,381 laboratory diagnoses of hepatitis C infection in the UK: 7,834 in England; 2,129 in Scotland; 312 in Wales; and 106 in Northern Ireland (HPA et al.2011; ST09).

Incidence of hepatitis C amongst IDUs

A recent study combining data from a number of surveys has assessed the incidence of hepatitis C among IDUs in the UK and the impact of needle and syringe programmes (NSP) and opiate substitution therapy (OST) on this (Turner et al.2011). The study pooled data from community surveys undertaken in six areas of the UK (Birmingham, Bristol, Glasgow, Leeds, London and Wales). A total of 2,986 IDUs took part in these surveys between 2001 and 2009. The estimated prevalences and incidences of hepatitis C infection varied by area; prevalence ranged from 26% to 70%, and incidence from 5.6 infections per 100 person years of exposure to 42 infections per 100 person years of exposure. Questionnaire responses were used to define intervention categories for OST (on OST or not) and high NSP coverage ($\geq 100\%$ versus $< 100\%$ needles per injection). The analysis looking at both interventions included 919 subjects with 40 new HCV infections. Both receiving OST and

high NSP coverage were associated with a reduction in new HCV infection.¹⁶⁷ Full harm reduction (on OST plus high NSP coverage) reduced the odds of new HCV infection by nearly 80%.¹⁶⁸ Full harm reduction was also associated with a reduction in self-reported needle sharing by 48%¹⁶⁹ and mean injecting frequency by 20.8 injections per month.¹⁷⁰ The authors conclude that there was good evidence that uptake of OST and high coverage of NSPs can substantially reduce the risk of hepatitis C virus transmission among injecting drug users.

Hepatitis B

Overall about one in six IDUs has ever had hepatitis B infection. In 2010, 16% of the current and former IDUs who took part in the UAM Survey in England, Wales and Northern Ireland had antibodies to hepatitis B core antigen (anti-HBc, a marker of previous or current hepatitis B infection); this is lower than in 2000 when prevalence was 28% (HPA 2011a, HPA 2011b). This decrease may reflect the impact of increased uptake of the hepatitis B vaccine among injecting drug users (HPA 2011b; see section 7.3.2).

6.2.3 Other infectious morbidity

Tuberculosis

In total, there were 9,040 cases of tuberculosis reported across the UK in 2009 (HPA 2010). The collection of information on social risk factors for tuberculosis was introduced to Enhanced Tuberculosis Surveillance in England, Wales and Northern Ireland during 2009. Regions/countries began collecting these data at different points throughout the year and so completeness levels for 2009 vary (HPA 2010). Information on social risk factors was known for 69 to 74% of cases. Among the cases with known information, 3.3% (213/6,369) had a history of problem drug use and 4.6% (272/5,930) a history of problematic alcohol use (HPA 2010). Social risk factor information is also collected in Scotland, but different definitions are used. Information on risk factors was recorded for the majority of the Scottish cases (454/457; 99.3%) in 2009 (HPS 2010). Risk factors were identified for 114 cases (25%), of which, 12 cases had more than one known risk factor. In 2009, alcohol misuse was a risk factor in 47 cases (10%), and drug misuse in one case (0.2%) (HPS 2010).

Anthrax

An outbreak of anthrax, which began in December 2009 and was thought to have been due to a contaminated batch of heroin,¹⁷¹ was reported last year (see 2010 UK Focal Point Report). Five cases resulting in four deaths were reported by the HPA in England and there were 47 confirmed cases in Scotland, 13 of whom died. As part of this outbreak, Powell et al. (2011a) reported on an individual case of septicaemic anthrax in a 32 year old intravenous drug user, who later recovered following four weeks of treatment. The outbreak was declared as over on 23rd December 2010 by Health Protection Scotland (HPS).¹⁷² A report on the anthrax outbreak by the Outbreak Control Team (OCT) is due to be published on the HPS website in late 2011.

¹⁶⁷ Adjusted odds ratios (AORs) = 0.41, 95% confidence interval (CI) 0.21-0.82 and 0.48, 95% CI: 0.25-0.93, respectively.

¹⁶⁸ AOR=0.21, 95% CI: 0.08-0.52

¹⁶⁹ AOR 0.52, 95% CI: 0.32-0.83

¹⁷⁰ 95% CI: -27.3 to -14.4

¹⁷¹ Anthrax is a very rare infection caused by a spore forming bacterium. Anthrax spores can survive in the environment for a long time and so can contaminate heroin during production or distribution.

¹⁷² See:

<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Anthrax/AnthraxOutbreakInformation/> and <http://www.documents.hps.scot.nhs.uk/news/anthrax-closure-press-release-2010-12-23.pdf>

Other infections

Cases of infections caused by other spore forming bacteria are continuing to occur. In 2010, three suspected cases of wound botulism among IDUs were reported in the UK. This was lower than in the previous year but comparable to the annual number of cases seen in the preceding two years; there had been 20, four, three, 21, 28 and 41 suspected cases reported in 2009, 2008, 2007, 2006, 2005, and 2004 respectively (HPA et al. 2011). There was also one reported case of tetanus in an IDU in 2010. Cases of tetanus have been occurring amongst IDUs in recent years albeit in lower numbers than earlier this decade (HPA et al. 2011).

Cases of severe infection related to both meticillin resistant *Staphylococcus aureus* and Group A streptococci continue to occur among IDUs (HPA et al. 2011). For example, data from the mandatory enhanced surveillance of MRSA bacteraemia in England from 2006 and 2010 indicate that among those reports with risk factor information (optional and provided in 34% of all reports) three per cent reported injecting drug use as a risk (HPA et al. 2011).

In 2010, a third (35%) of IDUs participating in the UAM Survey in England, Wales and Northern Ireland reported that they had experienced an abscess, sore or open wound, all possible symptoms of an injecting-site infection, during the preceding year (HPA et al, 2011; HPA 2011a). This level has not changed since the UAM Survey first asked about this in 2006, with women more likely to report a symptom than men (HPA et al. 2011). These symptoms of possible injecting-site infections were found to be associated with a number of factors among those who had injected during the last four weeks. Overall, 37% of the participants in the UAM survey who had injected during the last four weeks reported having had these symptoms during the preceding year. Those who had injected into the fragile veins of their hands, legs and feet during the last four weeks reported higher levels of symptoms. Higher levels of symptoms were also found among those who had injected crack-cocaine or cocaine powder in the last four weeks. However, those who had injected amphetamines had a lower level of symptoms (HPA et al. 2011).

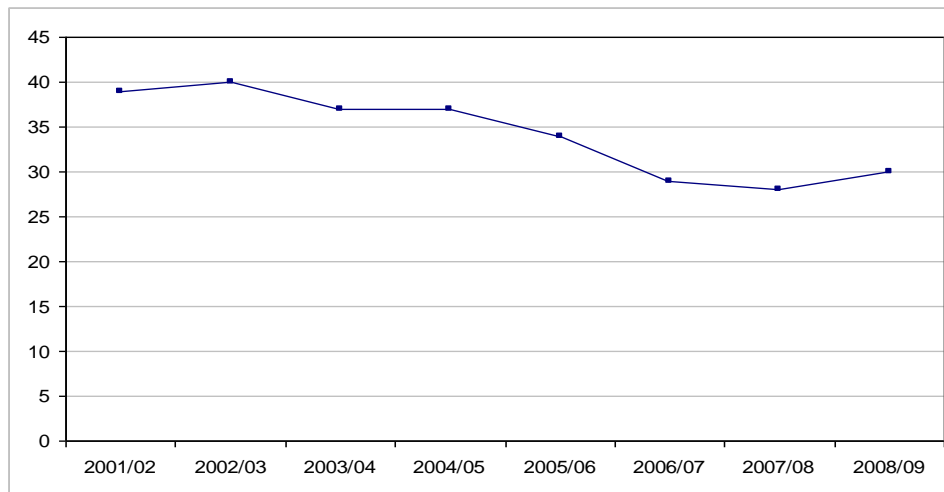
6.3 Other drug-related health correlates and consequences

6.3.1 Psychiatric co-morbidity

Scotland

Inpatient hospital data from Scotland show that in 2008/09, 6.2% (n=1,497) of psychiatric inpatient discharges had a diagnosis of drug misuse (as either a main or supplementary diagnosis), a rate of 30 discharges per 100,000 population. After remaining stable between 2001/02 and 2004/05 (from 36 to 37), the rate per 100,000 population fell until 2007/08, when it was 28, before increasing in 2008/09 to 30 (Figure 6.3) (ISD Scotland 2010).

Figure 6.3: Psychiatric inpatient discharges with a diagnosis of drug misuse in Scotland, 2001/02 to 2008/09; rate per 100,000 population



Source: ISD Scotland (2010)

In 2008/09, 58% of psychiatric inpatient discharges with a discharge diagnosis of drug misuse (resulting in mental and behavioural disorder) recorded use of multiple drugs or other psychoactive substances, a decrease from 63% in 2007/08. The most frequently reported drugs in psychiatric discharges were opioids, recorded in 29% (n=427) of cases and cannabinoids, recorded in six per cent (n=97) of cases (ISD Scotland 2010).

Substance use and mental health problems in adolescents

In a three-year longitudinal study¹⁷³ of young people aged between 11 and 16, associations between adolescent substance use and mental health issues were investigated (Goodman 2010). Participants were asked about their substance use and their mental health was evaluated at baseline and at three-year follow-up by clinicians via a series of brief interviews with participants and their parents. It was reported that there was an independent association between having an externalising¹⁷⁴ mental health problem at baseline and substance use at the three-year follow up (which was particularly strong in the case of cigarette smoking). However, there was no such association between internalising¹⁷⁵ mental health problems and substance use. There was no evidence to suggest an association between substance use at baseline and mental health issues at follow-up.

6.3.2 Non-fatal overdoses and drug-related emergencies

Data on drug overdoses and drug-related emergencies are provided using hospital inpatient data and International Classification of Diseases (ICD-10) codes¹⁷⁶. It is difficult to assess the full extent of non-fatal overdoses and drug-related emergencies due to the use of illegal

¹⁷³ A total of 3,607 young people aged between 11 and 16 years old (at baseline) participated in a three-year longitudinal cohort study. Parents of the participants were asked to complete the Strengths and Difficulties questionnaire on behalf of their children in order to identify internalising and externalising mental health problems amongst them. Diagnostic interviews and clinician-rated diagnoses of mental disorder were also utilised to measure mental health issues. Participants self-reported substance use including smoking, alcohol and illicit drugs.

¹⁷⁴ Externalising disorders are a cluster of problem behaviours characterised by behaviours directed outward, typically towards and/ or involving conflict with other people. Examples include disobedience, aggression, temper tantrums and over-activity.

¹⁷⁵ Internalising disorders are problems 'within the self', such as fears, physical complaints, worrying, shyness. Individuals with these types of disorders seem to deal with problems internally, rather than acting them out in the environment.

¹⁷⁶ See: <http://www.who.int/classifications/icd/en/>

drugs. This is due to the fact that the ICD-10 coding system includes some legally available drugs such as codeine, which is available over-the-counter at pharmacies. Conversely, ICD-10 codes do not include new psychoactive substances. Furthermore, data from hospitals are only available for those who are admitted to hospital and have an inpatient stay.

A recent study, conducted in a large London hospital, retrospectively investigated the coding of patients¹⁷⁷ who had presented with acute drug toxicity due to recreational drug use. Of the 484 presentations to hospital with acute recreational drug toxicity, only 30% were admitted to hospital. Furthermore, the authors found that inappropriate coding of patients had occurred in many cases, with only 44% of those admitted to hospital assigned to the appropriate ICD-10 codes (Wood et al. 2011). The authors state that the ICD-10 codes do not embrace all recreational drugs covered by the *Misuse of Drugs Act 1971* and there is currently no provision for the recording of novel drugs. In a further study of ICD-10 coding for recreational drug toxicity cases¹⁷⁸ it was reported that admissions which were not assigned to a specific ICD-10 code were assigned to a wide variety of codes and often, the use of recreational drugs were not recorded (Shah et al. 2011).

Hospital inpatient data

Hospital inpatient data for 2009/10 show that, of the 30,618 inpatient discharges recording poisoning by drugs in the UK,¹⁷⁹ over half (63%) were due to 'other opioids' (including morphine and codeine). Almost all drug poisonings were emergencies (99%). There were 3,155 heroin poisonings, almost all of which were emergencies (99%). The next most common individual drug was cocaine (1,986 discharges) followed by methadone (1,533 discharges).

The proportion of poisonings due to other opioids has increased year on year since 2007/08 (Table 6.1), whilst the proportion of cocaine poisonings decreased between 2008/09 and 2009/10.

Table 6.1: Number and percentage of inpatient discharges in the UK recording poisoning by drugs 2007/08 to 2009/10 by drug

Drug	Year					
	2007/08		2008/09		2009/10	
	n	%	n	%	n	%
Other opioids inc. morphine and codeine	16,452	50.6	17,902	57.2	19,266	62.9
Heroin	3,071	9.4	3,053	9.8	3,155	10.3
Cocaine	2,477	7.6	2,627	8.4	1,986	6.5
Methadone	1,365	4.2	1,493	4.8	1,533	5.0
Total	32,511	100.0	31,319	100.0	30,618	100.0
% Emergencies	<i>n/a</i>	99.0	30,991	99.0	30,311	99.0

Source: Health and Social Care Information Centre, DHSSPSNI, ISD Scotland, Public Health Wales

¹⁷⁷ The records for 484 presentations to hospital with acute recreational drug toxicity between 1st January 2008 and 31st December 2008 were examined. Of those presentations, 337 (69.9%) were dealt with in the emergency department and/or on the observation ward and therefore, were not admitted to hospital. The remaining 145 cases were admitted to hospital and were each assigned one or more diagnostic code(s) related to their presentation with acute drug toxicity (the other 337 cases did not have any diagnostic codes relating to their presentations available).

¹⁷⁸ Seventy clinical coding departments in hospitals in England and Wales responded to a survey which asked them to assign codes to a range of hypothetical cases of acute recreational drug toxicity.

¹⁷⁹ Using ICD-10 diagnosis codes T40 and T43.6.

There were 22,271 inpatient discharges related to mental and behavioural disorders due to drugs.¹⁸⁰ This excludes those related to 'dependence syndrome' since these are likely to be planned inpatient treatment patients. The drugs most commonly involved were cannabinoids (6,505), opioids (5,788), and cocaine (3,502).

6.3.3 Pregnancies and children born to drug users

Inpatient hospital data on the effects of maternal use of drugs are presented in section 12.2.1.

6.3.4 Injecting drug use

Risks associated with public injecting

Parkin and Coomber (2011) investigated the motivations for public injecting by intravenous drug users (IDUs)¹⁸¹ and the consequences of injecting in public areas. The most significant finding was the reported incidence of public injecting in shared spaces in high-rise flats, typically in stairwells, garbage units and small rooms such as those with electricity meters. The most regularly attended shared space was the bin chute room (BCR) with 100% of the participating IDUs having a lifetime experience of using a BCR to inject and/or smoke illicit substances. The need for rapid injection, so that areas used regularly for injecting can be preserved and detection avoided, had resulted in various negative practices. Quick injection led to missing veins and sharing needles even when aware of another's blood-borne virus. 'Slamming'¹⁸² of syringes was also noted as a way of quickening the process, which consequently increased overdose risk. Forty-five per cent of respondents had experienced an overdose and two-thirds of respondents (65%) had witnessed an overdose in a public setting. Areas such as BCRs were noted as unhygienic and one participant reported blood poisoning from injecting in BCRs. The authors noted how the shared space had caused hazardous practices.

6.3.5 Health correlates and consequences related to the use of opiates

To investigate the effects of stress on attention to drug-related stimuli and cravings in opiate addicts in treatment, Constantinou et al. (2010) used a mild psychological stressor on current opiate users, ex-users, and healthy participants.¹⁸³ Results demonstrated consistently higher stress and cravings in current users than other groups when exposed to drug-related stimuli. Current heroin users also demonstrated greater attentional bias to heroin-related stimuli than the other groups, while findings in ex-opiate users suggest that attentional bias reduces with lengthier abstinence periods. The authors claim that the results may demonstrate the role of attentional biases in addiction and therefore, successful recovery should include an avoidance of drug-related stimuli.

Gorodetzky et al. (2010) investigated the self-reported decision-making styles of drug users¹⁸⁴ compared to non-drug using controls. Controls and opiate users reported more

¹⁸⁰ Using ICD-10 diagnosis codes F11 to F19 excluding F17. Codes ending in .2 were also excluded.

¹⁸¹ The London Borough of Barking and Dagenham Drug and Alcohol Action Team (DAAT) carried out a qualitative enquiry over a period of six months from March 2010. Methodology included semi-structured interviews, reflexive field accounts, photography, visits to public injecting areas with IDUs and direct observation. Agency staff (n= 63) familiar with public injecting issues (e.g., caretakers and security guards) and 20 IDUs participated in the enquiry.

¹⁸² Slamming down the syringe pusher fast and all at once instead of gradually.

¹⁸³ The sample comprised of 48 participants (16 per group). Current users were undergoing methadone substitution treatment, ex-users were opiate-abstinent and in rehabilitation, and healthy participants had never taken opiates. Participants completed mental arithmetic tasks as part of the stress condition, the Go-No-Go task to assess inhibitory control, the dot probe task to assess attentional bias and the Visual Analogue Scales (VAS) in order to assess stress and drug cravings.

¹⁸⁴ Opiate users (n=40), cocaine users (n=51), amphetamine users (n=380) and those with no drug dependence (n=57) from the East Anglia region (UK), aged between 18 and 60 years were recruited.

rational decision-making styles than cocaine users, with opiate users reporting the most rational decision-making style. Amphetamine users were more likely to delay decisions than controls and demonstrated lower scores for vigilance. The authors conclude that the findings are in line with the literature suggesting that stimulant-users have more decision-making impairments than opiate-users.

6.3.6 Health correlates and consequences related to the use of cathinones

Mephedrone

The National Poisons Information Service (NPIS) collects information in the UK on the clinical features of toxicity related to drug use and stores the results in an online database, TOXBASE®¹⁸⁵. The database can be accessed by medical professionals and includes entries regarding the recreational use of synthetic cathinones (including mephedrone). The number of accesses to the TOXBASE® database and the number of telephone enquiries made by medical professionals regarding cathinones increased steeply between March 2009 and February 2010, mainly relating to mephedrone (James et al. 2010). Common clinical features of case reports included: tachycardia¹⁸⁶; palpitations; agitation; anxiety; mydriasis¹⁸⁷; tremor, fever or sweating, and hypertension. Other commonly reported effects were nausea, breathlessness, dizziness and headaches.

Schifano et al. (2010) reviewed the current literature on the prevalence, pharmacology and health effects of mephedrone. They posit that mephedrone is a sympathomimetic¹⁸⁸ drug and many of its undesirable effects bear similarities to those associated with amphetamine, methamphetamine and MDMA. These include loss of appetite; headache; tense jaws; bruxism¹⁸⁹; mild muscle clenching; anxiety; agitation; confusion; depression; tachycardia; and elevated blood pressure.

Toxicological analysis¹⁹⁰ was carried out on the serum of nine patients presenting to an emergency department in London following self-reported mephedrone use (Wood et al. 2010b). It was reported that in seven cases mephedrone had been used¹⁹¹ and the case notes of these patients were examined to investigate acute symptoms of mephedrone toxicity. It was reported that symptoms included agitation, tachycardia, and systolic hypertension and the authors conclude that this is similar to symptoms shown with acute toxicity of other sympathomimetic drugs such as MDMA and cocaine.

In Scotland, the case notes of individuals who had presented to an emergency department or acute mental health services with self-reported mephedrone use were reviewed to investigate its adverse psychological effects¹⁹² (Mackay et al. 2011). As in the case studies

Drug users were only included if they satisfied the DSM-IV criteria for drug dependence. Participants completed the National Audit for Reading Test and the Melbourne Decision-Making Questionnaire (MDMQ) to assess decision-making styles.

¹⁸⁵ See: <http://www.toxbase.org/>

¹⁸⁶ Accelerated heart rate.

¹⁸⁷ Dilation of the pupil due to disease, trauma or the use of drugs.

¹⁸⁸ Sympathomimetic drugs mimic the effects of the sympathetic nervous system, such as catecholamines, epinephrine (adrenaline), norepinephrine (noradrenaline) and dopamine.

¹⁸⁹ Teeth grinding and clenching.

¹⁹⁰ Toxicological analysis, by gas-chromatography coupled with mass-spectrometry and liquid chromatography with tandem mass-spectrometry was performed to confirm mephedrone use.

¹⁹¹ In the other two cases mephedrone was not detected. They had presented more than 24 hours after self-reported mephedrone use and the authors posit that this may be a reason why mephedrone was not detected.

¹⁹² The case notes of all individuals who presented with reported mephedrone use to an emergency department or acute mental service in Edinburgh (n=14) and Falkirk (n=16) between January and

above, agitation was the most commonly reported effect (70%) and in this study it was severe in most cases. Sixty per cent of all cases in this study reported concurrent alcohol use. It is reported that psychotic symptoms were present in 40% of all cases, with 88% of these individuals reporting heavy or daily use for at least the previous month and of those with psychotic symptoms, three-quarters had a previous history of mental illness.

A survey was carried out amongst a sample of clubbers¹⁹³ who were asked about the subjective effects of mephedrone and their consumption patterns (Winstock et al. 2011a). It was reported that mephedrone use produced physical effects common to other stimulants such as increased energy, euphoria, talkativeness, urge to move/ do things, empathy and jaw clenching in the vast majority of cases. The most common withdrawal effects were reportedly tiredness and insomnia after a 'session'. The authors suggest that the dependence potential of mephedrone may be high, as nearly a third of participants reported three or more symptoms as classified by the DSM-IV scale (mainly increased tolerance, impaired control, strong urge to use mephedrone). However, they state that this on its own is not a diagnosis of dependence but it is an indicator of a potential issue.

Khat

In a small study on the social harms of khat (Sykes et al. 2010) (see section 8.2.7) perceived health consequences of heavy use frequently mentioned by participants¹⁹⁴ included: loss of teeth, gum disease and general mouth problems; constipation and digestive problems; sleep loss; and weight loss. There were also some less frequently mentioned perceived health risks including cardiovascular problems; heavy smoking whilst chewing khat; and mental health problems such as paranoia, mood swings and aggression. It is noted in the report that "the views describe what the respondents believe the negative consequences of heavy khat use to be, including received wisdom and folklore, but are not scientific evidence of cause and effect".

In a review of case studies into 13 UK deaths of khat users occurring between 2004 and 2009, Corkery et al. (2010) describe the characteristics of the deceased individuals and the background to their deaths. All individuals were male with an average age of 35. It is reported that four cases involved long-term khat users, with the specific cause of death given as liver failure in three cases and heart failure¹⁹⁵ in the other case. A further death caused by a 'cardiovascular event' was preceded by khat use. At least three deaths were confirmed as suicides amongst individuals with psychoses; intoxication due to a combination khat use and alcohol was mentioned in two road fatalities; and one fatality was as a result of heroin intoxication where khat was also present. In response to this article Klein (2011) and Singleton (2011b) commented that, whilst an association between khat use and death was

June 2010 were retrospectively examined. Most cases were male (n=17) and the age range was between 19 and 59 years, with most (n=14) aged between 19 and 29 years.

¹⁹³ A total of 100 individuals took part in the survey. All had previously participated in an online survey of clubbers (in 2009), advertised in Mixmag dance music magazine, and had expressed an interest in being involved in further studies. A 25 minute structured quantitative telephone interview was carried out with participants between February and 10th April 2010. They were asked to rate a series of 28 typical stimulant or empathogenic drug effects and 12 withdrawal symptoms in terms of how often they experienced those feelings and how intense they were on occasions when they had taken mephedrone. Seven dependence items were also included from the DSM-IV scale.

¹⁹⁴ A series of ten focus groups and interviews were held with members of the Somali, Yemeni, and Ethiopian communities (n=82). Focus groups were made up of khat users and non-users and explored participants' views on khat use, perceived harms and government intervention. Focus group interviews were also held with members of the wider communities to gauge their perceptions of anti-social behaviour linked to khat use. Service provision for khat users was investigated via a short survey completed by local Drug Action Teams (DATs). Fieldwork was carried out in London, Sheffield and Cardiff during May and June 2009.

¹⁹⁵ Left ventricular failure and pulmonary odema.

demonstrated by Corkery et al. (2010), causality was not determined. They make the point that, as this study focuses on a few isolated cases, there is a danger that this may overstate the risk of harm to the general population from khat use.

Ivory Wave

In a case report of an individual in police custody who had earlier ingested 2g of Ivory Wave, the following acute effects were recorded: palpitations; anxiety; hallucinations and hypermetabolism¹⁹⁶ (Durham 2011). It is reported that there is also a lack of consistency in the chemical composition of the products that are currently being sold as Ivory Wave (see 2010 UK Focal Point Report). The Home Office announced, in September 2011, that desoxypipradrol (2-DPMP), which has been found in samples of Ivory Wave is to be classified as a Class B drug under the *Misuse of Drugs Act 1971* (see section 1.2.1)

6.3.7 Health correlates and consequences related to the use of ecstasy

Impulsivity, and psychopathology in recreational ecstasy users

Roderique-Davies and Shearer (2010) investigated impulsivity and psychopathology in light and heavy recreational ecstasy users.¹⁹⁷ Ecstasy users were compared to those who had never used drugs (non-drug controls) and those who had used drugs but not ecstasy (non-ecstasy poly drug users). Based on various questionnaires, they found that heavy ecstasy users scored higher on non-planning impulsivity, cognitive impulsivity, anxiety, and obsessive compulsiveness, which is linked to psychopathology, comparative to non-drug controls and non-ecstasy poly drug users. Heavy ecstasy users also scored higher than the two non-ecstasy groups on the Positive Symptom Total: a self-reported scale of symptoms. There was no difference between groups on motor impulsivity.

Modelling adverse effects associated with ecstasy usage

Fisk et al. (2011) studied self-reported adverse effects of ecstasy and aimed to overcome the difficulties of self-reporting studies caused by distorting influences such as consumption of other drugs and awareness of ecstasy-related harms from the media¹⁹⁸. Using questionnaires, the authors found that recent use of ecstasy was negatively correlated with an increase in adverse effects. In addition, an increased number of adverse effects were significantly related to increases in estimated lifetime ecstasy consumption, frequency of concurrent alcohol use, daytime sleepiness, anxiety, and levels of concern about adverse effects associated with ecstasy. However, there was no significant relationship between awareness of effects of ecstasy and self-reported adverse effects, suggesting that media and other influences do not magnify self-reported effects.

Recent and abstinent ecstasy use and memory

Recent and abstinent ecstasy users were assessed for long-term memory deficits by comparing their results on procedural¹⁹⁹ and declarative²⁰⁰ memory tests with drug naive

¹⁹⁶ Increased rate of metabolic activity usually accompanied by excessive body heat.

¹⁹⁷ Participants (n=205) were recruited from the University of Glamorgan and completed a drug history questionnaire, the Barratt impulsivity scale and the SCL-90-R factorising a number of psychopathological symptoms.

¹⁹⁸ A sample of 159 ecstasy polydrug users participated. They were required to abstain from taking ecstasy for seven days and other illegal drugs for 24 hours before testing. Questionnaires recorded drug history, self-reported mood and other psychological variables, changes since ecstasy initiation, concern over ecstasy dangers, awareness of harms and quality of sleep (using the Epworth Sleepiness Scale).

¹⁹⁹ The part of long-term memory concerned with how to do things and perform tasks which are accessed and used without the need for conscious control or attention.

²⁰⁰ The part of long-term memory which refers to memories that are consciously recalled such as facts and events.

controls²⁰¹ (Blagrove et al. 2010). It was found that performance in the procedural memory task did not differ between groups. Scores for recent ecstasy users (who had also used other illicit drugs in the preceding one to two days before the testing) in the declarative memory test were significantly lower than drug naive controls. However, recent users, who had not taken other drugs in the two days prior to testing, did not differ from the control group.

Prospective memory functioning among ecstasy/polydrug users

The effect of illicit drug use on prospective memory (PM)²⁰² was investigated by exploring the differences in PM performance between ecstasy/polydrug users, cannabis-only users, and non-illicit drug users²⁰³ (Hadjieftiyvoulou et al. 2011). Results showed that compared to ecstasy/polydrug users and cannabis-only users, non-illicit drug users performed significantly better in PM tasks with ecstasy/polydrug users performing worst. Female ecstasy/polydrug users displayed 65% higher scores (poorer performance) than female non-users, while male ecstasy/polydrug users only displayed 16% higher scores than male non-users. Cocaine use, specifically within the ecstasy/polydrug user group, was significantly correlated with event-based PM performance with increased lifetime dose, greater consumption during the previous 30 days and increased frequency of use all associated with poorer event-based PM performance.

A number of additional articles have been published examining the impact of ecstasy use on memory, including Burgess et al. (2011) who found that despite having equivalent memory performance to cannabis users and non-drug users, ecstasy users showed evidence of impairment in the part of the brain thought to be responsible for recollection. A case study was published in the Emergency Medicine Journal (Foëx et al. 2010) concerning a male who had become unconscious following an ecstasy overdose. An MRI scan showed hippocampal damage leading to an inability to form new memories, while long-term memory was unaffected.

6.3.8 Health correlates and consequences related to the use of other drugs

Cocaine

Ersche et al (2011) investigated impulsivity in a small sample of cocaine dependent users and any anatomical changes to their brain's grey matter compared to those without cocaine

²⁰¹ Sixty-six participants were recruited via advertising for individuals who frequently attended nightclubs. They were split into three groups: control (n=24); recent ecstasy use (n=25); abstinent ecstasy use (n=17). The control group had never taken any illegal drugs apart from minor cannabis use (<= 10 joints) that was not in the past year. Recent ecstasy users were defined as those using at least twice per month and who had taken it two to three days before the first testing session. Abstinent ecstasy users comprised regular users who had not taken it for at least eight days before the first testing session (ranging from 8 to 28 days). Participants were asked to complete the Rivermead Behavioral Memory Test (RBMT) to assess declarative memory and the Finger Tapping Test (FTT) for procedural memory. They were tested on two occasions, 24 hours apart to also assess the effect of sleep on memory function for each group.

²⁰² Prospective memory refers to remembering to execute a particular behaviour in the future (i.e. switching off the light when leaving a room). PM functions can be divided into either event-based (external act may trigger the retrieval of the intention to act) or time-based cues (triggered by the elapse of a certain time period).

²⁰³ Twenty-nine ecstasy/polydrug users (12 females), 12 cannabis-only users (7 females) and 18 non-users of illicit drugs (16 females) were recruited from University of Lancashire and Liverpool John Moores University. Drug use was assessed using a background drug use questionnaire. There were significant differences in gender composition: females dominated the non-illicit drug user group and males dominated the ecstasy/polydrug group. The Cambridge Prospective Memory Test (CAMPROMPT) is laboratory-based and was used to measure prospective memory, consisting of six PM tasks, half cued by time and half cued by event.

dependence²⁰⁴. Cocaine users reported increased impulsivity, however this was not reflected in behavioural measures. Compared to healthy controls, cocaine users showed significantly decreased amounts of grey matter in areas of the brain associated with compulsivity and an increase in grey matter in areas of the brain associated with dopamine production and release.

Ketamine

In an evidence review of the harms associated with ketamine use (Morgan and Curran 2011), the authors classified harms using a previously developed matrix²⁰⁵ (Nutt et al. 2007). Major harms discussed included ulcerative cystitis, thought to be associated with chronic, frequent use. Cognitive deficits, particularly in working and episodic memory have also been associated with frequent use although it is suggested that these may be reversible.

In a study examining the psychological effects of ketamine, participants²⁰⁶ were asked to report the frequency of experiencing a range of positive²⁰⁷ and negative experiences whilst under the influence of ketamine (Stirling and McCoy 2010). In terms of positive experiences, most respondents said that ketamine made them feel happy, relaxed laid back and excited (84%, 81%, 73% and 69% respectively). Nearly three-quarters reported a 'sense of enhanced perceptual powers' (71%). Negative experiences reported by most respondents whilst under the influence of ketamine included: time appeared slowed down (85%); slurred speech (81%); loosened grasp on reality (80%); and induced anomalous visual imagery (75%). The reported after-effects of ketamine included: feeling slowed down physically and emotionally (79%); feeling de-motivated (77%); slowed down ability to think (73%); and affected ability to concentrate (70%). Frequent 'K-hole'²⁰⁸ experiences reported by participants in this study included confusion, a sense of floating, disturbed speech and a sense of things being unexplainable.

²⁰⁴ Six participants with a history of chronic cocaine abuse and 60 healthy controls with no history of cocaine abuse were recruited (age range 18 to 50 years). Impulsivity was assessed using the Barratt Impulsiveness Scale, the Behavioural Inhibition/Activation System scale, the Rapid Visual Information Processing Task, and the Stop-Signal task. Brain matter was investigated through data from MRI scans.

²⁰⁵ The 'rational scale' of harms associated with psychoactive substances is a matrix which divides these harms into three broad categories, and three sub-categories for each. These are: physical harms (acute physical risks, chronic risks, propensity for intravenous use); dependence-related harms (acute pleasure, risk of physical dependence, propensity for psychological dependence); social harms (acute social harms of intoxication, harms to the individual within society, costs to the health service) (Nutt et al. 2007).

²⁰⁶ Fifty-two participants comprised of 35 current ketamine users and 17 former ketamine users were recruited using opportunistic sampling via flyers and notices posted in two Manchester Universities and snowball sampling of friends of participants who were opportunistically recruited.

²⁰⁷ In a quantitative, postal survey participants were presented with 18 positive experiences (such as feeling happy; excited; laid back; full of ideas) and they were asked to rate on a five-point scale how often they had experienced each positive experience whilst using ketamine (from rarely or never to almost always or always). They were then asked to repeat this process using a list of 24 negative experiences (such as feeling fearful; paranoid; depressed; angry). Participants were also asked to rate how often they had experienced a list of 12 after-effects of taking ketamine and how often they had experienced a list of 16 items pertinent to the ketamine 'k-hole' effects (see next footnote).

²⁰⁸ K-hole experiences are defined here as a cluster of psychedelic/dissociative experiences frequently reported by ketamine users, especially in relation to heavy use.

Cannabis

A study investigated the impact that varying levels of the two main chemical compounds²⁰⁹ found in cannabis, cannabidiol (CBD) and delta-9-tetrahydrocannabinol (THC), have on the acute effects of cannabis²¹⁰ (Morgan et al. 2010a). The aim of the study was to establish whether the type of cannabis smoked may have an effect on the acute cognitive impairments that have previously been associated with cannabis use. In this study the cannabinoids in the cannabis that participants smoked were analysed to establish the THC and CBD content.²¹¹ It was reported that the THC content of the cannabis smoked by participants did not differ amongst the two groups (low-cannabidiol group and high-cannabidiol group). When intoxicated, the scores gained on the verbal recall tests by the low-cannabidiol group were significantly poorer than those of the high-cannabidiol group, although there were no differences when not intoxicated. There were no differences amongst the two groups for the episodic memory tests. The authors suggest that this study demonstrates that higher levels of cannabidiol appear to protect against acute memory deficits when cannabis users are intoxicated. The authors also reported that when participants were intoxicated with cannabis there were no differences between the two groups in terms of the level of psychotic symptoms recorded.

6.3.9 Other drug-related health correlates and consequences

Drug harms

As part of the harm reduction strategy in England, the Department of Health and NTA has published a summary of the health harms of drugs (Jones et al. 2011a). This is an update of the 2003 *Dangerousness of Drugs* publication (DH 2003). Following a systematic review of the latest scientific evidence, the authors produced a summary of the acute and chronic health harms of 17 substances (both legal and illegal)²¹². The report also provides a summary of the mediating factors relating to the associated harms of each substance such as: the setting in which the drug is taken; route of administration; dose; combination with other drugs; age/developmental issues of the user; and individual vulnerability. The potential harms of common adulterants found in drugs were also considered, in addition to polysubstance use and age and gender-related issues (Jones et al. 2011a, b).

²⁰⁹ Cannabinoids are chemicals that are uniquely contained in the cannabis plant. Cannabis contains around 70 cannabinoids. Delta-9-tetrahydrocannabinol (THC) and cannabidiol are cannabinoids. THC is the main psychoactive ingredient of cannabis. Cannabidiol is thought to have opposing neuropharmacological effects to THC. It has been reported in previous studies that cannabidiol may have antipsychotic effects and may protect users from the chronic psychotic-like effects of THC.

²¹⁰ A convenience sample of 134 cannabis users (98 male, 36 females) aged 16 to 23 years were recruited by word of mouth and snowball sampling. They were tested on two occasions, seven days apart, using a repeated measures design on episodic and verbal memory and psychotic symptoms. Psychotic symptoms were measured using the Psychotomimetic States Inventory (PSI). They were tested once when they were drug free (not intoxicated day) and then again seven days later whilst they were acutely intoxicated with cannabis (intoxicated day).

²¹¹ The participants smoked their usual type and amount of cannabis in front of the researchers in a naturalistic setting (either in their own home or that of a friend) and provided the authors with a sample of the cannabis they had smoked and also a sample of their saliva. Both the sample of cannabis and the saliva were analysed for each participant to establish the levels of cannabidiol present in the cannabis. Participants were then split into two groups to correspond to the highest and lowest levels of cannabidiol. The low-cannabidiol group (n=22) was made up of individuals whose cannabis samples contained less than 0.14% cannabidiol. The high-cannabidiol group (n=22) was made up of individuals whose cannabis samples contained more than 0.75% cannabidiol. The results of these two groups were then compared in terms of THC content of the cannabis smoked and results of memory and psychotomimetic tests.

²¹² Substances considered were: alcohol; amphetamines; MDMA and related analogues; anabolic agents; cannabis; cocaine (crack and powder); dissociative anaesthetics; GHB and GBL; serotonergic hallucinogens; nitrites; novel synthetic drugs; opioids; over-the-counter products; khat and salvia divinorum; prescription drugs; tobacco; volatile substances.

Morgan et al. (2010) discussed the harms and benefits²¹³ associated with psychoactive substances from a user perspective, using the results of an online survey. The survey was based on an earlier study (Nutt et al. 2007)²¹⁴ whereby the relative harms of 20 substances had been assessed and rated by an expert panel and presented as a 'rational scale.' In this study users were asked to rate the harms of these drugs using the same scale and were also asked to rate the perceived benefits of each of these substances. The results showed a good agreement between user ratings of harm and the evaluations of the experts in the original study (at a statistically significant level for half of the substances)²¹⁵ and suggest that this shows that users are generally well informed about the potential harms associated with the drugs they take. As in the original study, there were discrepancies between the rankings of drugs, in terms of their harms, and their legal status within the *Misuse of Drugs Act 1971*, with legal drugs alcohol, solvents and tobacco all ranked highly in terms of relative harms (5th, 7th and 9th most harmful respectively). Heroin, crack cocaine, cocaine powder and street methadone were rated the most harmful. The drugs rated most highly by users in terms of perceived benefits were ecstasy, LSD and cannabis, both for acute and chronic benefits (see section 1.2.4).

In an international²¹⁶ online study of hallucinogenic drug users participants were asked for their opinions on the harms and benefits of LSD, psilocybin, MDMA, cannabis, ketamine and alcohol (Carhart-Harris and Nutt 2010). The qualitative results suggested a positive pattern of responses for the 'classic hallucinogens'²¹⁷, which were reportedly regarded as having a positive impact on wellbeing and the least physical and mental harms.

Drug driving

In 2009, impairment by drugs (illicit and medicinal) was recorded as a factor in 46 fatal road traffic accidents (2% of total) and 169 serious accidents (1% of total).²¹⁸

Comparison of co-morbidity amongst dependent drug and alcohol users

Keaney et al. (2011) compared the nature and severity of co-morbid physical health problems amongst those seeking treatment for drug dependence disorders compared to those with alcohol dependence disorders.²¹⁹ Half of the sample (51%) had multiple health problems and, across the sample, gastrointestinal and liver disorders were most common.

²¹³ Conducted in the UK in 2007, the online UK National Drug Survey was completed by 1,501 individuals. Participants were asked, in their opinion, to rate 20 substance in terms of their harms and benefits. Only those who had used a particular drug or knew somebody that had were able to rate its particular harms and benefits.

²¹⁴ A panel of drug experts assessed the relative harms of 20 psychoactive substances and devised a 'rational scale' using nine parameters of risk. It was developed using a matrix which divided drug harms into three broad categories, with three sub-categories for each. These are: physical harms (acute physical risks, chronic risks, propensity for intravenous use); dependence-related harms (acute pleasure, risk of physical dependence, propensity for psychological dependence); social harms (acute social harms of intoxication, harms to the individual within society, costs to the health service).

²¹⁵ Alcohol, amphetamine, cannabis, ecstasy, GHB, heroin, LSD, khat, street methadone and tobacco.

²¹⁶ A total of 620 individuals completed the web-based questionnaire. Thirty per cent of respondents were British.

²¹⁷ LSD and psilocybin.

²¹⁸ See:

<http://nds.coi.gov.uk/clientmicrosite/Content/Detail.aspx?ClientId=202&NewsAreaId=2&ReleaseID=418725&SubjectId=36>

²¹⁹ Two groups of participants (total n=252), clinically diagnosed as having (ICD-10) substance dependence of either alcohol dependence (n=165, 65.5%) or drug dependence (n=87, 34.5%) were recruited from inpatient and outpatient units in southeast London. Clinicians, using the Health Morbidity Scale with each item referring to a different health domain, measured type and severity of physical health problems. Dependence was measured using the Severity of Dependence Scale. Data were analysed using logistic and multiple regressions.

Severity of health problems were rated as 'moderate' or 'severe' for 47% of the sample and inpatients had worse physical health than outpatients. Quantity of alcohol consumed and increased age in alcohol dependents were related to physical health problems, as was injection status and homelessness in drug dependents. Alcohol dependent patients had more severe physical health problems and were significantly more likely to suffer from neurological, gastrointestinal and liver, and dermatological problems. Drug dependent patients commonly suffered from respiratory disorders, although not significantly more than alcohol dependent patients, and reported more contact with treatment services (85%) than those dependent on alcohol (62%).

Older drug users

The First Report of the Older Persons' Substance Misuse Working Group of the Royal College of Psychiatrists was published in 2011 (RCP 2011; see section 5.3.6). Key messages from a brief review of the physical and psychiatric complications of substance misuse by older people were:

- increased risk of adverse physical effects, even at relatively modest levels of intake, due to physiological changes;
- adverse effects can be subtle or non-specific; the "aetiological role of substance use in physical conditions is frequently overlooked"; and
- psychiatric comorbidities of substance misuse are common in older people (including intoxication and delirium, withdrawal syndromes, anxiety, depression and cognitive changes/dementia).

Adulterants in illicit drugs

In an evidence review of adulterants commonly found in illicit drugs, it was reported that most are substances that are easily available and are typically added to act as bulking agents, to mimic and/or enhance drug effects and to facilitate administration (Cole et al. 2010). The most commonly reported bulking agents were typically legal and fairly inexpensive substances such as caffeine, paracetamol and sugars.²²⁰ Procaine and lidocaine were reportedly added to mimic or enhance the effects of cocaine, and the use of caffeine to facilitate heroin administration was discussed. The authors suggest that whilst these substances would likely pose minimal health risks to users at a low dosage there is a need for vigilance in this area. They stress the importance of timely dissemination of information in serious cases of contamination, such as the anthrax outbreak in the UK in 2010-11 (see section 6.2.3).

6.4 Drug-related deaths and mortality of drug users

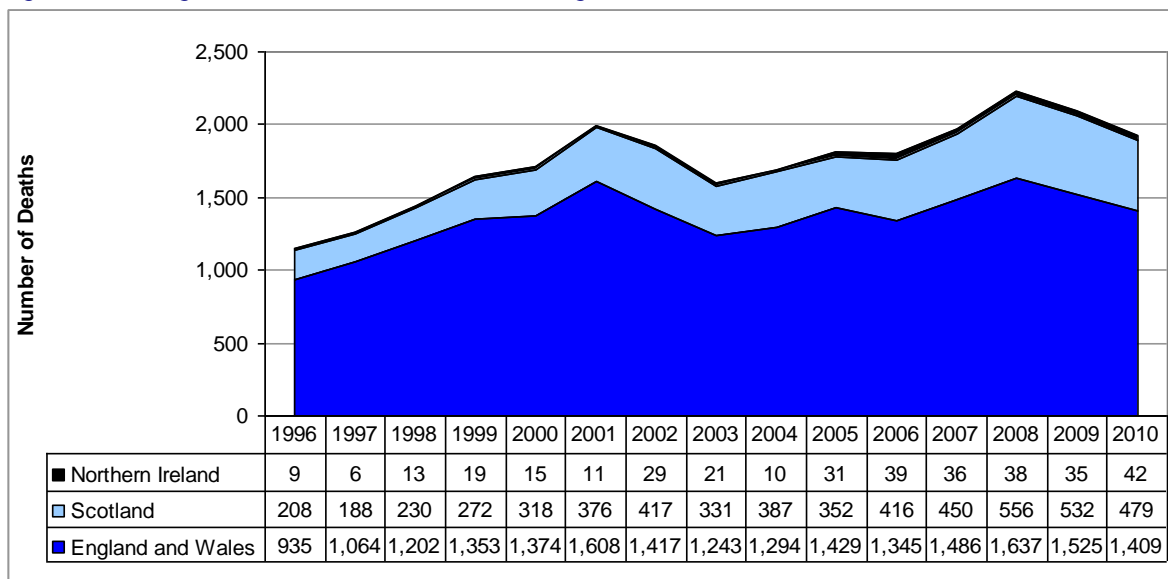
6.4.1 Direct overdoses and indirect drug-related deaths (DRD)

Using the EMCDDA definition of drug-related deaths (DRD), the latest data across the United Kingdom are for 2010²²¹. There were 1,930 deaths in 2010, a decrease of 7.7% since 2009 (n=2,092) (Figure 6.4). Since 1996, DRDs have increased by 67.5% (from n=1,152).

²²⁰ Sucrose, lactose, dextrose and mannitol.

²²¹ Data on drug-related deaths are recorded using year of registration rather than year of death.

Figure 6.4: Drug-related deaths in the United Kingdom, 1996 to 2010: EMCDDA definition

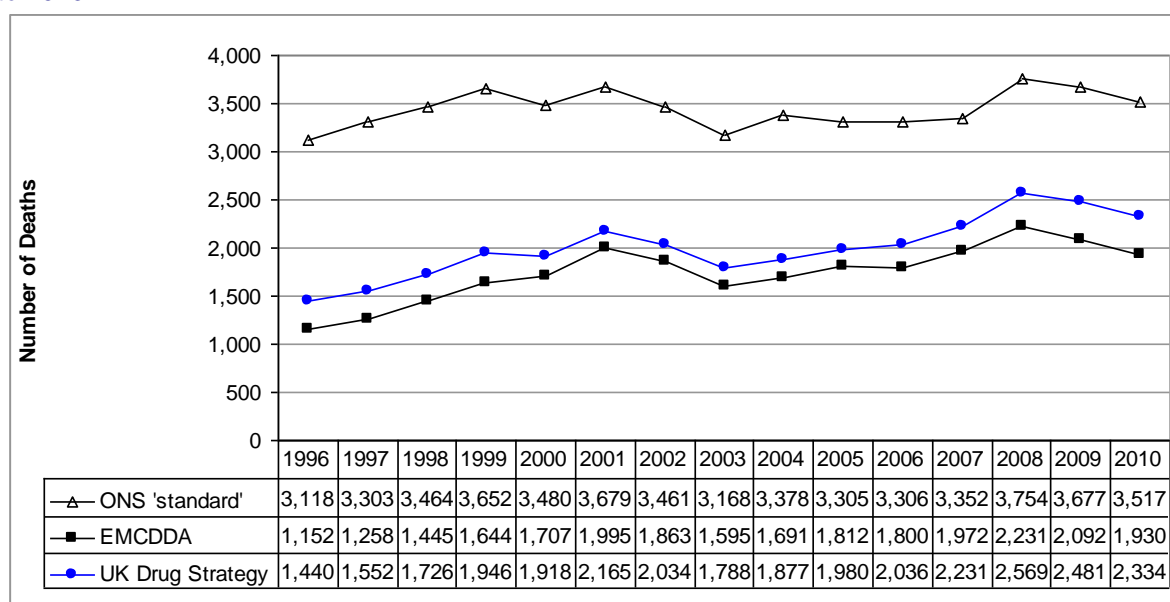


Source: Standard Table 06

The rate of deaths per 100,000 population (all ages) shows that differences exist between the different countries within the UK. Thus, in 2010 the rate using the EMCDDA definition was 9.17 in Scotland compared to 2.55 in England & Wales and 2.33 in Northern Ireland. The UK average was 3.10 (this figure was 1.98 in 1996).

The slightly different Drug Strategy definition, which was originally adopted to measure the impact of the former UK Drug Strategy (Home Office 2002), shows that the number of deaths in 2010 was 2,334, a decrease of 5.9% since 2009 (n=2,481). Using the much wider ONS definition, the total number of deaths in 2009 was 3,517 a decrease of 4.4% from the previous year (n=3,677) (Figure 6.5).

Figure 6.5: Comparison of total number of deaths using three definitions in the United Kingdom, 1996 to 2010



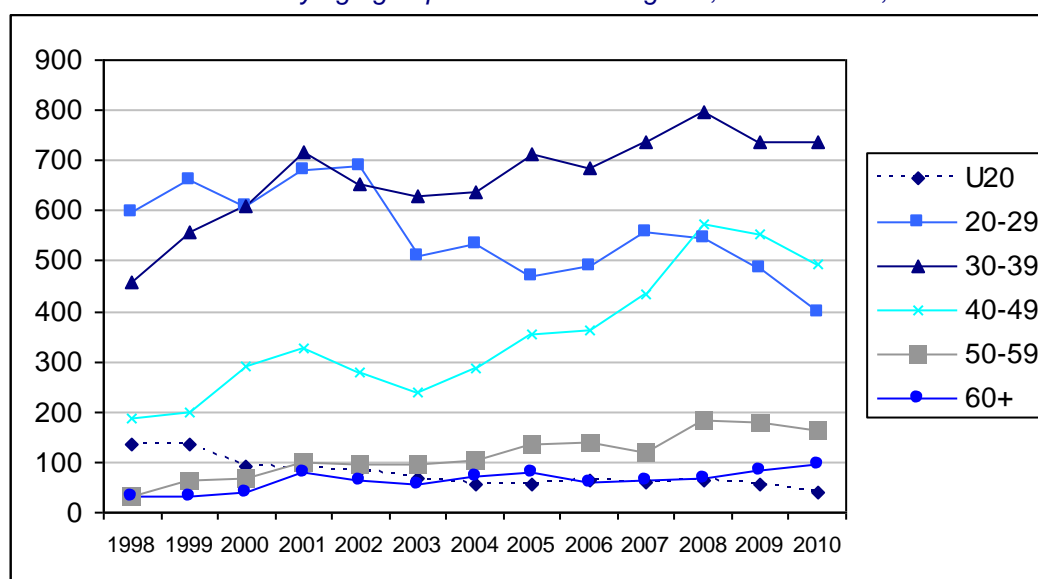
Source: Standard Table 06

Age and gender

In the UK in 2010, using the EMCDDA definition, males accounted for 1,532 deaths (79.4%) and females for 398 (20.6%) (male to female ratio=3.8:1). The highest proportion of males was 83.3% in Northern Ireland²²², then 81.0% in England & Wales and the lowest was Scotland (74.3%). The number of deaths amongst males in the UK decreased by 9.4% between 2010 and 2011.

The average age of death was 38.7 years with males (37.9 years) tending to be around 4 years younger than females (42.0 years). The average age of death increased from 31.5 in 1996. Deaths of both males and females tended to occur in younger age groups in Northern Ireland. Overall, most deaths in the UK in 2010 occurred in the 35 to 39 age group, although deaths amongst this age group decreased by 5.3% from the previous year. Figure 6.6 shows that, since 2008, when drug-related deaths were at their peak, deaths decreased for all age groups apart from those aged over 60 years old.

Figure 6.6: Number of deaths by age group in the United Kingdom, 1998 to 2010; EMCDDA definition



Source: Standard Table 06

Drugs mentioned on death certificates in the United Kingdom

As in the past 10 years, most deaths continue to be linked with the use of opiates, primarily heroin/morphine (n=1,061) and, to a lesser extent, methadone (Table 6.2). There has been a sharp fall in ecstasy mentions between 2009 and 2010 (72%) and cocaine mentions have also fallen by around a quarter in that time, although they remain at around twice the level of 2000 (n=88). The ONS reported six death registrations in England and Wales involving mephedrone in 2010.

Table 6.2: Drug mentions on death certificates in the United Kingdom, 2002 to 2010

²²² Note there was a comparatively low number of deaths in Northern Ireland (n=42).

Drug	Year								
	2002	2003	2004	2005	2006	2007	2008	2009	2010
Heroin/ Morphine	1,118	883	977	1,043	985	1,130	1,243	1,210	1,061
Methadone	300	292	300	292	339	441	565	582	503
Cocaine	161	161	192	221	224	246	325	238	180
Amphetamine	55	41	47	57	55	62	68	46	50
Ecstasy-type	79	66	61	73	62	64	55	32	9
Diazepam ²²³	356	282	217	205	186	223	489	300	315
Temazepam	89	114	87	55	55	56	55	48	38

Source: GROS 2011; NISRA 2011; ONS 2011

6.4.2 Drug-related deaths database in Scotland

The first report from the National Drug-related Deaths Database in Scotland was published in 2010 covering data for 2009²²⁴ (Graham et al. 2011) (see section 7.2.1). The report showed that:

- sixty per cent of individuals who died of a drug-related death had previously been in contact with drug treatment services (65%, n=168 of those in 6 months before death);
- two thirds (67%, n=291) had been in contact with either a GP or drugs service at least 12 weeks before their death;
- the majority were under 45 (87%, n=374);
- nearly two-thirds had been long term drug users, using for five years or more;
- half had injected drugs and heroin was the most frequently reported drug used;
- three-quarters were unemployed (77%, n=296);
- one-third had children under 16 years of age and nearly a tenth lived with a child at the time of death;
- three-quarters were single or not in a long-term relationship and nearly half lived alone;
- three quarters of deaths occurred at home and another person was present in two thirds of cases; and
- a total of 254 children either lost a parent or parental figure to a drug-related death in Scotland in 2009 and 59 children were living with the individual that died at the time of death.

The toxicology reports were not able to attribute deaths to individual drugs. However, they were able to demonstrate the drugs which were most commonly found in the body at the time of death, with diazepam and heroin each found in three-quarters of cases. The report concludes that these individuals did not form part of a homogenous group and it was not possible to generalise risk and protective factors of a drug-related death from these cases.

6.4.3 Systematic review of drug-related deaths in Wales

In 2010, four regional panels across Wales reviewed details of a random sample of drug-related deaths (Welsh Government 2011f; see section 7.2.1). The results of the 2010

²²³ A revised data collection form was introduced in Scotland in 2008 which has resulted in more specific drugs being identified than in previous years.

²²⁴ The database covers the whole of Scotland and went live on 1st January 2009. National Drug-Related Deaths (NDRDD) Data Collection Co-ordinators are assigned to each area of Scotland. These Co-ordinators are tasked with collecting and collating DRD data from different agencies (e.g. drug treatment services, police, GPs, and pathologists) and sending completed NDRD datasets to the NHS Information Services Division (ISD). Data are collected on personal circumstances, drug use history, contact with drug treatment services and GPs, medical history, substitute prescriptions, contact with the criminal justice system, scene of death, and toxicology results.

reviews were compared with data that were collected in 2008 and 2009²²⁵. It was reported that in 2010:

- 83% of deaths were male and most were in the 20 to 40 year old category;
- 64% died at their home address, 14% in a public place and 12% at a friend's home;
- heroin/morphine²²⁶ was the recorded cause of death in 65% of cases in 2010 compared to 53% of cases in 2008 and 2009 (n=38 and 61 respectively);
- one-third of cases were injecting drug users;
- benzodiazepines in combination with other substances were recorded in 29% of cases (n=17) compared to 26% in 2008-09 (n=30). Of the 47 benzodiazepine deaths, the co-presence of alcohol was recorded in 30% of cases (n=14);
- methadone²²⁷ was recorded in 21% of cases (n=12) compared to 25% of cases in 2008-09 (n=29); and
- 61% of cases (n= 30) had accessed treatment services in the two years preceding death, and 16% were accessing treatment services at the time of death (n=9).

6.4.4 Deaths associated with volatile substance abuse

There were 46 deaths associated with Volatile Substance Abuse in 2009 (38 in 2008). This is the second lowest figure since data collection methods became stable in 1983 and compares with the all-time peak of 152 in 1990 (Ghodse et al, in preparation). Gas fuels, including eight lighter fuel deaths, accounted for 31 cases; aerosols for five; alkyl nitrites ('poppers') two; nitrous oxide five; chloroform one; and other substances accounted for 10 cases. There were no deaths in the under 15 age-group, 13 were aged 15 to 19 years, seven were aged 20 to 24, and two were 25 to 29. The median age was 30 years (range 15 to 66 years). In 2009, there were also 46 deaths resulting from the inhalation of helium, compared to 26 in 2008, 10 in 2007 and 31 in the period 2000-06. For the first time, ONS published information on death registrations for England and Wales where helium was recorded (ONS 2011).

6.4.5 Deaths from HIV/AIDS

Deaths of IDU with AIDS accounted for 7.9% (1,428) of the total number of AIDS deaths in England and Wales up to the end of December 2010 (n=18,117). In Northern Ireland the proportion was 7.1% (7 deaths, n=98), but in Scotland it was 47.6% (800 deaths, n=1,679). The levelling off in the number of deaths of IDU AIDS deaths seen in recent years gave way to a slight increase in 2009. By the end of December 2010, 46 deaths had been reported for that year: the number is likely to increase. The UK figure of 46 for 2010 (68 in 2009) is about 22% of the peak level in 1995 (212) (personal communication - Health Protection Agency).

6.4.6 Mortality and causes of deaths amongst drug users (mortality cohort studies)

Merrall et al. (2011) examined major causes of death amongst individuals in contact with drug treatment services across Scotland between April 1996 and March 2006 (n=69,456). Drug treatment records were linked to national registers of deaths and hepatitis C virus (HCV) diagnoses. For the periods 1996/97 to 2000/01 and 2001/02 to 2005/06, cause-specific death rates and standardised mortality ratios (SMRs)²²⁸ were calculated. A total of 2,590 deaths were examined and major causes of death were identified by high SMRs²²⁹ or cause-specific death rates²³⁰ and their time-specific influences.²³¹ It was reported that the

²²⁵ In 2010, 58 cases were reviewed and, in 2008 and 2009, 114 were reviewed, representing in total 47% of all DRD cases between 2008 and 2010.

²²⁶ Either alone or in combination with other substances.

²²⁷ Either alone or in combination with other substances.

²²⁸ These were calculated using age, sex and calendar-rates of the general Scottish population.

²²⁹ Defined here as >5 across periods.

²³⁰ Defined here as >50 per 100,000 person-years in either era.

²³¹ Characterised by proportional hazards analysis.

overall SMR reduced from 6.4 to 4.8 between periods.²³² Five major causes of death were identified: drug-related (n=1,383); homicide (n=118); and infectious diseases (n=90) had high SMRs; suicide (n=269); and digestive system disease (n=168) were identified as having high cause-specific rates. HCV diagnosis marked individuals with at least double the risk of cause-specific mortality.²³³ An increased drug-related death (DRD) risk at older age (34 years old and over) was reported amongst HCV-diagnosed individuals. Alcohol misuse increased hazard ratios for: DRD²³⁴; suicide²³⁵; deaths from digestive system disease²³⁶; and non-major causes.²³⁷ Stimulant misuse increased suicide risk.²³⁸ It was concluded that drug-users in Scotland are exposed to variously increased mortality risks. Individuals diagnosed with HCV are particularly vulnerable, and may need additional support (ST18).

Cornish et al. (2010) investigated the effects of opiate substitution treatment in UK primary care on drug-related mortality rates, all mortality rates, and whether the risk of death varies according to treatment period. Analysis of patient data²³⁹ revealed that of the 178 deaths, 62 (35%) died while in treatment. The adjusted mortality rate²⁴⁰ for those out of treatment was more than double (2.3) that of those in treatment. Mortality was raised in the first four weeks of treatment: 3.1 (weeks 1 and 2) and 2.4 (weeks 3 and 4) times higher than in the remainder of the treatment, and was eight times higher immediately after treatment than during the time in treatment, after the first month. The death rate for the first month out of treatment was four times higher than for the remaining period out of treatment. Mortality did not differ significantly between using either methadone or buprenorphine for opiate substitution treatment (ST18).

6.4.7 Other research into DRDs

Effect of drug-related deaths on drug service staff

A study carried out in Scotland explored the effect of a client's drug-related death on staff working in drug services²⁴¹ (McAuley and Forsyth 2011). The majority of participants in this study (88%) were affected by grief as a result of a DRD. The most commonly reported feelings were sadness (83%), guilt (40%), and anger (37%). The authors recommend that after a drug-related death has occurred, the feelings of staff who have been involved in the case of the deceased should be taken into consideration and suggestions for a range of support mechanisms are discussed.

Impact of homelessness on drug-related deaths

A study by Dibben et al. (2010) sought to estimate the additional impact of homelessness on risk of death among young drug misusers. Data were obtained for drug misuse-related

²³² 95% Confidence Interval (CI) 6.0-6.9) and 95% CI: 4.6-5.0 respectively.

²³³ Including adjusted hazard ratio (HR) for no HCV diagnosis of 0.46 (95% CI: 0.41-0.53) for drug-related deaths (DRDs) and 0.15 (95% CI: 0.10-0.22) for death from digestive system disease.

²³⁴ 1.76, 95% 1.50-2.06

²³⁵ 1.88, 95% CI: 1.35-2.60

²³⁶ 3.19, 95% CI: 2.21-4.60

²³⁷ 1.87, 95% CI: 1.49-2.35

²³⁸ Adjusted HR 1.91 (95% CI: 1.43-2.54)

²³⁹ Analysis was conducted on the data of 5,577 anonymous patients listed on the General Practice Research Database, collated from 460 general practices in the UK, as having received prescription(s) for methadone or buprenorphine for substance misuse between 1 January 1990 and 31 December 2005.

²⁴⁰ Mortality rates were adjusted for sex, age, calendar year and co-morbidity, although the authors note that the adjustment for co-morbidity was weak as it was not specific to opiate users.

²⁴¹ A sample of 65 individuals, working in specialist substance misuse services in Lanarkshire, Scotland who had experienced a client's DRD, self-completed an anonymous questionnaire regarding their grief-related reactions to either the most recent or most important DRD that they had experienced as part of their job.

admissions to Scottish NHS hospitals from 1986 to 2001, for individuals born between 1970 and 1986 and aged over 15 years (n=13,303). All subsequent admissions and registrations of death were linked to this dataset. Each patient was coded as homeless if the health board of residence was recorded as 'no fixed abode'. The results indicated that, immediately after a drug-related hospital admission, there was no difference in survival between the homeless individuals and those with a 'fixed address'. However, over a three-year period the risk for those who were homeless was 3.5 times greater (CI 95% 1.2 - 12.8). This heightened risk seemed to be particularly focused on the second year after an admission. The causes of death were similar for the two groups. The authors suggest that although a homeless hospital admission is associated with a greater risk of death for young drug users, it is also a point in time when a young person is in contact with public services. Therefore, an attempt to link their discharge with housing services would seem a potentially productive policy.

Risks associated with prison release

Leach and Oliver (2011) undertook a review of the published literature to quantify the risk associated with recent prison release and to identify risk factors and prevention strategies.

Other risk factors for drug-related deaths

Using retrospective data from two Scottish NHS Board areas, a study by McAuley and Best (2011) examined three main types of DRD (heroin, alcohol or methadone), exploring the associations between personal and population DRD risk factors and attempting to predict their impact. From a total of 291 DRDs in 2006-07, nearly two-thirds (65%) involved heroin, one-third methadone (34%), and 28% involved alcohol. Benzodiazepines were directly involved in only four per cent of cases. Age and geographical area were both significant predictors of DRDs involving both heroin and alcohol. Heroin-related DRDs were significantly more likely to affect males than females and prison release within the last 14 days was a significant predictor. The authors found a higher risk of alcohol involvement in DRDs with increasing age and an increased risk of methadone-related DRD for females.

In a review of DRDs in Scotland between 2000 and 2007²⁴² (Bird and Robertson 2011) the authors discussed the toxicology and demographics of 2,893 deaths. They examined whether heroin, methadone, diazepam or alcohol was present at the time of death (one or more of which were present in 87% of cases) and compared the results over specific time periods. It was reported that diazepam was present in around half of DRDs in 2000-02 but by 2006-07 this had decreased to 18%. The presence of alcohol and heroin were positively associated and, for males this was also related to age. Amongst male deaths with heroin present, those in the older age group were more likely to also have alcohol present; 53% amongst those aged 35 and over compared to 36% in the under 35 age group. The authors suggest that older heroin users should moderate the amount of alcohol that they consume.

McDonald et al (2011) examined the risk of hospital admission or death for a liver-related cause amongst injecting drug users (IDUs) testing HCV-positive and compared this with the risk for IDUs testing HCV negative²⁴³. The study found that, amongst IDUs with no prior alcohol-related hospitalisation, the risk of hospitalisation/death from a liver-related or an alcoholic liver-related condition was greater for those who tested HCV positive²⁴⁴ compared

²⁴² DRD data from the GROS between 2000 and 2007 was cross-classified by the presence/ absence of heroin, methadone, diazepam and alcohol.

²⁴³ Data for 6,566 current/former IDUs who had been tested for anti-HCV and/or HCV RNA by polymerase chain reaction in Greater Glasgow Health Board between 1993 and 2007 were linked to the Scottish national hospitalisation database and deaths registry to identify all admissions and deaths from a liver-related condition. Relative risks were estimated. Using Cox proportional hazards regression for recurrent events. Time at risk was censored at 2 years following an HCV test to address bias owing to unobserved seroconversion.

²⁴⁴ Adjusted hazard ratio (HR) = 3.2, 95% CI: 1.5-6.7 and 4.9, 95% CI: 1.8-13.1, respectively.

to those who tested anti-HCV negative. However, this was not the case for those IDUs with a prior alcohol admission.²⁴⁵ The authors conclude that within Glasgow's IDU population, HCV positivity is associated with an increased risk of a liver-related outcome, but this is not observed for those IDUs whose problem alcohol use already increases their risk.

Mephedrone

In a review of four deaths associated with mephedrone consumption²⁴⁶, Maskell et al (2011a) reported that of the four deaths, one was attributed to the adverse effects of mephedrone, with cardiac fibrosis and atherosclerotic coronary artery disease as a contributing factor. The second death was attributed solely to mephedrone; a third death was attributed to the combined effects of mephedrone and methadone. In the fourth case, a multiple blunt force injuries as a result of a car crash was the cause of death.

Torrance and Cooper (2010) identified mephedrone in four Scottish fatalities between February and May 2010. Their paper summarises the concentrations of mephedrone detected in biological samples submitted for analysis in each of the four cases. Various prescribed and illicit drugs were also detected in the blood for three of the cases.

Phenazepam

Maskell et al. (2011b) reported that from the end of January 2011 to the end of June 2011, nine cases had been identified in Dundee, Scotland in which postmortem blood samples contained phenazepam. There was a history of drug misuse in all cases, and they occurred in men and women aged 31 to 45 years old. Death was from the adverse effects of opiates in seven cases and from non drug-related causes in two. The authors suggest that these cases indicate that the use of phenazepam by drug misusers in the UK may be on the rise.

Corkery et al (2011) reported the first UK instance notified by a coroner in England of a death involving phenazepam.

²⁴⁵ HR = 0.8, 95% CI: 0.4-1.5; and 0.8, 95% CI: 0.4-1.6.

²⁴⁶ Qualitative and quantitative analysis of mephedrone was performed using high-performance liquid chromatography-diode-array detection.

7. Responses to health correlates and consequences

7.1 Introduction

In 2001, an *Action plan to reduce drug-related deaths* (DRDs) was introduced in England and Wales (DH 2001). In England, this was updated as part of *Reducing Drug-related Harm: An Action Plan* with a focus on three key areas: campaigns, improving delivery and surveillance (DH and NTA 2007). In Scotland, a strategy and action plan to reduce DRDs was published in 2005 (SACDM 2005). In relation to the prevention of drug-related infectious diseases, a public health approach aimed at containing HIV transmission began in the 1980s. The subsequent action, involving harm reduction measures, is regarded as having been successful in helping to contain HIV amongst injecting drug users (IDUs). Measures include: the provision of free needles and syringes; promoting the safe disposal of used equipment; information campaigns on safer sex and safer injecting; and HIV/AIDS counselling, support and testing. Treatment for infectious diseases is provided as part of the National Health Service (NHS), including the provision of anti-retroviral treatment for HIV and hepatitis C virus (HCV).

A *Hepatitis C Action Plan for England* was published in 2004 (DH 2004), prioritising prevention of infection and disease progression. A *Hepatitis C Action Plan* for Scotland was launched in 2006 (Scottish Executive 2006a) and a second phase of the plan was launched two years later (Scottish Government 2008e). An *Action Plan for the Prevention, Management and Control of Hepatitis C* was launched in Northern Ireland in 2007 (DHSSPSNI 2007). The Welsh Assembly Government published its *Blood-borne Viral Hepatitis Action Plan for Wales 2010-2015* in 2010 (WAG 2010d).

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

Treatment for wound infections is available through primary care, accident and emergency (A&E) departments, and in some areas, through needle exchange schemes and specialist drug services. Those in prison have access to HIV and hepatitis testing, and vaccination against hepatitis B.

There are systems in place to ensure that pregnant drug users are identified and that their needs, and those of their babies, are met.

7.2 Prevention of drug-related emergencies and reduction of drug-related deaths

7.2.1 Data collection and information provision

As part of the harm reduction strategy in England, the Department of Health and NTA published a document setting out the health harms of drugs (Jones et al. 2011a, b; see section 6.3.9). This is an update of the 2003 *Dangerousness of Drugs* publication (DH 2003).

Drug-related deaths

England

The National Treatment Agency for Substance Misuse (NTA) has produced a document aimed at local commissioners containing information and examples of reviewing processes used by local partnerships when investigating the cause of drug-related deaths (NTA 2011f). It also outlines the procedures and issues to consider for setting up new reviews and/or improving existing practices.

Scotland

The National Drug-related Deaths Database (NDRDD)²⁴⁷ reported on a cohort of 432 deaths which occurred in 2009²⁴⁸ (Graham et al. 2011; see section 6.4.3). The report detailed the circumstances and wider context of 432 deaths using data gathered from a variety of local sources. Data suggested support for interventions such as a national naloxone programme and substitute prescribing. The authors also recommend that services are tailored to the individual and provide holistic and integrated care supported by 'the principles of recovery'.

In its annual report, the Scottish Drugs Forum (SDF)²⁴⁹ states that, in the past 12 months, it has provided information and training on the prevention of drug-related deaths through its 'critical incidents, overdose prevention and response training programme'. This programme is delivered to drug users and their family and friends, professionals who work with drug users, police and prison staff, and voluntary workers who come into contact with drug users. It is reported that, as part of a national rollout of naloxone in the next 12 months (see section 7.2.2) a newly established Naloxone Training and Development Team will provide training on emergency opiate-reversal across Scotland (SDF 2011).

Wales

A report discussing a random sample of 55 drug-related deaths reviewed in 2010 by regional panels has been published (Welsh Government 2011f; see section 6.4.4). As a further output of the confidential review panels a series of themed 'learning the lessons' bulletins are to be developed. The first published bulletin highlights the key issues surrounding deaths of newly released prisoners, a further bulletin aimed at GPs is planned (WAG 2010a).

Heroin shortage in the UK

In England, the NTA issued an alert regarding a reported heroin shortage across the UK. It advised service providers to be aware of the potential risks of a heroin 'drought' such as adverse effects due to heavy adulteration and heroin overdose due to lost tolerance if the purity of heroin increases in the future. A template for information posters and leaflets has been produced in collaboration with the Department of Health and the Health Protection Agency (HPA) for local services to tailor to their own needs.²⁵⁰ This includes harm reduction advice about using heroin and how to deal with an overdose situation. The Lifeline²⁵¹ drugs charity has produced a poster²⁵² aimed at heroin users and additional advice and information for heroin users has been published on the 'injecting advice website'²⁵³. It has been suggested that the heroin shortage in the UK started in Spring 2010 and ended in Spring 2011 (personal communication – Serious Organised Crime Agency (SOCA)).

²⁴⁷ The database gathers information about drug-related deaths that have occurred in Scotland since 1st January 2009. For every deceased drug user, collected information includes personal circumstances; drug use history; contact with drug treatment services and GPs; medical history; substitute prescriptions; contact with the criminal justice system; scene of death; and toxicology results.

²⁴⁸ These were a subset of the drug-related deaths which were included in the *GROS Drug-Related Deaths 2009* report (GROS 2010).

²⁴⁹ Scottish Drugs Forum is a national, voluntary sector and membership-based drugs policy and information agency. See:

<http://www.sdf.org.uk/sdf/files/SDF%20Annual%20Report%202009.2010.Web.pdf>

²⁵⁰ See: <http://www.nta.nhs.uk/who-healthcare-reducing.aspx>

²⁵¹ See: <http://www.lifeline.org.uk/index.php>

²⁵² See: <http://www.lifeline.org.uk/docs/DROUGHT-POSTER2.pdf>

²⁵³ See: <http://injectingadvice.com/downloads-mainmenu-31/otherdownloads/220-droughtposter>

Legal Highs

In May 2011 the Home Office issued a warning to the organisers of music festivals²⁵⁴ regarding the potential dangers of legal highs. The letter asked them to be vigilant to the presence of these substances and be aware of the potential for harm that they may cause.

7.2.2 Naloxone

England

A pilot scheme, introduced by the National Treatment Agency (NTA), provided naloxone and life support training for use in the event of an overdose to families and carers of drug users,²⁵⁵ across 16 sites in England. Basic life support training was given to 495 carers and in 15 pilot sites, training in the administration of naloxone was also provided. It is reported that 18 drug users were given naloxone and a further two were given basic life support in an overdose situation during the pilot and all 20 individuals survived the overdose (NTA 2011g).

Recruitment to the N-ALIVE randomised controlled trial (RCT)²⁵⁶ commenced in 2011 with the aim of reducing DRDs amongst newly released prisoners in England (see section 11.3.5).

Scotland: National take-home naloxone programme

In November 2010, the Minister for Community Safety wrote to all Alcohol and Drug Partnerships (ADPs), and to the Chief Executives of NHS and Local Authorities, setting out the Scottish Government's support for the roll out of the take-home naloxone programme. In August 2010 it was announced that €587,600 (£500,000) would be provided over two years to local partners to support the implementation of the national naloxone programme. This will ensure that:

- all prisons in Scotland supply naloxone and training to prisoners vulnerable to overdose before release;
- national trainers are available to offer critical incidents and Naloxone training to key workers across Scotland;
- Health Boards are reimbursed for every naloxone kit they give out; and
- a programme of evaluation is implemented to determine the long term impact of naloxone in Scotland.

The Scottish Government is providing support to the Scottish Prison Service to establish a prison-specific naloxone programme (see section 11.3.5).

The Scottish Government's National Naloxone Advisory Group and the Specialist Pharmacists in Substance Misuse Group have published a series of informative leaflets for individuals who may need to administer naloxone.²⁵⁷ The leaflet will be included in take-home naloxone packs and also given to those who attend training sessions. The 'train the trainer' course will be run by the Scottish Drugs Forum (SDF), with Scottish Government funding, and will instruct key staff on how to provide training for those at risk of opiate overdose as well as their families and friends.

²⁵⁴ See: <http://www.homeoffice.gov.uk/publications/media-centre/letter-festival-organisers?view=Binary> and <http://www.homeoffice.gov.uk/publications/media-centre/letter-festival-organisers>

²⁵⁵ See: <http://www.nta.nhs.uk/uploads/naloxonereport2011.pdf>

²⁵⁶ Funded by the Medical Research Council (MRC), the aim of the project is to recruit 56,000 participants. In the pilot phase 5,600 participants will be recruited to assess feasibility of the study and qualitative data will also be collected from these participants who give consent. See: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124595.pdf

²⁵⁷ See: <http://www.sdf.org.uk/sdf/4650.html>

Wales: Take Home Naloxone project

The Take Home Naloxone (THN) scheme has been available in a number of demonstration sites²⁵⁸ in Wales since September 2009. By the end of March 2011, almost 700 kits had been issued and 51 had been used to reverse opiate overdose. An outcome and process evaluation²⁵⁹ into the scheme was conducted to establish the feasibility of expanding it nationally. It was reported that the THN training received by participants had improved their knowledge and skills regarding dealing with an overdose across a wide range of measures and that the project had been implemented according to its original objectives. Using the results of interviews with participants and staff, the authors suggested some improvements to the development and delivery of future training sessions (Bennett and Holloway 2011). Following this evaluation it was announced that the scheme would be rolled-out across Wales. A national data collection system for take home naloxone is to be implemented in 2011 which will enable the recording of naloxone training and supply/resupply to all applicable individuals across Wales.

Northern Ireland: Naloxone Pilot

A take-home naloxone scheme is being piloted in Northern Ireland during 2011. Following evaluation of the scheme, consideration will be given to rolling it out across Northern Ireland.

Naloxone training for healthcare professionals

In a study of healthcare professionals²⁶⁰ who received training in overdose management and naloxone administration (n=219), it was reported that post training, the proportion of clinicians willing to use naloxone in an emergency increased from 77% to 99% (Mayet et al. 2010). A significant improvement in knowledge of overdose risks and actions to manage the situation was recorded. The authors discussed possible barriers to the implementation of such training in the future including: time and confidence of clinical staff; lack of resources within services; and willingness of clients to participate.

7.3 Prevention and treatment of drug-related infectious diseases

7.3.1 Needle exchanges and sharing of equipment

The level of needle and syringe (direct) sharing reported by participants in the UAM Survey (see section 6.2.1) in England, Wales and Northern Ireland has declined from 31% in 2000 to 21% in 2010 (HPA 2011a; HPA 2011b). Direct sharing was reported by 21% of the participants in England (regional range: 12% to 31%), 20% of those in Wales, and 23% of those in Northern Ireland in 2010 (HPA 2011a).

Sharing of any of the injecting equipment asked about in the UAM Survey (i.e. needles, syringes, mixing containers, water or filters; direct and indirect sharing) was reported by 40% of those participating in the survey in 2010. Sharing of any of this equipment was reported by 40% of the participants in England (regional range: 27% to 51%), by 41% in Wales, and by 39% in Northern Ireland in 2010 (HPA et al 2011).

²⁵⁸ See:

<http://wales.gov.uk/topics/housingandcommunity/safety/substancemisuse/publications/naloxone/;jsessionid=XLwxN5GWJ6x9BHm2np4DhvGph192mwnNrt5nLx3ZQqzCr7vhnL6h!912425714?lang=en>

²⁵⁹ An outcome evaluation of effectiveness of the training provided in the THN scheme was carried out via a pre- and post-training quantitative questionnaire amongst participants to establish changes in knowledge. The process evaluation used a mixed methods approach which included observation of training sessions and interviews with participants and staff.

²⁶⁰ A total of 219 clinicians received training in overdose management and naloxone administration. Primarily, 100 clinicians received training and they then trained a further 119 clinicians. The clinicians trained 239 drug users. Clinicians' knowledge was evaluated pre and post-training using a repeated measures design.

In Scotland, data from the Scottish Drug Misuse Database indicates that 18% of IDUs reported needle and syringe sharing in 2009/10 (HPA et al. 2011).

The vast majority of participants in the UAM Survey from across England, Wales and Northern Ireland reported that they had used a needle or syringe exchange, with 91% reporting having ever done so in 2010 (HPA 2011a).

Scotland

Injecting Equipment Provision (IEP) Survey 2009/10

Results from an IEP survey in Scotland have been published (ISD Scotland 2011) as part of the response to the *Hepatitis C Action Plan for Scotland Phase II*²⁶¹ (Scottish Government 2008e). It was reported that in 2009/10:

- there were approximately 260,000 contacts with IEP services;
- the majority of clients were male (78%);
- 4.68 million needles/ syringes were distributed, an increase from 4.38 million in 2008/09;
- an estimated 2.62 million needles/syringes were returned, compared to 2.48 million in the previous year²⁶²;
- after needles and syringes, wipes/swabs and citric acid were the next most commonly provided injecting paraphernalia;
- 99% of services provided sharp bins (n=252) and wipes/swabs (n=252); and
- 90% of services provided citric acid/vitamin c (n=227).

A national data collection system for the provision and uptake of injecting equipment has been developed this year and it is anticipated that this will be rolled out across Scotland in 2011/12 (ISD Scotland 2011).

Northern Ireland Needle and Syringe Exchange Scheme

Northern Ireland has operated a Needle and Syringe Exchange Scheme since 2001 with activity monitoring information collected from 12 pharmacies and one Community Addiction Team offering the service. In 2010/11:

- there were 17,712 visits to participating pharmacies by users of the scheme, an increase of 12% from 2009/10; and
- 179,700 syringes were issued, an increase of 17% from 2009/10 (Table 7.1).

²⁶¹ A total of 255 outlets responded to the survey; 200 pharmacies and 55 agencies.

²⁶² There are other safe disposal routes that are not covered by this survey so this figure is likely to be an underestimate.

Table 7.1: Syringe provision: number of visits, syringes issued and proportion of visits involving return of used equipment in Northern Ireland, 2001/02 to 2010/11

Year	Number of visits	Number of syringes issued
2001/02	5,213	67,989
2002/03	6,043	67,516
2003/04	7,508	82,731
2004/05	7,440	86,056
2005/06	8,797	85,801
2006/07	9,997	97,684
2007/08	11,387	116,935
2008/09	13,389	135,700
2009/10	15,828	153,625
2010/11	17,712	179,700

Source: DHSSPS (DAIRU/PHIRB) 2001/02 to 2009/10; HSCB 2009/10

Welsh needle exchange data collection project

In September 2010, a comprehensive data collection system for needle exchange, the Harm Reduction Database (HRD) was implemented in all statutory, voluntary and mobile exchanges across Wales. There are currently 46 sites registered and it is hoped that by the end of 2011 implementation of this system will extend to all existing pharmacy based needle exchanges establishing a national database of activity for the purposes of improving planning, service delivery and surveillance. In addition to recording needle exchange activity, the HRD provides data on: demographics; substances used (including those not injected); health and blood borne virus prevention and testing needs; information and advice given; and onward referral.

Delivery of needle and syringe programmes in Wales

The Welsh Assembly Government published a service framework for Needle and Syringe Programmes (NSPs) in Wales (Welsh Government 2011g) aimed at those responsible for NSPs. The framework provides guidance on: assessing local needs; engaging with service users; developing consistent policies procedures and equipment; and advice provision. Guidance on models of service delivery is provided including: the utilisation of community pharmacies; outreach services; prison NSP services; vending machines; and hospital based services. Specific guidance for the provision of NSP services for young people is also included.

ACMD: foil as a harm reduction intervention for heroin injectors

The Advisory Council on the Misuse of Drugs (ACMD) reviewed the evidence around the use of foil by drug users (usually those who smoke crack cocaine or heroin) and its place as a harm reduction intervention, primarily with IDUs (ACMD 2010). Possible benefits of the use of foil in controlled settings identified in the literature included: the promotion of smoking over injecting and therefore the potential for associated reduction in blood borne viruses; increased contact with treatment services; reduced systemic infections; reduced soft tissue and venal damage; lower risk of overdose and reduced litter. The authors were unable to find any evidence to support possible disadvantages of foil provision (see also section 1.2.3).

Research

Groin injection

A study of IDUs in opioid substitution treatment (OST)²⁶³ aimed to identify factors which may influence the cessation of groin injecting (Senbanjo et al. 2010). Participants (n=114) were grouped as either current (n=65) or former groin injectors (n=49). The authors reported that former groin injectors had been injecting drugs for a significantly longer time than current groin injectors (15.2 years compared to 11.9 years) and were significantly older than current groin injectors (39.4 years compared to 34.0 years). Nearly a third (30.6%) of former groin injectors reported that they had ceased the practice due to 'effective OST', although regression analysis demonstrated that this was not a statistically significant factor in cessation. Other reasons for cessation were given as 'deterioration in physical health' (29%) and difficulties in finding the femoral vein in the groin (10%). The authors conclude that groin injecting can become an 'intractable' behaviour for some and cessation should be promoted at an early stage.

Availability of injecting equipment

A survey of drug services²⁶⁴ across the UK was undertaken to assess the availability of injecting equipment following a change to legislation in 2003 which made the supply of such paraphernalia legal (Scott 2010). It was reported that the vast majority of service providers (92%) stated that their services supplied needles, syringes and one or more additional items (including swabs); 12% supplied needles, syringes and swabs only; nine per cent supplied one or more items of paraphernalia, but not swabs; and eight per cent supplied needles and syringes only. Only four per cent supplied each item of paraphernalia that is necessary for injecting.²⁶⁵

Injecting practices and knowledge of the associated risk amongst young IDUs

Young IDUs accessing treatment²⁶⁶ were interviewed to explore their knowledge of risks associated with injecting practices (Trudgeon and Evans 2010). Thematic analysis highlighted that: participants knew very little or nothing about the risks associated with injecting drugs when they first tried; practical knowledge was gained through interaction with other injectors, whether they were parents or peers; and all participants stated that they had been introduced and helped to inject by older and more experienced IDUs. All participants were able to; identify risks associated with injecting, knew about certain safer practices and had experienced some of the harms associated with injecting. However, adoption of safer practices was preceded by the desire to obtain a 'hit' and avoid withdrawal. Participants were all provided with information and advice from their key workers as part of their treatment but were more influenced by advice from injecting peers, regardless of its accuracy. The authors suggest that key workers may not be successful in influencing young IDUs injecting practices.

7.3.2 Viral hepatitis prevention and treatment

²⁶³ A total of 114 patients attending a health clinic for groin injectors in the South East of England participated in the study. They were assigned to two groups: current groin injectors who had injected into the femoral vein in the previous month (current GIs), n=65; and former groin injectors (former GIs), n=49. Participants provided explanations as to why they changed their behaviour and ceased groin injecting.

²⁶⁴ A total of 228 drug service co-ordinators, responsible for the co-ordination of needle exchange services across the UK, responded to a postal questionnaire which was sent out in spring 2005, 18 months after the law had been changed. The aim was to establish how well the law had been implemented and to investigate the types of paraphernalia that was available at these services.

²⁶⁵ Defined as sterile water, spoons, filters, tourniquets, swabs and at least one type of acid.

²⁶⁶ A purposive sample of three females and two males in treatment aged between 16 and 19 and from Plymouth in South West England were identified by their key worker as having commenced injecting before the age of 18. Participants were interviewed using a semi-structured format and transcribed data were thematically analysed.

Hepatitis C: uptake of testing

In England, increasing the proportion of IDUs who are aware of their infection status through improved uptake of voluntary confidential testing is one of the aims of the *Hepatitis C Action Plan for England* (DH, 2004). Of those IDUs taking part in the UAM Survey in England in 2010, 83% reported having undertaken a voluntary confidential test, compared to 49% in 2000. Fifty-five per cent of those infected with hepatitis C were aware of their status in 2010, compared to 40% in 2000 (HPA 2011a).

Of the UAM Survey participants from Wales, 62% reported having a voluntary confidential test for hepatitis C in 2010, with 34% of those with hepatitis C aware of their infection. Ninety per cent of the participants from Northern Ireland reported having been tested for hepatitis C, and 60% of the participating IDUs with hepatitis C were aware of their hepatitis C infection (HPA 2011).

In 2010, 77% of the current and former IDUs surveyed at needle exchanges across Scotland through NESI reported ever having had a voluntary confidential test for hepatitis C (HPA et al. 2011). In the 2008/09 NESI survey, 74% of those participating reported ever being tested. Amongst IDUs who were hepatitis C antibody positive on dried blood spot testing in the Needle Exchange Surveillance Initiative (NESI) in 2010, 44% reported that they had been diagnosed hepatitis C positive and a further 12% reported having cleared the virus.

Scotland:

Hepatitis C Action Plan Phase II and Sexual Health and Blood-borne Virus Framework

In Scotland, a year-two progress report on the second phase of Scotland's *Hepatitis C Action Plan* (Scottish Government 2008e) was published. Achievements include:

- the number of individuals starting treatment for hepatitis C doubling since 2007/08 from 450 to 900 in 2009/10;
- an increase in treatment numbers in Scottish prisons since 2007/08 (from 17 to 112);
- a 34% increase in the number of new diagnoses between 2007 and 2010 (1,550 to 2,081); and
- the publication of best practice guidelines for the provision of injecting equipment.

The Scottish Drug Forum report that the government funded hepatitis C prevention training programme²⁶⁷ has, since 2009, delivered training sessions in HCV awareness to workers in voluntary youth organisations that deal with young people at high risk of involvement in drug injecting. At the end of 2010, a total of 37 sessions had been delivered to nearly 400 workers at around 60 different projects across Scotland (SDF 2011). The Action Plan ended in March 2011.

A new *Sexual Health and Blood-borne Virus Framework 2011-2015* (Scottish Government 2011a) has been published by the Scottish Government. The framework will take forward the work of the *Hepatitis C Action Plan*, alongside work on HIV sexual health and hepatitis B. It seeks to promote better joint working across the different policy areas, and recognise that many individuals affected by these various health concerns are likely to have multiple needs. It encompasses the work of agencies from sexual health, HIV, hepatitis C and hepatitis B and takes a multi-agency, cross agenda approach. The framework has five high level outcomes: fewer new BBV and sexually transmitted infections and unintended pregnancies; reduction in health inequalities in sexual health and BBV services; longer lives for people with BBVs; freedom from sexual harm and coercion; and positive attitude from society towards sexual health and BBV. As part of this work a new national third-sector body,

²⁶⁷ See: <http://www.sdf.org.uk/sdf/429.200.321.html#training>

Hepatitis Scotland,²⁶⁸ has been established to take a lead role in supporting the delivery of the framework.

Wales: Blood-borne viral hepatitis action plan for Wales 2010-2015

The *Blood-borne Viral Hepatitis Action Plan for Wales 2010–2015* (WAG 2010d) was approved by the Welsh Government and implementation began in April 2010. To date a number of actions have been completed. Key achievements include:

- the introduction of the Harm Reduction Database in all statutory and voluntary needle exchange services across Wales highlighting BBV prevention and facilitating testing;
- roll out of a 'Training the Trainer' course on blood-borne viruses to key individuals across a range of organisations throughout Wales;
- the introduction of diagnostic dried blood spot testing (DBS) in selected substance misuse services along with an enhanced surveillance system designed to capture the results alongside a limited set of behavioural data; and
- the introduction of DBS testing in the five prisons in Wales and the appointment of a BBV prison nurse specialist to work across these prisons.

Future proposals include: the development of both targeted and generic education and awareness raising tools for use in a variety of settings, including the prison environment to improve rates of diagnosis and referral into treatment; encouraging the uptake of hepatitis B vaccination and BBV screening in at-risk populations; expanding the availability of DBS testing and improving the follow-up rates of DBS positive individuals; and undertaking further validation work to determine the sensitivity and specificity of polymerase chain reaction (PCR)²⁶⁹ from dried blood spot testing compared to venepuncture.

Hepatitis B vaccination

The proportion of IDUs participating in the UAM Survey in England, Wales and Northern Ireland who reported having taken up an offer of hepatitis B vaccination has increased markedly over time, rising from 35% in 2000 to 74% in 2010²⁷⁰ (HPA 2011a; HPA 2011b). Self-reported vaccination uptake varied by region and country; in 2010 it was 75% in England (regional range: 63% to 88%), in Wales it was 64%, and in Northern Ireland it was 73% (HPA 2011a).

Over two-thirds (68%) of the current and former IDUs surveyed at needle exchanges across Scotland as part of the NESI in 2010 reported uptake of the hepatitis B vaccine (HPA et al. 2011).

7.3.3 HIV prevention and treatment

HIV testing

Amongst IDUs, there has been an increase in the uptake of HIV testing in recent years. In 2010, 75% of IDUs who took part in the UAM Survey reported ever having had a voluntary confidential test for HIV (HPA 2011a). This the highest level ever recorded in this survey, and compares with only 52% having ever been tested in 2000 (HPA 2011b). Of the participants in the UAM survey who had antibodies to HIV, 89% reported being aware of their infection in 2010. This was the highest level of awareness of HIV infection reported since the survey began (HPA 2011b).

²⁶⁸ Hosted by the Scottish Drugs Forum. See: <http://www.sdf.org.uk/sdf/4570.html>.

²⁶⁹ The polymerase chain reaction (PCR) is a scientific technique in molecular biology to amplify a single or a few copies of a piece of DNA across several orders of magnitude, generating thousands to millions of copies of a particular DNA sequence.

²⁷⁰ Vaccination uptake data should be interpreted with caution as they are based on self-reports.

HIV treatment and care

The number of HIV-infected people seen for HIV treatment and care in the UK who had acquired their infection through injecting drug use has increased over the past decade, with 1,565 seen in 2010 (HPA et al. 2011). In 2010, 492 people who had acquired their HIV-infection through injecting drug use, and who were seen for care, had CD4 counts of 350 or less (the level at which it is recommended to start anti-retroviral therapy).²⁷¹ Of these, 86% were on anti-retroviral treatment; this level is comparable to that for other groups (HPA et al. 2011).

Condom use

Participants in the UAM Survey are asked about the number of sexual partners they had and the use of condoms with these partners during the preceding year. Data from the survey for England, Wales and Northern Ireland indicates that among those reporting more than one sexual partner during the past year, only 22% had always used a condom for vaginal or anal intercourse (HPA 2011a).

7.4 Responses to other health correlates amongst drug users

7.4.1 Mental health

The Department of Health has published *No health without mental health: a cross-Government mental health outcomes strategy for people of all ages*²⁷², which aims to develop and improve the delivery of mental health services and outcomes for people with mental health problems (HM Government 2011b). An action plan and other supporting documents have been published to complement the strategy. The strategy contains six key objectives to ensure that more people with mental health problems recover and have good physical health; more people have good mental health and a positive experience of care and support; and fewer people suffer avoidable harm and experience stigma. It is hoped that the strategic aims of the promotion of mental wellbeing, prevention of mental illness and early intervention will also help to reduce the risk of substance misuse across the population. It is stated that the provision of fully integrated local care is an important feature in the treatment of dual diagnosis and improvements in service provision and commissioning will be supported by this strategy.

Assessment and management of psychosis with coexisting substance misuse

The National Institute for health and Clinical Excellence (NICE)²⁷³ published a clinical guideline entitled *Psychosis with coexisting substance misuse: assessment and management in adults and young people* (NICE 2011). A key aim of the guideline is to improve recognition of both conditions as it is suggested that substance misuse is often not identified in people with mental illness. The guideline was developed by the National

²⁷¹ Gazzard, B.G & BHIVA Treatment Guidelines Writing Group. British HIV Association Guidelines for the treatment of HIV-1-infected adults with antiretroviral therapy 2008. *HIV Medicine* 2008;9:563-608.

²⁷² See: <http://www.dh.gov.uk/en/Healthcare/Mentalhealth/MentalHealthStrategy/index.htm>. This document was referred to as *New Horizons: towards a shared vision for mental health* in earlier UK Focal Point reports.

²⁷³ NICE recommendations are based on systematic reviews of best available evidence and explicit consideration of cost effectiveness. When minimal evidence is available, recommendations are based on the Guideline Development Group's experience and opinion of what constitutes good practice; this was often necessary for this guidance because there was evidence for the treatment of either psychosis or substance misuse but little evidence for treatment when both conditions were present (Kendall et al. 2011 BMJ practice summary).

Collaborating Centre for Mental Health (NCCMH)²⁷⁴ and contains guidance on best practice in the assessment and management of people with psychosis and coexisting substance use issues including advice on:

- how to recognise and work with people with psychosis and coexisting substance misuse;
- the referral of all people with known or suspected substance misuse and coexisting psychosis to secondary mental health services for assessment and further management;
- how to prevent the non-exclusion of individuals with psychosis and coexisting substance misuse from mental healthcare because of their substance misuse and from substance misuse services because of their psychosis; and
- how to ensure that evidence-based treatments for both conditions are offered and that treatment plans are tailored to the individual's needs.

7.4.2 Parental substance use

Responses related to parental substance use are contained in Chapter 12.

Pregnant substance users

Following the introduction of the all-Wales maternity record in 2009 (see 2009 UK Focal Point Report), there has been an ongoing commitment by the Welsh Assembly Government (WAG 2010a) to routinely collect data regarding substance use amongst pregnant women, and to ensure that effective screening and services are offered.

Northern Ireland – Hidden Harm

A *Hidden Harm* implementation plan has been developed by the Public Health Agency with the support of the Health and Social Services Board. Specific resources have been set aside to support children and young people with substance misusing parents or carers, and to improving training and support to key professionals (such as midwives) (personal communication – Northern Ireland) (see 12.3.2).

7.4.3 Other research

Harm reduction at festivals

Wood et al. (2010c) reported on individuals who presented to medical facilities, provided on-site at a large outdoor lesbian, gay, bisexual and trans-gender (LGBT) music festival, with symptoms related to drug use. Physicians and St John's Ambulance²⁷⁵ were present at the facilities during the day-time part of the event, whereas during the evening part of the festival the medical facilities were managed only by the St John's Ambulance service, without doctors present. It compared the number of day-time presentations to the medical facilities which required further treatment at hospital to the number requiring hospitalisation at the evening event (which was not covered by physicians). They reported that a significantly higher proportion of cases requiring hospitalisation occurred during the evening; 39.1% (n=9) compared to 7.4% in the day time (n=15). The authors posit that the presence of physicians at such events may reduce the requirement for treatment at secondary healthcare facilities and suggest that this is further investigated.

²⁷⁴ The NCCMH is responsible for developing mental health guidelines in England and Wales, and is a partnership between the Royal College of Psychiatrists (RCPsych) and the British Psychological Society (BPS). See: <http://www.nccmh.org.uk/about.html>

²⁷⁵ The St. Johns ambulance service is a charity that provides first aid throughout the UK at public events such as music festivals, football matches and other sports events.

Service provision at community pharmacies

A qualitative study²⁷⁶ investigated the role that community pharmacies currently play in the provision of services to problematic drug users (Mackridge et al. 2010). It also explored the possibility of extending services. Interviews were conducted with service commissioners, pharmacy staff and service users to establish their views on current service provision and to discuss possible additional services. The authors suggest that the varied and sometimes complex health needs of current and former drug users are often not met by existing services and the expansion of pharmacy based services may be one way to improve the situation. This idea was generally met with agreement by commissioners and pharmacy staff, although service users tended to be less sure. It was also found that some service users were unaware of the levels of current service provision within pharmacies and therefore it is recommended that this is addressed before further expansion of services is considered.

²⁷⁶ Service commissioners and other key stakeholders (n=7) with experience of pharmacy services were purposively sampled from the study area in an urban region of the north west of England. They participated in structured telephone interviews lasting around 20 to 40 minutes in June and July 2008. All 116 community pharmacies which operated in the study area were invited by post to participate. Thirteen individuals from these pharmacies participated in one of two focus group discussions. The first was held with front-line staff (n=8) and the second with individuals employed by pharmacies in a more strategic capacity (n=5). Twenty problematic drugs users, recruited opportunistically through NSP's, also participated in two further focus group discussions. All participants were asked for their views on current service provision in community pharmacies.

8. Social correlates and social reintegration

8.1 Introduction

There is a large volume of evidence from the United Kingdom showing an association between problem drug use and social exclusion. A high proportion of problem drug users have been socially excluded as children and young people; many are poorly educated; a high proportion live in inappropriate housing; and research in 2008 suggested that just over 80% (266,798) of problem drug users in England were in receipt of state benefit, representing seven per cent of all those receiving such benefits (Hay and Bauld 2008). There are also further concerns about the effect of parental drug use on children, leading to problems of social deprivation for them.

Social reintegration is a key element within recent drug strategies in England, Scotland and Wales. The strategy for Northern Ireland also recognises the need to provide support with housing and employment, and wider support with social reintegration. There are various programmes to help drug users. The Supporting People Programme, introduced in 2003, provides housing related support to vulnerable groups generally, including people with drug problems. Employment support for drug users is delivered through the Work Programme which replaced a number of previous employment support programmes. Social inclusion programmes such as Positive Futures can bridge the gap between universal and targeted services (see section 3.2.2). Attention is also focused on the impact of parental drug use on children. In addition, there is a number of responses to neighbourhood problems associated with problem drug use, including drug dealing. For example, the *Anti-social Behaviour Act 2003* seeks to stop the use of premises for drug dealing. Also, there is guidance to tackle the inappropriate disposal of drug paraphernalia.

8.2 Social exclusion and drug use

8.2.1 Housing

Data from the National Drug Treatment Monitoring System (NDTMS) in England show that in 2010/11, nine per cent of clients presenting for treatment reported an urgent housing problem, a slight increase from eight per cent recorded the previous year (NTA 2011e).

Data show that between May 2010 and April 2011²⁷⁷ the majority of clients assessed as part of the Drug Interventions Programme (DIP) resided in 'settled'²⁷⁸ accommodation (75%, n=46,456). Seventeen per cent of individuals were living in temporary accommodation (n=10,623) and eight per cent had no fixed abode (4,598) (HC Deb, 11 July 2011, c77W).

Of those clients taken onto the Drug Interventions Programme (DIP) caseload in Wales during 2009/10, around one-quarter (24%) were in temporary accommodation with seven per cent of no fixed abode (WAG 2010e; see section 9.3.1).

Data from the Scottish Drug Misuse Database (SDMD) show that, in 2009/10, 80% of new clients accessing drug treatment services (and who provided information) reported that they lived in owned or rented accommodation at the time of presentation and, as in the previous year, 16% reported that they were homeless²⁷⁹ (ISD Scotland 2010). Of the new clients who provided information on their living situation, 38% lived alone, 22% lived with parents, 25% lived with a spouse/partner and 17% lived with other drug users (ISD Scotland 2010).

²⁷⁷ Information on individuals' housing needs are collected as part of the DIP assessment of needs. 62,490 assessments were carried out and 61,677 (99%) had an accommodation status recorded

²⁷⁸ Settled accommodation is defined as: Local Authority/ Registered Social Landlord; private rented; approved premises; supported housing/ hostel; caravan; own property; settled with friends; and other.

²⁷⁹ This includes those reporting living in temporary or unstable accommodation, or a hostel.

8.2.2 Employment and education

Treatment Demand Indicator (TDI) data (see section 5.4) show that in 2009/10 two-thirds of clients (66%) presenting to treatment in England, Scotland and Northern Ireland were unemployed. Only 13% reported being in regular employment, a decrease from 15% in 2008/09. Males (14%) were more likely to be employed than females (9%). A higher proportion of clients presenting to treatment for the first time were in regular employment (17%) but this had also decreased since the previous year (20%).

Seventy-three per cent of clients entering treatment in Scotland in 2009/10 were unemployed and 13% were in paid or unpaid employment.²⁸⁰ Seventy-two per cent reported that their drug use was funded by welfare benefits (ISD Scotland 2010).

Data from the Department of Work and Pensions (DWP)²⁸¹ show that, as at August 2010 in the UK, there were a total of 37,480 individuals claiming Incapacity Benefit/Severe Disablement Allowance and a further 9,870 in receipt of Employment and Support Allowance with their primary medical condition recorded as 'drug abuse'. One quarter of these had been claiming for ten years or more (n=9,200); 35% for five to 10 years (n=13,230); one-fifth for three to five years; and one-fifth for less than three years (n=7,640 and n=7,410 respectively) (DWP 2011).

In Wales, between 2008 and 2010, it was reported that 89% (n=153) of individuals who died of a drug-related death, and whose personal circumstances were reviewed by a regional panel, were unemployed or in receipt of benefits (WAG 2011a).

8.2.3 Families

In Scotland in 2009/10, 42% of new clients reporting to the SDMD stated that they had dependent children under the age of 16 years old.²⁸² The proportion of treatment entrants who reported that they have dependent children remained stable between 2006/07 and 2009/10 (ISD Scotland 2010).

In Northern Ireland in 2009/10, Treatment Demand Indicator (TDI) data show that 20% of clients presenting to outpatient treatment lived with a child, one-third of whom lived alone with a child.

For further data on the parental status of treatment entrants see section 12.1.1.

8.2.4 Sex workers

Data from Scotland for new clients reported to the SDMD showed that, as in 2008/09, two per cent of those entering drug treatment in 2009/10 funded their drug use through sex work (ISD Scotland 2010).

8.2.5 Stigmatisation of problem drug users

As part of a wider research project by the UK Drug Policy Commission (UKDPC) exploring the stigmatisation of drug users, and following on from an expert review of the published

²⁸⁰ Employed includes: paid and unpaid employment, support into employment and full time education/ training.

²⁸¹ See:

[http://statistics.dwp.gov.uk/asd/asd1/adhoc_analysis/2011/ib_sda_esa_medical_duration_aug_2010.x](http://statistics.dwp.gov.uk/asd/asd1/adhoc_analysis/2011/ib_sda_esa_medical_duration_aug_2010.xls)

ls

²⁸² The Scottish Drug Misuse Database (SDMD) records information on drug misusers using information collected from a standard reporting tool. It should be noted that, while this is a source of information on children affected by parental substance misuse, the main purpose of the database is not to assess the numbers of children living with substance misusing parents and only parents who are entering treatment will be recorded. Information on children is not reported for all clients, and relies upon honest self disclosure.

research²⁸³ (Lloyd 2010; see 2010 UK Focal Point Report), a survey of UK households was undertaken to investigate the attitudes of the general public towards people with a history of drug dependence and their families²⁸⁴ (Singleton 2010). In the majority of cases people felt that drug dependence was a chronic illness and were supportive towards providing help for drug users to overcome their dependence. However, it was reported that a significant proportion of respondents displayed a lack of tolerance towards people with a history of drug use, with the suggestion that many people think drug users are 'to blame for their condition'. Attitudes towards drug dependence were generally far more negative than those towards people with mental illness, and the author concludes that social stigma towards drug users is an issue in the UK that will potentially act as a barrier to the successful reintegration of drug users into society.

In an overview report (UKDPC 2010), and a separate report focusing on the stigmatisation of individuals with a history of drug problems in Scotland²⁸⁵ (Singleton 2011b), it was reported that negative attitudes towards individuals who use/have used drugs and their families can pose a challenge to the delivery and achievement of recovery. A series of recommendations aimed at changing public perception are made in the report including: improving public knowledge of drug dependency to reduce fear; developing the professional capabilities of those who work with drug users in order to improve services; removing barriers (legal and administrative) that reinforce stigma towards drug users; increasing support for peer mentoring and recovery communities; and developing further community engagement and contact with recovering drug users to improve public perception.

A content analysis of press reporting of drug use²⁸⁶ was also undertaken and published as part of a background report which informed the stigma research project. The results showed that newspapers most frequently reported drug use as a result of an event linked to crime, such as a court case or an arrest (25% of cases in the UK, 38% of cases in England). It is suggested that the dominance of reporting drug use in terms of crime may negatively influence the understanding the public have of drug use (UKDPC 2010).

A study investigating the effect of previous personal and family drug use on medical students' attitudes towards drug users²⁸⁷ found that, in general, attitudes tended to be fairly neutral (Linden 2010). The author reports that these results demonstrated generally positive

²⁸³ To investigate how far the findings of the review by Lloyd (2010) regarding stigma and drug users are applicable across the UK, the UKDPC undertook three further pieces of research: a survey of public attitudes in the UK towards drug users; a qualitative study of people with a history of drug problems and their families regarding their experiences of stigma; and a content analysis of media coverage regarding drug users in a selection of newspapers.

²⁸⁴ A total of 2,945 individuals aged 16 and over, selected to be representative of the UK adult population, participated in quantitative face to face interviews in their homes between 7th April and 2nd May 2010. A random location sampling methodology was used. Participants were asked to rate their agreement on a five-point likert scale to a series of 25 attitude statements. Thirteen statements were based on the existing *Attitudes to Mental Illness (AMI) survey* (DH 2010), with the terminology changed from mental illness to drug dependence; the responses to these statements were compared to the AMI results.

²⁸⁵ The UK-wide survey of public attitudes towards drug users included a boosted sample of 566 individuals who lived in Scotland and were aged over 16. A series of qualitative interviews and focus groups were also undertaken with a group of current and ex-drug users in Scotland and their families in 2010 which was complemented by a web-based survey.

²⁸⁶ A total of 6,600 items of press coverage which referenced drug use or drug users in eight newspapers from across the UK (representative of national, regional, broadsheet and tabloid papers) were analysed for the years 1995, 2002 and 2009.

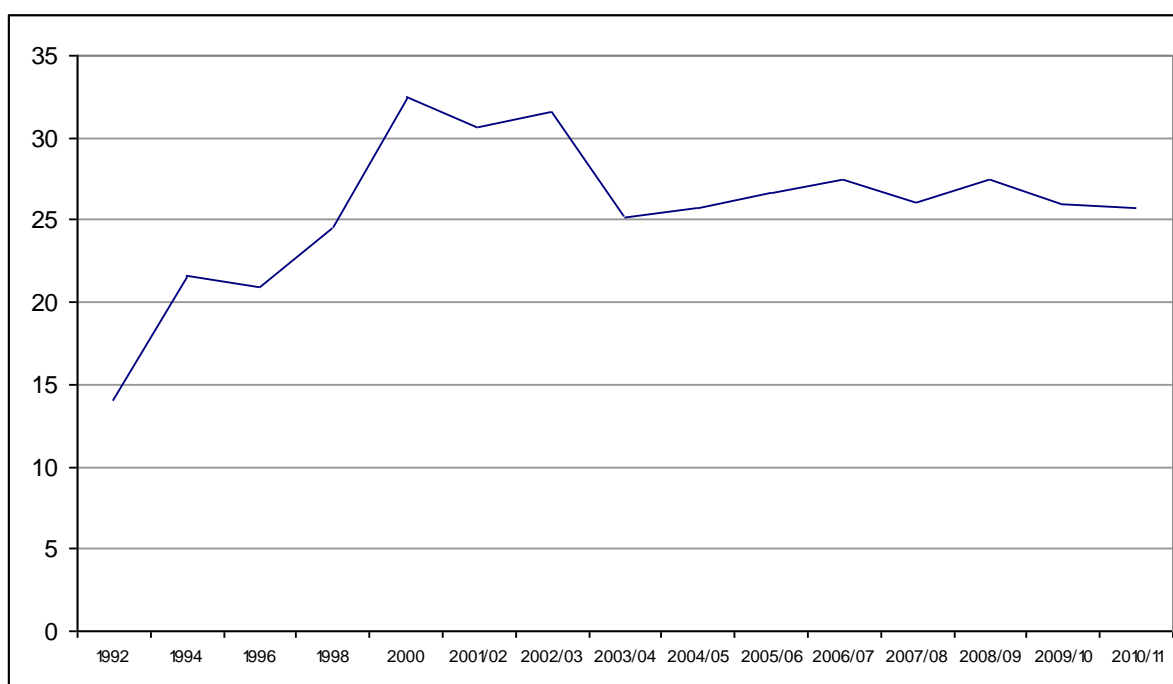
²⁸⁷ A sample of 1,105 medical students from a medical school in Sheffield in the north of England took part in an online survey between 19th May and 30th June 2008. The survey was open to all students at the medical school regardless of year of study. The study was advertised through an online news board and via a direct link to a specific 'evaluation and surveys' section on the institutional website.

attitudes towards substance users in terms of ‘non-stereotyping’ and ‘treatment optimism’ and that they are broadly in line with previous research.

8.2.6 Perceptions of anti-social behaviour

Analysis of the 2010/11 *British Crime Survey* (BCS) (Chaplin et al. 2011) looking at measures of anti-social behaviour shows that 13.7% of respondents perceive there to be a high level of anti-social behaviour in their area, a significant decrease from 14.4% in 2009/10. One of the seven indicators used to compile this measure is people dealing or using drugs. In 2010/11, 25.7% of respondents reported that this was a problem in their area, a slight decrease from 26.0% in 2009/10. Looking at the long-term trend, the levels are higher than that reported in 1996, but lower than the levels reported in the early 2000s, with rates relatively stable since 2003/04 (Figure 8.1).

Figure 8.1: Percentage of adults reporting people using or dealing drugs to be a problem in their area in England and Wales, 1992 to 2010/11



Source: Chaplin et al. 2011

The Scottish Household Survey 2009/10 (Scottish Government 2011b) found that 11% of respondents perceived drug misuse or dealing to be ‘very’ or ‘fairly common’ in their neighbourhood, a decrease from 12% in 2009. Between 2005 and 2009, the percentage of respondents reporting that drug misuse or dealing is ‘very’ or ‘fairly common’ in their neighbourhoods remained largely stable (around 12%).

In *Perceptions of Crime: findings from the Northern Ireland Crime Survey (NICS) 2009/10*²⁸⁸ (Freel et al. 2011), drugs were commonly cited as a major cause of crime (by 70% of

²⁸⁸NICS is a representative, continuous, personal interview survey of the experiences and perceptions of crime of 4,102 adults aged 16 years and over, living in private households at randomly selected addresses throughout Northern Ireland. Interviews for this survey were undertaken between 1st April 2009 to 31st March 2010. The survey was conducted on an ad hoc basis in 1994/95, 1998, 2001 and 2003/04. The NICS has operated on a continuous basis since January 2005. The core questions and format of the 2009/10 NICS closely mirror those of the 2009/10 BCS, allowing for comparisons with

respondents). The most frequently identified single reason for crime was lack of discipline from parents (25%) followed by drugs (22%). The survey also measures aspects of anti-social behaviour, with 13% of respondents feeling that levels are high in their local area. Similar to the BCS, one of seven measures of anti-social behaviour in Northern Ireland is people dealing or using drugs. Twenty-three per cent of respondents stated that this was a problem in their area.

8.2.7 Social harms associated with khat use

In a review of the literature on khat use and social harms it was reported that there was a dearth of literature available and a lack of robust evidence to determine causality between khat use and any of the social harms that have previously been suggested by what is generally anecdotal evidence (such as unemployment, criminality, anti-social behaviour, violence) (Anderson and Carrier 2011). The authors discussed the findings of three main quantitative UK studies and several qualitative studies. They state that the results are limited due to small sample sizes. Another limitation is that the focus of the currently available research is mainly on the Somali population, whilst research regarding other communities that also have a tradition for khat consumption (such as Ethiopians, Yemenis and some Kenyans) is unavailable. They conclude that future research should fully consider other variables (such as the effects of civil war, displacement and gender relations) as these may contribute to social harms within communities that use khat.

In a report into a Home Office research study²⁸⁹ (Sykes et al. 2010) it was suggested that khat was widely used by members of the three communities represented in the study and its use was regarded as socially acceptable within these communities, although the consequences of heavy use were generally thought to be negative and seen as unacceptable. Perceived social harms discussed by participants included those pertaining to: physical and mental health; work/finances; and family life and relationships. Most participants were in agreement about the need for some form of government intervention and suggestions included: regulation and import control; education; training for health workers; funding research into its health implications and treatment; and improved data collection on prevalence of use. Some participants were also in favour of a ban, although there was no clear consensus as perceptions on the degree of harms associated with khat use were mixed (see section 6.3.5).

8.2.8 Community impact of a medically supervised injectable maintenance clinic

An investigation into the impact on the local community of a medically supervised injectable maintenance clinic (MSIMC) was conducted with local stakeholders²⁹⁰ (Miller et al. 2010). Key concerns raised by residents prior to its opening included: a possible increase in crime; the 'honey pot' effect, whereby the facility would attract more drug users to the local area; and an increase in drug-related litter. After two years, follow-up interviews suggested that the initial fears of local residents about the clinic attracting more drug users into the area did not

data from England and Wales, with some additional questions and modifications to reflect local issues and the smaller sample size of the NICS.

²⁸⁹ Focus groups and interviews were carried out with members of the Somali, Yemeni, and Ethiopian communities. See section 6.3.5 for methodology.

²⁹⁰ The clinic in south London opened in October 2005 as part of the wider Randomised Injectable Opioid Treatment Trial (RIOTT). A total of 35 clients attended the clinic over the two years of this study between 2005 and 2007. Patients at this clinic attended twice-daily to self-administer either injectable methadone or injectable heroin under supervision. The research team spoke to members of the local community between May and October 2005 prior to the commencement of the injectable maintenance clinic (n=22) and asked them to discuss their fears and the possible negative effects operating such a clinic may have on their local community. At the two-year follow-up all of the original participants and 18 additional local stakeholders took part in in-depth interviews between 1st April and 14th April 2007.

materialise and several participants held the view that street drinkers in the local area were more problematic than drug users. Local crime data²⁹¹ for the period the clinic was operational were analysed and compared to levels prior to its opening. The results showed that crime levels had stayed stable over the period concerned. Overall, the authors concluded that there was 'no observable' impact on the community from the clinic and suggest that the model of service delivery used in this study, with a small number of clients, is one that is 'desirable'.

8.3 Social reintegration

8.3.1 Housing

England

In 2009/10 local authorities spent €35.5 million (£31.6 million) on housing-related support services for drug users funded through the Supporting People programme.²⁹²

Housing and employment needs assessment

The National Treatment Agency (NTA) has developed a housing and employment resource²⁹³ pack to accompany previously published needs assessment guidance²⁹⁴ (NTA 2011h). Its purpose is to help commissioners of treatment services to fulfil the employment and housing aspects of the 2011/12 treatment planning and needs assessment process.

Housing for recovery survey

The results of an online survey of housing provision for drug service clients carried out amongst service providers²⁹⁵ (Drugscope 2011) showed that many respondents felt housing services were difficult or very difficult to access in their local area; 89% reported that 'safe, secure and appropriate services' were difficult or very difficult to access in their local area. Many respondents (62%) also anticipated that funding for accommodation for their clients would become more difficult to obtain in the future and as such, accommodation may become less accessible.

Scotland

Turning Point Scotland²⁹⁶ set up a Housing First²⁹⁷ pilot housing scheme in Glasgow in 2010 (see 2010 UK Focal Point Report). The scheme provides accommodation for 12 homeless

²⁹¹ Crime statistics for the local area were accessed from the Metropolitan Police's crime statistics website.

²⁹² The Supporting People programme provides housing-related services to vulnerable client groups at risk of social exclusion. See: <http://www.communities.gov.uk/documents/housing/xls/1755045.xls>

²⁹³ See: <http://www.nta.nhs.uk/uploads/employmenthousingvfinal.pdf>

²⁹⁴ See: <http://www.nta.nhs.uk/planning-and-needs.aspx>

²⁹⁵ For two weeks between June and July 2011 an online survey was conducted with 91 practitioners from services from the private, statutory, voluntary and community sectors, covering a range of treatment modalities and homelessness services.

²⁹⁶ A charity which provides drugs services in Scotland. See:

http://www.turningpointscotland.com/substance_misuse_services

²⁹⁷ Housing First is an approach to tackling homelessness that has been developed in the USA, whereby homeless people are moved directly into independent housing rather than via a number of interim steps which is the more typical model of 'linear' housing in the UK. The Housing First

people who have problems with chaotic drug use. The aim of the project is to take a harm reduction approach, whereby clients feel they are able to be honest with the floating support staff employed at the service about the challenges they are facing, such as relapse, without their tenancy being revoked (Johnsen and Teixeira 2010). Turning Point Scotland has recently secured European funding to test and evaluate projects working within a Housing First framework in Europe. The scheme in Glasgow is one of several 'test' sites which will be evaluated over a two year period with an emphasis on mutual learning, support and policy transfer between each of the 'test' and 'peer' sites²⁹⁸.

8.3.2 Employment

The Government is currently in the process of undertaking welfare reforms as part of its Welfare to Work programme.²⁹⁹ This scheme will encompass all individuals who currently receive welfare benefits, including substance users. *The Welfare Reform Bill*³⁰⁰ (DWP 2011) was put before parliament in February 2011 by the Department for Work and Pensions (DWP). A key aim of this bill is to streamline the many and various forms of welfare payments that are currently available and to replace them with a Universal Credit.

As part of changes to the welfare benefits system, the Work Capability Assessment (WCA)³⁰¹ was introduced in October 2008 to assess a claimant's entitlement to the Employment and Support Allowance (ESA) on the grounds of illness or incapacity.³⁰² The WCA is independently reviewed each year and the results from a second annual report, due for publication in late 2011, will look at the experience of drug users. As of the 28th March 2011, people in residential treatment for drug or alcohol dependency have been automatically treated as having limited capability for work for the purposes of the Employment and Support Allowance. This legislative change brought the status of clients in residential drug treatment in line with individuals receiving medical treatment as a hospital in-patient (personal communication - Department for Work and Pensions).

Wales: Peer mentoring scheme

In Wales a voluntary peer mentoring scheme has received around €14 million (£12 million) of European Social Fund (ESF) funding until September 2013.³⁰³ The money will benefit around 13,000 individuals and will involve 210 peer mentors who themselves are ex-drug users. The aim of the scheme is to embed peer mentoring into the recovery process and to

approach means that homeless people are placed directly into independent tenancies, with support, rather than being placed into temporary or transitional accommodation such as hostels first whilst they prove that they are in treatment and are making progress which will enable them to move onto an independent tenancy in the future. It is based on a harm minimisation approach (Johnson and Teixeira 2010).

²⁹⁸ This project will be funded by the European Parliament as part of the Progress Programme. It will assess how Housing First services are implemented, the differences and similarities between the projects, and also the degree of consensus regarding the Housing First model. It will also assess the effectiveness of the approach for the resettlement of homeless people and develop the approach for possible use on a wider scale.

²⁹⁹ See: <http://www.dwp.gov.uk/supplying-dwp/what-we-buy/welfare-to-work-services/>

³⁰⁰ See: <http://www.dwp.gov.uk/policy/welfare-reform/legislation-and-key-documents/welfare-reform-bill-2011/>

³⁰¹ See: <http://www.dwp.gov.uk/policy/welfare-reform/employment-and-support/wca-independent-review/>

³⁰² Employment and Support Allowance (ESA) was introduced on 27 October 2008, replacing a range of incapacity benefits for individuals, including drug users, making a new claim for financial support on the grounds of illness or incapacity. An individual's capability for work is assessed via the Work Capability Assessment (WCA) which is carried out by a healthcare professional. Between October 2010 and 2014, individuals currently receiving the older style incapacity benefits will be reassessed and moved to ESA or other benefits more appropriate to their circumstances.

³⁰³ See: <http://wales.gov.uk/topics/housingandcommunity/safety/substancemisuse/peerment/?lang=en>

improve life chances for ex-drug users in the longer term. The peer mentors are actively recruited and can also put themselves forward to receive training to become a mentor and deliver the services. The scheme will involve drug users aged over 18 and individuals can enter on a self-referral basis. The aim is to provide wraparound services for post-treatment clients to help get them back into employment and training and provide long-term help for individuals in recovery. The scheme has been shaped and developed with service user involvement. It is an all-Wales initiative, involving six delivery partners who are substance use service providers. A scoping study has already been carried out and the scheme is currently being evaluated by the University of Glamorgan, with a report due in late 2011 and the final evaluation report to be provided by December 2013.

Employment guide for drug services in London

Drugscope (2010) has published a guide for drug and alcohol services in London intended to provide examples of good practice in assisting substance users into employment. The guide has been developed following a two-year 'Pathways to Employment' project. It contains the results of a literature review on employment education and training support for drug users and also acts as a directory of relevant employment and training service providers in London.

Occupational values, skills and development needs amongst detox clients

An investigation into self-reported occupational competencies and development needs was carried out amongst a sample of drug users undergoing residential detoxification using a self-assessment questionnaire³⁰⁴ (Davies and Cameron 2010). Semi-structured interviews were also conducted with some participants to further identify their work-related skills and limitations.³⁰⁵ The results showed that most participants had some or a lot of problems with: managing finances (90%); decision making (87%); getting necessary things done (83%); having a satisfying routine (83%) and working towards goals (83%). The areas that most participants saw as a priority area for development were: managing finances (47%); taking care of their home (43%) and taking care of themselves (43%). The authors suggest that these findings show that participants feel that they haven't got (or have lost) the ability to look after themselves and see this as a priority area for development. They recommend that clinicians should focus on developing skills in the areas of financial management and self-care with clients.

8.3.3 Families

Family Drug and Alcohol Court (FDAC) evaluation research study

Following the publication of an interim report last year (see 2010 UK Focal Point Report) a final evaluation report³⁰⁶ on the first family drug and Alcohol Court in England and Wales has now been completed (Harwin et al. 2011) (see section 12.4.2).

³⁰⁴ Thirty participants aged between 18 and 65 were recruited from an inpatient detoxification unit. Participants were referred through community drug teams. The Occupational Self Assessment (OSA) version 2.2 was used in this study. It is made up of two sections, the first entitled 'My environment' and the second entitled 'Myself'. The participants were asked to rate everyday skills and occupational task (such as managing finances, taking care of themselves and getting along with other people) in terms of importance and also rate their own ability to perform such tasks. The results were used to measure their competence and values and to establish priorities in terms of the participants' occupational development.

³⁰⁵ Six participants also took part in interviews in which they were asked to rate their own ability on the four areas that had been identified as priority areas for development through the OSA questionnaire and to further explore the difficulties they faced in these areas and why they were important to them.

³⁰⁶ See: <http://www.brunel.ac.uk/research/centres/iccfyr/fdac>. The pilot court has been running in London since January 2008 and will continue until March 2012. The evaluation was conducted with a sample of 55 families with 77 children who entered the FDAC between January 2008 and the end of

Wales

Integrated Family Support Services (IFSS)

In Wales, IFSS³⁰⁷ provides support to vulnerable children and families with complex needs. It is a multi-agency service which offers targeted support to families where there are concerns regarding child welfare and parental substance misuse (drugs and/or alcohol) (WAG 2010f). An evaluation of the project in four pilot areas is underway and is due for publication in 2012/13 (see section 12.4.2)

Early Parental Intervention Pilots

An evaluation examining the outcomes of early interventions with substance using parents has been concluded and disseminated to relevant service providers in Wales to inform future funding decisions. The five pilot projects focused on parents whose drug use had been identified as having a potential impact on their parenting ability (WAG 2010f) (see section 12.4.3).

Review of policies regarding substance use and families

In a review of recent UK drugs strategies and policies relating to substance use and families (Velleman 2010) it was suggested that whilst policies over the past few years have become more family orientated, there is still a need to increase understanding of the needs of family members affected by substance misuse and to provide more integrated and inclusive services for all those concerned.

8.3.4 Sex workers

In a review of a 2002 Home Office report and a 2007 sex worker service provision study, Cusick et al. (2011) discuss the emphasis which government policies place on 'exiting' strategies for sex workers. It is reported that high levels of problematic drug use amongst street workers often make exiting sex work difficult. The authors suggest that maintaining the individual's choice as to whether or not they exit sex work is vital in order to successfully engage clients with services and propose that, whilst current policies should include aims around exiting of sex work, this should not be the sole focus of support provided to sex workers.

In a small-scale qualitative study of the subjective experiences of sex workers³⁰⁸, factors which led them into sex work were discussed (Dodsworth 2011). It was reported that three quarters of the sample misused drugs and/or alcohol, and one of the recurring themes of the study was a cycle of coercion, drugs and sex-work. The results of this study suggest that there is no single pathway into sex work, rather a complex interplay of individual experiences and external factors. The author goes on to say that the individuals involved in this study have their own identities and perceptions about sex work and, as such, support should be tailored to take the views of the individual into account.

8.3.5 Social work

Review of social work services and recovery

June 2009. These families were from three pilot local authorities (Camden, Islington and Westminster). A comparison sample of families from areas outside of the pilot local authorities was utilised in the evaluation. This was made up of 31 families with 49 children who were the subject of care proceedings due to parental substance misuse. Over a six-month period, a total of 41 FDAC and 19 comparison cases were followed up to their conclusion.

³⁰⁷ See: <http://wales.gov.uk/topics/childrenyoungpeople/parenting/help/ifst/?lang=en>.

³⁰⁸ A total of 24 women aged between 18 and 65 were recruited using snowball sampling at specialist sex work projects. Fifteen were current sex workers and the rest had been sex workers at some point in their lives. In-depth interviews, following an interview schedule, were conducted asking about participants' experiences in terms of relationships, childhood, adolescence and adulthood alongside their perceptions of sex work and future aspirations.

In Scotland, a review of social care provision for individuals with substance related problems³⁰⁹ found that professionals work with a high number of clients with substance misuse problems (Galvani and Forrester 2011a). The review supported the suggestion that social work can, and should, have a strong role to play in the move towards recovery focused approaches to problem drug and/or alcohol use. It also highlighted that the values, theoretical models and ways of working with people, which are considered typical of social work and social care, are consistent with recovery. The evidence suggested that, while it is highly important for social workers to have the necessary skills to deal with this group, often substance use training and development was not received. There was a paucity of UK evidence on effective interventions, however, the mainly US studies which were reviewed suggested that several forms of intensive care management can be beneficial, particularly those that include the use of motivational interviewing techniques. The report stated that social workers caseloads should be limited. A practitioner briefing was also developed³¹⁰ (Galvani and Forrester 2011b) and the authors made several recommendations for further research and policy development including:

- expansion and review of current care management in Scotland and evaluation of its effectiveness ;
- development and evaluation of social care and social work interventions;
- research into effective substance use training methods and improved training for social workers and social care workers backed up with appropriate organisational support for skill development;
- development and monitoring of relationship skills amongst professionals in the field; and
- effective and informed supervision of case workers.

Substance use knowledge amongst trainee social workers

In a study investigating the knowledge of substance use amongst student social workers³¹¹, the results showed that the majority of participants were not confident in their level of knowledge regarding substance use (61%) and therefore their ability to dealing with substance users in practice (Galvani and Hughes 2010). There was a statistically significant and positive association between previous training and knowledge. The authors recommended that drug (and alcohol) education should be included as part of the training programme for social workers in the future to ensure that they have sufficient knowledge to meet the needs of their clients who have substance use issues.

³⁰⁹ This research was jointly commissioned by the Scottish Government (Drugs Policy Unit and Alcohol Policy Team), the Association of Directors of Social Work (ADSW) and the Institute for Research and Innovation in Social Services (IRISS) to review the existing evidence to determine what is currently known about the contribution that social work services make to supporting people, in particular adults, with alcohol and/or other drug problems.

³¹⁰ See: www.adsw.org.uk/doc_get.aspx?DocID=416

³¹¹ A self-completed, quantitative questionnaire was completed by a purposive sample of 121 social work students at the University of Birmingham in England. The questions asked for participants' attitudes towards, and perceived knowledge of, substance use. It also aimed to identify their training needs in relation to working with substance users and to explore their personal experiences of substance use and within their family and friends.

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

9.1 Introduction

Drug use is not a crime in the United Kingdom, but possession, dealing and trafficking are specific offences under the *Misuse of Drugs Act 1971*. Recorded drug crimes, after increasing in recent years, fell in 2009/10 and 2010/11. The number of persons dealt with by the courts or cautioned for drug offences has risen since 2005, mainly for cannabis and cocaine powder related offences, although the latter remained stable in 2009. A prison sentence is the most common outcome when found guilty at court of import/export and trafficking offences but a fine or community sentence are the most common disposals for possession offences.

Police records on general criminal offences do not contain information on the offenders' drug habits, neither do records of specific drug law offences. It is therefore not possible to provide an accurate estimate of the number of offences that are drug-related, but there is substantial research evidence of the link between drug use, particularly use of heroin and crack cocaine, and acquisitive crime. Around three-quarters of the users of these drugs admit to committing crime to support their habit. Around two-thirds of those in custody are reported to be recent drug users with an estimated 40% of prisoners received into custody being problematic drug users, 40% of whom identify themselves as injecting drug users (Stewart 2008). However, acquisitive crime, to which drug-related crime makes a substantial contribution, has fallen overall in recent years.

Since 2003, the Drug Interventions Programme (DIP) has operated in every local area in England and Wales to tackle Class A drug misusing offenders, managing around 60,000³¹² into drug treatment in 2009/10. Local programmes intervene at various stages through the criminal justice journey, making use of legislative sanctions to direct drug misusing offenders into treatment and offer support to reduce their offending. The Drug Rehabilitation Requirement (DRR), which can be attached to a Community Order or a suspended sentence of imprisonment, is the primary measure used at court stage to address drug-related offending in England and Wales (SQ31).

In Scotland, Drug Treatment and Testing Orders (DTTOs) provide offenders with access to treatment services as a requirement of the order. These have been extended to lower tariff offenders on a pilot basis in Edinburgh and Lothians in the form of DTTO IIs.

There is a range of measures to prevent drugs entering prison including clearly-defined searching procedures covering all possible routes; passive and active drug dogs, with passive dogs available to all prisons; CCTV surveillance of all social visit areas and low-level fixed furniture; and comprehensive measures to tackle visitors attempting to smuggle drugs, including closed visits, visit bans and police arrest. Recently introduced initiatives include mobile phone blocking to prevent contact with dealers and the introduction of body orifice scanning equipment. Since April 2006 in England and Wales, responsibility for prison health services has been fully devolved to the National Health Service (NHS), and an Integrated Drug Treatment System (IDTS) has been developed in England to improve the availability and quality of drug treatment in prison, bringing it in line with treatment in the community. From April 2011 the Department of Health assumed responsibility for funding and commissioning drug and alcohol treatment in all prisons and the community in England. In Scotland, responsibility for health care in prisons is to be transferred to the National Health Service in November 2011.

³¹² This figure is the number of offenders identified through DIP in the community and in prison in England and Wales, entering Tier 2 and Tier 3/4 drug treatment.

9.2 Drug-related crime

9.2.1 Drug law offences

Data on drug law offences are available at various points in the criminal justice system. Recorded crime data count the number of drug offences brought to the attention of police and represent the widest measure of drug offences available in the UK. However, at present the individual drug involved is not recorded (except for cannabis possession offences). Arrests data record the number of persons who are arrested for a drug offence and represent a smaller proportion of drug offences since some penalties such as formal warnings for cannabis do not constitute an arrest. These data are not available by drug or by offence type. Finally, convictions data record the number of offences where an individual is found guilty at court or cautioned for a drug offence. Data from each level of the criminal justice system cannot be compared for a number of reasons including: time lag between offence and conviction; the basis on which the data are provided (offender or offence); counting rules³¹³; and year of data (calendar or financial year). Further information on the recording of drug offence data are contained in a selected issue chapter on sentencing statistics in the 2008 UK Focal Point Report.

Recorded drug crime

Recorded drug crime decreased by three per cent in the United Kingdom between 2009/10 and 2010/11 with a larger decrease in trafficking offences (8%) than possession offences (2%) (Table 9.1). In Scotland, recorded drug offences decreased by 13% in the past year although illegal cultivation of drugs increased by 28% (n=964) (Scottish Government 2011c). There was a one per cent decrease in recorded drug crime in England and Wales between 2009/10 and 2010/11. As in previous years, over two-thirds (69%) of all recorded drug crime in England and Wales was for cannabis possession offences although the number of cannabis possession offences has decreased by one per cent since 2009/10 and by four per cent since 2008/09. The decrease in recorded drug offences since 2008/09 coincides with the end of the national target regime for police (Chaplin et al. 2011). The number of trafficking offences also decreased in England and Wales for the first time since 2004/05.

In Northern Ireland, recorded drug crime increased by 11% from the previous year with a larger increase in trafficking offences (14%) than possession offences (10%). This continues the trend in year-on-year increases since 2006/07 (Table 9.1).

³¹³ See: <http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/counting-rules/>

UNITED KINGDOM FOCAL POINT REPORT 2011

 Table 9.1: Recorded crime:³¹⁴ Drug offences in the United Kingdom by offence type and country, 2004/05 to 2010/11

	Year						
	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
England and Wales							
Trafficking*	24,190	25,276	26,550	28,323	29,885	33,234	32,069
Possession	120,866	152,602	167,003	200,773	212,528	201,240	199,012
Other drug offences**	781	601	680	816	1,123	1,122	1,135
<i>Total offences</i>	<i>145,837</i>	<i>178,479</i>	<i>194,233</i>	<i>229,913</i>	<i>243,536</i>	<i>235,596</i>	<i>232,216</i>
Northern Ireland							
Trafficking	375	349	473	529	607	668	759
Possession	2,247	2,595	1,938	2,191	2,367	2,478	2,723
<i>Total offences</i>	<i>2,622</i>	<i>2,944</i>	<i>2,411</i>	<i>2,720</i>	<i>2,974</i>	<i>3,146</i>	<i>3,482</i>
Scotland							
Trafficking	9,333	9,613	10,890	9,827	10,315	9,901	7,138
Possession	32,268	34,440	31,329	30,559	31,805	29,179	26,690
Other drug offences ***	222	194	203	360	389	328	249
<i>Total offences</i>	<i>41,823</i>	<i>44,247</i>	<i>42,422</i>	<i>40,746</i>	<i>42,509</i>	<i>39,408</i>	<i>34,347</i>
United Kingdom							
Trafficking	33,898	35,238	37,913	38,686	40,816	43,578	39,966
Possession	155,381	189,637	200,270	233,485	246,699	232,529	228,425
Other drug offences	1,003	795	883	1,176	1,512	1,445	1,384
<i>Total offences</i>	<i>190,282</i>	<i>225,670</i>	<i>239,066</i>	<i>273,347</i>	<i>289,027</i>	<i>277,552</i>	<i>270,045</i>

* Trafficking usually includes production, supply, possession with intent to supply, possession on a ship, carrying on ship and unlawful import and export.

** For England and Wales 'other drug offences' mainly concerns permitting premises to be used for the production, supply and use of drugs.

*** For Scotland 'other drug offences' includes production and manufacture of drugs (not illegal cultivation), offences related to money laundering, and other drug offences not designated as trafficking or possession.

Source : Chaplin et al. 2011 PSNI 2004a; PSNI 2006a; PSNI 2008a; PSNI 2010a; PSNI 2011a; Scottish Government 2011c

Arrests for drug offences

Arrests for drug offences³¹⁵ continued to rise in 2009/10 with a five per cent increase from the previous year and a seven per cent increase from 2003/04 (Table 9.2), the last year before the cannabis warning was introduced (which does not count as an arrest). This increase is in contrast to the number of recorded drug offences which fell by seven per cent in 2009/10, although the number of the more serious trafficking offences increased (Table 9.2).

Table 9.2: Number of persons arrested for drug offences in England and Wales, and Northern Ireland, 2003/04 to 2009/10

	Year						
	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
England and Wales	113,100	84,800	88,600	89,393	104,532	115,116	121,010
Northern Ireland	1,754	1,356	1,440	1,726	1,896	2,014	2,250
<i>Total</i>	<i>114,854</i>	<i>86,156</i>	<i>90,040</i>	<i>90,926</i>	<i>106,428</i>	<i>117,130</i>	<i>123,260</i>

Source: Povey et al. 2009; Povey et al. 2010; Povey et al. 2011 ; PSNI 2004b; 2006b; 2008b ; 2010b

Stop and searches for drugs

In 2009/10, the number of stop and searches for drugs in England and Wales increased by three per cent from the previous year to 550,342, accounting for almost half (48%) of all police stop and searches and two-thirds of British Transport Police stop and searches (Povey et al. 2011). The number of stop and searches has increased by 69% since the introduction of the cannabis warning and it is possible that the fall in the proportion arrested

³¹⁴ Police forces in England and Wales revise their data as further information becomes available and figures in this table therefore may not agree with those previously published.

³¹⁵ Data refer to England, Wales and Northern Ireland only. There are no arrests data for Scotland.

after a drugs search since then (from 11% in 2004/05 to 7% in 2009/10) is due to the availability of alternative methods of dealing with cannabis possession offences.

Convictions for drug offences

There were 147,013 drug offences where the person was found guilty at court or cautioned in the United Kingdom during 2009 (ST11). The number has remained stable since 2008 after increases in the previous three years. For the first time since 2001 the number of cocaine powder convictions did not increase and, across all drugs, only cannabis convictions increased in 2009, by six per cent. Ecstasy offences continued to fall with the number in 2009 half of the number in 2007. While the number of heroin offences decreased by nine per cent in 2009, the level is still almost 40% higher than in 2000 (Table 9.3).

Table 9.3: Drug offences where the offender was found guilty or issued a caution in the United Kingdom, 2002 to 2009 by individual drug

	Year							
	2002	2003	2004	2005*	2006*	2007*	2008*	2009*
Amphetamines	5,820	6,163	6,249	6,864	7,422	7,478	7,822	7,096
Cannabis	83,152	85,768	82,845	54,813	55,984	55,563	63,103	66,598
Cocaine powder	6,990	7,905	9,382	12,028	15,470	19,216	22,874	22,529
Crack cocaine	1,830	2,270	2,450	3,734	4,076	4,613	5,895	4,241
Ecstasy	6,590	5,940	6,209	6,337	6,233	7,189	5,107	3,608
Heroin	11,860	11,277	12,412	15,629	15,741	16,557	17,926	16,354
LSD	90	150	90	183	172	165	156	106
<i>Total</i>	<i>113,465</i>	<i>117,532</i>	<i>122,459</i>	<i>118,706</i>	<i>124,344</i>	<i>135,655</i>	<i>146,909</i>	<i>147,013</i>

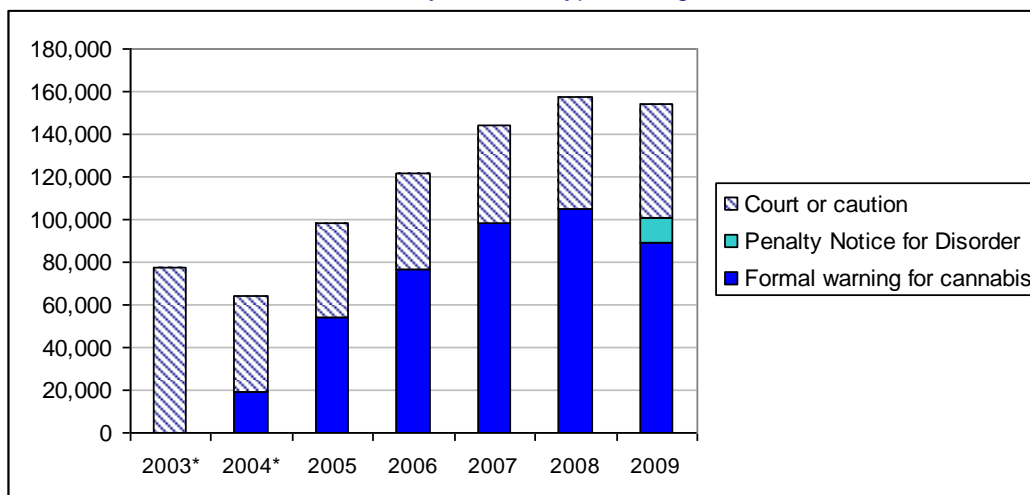
* Data since 2005 are on an all offence basis; data for 2000 to 2004 are based on principal drug offence.

Source: Standard Table 11

The increase in cannabis convictions continues the pattern from the previous year when cannabis convictions increased for the first time since the introduction of the cannabis warning in 2004. In addition to the 66,598 offences dealt with through the court or by caution, 89,000 formal warnings for cannabis were issued in England and Wales in 2009, a 15% decrease on the previous year (n=105,000). This decrease is partly due to the introduction, in England and Wales during 2009, of penalty notices for disorder (PNDs) for cannabis possession as part of the three-stage escalation procedure.³¹⁶ In 2009, 11,500 PNDs were issued for cannabis possession and the total number of cannabis offences dealt with by criminal justice agencies was 154,345, a two per cent decrease since 2008 following large increases since 2004. Figure 9.1 shows that, although there have been decreases since 2003 in cannabis possession offences dealt with by the court or with a caution, the total number of cannabis offences dealt with by all criminal justice agencies has doubled. This contrasts with the trend in cannabis use prevalence, which has been decreasing since 2004 (see section 2.2.2) but may be explained by the increased use of stop and search powers by the police over this period (see above).

³¹⁶ If there are no aggravating factors, it is suggested that the first cannabis possession offence is dealt with by a formal warning for cannabis, the second with a penalty notice for disorder and the third with arrest. See: <http://www.justice.gov.uk/publications/docs/circular-05-2009-pnds-cannabis-possession.pdf>

Figure 9.1: Number of cannabis offences by sanction type in England and Wales, 2003 to 2009



Source: Standard Table 11; MOJ 2010a

9.2.2 Other drug-related crime

Drug driving

The Government published its response to the reports of the North Review and House of Commons Transport Committee (HM Government 2011a; see section 1.2.3)

9.3 Prevention of drug-related crime

9.3.1 Drug Interventions Programme (DIP) in England and Wales

DIP remains the primary method of engaging drug misusing offenders with drug treatment services in England and Wales. In 2010/11 the Home Office allocated €127.7 million (£108.7 million) in the form of DIP grants to Drug Action Teams (DATs) in England and to the Welsh Government. This represents a seven per cent reduction on the previous year (€130.6 million, £116.3 million)³¹⁷ (see section 1.4.1).

DIP data show that in 2009/10 around 60,000 individuals were helped into drug treatment and recovery services, including Tier 2 treatment³¹⁸ in England.

Treatment data show that, in 2009/10, there were 10,626 adults entering structured treatment from arrest referral/DIP in England,³¹⁹ accounting for 13% of all those entering treatment. This is a similar figure and percentage to the previous year (NTA 2010b).

The annual report for DIP in Wales 2009/10 outlines the key objectives for the programme during 2010/11 and summarises the performance of DIP in 2009/10 (WAG 2010e). In those areas where powers have been granted for police to test on arrest for trigger offences, 35% of offenders tested positive for opiates and/or cocaine. Of these, 61% were positive for opiates, 23% for cocaine, and 15% for both. Across Wales there were 3,375 referrals for assessment, of which 98% were assessed and 88% of those requiring interventions were taken onto the DIP caseload. Including transfers, there were a total of 2,710 individuals

³¹⁷ See: <http://www.homeoffice.gov.uk/publications/about-us/non-personal-data/drugs/dip-grants/?view=Standard&pubID=908020>

³¹⁸ Non-structured treatment

³¹⁹ Tiers 3 and 4 are structured treatment. This cannot be compared to the DIP figure, which includes Tier 2 treatment.

added to the caseload in 2009/10 and 3,144 cases were closed. Twenty-eight per cent of closures were due to treatment completion, 44% due to client disengagement and 18% were transferred to prison.

DIP Guidance

The Home Office has published a number of DIP guidance documents. The operational guidance covers the governance of DIP, the roles within the programme and the management of the DIP process from identification, assessment and case management (Home Office 2010a).

A good practice guide on introducing locally funded drug testing on arrest was also published (Home Office 2011a). The requirement for the Home Office to grant specific site authorisation before drug testing on arrest can be introduced has been removed allowing local partners to decide themselves whether to introduce testing. Police are also free to decide who should be tested for drug use instead of the previous method which required all individuals arrested for 'trigger offences' to be tested. The Home Office guide sets out the benefits of drug testing and who should be involved in the process as well as the necessary steps to be taken before introduction of testing on arrest. To assist local areas in their decision making and planning, the guide also estimates the costs to local areas of introducing the scheme.

Finally the DIP Impact Toolkit, which provides guidance on conducting an evaluation of DIP at a local level was published. It covers methods, data sources, data analysis and how evaluation findings can be translated into practice improvement (Home Office 2011b).

9.3.2 Re-offending and reconviction

Although sometimes used interchangeably, there is a difference between re-offending and reconviction. It is difficult to measure the level of re-offending without self-report data. Data provided here generally refer to reconviction.

England and Wales

The 12 month rate of reconviction amongst a 2009 national cohort of drug misusing offenders in England and Wales³²⁰ was 2.2 offences per individual, 15% less than the 2.6 offences recorded amongst the 2008 cohort (Home Office 2010b). The prevalence of offending decreased from 61% in 2008 to 57% in 2009 and amongst those convicted of an offence, the rate was 3.9 offences per offender compared with 4.3 offences in 2008. The most common type of offence amongst the 2009 cohort was theft (40%), of which an overwhelming majority of offences (91%) were shoplifting, supporting previous evidence of the link between drug use and acquisitive crime. Forty-one per cent of offences committed by the 2009 cohort in the year after identification received immediate custody with two-thirds (66%) of these sentences for less than 90 days. Results from the local cohorts showed that re-offending was less than predicted³²¹ in 87% of local areas compared to 42% in the previous year.

³²⁰ A cohort of Class A drug misusing offenders was identified between 1 January 2009 and 31 March 2009 through contact with the criminal justice system, either: drug test on arrest or charge through DIP; a National Offender Management Service Offender Assessment (OASys) whilst on a community sentence or on license; if released from prison, a CARAT assessment; or a Criminal Justice Integrated Team (CJIT) drugs worker assessment when in the community. They were then linked to the National Police Computer for any offence committed in the 12 months after identification for which they were convicted within 18 months.

³²¹ Predicted offending for each local area was based on analysis of historical offending of that area's cohort.

Draft outcomes for the drug recovery Payment by Results (PbR) pilots include a reduction in the rate of proven offending over a six month (initial outcome) and 12 month (final outcome) period (see section 5.2).

A study by Powell et al. (2011b) used data from the Home Office's Offenders Index (OI) to assess outcomes of those subject to a Drug Treatment and Testing Order (DTTO)³²² in one area in England between 2000 and 2002.³²³ Data showed that the mean number of convictions over a two-year period decreased from 12.0 pre-DTTO to 9.4 post-DTTO. Sixty-one per cent of the sample had fewer convictions post-DTTO, seven per cent showed no change and 33% had a higher conviction rate. Lower reconviction rates were associated with lower numbers of convictions pre-DTTO, a positive DTTO outcome, and a larger proportion of negative drug tests while in treatment. Analysis of offence type showed that, while there was a reduction in all types of offending, there was no significant reduction in the proportion of offenders convicted of acquisitive crimes. Conversely, there was a significant reduction in those convicted of driving and vehicle-related offences, and drug offences. The authors recommend that further research is undertaken to examine those offenders who seem resistant to treatment.

Scotland

Data from Scotland show that the one-year reconviction rate fell for both the 2007/08 and 2008/09 cohort of drug offenders (Table 9.4). The reconviction frequency³²⁴ was also lower than amongst the 2006/07 cohort. The two-year reconviction rate for the 2007/08 drug offender cohort was 38.8%, slightly lower than for all offenders (42.4%). Of the 6,574 offenders convicted of an index drug offence in 2007/08, 19% were convicted of another drug offence in the following two years, 12% breach of the peace, 10% crimes against public justice, eight per cent petty assault and six per cent shoplifting.³²⁵ The one-year reconviction rate of those given a DTTO was 63.9% amongst the 2008/09 cohort down from 70.2% amongst the 2007/08 cohort and 73.9% amongst the 2006/07 cohort (Scottish Government 2011d).

³²² The DTTO in England and Wales was replaced by the Drug Rehabilitation Requirement for offences committed after April 2005.

³²³ All offenders sentenced to a DTTO in one area between November 2000 and December 2002 were identified through the OI with data available for 96.8% of these (n=183). Two-year reconviction was analysed from the beginning of DTTO commencement using the OI. Data on drug use, offending behaviour and order outcome were taken from a separate evaluation of a DTTO team.

³²⁴ The reconviction frequency is the average number of reconvictions within a specified follow up period from the date of the index conviction per 100 offenders

³²⁵ See: <http://www.scotland.gov.uk/Topics/Statistics/Browse/Crime-Justice/Datasets/ReconrateAug2011>

Table 9.4: One year reconviction rates and frequency rates for cohorts of drug offenders in Scotland, 1997/98 to 2008/09

Cohort year	Number of offenders	Reconviction rate	Reconviction Frequency
1997/98	5,654	26.3	40.1
1998/99	5,321	27.5	42.5
1999/00	4,836	25.5	37.4
2000/01	4,185	26.1	40.3
2001/02	4,691	25.2	40.9
2002/03	4,671	28.0	45.8
2003/04	5,522	29.3	45.3
2004/05	5,770	28.9	45.3
2005/06	5,788	29.4	46.5
2006/07	6,807	28.0	45.0
2007/08	6,574	27.2	42.0
2008/09	5,689	26.5	42.6

Source: Scottish Government 2011d

9.3.3 Persistent offenders

An analysis of the costs and benefits of the Persistent Offender Project in Glasgow, Scotland³²⁶ found that the project had a total net benefit of £10 million over three years, equating to £14 worth of benefit for every £1 spent (Glasgow Addiction Services 2011). Recorded crime decreased by 32% amongst the 137 offenders signed up to the programme between November 2006 and March 2009 with a 39% decrease in the estimated incidence of crime.³²⁷ A sensitivity analysis looking at the reduction in recorded crime only still gave a cost-benefit ratio of 1:1.3.

9.4 Interventions in the criminal justice system

The Ministry of Justice published its *Green Paper, Breaking the cycle: Effective punishment, rehabilitation and sentencing of offenders* in December 2010 (MOJ 2010c). It sets out the Government's aims for more effective rehabilitation and sensible sentencing of offenders. It states that the MOJ will work with the Department of Health to divert more of the less serious offenders with drug dependency into treatment rather than prison. Proposed actions include:

- reducing the availability of illicit drugs in prison and increasing the number of drug free environments;
- introducing pilots for drug recovery wings in prisons;
- working with the Department of Health and other government departments to support the design and running of pilots to pay providers by the results they deliver in getting offenders to recover from their drug dependency;
- testing options for intensive community based treatment; and
- learning the lessons from the approach to managing women offenders and applying them more broadly.

³²⁶ The Persistent Offenders Project was funded between 2006 and 2010 and run jointly by Glasgow Addiction Services and Strathclyde Police. Its aims were to identify substance misusing persistent offenders and provide intensive support and treatment.

³²⁷ Incidence of crime was estimated by using recorded crime, clear-up rate and estimates of the full incidence of crime by crime surveys such as the Scottish Crime and Justice Survey.

9.4.1 Sentencing for drug offenders

In March 2011, the Sentencing Council³²⁸ launched a consultation on proposals for a drug offences guideline for Crown and Magistrates' courts (Sentencing Council 2011). The proposals include the recommendation by the Sentencing Advisory Panel (SAP 2010; see Focal Point Report 2010) to use the role of the accused and the quantity of drugs to determine the seriousness of the case. The guideline states that all individual drugs in the same class should be treated equally and proposes thresholds for quantity levels. If the proposed guideline was implemented, the Sentencing Council suggests that the penalties for drug mules would be reduced and the penalties for cannabis production would increase.

England and Wales

Of the 61,434 individuals sentenced for drug offences in England and Wales during 2010, 15.8% were given immediate custody (Table 9.5). Almost all of those convicted of the most serious offence of import/export were given an immediate custodial sentence whilst for possession offences the most common disposal was a fine. Those convicted of trafficking offences were also most likely to receive immediate custody (45%) although just over one quarter (26%) were given a community sentence.

Table 9.5: Number and percentage of offenders receiving each disposal for drug offence type in England and Wales, 2010

	Immediate custody		Suspended sentence		Community sentences		Fine		Other		Total sentenced	
	n	%	n	%	n	%	n	%	n	%	n	%
Import/export	575	93.5	23	3.7	10	1.6	2	0.3	5	0.8	615	100
Trafficking*	7,638	45.0	3,007	17.7	4,447	26.2	1,277	7.5	600	3.5	16,969	100
Possession	1,342	3.1	679	1.6	8,788	20.4	21,947	50.9	10,401	24.1	43,157	100
Other	138	19.9	111	16.0	173	25.0	127	18.3	144	20.8	693	100
Total	9,693	15.8	3,820	6.2	13,418	21.8	23,353	38.0	11,150	18.1	61,434	100

*Includes production, supply, and possession with intent to supply

Source: MOJ 2011a

The average sentence length for those convicted of Class A drug offences in England and Wales is much higher for importation and trafficking offences than for those convicted of Class B and Class C offences (Table 9.6). There is little difference in sentence length between Class B and Class C offences and, where there is, it is in the opposite direction to what one may expect. This is likely to be due to the re-classification of cannabis at the beginning of 2009.³²⁹

Table 9.6: Average sentence length (months) for offenders given immediate custody in England and Wales, 2010 by offence type and drug class

Drug class	Importation	Trafficking	Possession
Class A	86.2	39.1	4.0
Class B	29.7	18.7	2.0
Class C	31.6	18.7	4.1

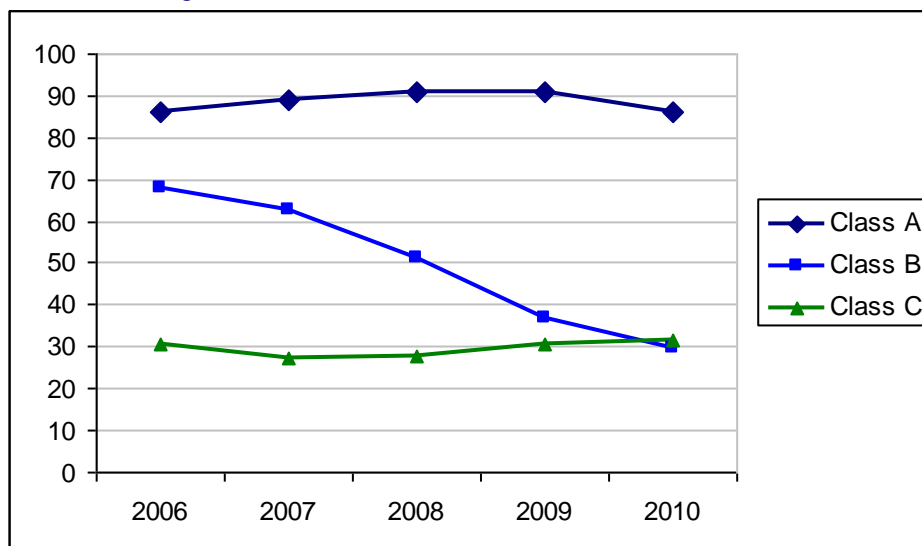
Source: MOJ 2011a

³²⁸ The Sentencing Council is an independent, non-departmental public body of the Ministry of Justice and replaces the Sentencing Guidelines Council and the Sentencing Advisory Panel. See: <http://sentencingcouncil.judiciary.gov.uk/about-us.htm>

³²⁹ The maximum penalty for trafficking/import and export offences is life imprisonment for Class A and 14 years for Class B and Class C drugs. For possession offences maximum sentences are 7 years, 5 years, and 2 years respectively.

Analysis of data on sentence length shows that since 2009, the average sentence length for Class B offences has decreased while increasing slightly for Class C offences. The change is most apparent in the more serious, import offences (Figure 9.2). Between 2008 and 2010 the number of offenders given a prison sentence for Class B trafficking offences increased from 379 to 2,453 with Class C trafficking offences dropping from 1,179 to 344. This suggests that cannabis re-classification may have had an impact on the volume of cases dealt with at court but that sentencing for cannabis offences may have remained largely unchanged.

Figure 9.2: Average sentence length (months) for offenders given immediate custody for drug importation offences in England and Wales, 2006 to 2010



Source: MOJ 2007a;2008;2009a;2010b;2011a

Scotland

In Scotland during 2009/10 there were 7,662 persons³³⁰ found guilty of drug offences representing six per cent of all those found guilty of criminal offences (Scottish Government 2011e). Of these, 19% were sentenced to custody, 15% to a community sentence and 54% to a monetary penalty. The average sentence length of those given custody was 567 days, similar to previous years. Eighteen per cent of custodial sentences were three months or less³³¹ with 17% between three months and six months.

9.4.2 Alternatives to prison

Drug Rehabilitation Requirement

The Drug Rehabilitation Requirement (DRR) within a community order or suspended sentence of imprisonment is an intensive vehicle for tackling the drug misuse and offending of many of the most serious and persistent drug misusing offenders in England and Wales (SQ31). DRRs involve treatment, regular testing and court reviews of progress and are subject to rigorous enforcement.

There is no longer a DRR commencement target in the National Offender Management Service (NOMS) Performance Metrics but data are collected from probation trusts and published in Offender Management Caseload Statistics. The most recent published data

³³⁰ Data in 2009/10 include disposals issued by Police and by the Crown Office and Procurator Fiscal Service for the first time so cannot be compared with previous years.

³³¹ The *Criminal Justice and Licensing (Scotland) Act 2010* introduced a presumption against short prison sentences of three months or less. It came into effect in August 2010 so current data do not cover that period.

shows that 16,071 DRRs were commenced in 2010, 11,996 as part of a community order and 4,075 as part of a suspended sentence order. This represents a decrease from 16,207 starts in 2009 and 17,457 in 2008. The reduction in DRR commencements was partly due to police initiatives which divert offenders from charge and a change in focus from commencement to completion targets (MOJ 2011b).

The main performance indicator for DRRs in 2010/11 was the completion rate with the number of completions as a secondary indicator. Fifty-six per cent of DRRs were successfully completed in 2010/11 against a target of 49% with all regions reaching this target. There were 8,392 successful DRR completions which significantly exceeded the aggregated annual target³³² of 6,837 (MOJ 2011b).

The completion rate has doubled since 2003. This is encouraging because research into DTTOs, the predecessor of the DRR in England and Wales, suggests that offenders who complete orders have much lower reconviction rates (53%) than those who do not (91%), though it is not possible to attribute the difference entirely to the effect of the order (Hough et al. 2003).

Scotland

There are a number of interventions at different levels of the criminal justice system in Scotland (SQ31). In 2009/10, there were 17 diversion from prosecution cases referred to drug treatment or education in Scotland, down from 43 in 2008/09 and 51 in 2007/08 (Scottish Government 2010a). The number of probation orders commenced with a condition of drug treatment/education increased by 2% to 506 in 2009/10.

In Scotland during 2009/10, a total of 740 Drug DTTOs were made, a two per cent decrease from 2008/09 (Scottish Government 2010a). In 2009/10 a total of 1,500 DTTO assessments were carried out, a decrease of 13% on the previous year. Data show that there was an increase in the proportion successfully completing DTTOs from 40% in 2008/09 to 44% in 2009/10 and a decrease in the proportion that had their order revoked due to a breach from 36% to 26% over the same period (Table 9.7).

Table 9.7: Reasons for termination of DTTOs in Scotland, 2004/05 to 2009/10

	2004/05		2005/06		2006/07		2007/08		2008/09		2009/10	
	n	%	n	%	n	%	n	%	n	%	n	%
Successfully completed	120	38.1	186	40.0	208	38.9	183	37.3	215	39.7	243	44.1
Revoked due to review	32	10.2	81	17.4	76	14.2	68	13.8	83	15.3	109	19.8
Revoked due to breach	133	42.2	154	33.1	197	36.8	173	35.2	193	35.6	143	26.0
Transfer out of area	-	-	4	0.9	2	0.4	7	1.4	8	1.5	4	0.7
Death	1	0.3	4	0.9	1	0.2	2	0.4	3	0.6	4	0.7
Other	29	9.2	36	7.7	51	9.5	58	11.8	40	7.4	48	8.7
Total	315	100	465	100	535	100	491	100	542	100	551	100

Source: Scottish Government 2010a

In 2011, the Scottish Government published guidance for schemes on Drug Treatment and Testing Orders covering all aspects of the orders from assessment, child protection issues, the operation of DTTOs, and monitoring (Scottish Government 2011f).

³³² Individual targets were set at probation trust level. These targets were aggregated to regional and national level to provide an overall comparison against outcomes.

9.4.3 Drug Courts

Dedicated Drug Courts (DDCs) have been piloted in magistrates' courts in England and Wales since 2005 and an initial process evaluation report was published in April 2008.

In 2010 a final process evaluation of the pilot DDC found that staff and offenders viewed the DDCs as a useful addition to existing measures addressing drug use and offending (Kerr et al. 2011). The continuity of the judiciary between sentencing and review was seen as having a positive impact as was the existence of a dedicated co-ordinator, although the latter could increase the amount of court work for other legal advisors. The evaluation suggests that the self-selection of magistrates may make the judiciary in DDCs more sympathetic to an offender's situation and more likely to believe in a rehabilitative approach towards drug misusing offenders. The increased partnership working helped build relationships between the judiciary and partners and led to discussions around the quality of treatment. There were large differences across sites in the way that someone was referred to the DDC, where the review took place and the type of disposal most commonly handed out. The authors suggest that, if the pilot were to be rolled out nationally, guidelines should be produced on how to implement the DDC model and on the training of judicial, court, probation and other staff.

9.4.4 Interventions for substance misusing offenders with mental health problems

Long et al. (2010) assessed the effectiveness of a cognitive behavioural therapy substance misuse intervention amongst women in a medium security psychiatric hospital.³³³ The intervention involved 12 group sessions to help patients understand and overcome substance misuse. Brief individual sessions ran alongside the group work, setting it into an individual context. Of the 34 women taking part, the majority were diagnosed with personality disorder (n=23). Other participants were diagnosed with schizophrenia and schizoaffective disorder (n=7) and bipolar and depressive disorder (n=2). Around one-third were convicted of major violence and one-third were convicted of minor violence. Twenty-three of the women (68%) completed the treatment³³⁴ with the main reasons for non-completion given as deterioration in mental state or escalation of risk behaviours. Completers were younger, single and all identified their primary substance as a drug other than alcohol. Completers showed pre-post changes in outcome measures of need, symptomatology and self-efficacy. The authors conclude that differences between completers and non-completers highlight the importance of timing and intensiveness of treatment for women at various stages of their treatment journey in secure settings.

9.4.5 Other interventions in the criminal justice system

Whilst the Department of Health is responsible for funding substance misuse services for prisoners and offenders in the community, there is a critical role for NOMS in representing the needs of their local substance misusing offenders to ensure the commissioning of services which are appropriate and deliverable in the correctional environment.

NOMS supports a range of accredited offending behaviour programmes which are designed to reduce the likelihood of re-offending by offenders with substance misuse problems. Following a review of these interventions in 2010, a new programme for adult male offenders was developed to replace existing provision. Building Skills for Recovery is a group-based

³³³ Women who were identified as having a substance misuse issue were offered group treatment once their mental state had stabilised. A total of 34 out of 38 identified women took part in four treatment groups. A number of instruments were used pre- and post- intervention to assess: need; self-efficacy; alcohol and drug-taking confidence and consequences; and psychiatric state. The majority of participants were polydrug users with a mean age of 33.8 years.

³³⁴ Defined as attending more than 75% of sessions.

psychosocial programme which aims to reduce offending behaviour and problematic substance misuse, with an eventual goal of recovery.³³⁵

9.5 Drug use in prisons and responses

Due to the topic of this year's selected issue, data and information on drug use in prisons and related health responses is contained in Chapter 11.

³³⁵ The programme aims to achieve this through the exploration of previous and current substance use and the acquisition of a skillset to prevent future relapse into former patterns and behaviours; the formulation of a person centred 'Recovery toolkit' is a key objective. The programme consists of an introductory phase and a core module of 16 sessions in total. In addition to the group sessions participants complete supplementary between-session written work, skills practise and attend two individual one-to-one sessions with a programme facilitator. There are also specific modules that can be used to supplement treatment that have been designed specifically to meet individual needs. As participants work through the programme, they build upon existing skills and learn and practice new skills and techniques to add to their 'toolkit' to assist them on the journey towards recovery. The prevention of relapsing into former patterns of behaviour is a key focus within the programme.

10. Drug markets

10.1 Introduction

Most of the identified drug supply chains to the United Kingdom follow well-established trafficking routes. Cannabis continues to be imported in large quantities to the United Kingdom from Europe, but there has been a large increase in domestic cannabis cultivation over the past five years. Throughout the UK, large commercial cannabis cultivation operations have been discovered and there is increasing evidence of involvement by South East Asian criminal gangs and recently by White British criminals.

The overall picture of United Kingdom drugs distribution appears increasingly complex and diverse, and is better described as a network as distribution occurs through long chains. Many traffickers in the United Kingdom, particularly White British criminals, import and distribute more than one type of drug. London, Birmingham and Liverpool continue to be important centres for drugs distribution but other smaller cities and towns are also involved. In Scotland, the main source of heroin is from the North West of England via the Glasgow area.

In general the numbers of seizures have been increasing in the United Kingdom although there was a decrease in 2009/10. Cannabis is the most seized drug and the number of herbal cannabis seizures has increased since the introduction of cannabis warnings although quantities have fallen. There have been increasing seizures of cannabis plants. Seizures, mainly of Class A drugs, have achieved short-term disruptions rather than a sustained reduction in the size of the United Kingdom drugs market.

Purity of cocaine powder has fallen substantially at street level since 2003 and crack cocaine purity has also fallen. The street-level price of cocaine powder, heroin and ecstasy has decreased since 2003 while the price of other drugs has remained relatively stable. When adjusting for purity, however, cocaine powder prices have risen since 2003.

The most recent estimate of the size of the illicit drug market in the United Kingdom is €7.7 billion (£5.3 billion) in 2003/04, with a wide margin of error of €5.8 billion (£4 billion) to €9.5 billion (£6.6 billion). In Scotland the size of the illicit drug market has been estimated at €2.1 billion (£1.4 billion) for 2006.

10.2 Availability and supply

10.2.1 Availability in the general population

Most areas of the UK reported a heroin shortage from April 2010 (see section 10.4.3). It has been reported that the shortage ended in spring 2011.

In Scotland in 2009/10, 12.9% of adults aged over 16 reported being offered drugs in the last year, most commonly cannabis (10.3%), cocaine powder (6.3%) and ecstasy (5.4%). Males (17.5%) were twice as likely as females (8.7%) to report being offered drugs in the last year (Macleod and Page 2011).

10.2.2 Availability amongst school children and young people

In 2010, 28% of school pupils aged 11 to 15 years old in England reported ever being offered drugs, a decrease from 33% the previous year and 40 to 42% in the early 2000s (Fuller 2011; see section 2.4.1). Since the previous year, there has been a large decrease in the proportion having been offered stimulants, from 17% in 2009 to 13% in 2010; and decreases in the proportion being offered cannabis (from 21% to 18%); any psychedelics (10% to 8%); and volatile substances (14% to 10%). Older pupils are more likely to have

been ever offered drugs (49% of 15 year olds compared to nine per cent of 11 year olds) and girls are less likely to have been offered drugs at every age.

In a survey of schoolchildren aged 11 to 17 years in Northern Ireland (NISRA 2011; see section 2.4.3) almost one-quarter (23%) of respondents thought it would be easy to get some cannabis. Twelve per cent thought it would be easy to get some ecstasy and 11% thought it would be easy to get some cocaine powder. The drug that schoolchildren were most likely to have been offered was cannabis, with 15% saying they had ever been offered it. Six per cent had ever been offered mephedrone. Of those who had ever been offered drugs (n=649), 70% said someone around their own age had first offered them drugs.

10.2.3 Production, sources of supply and trafficking patterns within the country and from and towards other countries

Trafficking patterns to the United Kingdom

The information provided below is from the Serious Organised Crime Agency (SOCA) in the UK and the Scottish Crime and Drug Enforcement Agency (SCDEA) in Scotland.

Heroin

Almost all the heroin in the UK originates from Afghan opium. Heroin trafficked to the UK is most likely to have either: passed west through Pakistani Baluchistan into Iran, to Turkey and then onward through Europe; have been sent directly from Pakistan by parcel, courier or container; or have been trafficked by sea onto eastern and southern Africa where a proportion moves onward to western Europe and the UK.

Cocaine

The majority of the UK's identified cocaine supply is produced in Colombia, although UN production figures suggest that Peru and Bolivia are becoming more important in this regard. Various routes and methods are used to get the cocaine to the UK, one of Europe's largest markets. Traditionally, most of the cocaine destined for Europe, including the UK, has crossed the Atlantic by ship, especially maritime container shipments. West Africa is a transit region for large amounts of cocaine from South America destined for Europe. It often enters via Spain and other important drugs hubs such as the Netherlands. The importation of cocaine is continually becoming more sophisticated; with professional concealments coming into the UK by plane as well as ships. There is a trend towards importing 'little and often'.

Synthetic drugs

Synthetic drugs are defined as artificial substances produced for the illicit market, almost entirely manufactured from chemical compounds in illicit laboratories. Those most commonly seen in the EU and trafficked to the UK are known as amphetamine type stimulants (ATS): amphetamine, methylamphetamine and 3, 4 methylenedioxymethamphetamine (MDMA). Following the classification to Class B of mephedrone in April 2010, many Internet-based traders ceased openly offering the substance for sale. India has a large legitimate market for ketamine and intelligence suggests a significant quantity is diverted to the UK illicit drugs market. Ketamine is trafficked to the UK through mail and fast parcel services but recently larger shipments have been transported by maritime container.

Cannabis

The UK wholesale cannabis market is worth in excess of €1.17 billion (£1 billion) a year. Substantial quantities of cannabis resin and herbal cannabis continue to be imported into the UK. There is evidence of widespread intensive commercial cultivation of the high potency cannabis 'sinsimilla' (or skunk) throughout the UK. Organised criminals involved in the supply of cannabis perceive it as a high profit, low risk activity that provides them with the money to acquire assets and to fund further organised criminal activity.

Research

Niewiarowski et al. (2010) report on abdominal x-ray signs of intra-intestinal drug smuggling and the signs most commonly encountered in radiological reports.

Distribution within the UK

Once drugs are in the UK, they have traditionally been transported to major cities such as London, Liverpool and Birmingham before being distributed. Many other cities and large towns act as secondary distribution points, with drugs moved in bulk before being sold on to local dealers. Drugs destined for Wales, Scotland and Northern Ireland are mostly routed via England, reflecting the extensive use of the Channel ports. In addition there is clear evidence to suggest that Scottish Serious and Organised Criminal Groups are operating internationally with drugs being imported directly into Scotland (personal communication - SCDEA).

Sources of supply

Findings from the 2010/11 British Crime Survey (Smith and Flatley 2011; see section 2.2.2) show that three-quarters of those who had taken drugs in the last year had last obtained drugs from a friend or family member (54%) or someone else they knew (21%). One-fifth (22%) of recent drug users reported last obtaining drugs from a contact or dealer. The most common location for obtaining drugs was at someone else's house (38%) or at home (21%). Twelve per cent of users reported last obtaining drugs from a party, club or rave, nine per cent from a bar or pub and ten per cent on the street, in a park or another outdoor area. One per cent reported obtaining drugs from school, college, university or work the last time they had obtained them.

Mephedrone

A study looking into experiences with mephedrone in Northern Ireland pre- and post-legislative changes found that initiation into mephedrone use was influenced by market level factors such as availability, price and reduced access to illicit drugs of choice (McElrath and O'Neill 2010). Most respondents reported that they had never bought mephedrone from an online supplier or headshop even pre-classification, with many obtaining it through friends/acquaintances. While some participants purchased mephedrone from a dealer prior to classification, almost all had done so since classification. Participants reported increased prices since classification with the price of a gram doubling.

A survey of mephedrone use and sources of supply amongst school and college/university students (Dargan et al. 2010; see section 2.4.4), undertaken before legislative changes took place, found that almost half of mephedrone users (49%) sourced the drug from a dealer. Only 11% reported obtaining mephedrone through the internet although this increased with age (8% of those aged 13 to 15 years compared to 31% of those aged over 24 years). The authors posit that this may be because younger users are less likely to have a debit card that can be used to purchase items over the internet.

10.3 Seizures

10.3.1 Drug seizures in England and Wales

In 2009/10 there were 224,080 drug seizures in England and Wales, a seven per cent decrease from the previous year and the first decrease since the introduction of the cannabis warning³³⁶ in 2004. The total number of cannabis seizures fell from 186,417 in 2008/09 to 176,578 in 2009/10, a five per cent decrease. However, continuing the trend since 2004, the

³³⁶ For a description of the cannabis warning see:

<http://www.drugscope.org.uk/resources/drugsearch/drugsearchpages/cannabis-laws>

number of cannabis plants seized increased by 38% on the previous year. The large year-on-year increase in cocaine powder seizures since 2004 reversed in 2009/10 with a 13% decrease on the previous year. Ecstasy seizures continued to decrease, by 29% between 2008/09 and 2009/10 and by 55% since 2006/07 (Table 10.1).

Table 10.1: Number of seizures of drugs by law enforcement agencies in England and Wales, 2004 to 2009/10

Drug	2004	2005	2006/07*	2007/08	2008/09	2009/10
Amphetamines	6,504	7,837	8,477	8,863	7,760	7,290
Cannabis – herbal	43,072	76,157	109,649	137,526	145,353	144,228
Cannabis – resin	35,219	41,454	32,590	30,870	35,795	24,319
Cannabis plants	2,930	4,327	5,805	8,539	9,380	12,901
Cocaine powder	8,279	12,512	16,917	21,346	24,659	21,337
Crack cocaine	5,164	6,705	6,955	7,578	6,623	5,075
Ecstasy type substances	6,256	6,688	8,184	7,173	5,218	3,720
Heroin	11,668	14,072	13,942	14,186	13,302	12,812
LSD	144	204	169	145	132	101
Total	112,923	169,802	196,099	228,131	241,473	224,080

*in 2006/07 data moved to a financial year basis

Source: Mulchandani et al. 2010

Similar to the number of seizures, the quantity of drugs seized decreased for almost all individual drugs, particularly herbal cannabis where the quantity almost halved (Table 10.2). After a large increase in the previous year, the quantity and number of cannabis resin seizures decreased to below 2007/08 levels. The number of ecstasy tablets seized decreased substantially and is now far below seizure levels in 2006/07 and earlier.

Table 10.2: Quantity of seizures of drugs by law enforcement agencies in England and Wales, 2004 to 2009/10

Drug	Unit	2004	2005	2006/07*	2007/08	2008/09	2009/10
Amphetamines	Kg	1,257	2,091	1,390	1,811	2,939	1,326
Cannabis – herbal	Kg	21,535	20,583	25,832	20,093	33,363	17,946
Cannabis – resin	Kg	63,234	50,591	19,851	16,710	31,799	12,563
Cannabis plants	Plant	93,469	220,019	363,679	535,888	643,510	758,700
Cocaine powder	Kg	4,640	3,821	3,244	3,453	2,916	2,642
Crack cocaine	Kg	140	51	60	37	33	59
Ecstasy	Tablet (000s)	4,740	3,019	6,685	965	547	171
Heroin	Kg	2,170	1,907	1,030	1,059	1,552	1,516
LSD	Dose (000s)	37	1,137	6	3	20	3

*in 2006/07 seizures data moved to a financial year basis

Source: Mulchandani et al. 2010

10.3.2 Drug seizures in Northern Ireland

There was a total of 3,564 drug seizures in Northern Ireland in 2010/11, a seven per cent increase on the previous year (Table 10.3). However, this increase can be partly explained by the classification of mephedrone (not shown), which resulted in 286 seizures of the drug in 2010/11. There were a larger number of mephedrone seizures than seizures of amphetamines (128 seizures) and ecstasy (150 seizures) and only slightly fewer seizures than for cocaine powder (304 seizures), where there was a 36% decrease from the previous year. Seizures of cannabis plants continued to rise, as did the number of herbal cannabis seizures. Similar to the rest of the UK, herbal cannabis is now the most commonly seized type of cannabis, with the number of cannabis resin seizures lower than the number of herbal cannabis seizures for the second year running. However, herbal cannabis does not appear to have reached the level of market domination in Northern Ireland as it has in England and Wales; the ratio of cannabis resin seizures to herbal cannabis seizures was 1:1.5 in Northern Ireland in 2010/11 compared to 1:5.9 in England and Wales in 2009/10.

Table 10.3: Number of seizures of drugs by police in Northern Ireland, 2005/06 to 2010/11

Drug	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Amphetamines	138	188	132	95	129	128
Cannabis – herbal	180	486	811	897	1,434	1,644
Cannabis – resin	2,086	1,438	1,480	1,630	1,118	1,072
Cannabis plants	45	105	115	173	158	231
Cocaine powder	168	278	405	345	474	304
Crack cocaine	0	0	0	1	0	0
Ecstasy	256	411	436	353	204	150
Opiates (powder)	30	43	38	46	55	47
LSD	15	7	6	10	8	3
Total	2,767	2,590	2,968	3,198	3,319	3,564

Source: PSNI 2006b; PSNI 2010b; PSNI 2011

The quantity of drugs seized decreased in the last year for all individual drugs except for cannabis plants (Table 10.4). The average number of cannabis plants per seizure increased from 34.7 in 2009/10 to 44.7 in 2010/11. In addition to a large decrease in the number of cocaine powder seizures, there was also a 72% decrease in the quantity of cocaine powder seized, with the quantity now at its lowest level since 2002/03.

Table 10.4: Quantity of seizures of drugs by police in Northern Ireland, 2005/06 to 2010/11

Drug	Unit	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Amphetamines	Kg	74	18	13	6	95	11
Cannabis – herbal	Kg	69	27	70	249	216	176
Cannabis – resin	Kg	426	3,684	78	743	127	87
Cannabis plants	Plant	1,504	1,448	4,006	30,904	5,484	10,330
Cocaine powder	Kg	27.1	36.1	17.9	24.2	27.5	7.8
Crack cocaine	g	0	0	0	7	0	0
Ecstasy	Tablet (000s)	92	119	245	34	54	15
Opiates (powder)	Kg	0.3	0.6	0.1	0.1	8.6	4.6
LSD	Dose	308	127	186	169	261*	61*

* Doses only. Previous years have combined doses and microdots.

Source: PSNI 2006b; PSNI 2010b; PSNI 2011

10.3.3 Other seizures data

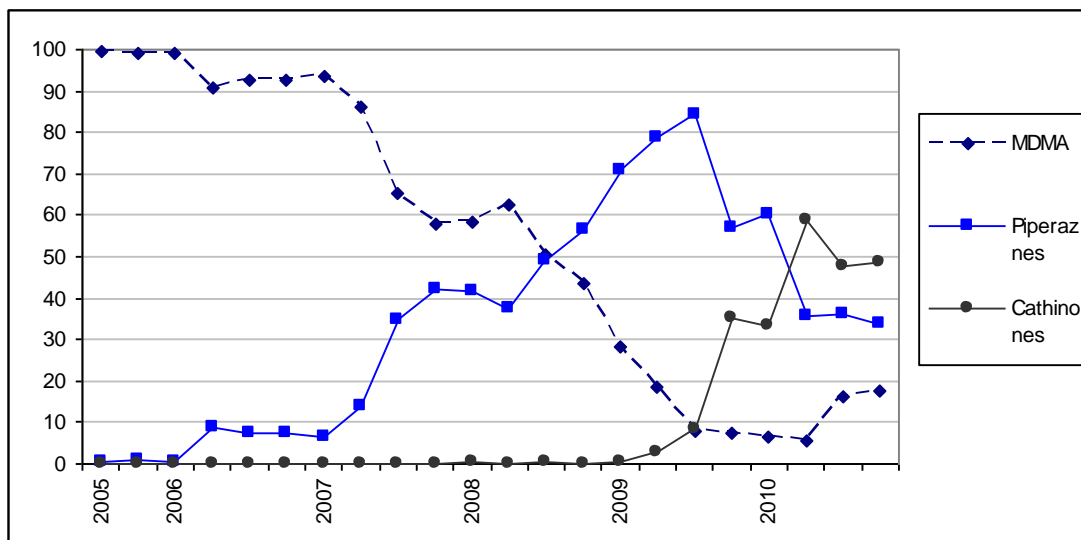
Data from the Forensic Science Service (FSS)³³⁷ show that since mid-2006 there has been a decrease in the proportion of tablet seizures³³⁸ analysed by the FSS that contain MDMA and a corresponding increase in the proportion containing piperazines (Figure 10.1). In mid-2008 FSS data showed that piperazine tablet seizures outnumbered MDMA tablet seizures and continued to increase until mid-2009 when there was an increase in the proportion of tablets containing cathinones. After piperazines were controlled at the end of 2009, the proportion of analysed tablets that contained piperazines fell sharply, whilst the proportion containing cathinones continued to increase. In April 2010, cathinones were classified under the *Misuse of Drugs Act 1971*. Since then the proportion of tablets containing MDMA has increased and the proportion containing cathinones fell slightly in the first quarter after control but has remained stable since. The proportion of tablets containing piperazines decreased slightly over this period but still account for a higher proportion of tablet seizures than MDMA tablets.

Research undertaken with recreational drug users suggest that the cathinone, mephedrone, was actively purchased by young people, in part due to the perceived low quality of ecstasy (Measham et al. 2010). In contrast, few users report using piperazines with the 2010/11 BCS reporting last year use at 0.2% amongst 16 to 24 year olds (Smith and Flatley 2011) and a survey of young clubbers for Mixmag magazine reporting lifetime prevalence of 17%, a relatively low prevalence given that lifetime prevalence of ecstasy use amongst this group is at 88% and mephedrone at 61% (Winstock 2011; see section 2.5.3). Indeed, it has been reported that many users have never even heard of the most commonly encountered piperazine, BZP (personal communication - Dr. Fiona Measham). This could suggest that dealers may have been selling piperazine tablets as ecstasy and shows the importance of combining seizures data with user reports to help determine the role of supply and demand in drug markets.

³³⁷ The FSS is to cease operating in March 2012. Some of its work has already been transferred to other forensic providers. Percentages are reported here rather than numbers to avoid the reduction in workload having an impact on analysis. Data for 2010 have been compared to data from all forensic providers and there is little difference in proportions.

³³⁸ Around 1,000 seizure records are analysed per quarter.

Figure 10.1: The percentage of seized tablets analysed by the Forensic Science Service (FSS) containing MDMA, piperazines and cathinones by quarter in England and Wales, 2005 to 2010.



Source: Forensic Science Service

10.4 Price/purity

Drug price data are provided by law enforcement agencies. Figures are supplied by UK Police Forces who use information which is derived from a number of sources including: interviews with prisoners; CHIS (covert human intelligence sources or informants); test purchases; and sensitive and non sensitive recording procedures and intelligence (ST16).

10.4.1 Price of drugs at street level

Street-level prices of most individual drugs remained stable in 2010 (Table 10.5). Skunk cannabis continues to retail at a much higher price than traditional herbal cannabis and cannabis resin, although it is difficult to establish the extent to which price relates to potency due to a lack of recent potency data.

There has been a decrease in the price of crack cocaine, which may be linked to a decrease in its purity (section 10.4.2). The price of cocaine powder remains stable although purity-adjusted price has fluctuated in recent years (see section 10.4.3).

Heroin prices also remained stable despite a decrease in purity and reports of a heroin shortage in late 2010, although there may be a time lag in price data.

Table 10.5: Law enforcement agencies: Mean price of illegal drugs in the United Kingdom, 2005 to 2010

Drug	Price per gram except where otherwise stated					
	2005	2006	2007	2008	2009	2010
	Exch. rate: £1=€1.4629	Exch. rate: £1=€1.467	Exch. rate: £1=€1.4619	Exch. rate: £1=€1.2588	Exch. rate: £1=€1.1233	Exch. rate: £1=€1.1752
Amphetamines	£10.00	£9.00	£9.00	£10.00	£10.00	£10.00
	€14.63	€13.20	€13.16	€12.59	€11.23	€11.75
Cannabis herb*	£2.64	£2.68	£3.95	£2.85	£2.85	£2.82
	€3.86	€3.93	€5.77	€3.59	€3.20	€3.31
Cannabis resin*	£1.94	£2.12	£2.82	£2.85	£2.85	£2.82
	€2.84	€3.11	€4.12	€3.59	€3.20	€3.31
Cannabis (sinsemilla)			£6.21	£5.63	£7.15	£7.15
			€9.08	€7.09	€8.03	€8.40
Cocaine powder	£49.00	£49.00	£46.00	£40.00	£40.00	£40.00
	€71.68	€71.88	€67.24	€50.35	€44.93	€47.01
Crack cocaine**	£19.00	£18.00	£65.00	£65.00	£60.00	£50.00
	€27.80	€26.41	€95.02	€81.82	€67.40	€58.76
Ecstasy (per tablet)	£4.00	£3.00	£3.00	£3.00	£2.50	£2.50
	€5.85	€4.40	€4.39	€3.78	€2.81	€2.94
Heroin	£54.00	£52.00	£48.00	£45.00	£45.00	£45.00
	€79.00	€76.28	€70.17	€56.65	€50.55	€52.88
LSD (per dose)	£3.00	£3.00	£3.50	£3.00	£3.00	£3.00
	€4.39	€4.40	€5.12	€3.78	€3.37	€3.53

Note : The source data were provided rounded, usually to the nearest pound.

*Before 2007 the cannabis values were based on the price for an ounce. In 2007 this changed to being based on a usual street deal of 1/8oz. The price has been converted to gram equivalent.

**Crack cocaine prices before 2007 were provided per rock (0.2g) not per gram. Prices after 2007 cannot be compared to earlier prices.

Source: Standard Table 16

The price of ketamine is between €23.5 (£20) and €35.3 (£30) a gram, similar to the cost of MDMA powder. Since the classification of mephedrone in 2010, street-level prices have risen from around €11.8 (£10) per gram to around €23.5 (£20) (see also 10.2.3). The wholesale kilogram price in the UK increased from between €2,350 (£2,000) and €3,526 (£3,000) to around €7,639 (£6,500). In many cases, organised criminals saw the classification of mephedrone as an opportunity to increase its price and make a significant profit (personal communication - SOCA).

In Scotland, there is a large market for benzodiazepines with the most common 10mg diazepam blue tablet selling for approximately €1.2 (£1) (personal communication - SCDEA). It should be noted that the prices in Table 10.5 are averages and conceal geographic variations within the UK. In Scotland, drug prices are collected regularly from the eight police forces and the SCDEA from a network of Statement of Opinion (STOP) Units or Drug Expert Units. A quarterly publication with definitive price data for Scotland for use by law enforcement agencies is produced from these. The latest data published in October 2011 show that there are some substantial differences from the prices shown in Table 10.5. The most notable differences are that in Scotland cannabis can retail at €11.8 (£10) per gram, MDMA (ecstasy) tablets cost up to €11.8 (£10) each and, when sub-divided into £10 bags, heroin can reach between €82.3-€117.5 (£70 -£100) per gram. Crack cocaine is often transported into Scotland from England in ready made 'rocks' and can cost up to €117.5 (£100) per gram.

10.4.2 Purity of drugs at street level and composition of drugs/tablets

After a period of declining purity, the average purity of cocaine powder increased slightly from 20.3% in 2009 to 23.8% in 2010, although it remains lower than in 2008 (Table 10.6).³³⁹ Similarly, the purity of crack cocaine increased slightly. The purity of heroin decreased to around 2003 levels and there have been reports of a shortage of heroin from late 2010, which may affect the purity of the heroin available (see section 10.4.3).

Table 10.6: Mean percentage purity of certain drugs seized by police in England and Wales, 2003 to 2010

Drug	2003	2004	2005	2006	2007	2008*	2009*	2010**
Amphetamines	10.8	9.0	10.1	10.6	10.9	7.8	8.0	8.0
Cocaine powder	51.2	42.4	42.7	34.5	33.2	28.8	20.3	23.8
Crack cocaine	69.6	63.7	64.8	49.5	52.3	43.1	27.1	31.0
Ecstasy***	64.5	66.7	66.3	48.0	51.8	33.1	43.5	49.0
Heroin (brown)	32.7	39.9	46.5	43.5	49.8	42.7	44.4	34.9

*Data provided by both FSS and LGC Forensics. Previous data were supplied from FSS only.

**Data provided by FSS, LGC Forensics, Environmental Services Group and Key Forensic Services Ltd.

***mg of MDMA base per tablet.

Source: Standard Table 14

MDMA content

While the MDMA content of ecstasy tablets increased in 2010, it is still well below the purity levels at the beginning of the 2000s. Data from forensic providers show that only 11% of all tablets analysed contain MDMA as the only scheduled substance compared to 99.5% in 2005 (ST15; see section 10.3.3). Analysis of the content of ecstasy tablets collected in amnesty bins in nightclubs during 2006 (Wood et al. 2010d), showed a large variability in the content of ecstasy tablets with as much as a 6.5-fold difference in MDMA content. The authors raised concerns about how this variability in content could increase the risk of acute MDMA toxicity.

10.4.3 Purity-adjusted price

Cocaine powder

Due to stable prices and an increase in average purity in 2010, the purity-adjusted price of cocaine powder (indexed to 2003) decreased from €113 (£101) to €101 (£86) (Table 10.7). As seen in Figure 10.2, purity has fallen at a faster rate than price, although the trend was downwards for both indicators until 2008. Since 2008, price has stagnated and despite an increase in purity during 2010, it has not increased enough to compensate for the large decrease in purity witnessed in 2009.

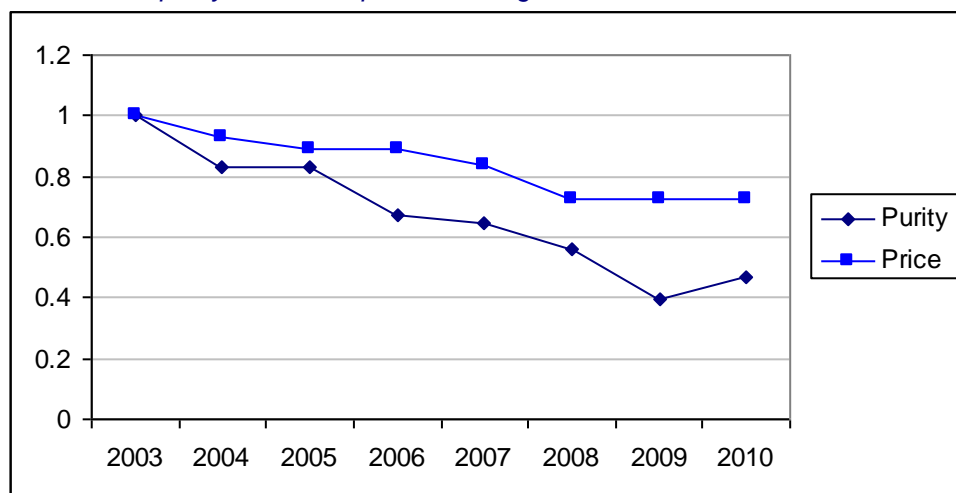
Table 10.7: Purity-adjusted price of cocaine powder per gram in the United Kingdom, 2003 to 2010: indexed to 2003

Drug	2003	2004	2005	2006	2007	2008	2009	2010
Cocaine powder	£55	€61.58	£58.75	£72.70	£70.94	£71.11	£100.89	£86.05
	€79.51	€90.76	€85.95	€106.63	€103.71	€89.51	€113.33	€101.13

Source: Standard Tables 14 and 16

³³⁹ Caution should be taken in interpreting trends since 2010 data includes data from more forensic providers than in previous years (see Table 10.8).

Figure 10.2: Price and purity of cocaine powder in England and Wales, 2003 to 2010: indexed to 2003



Source: Standard Tables 14 and 16

Heroin

The purity-adjusted price of heroin had been relatively stable over the last three years after large decreases after the start of the war in Afghanistan in 2003. However, in 2010 purity-adjusted prices increased to €50 (£42), the highest level since 2004, which is wholly attributable to a decrease in purity (Table 10.8).

Table 10.8: Purity-adjusted price of heroin per gram in the United Kingdom, 2003 to 2010: indexed to 2003

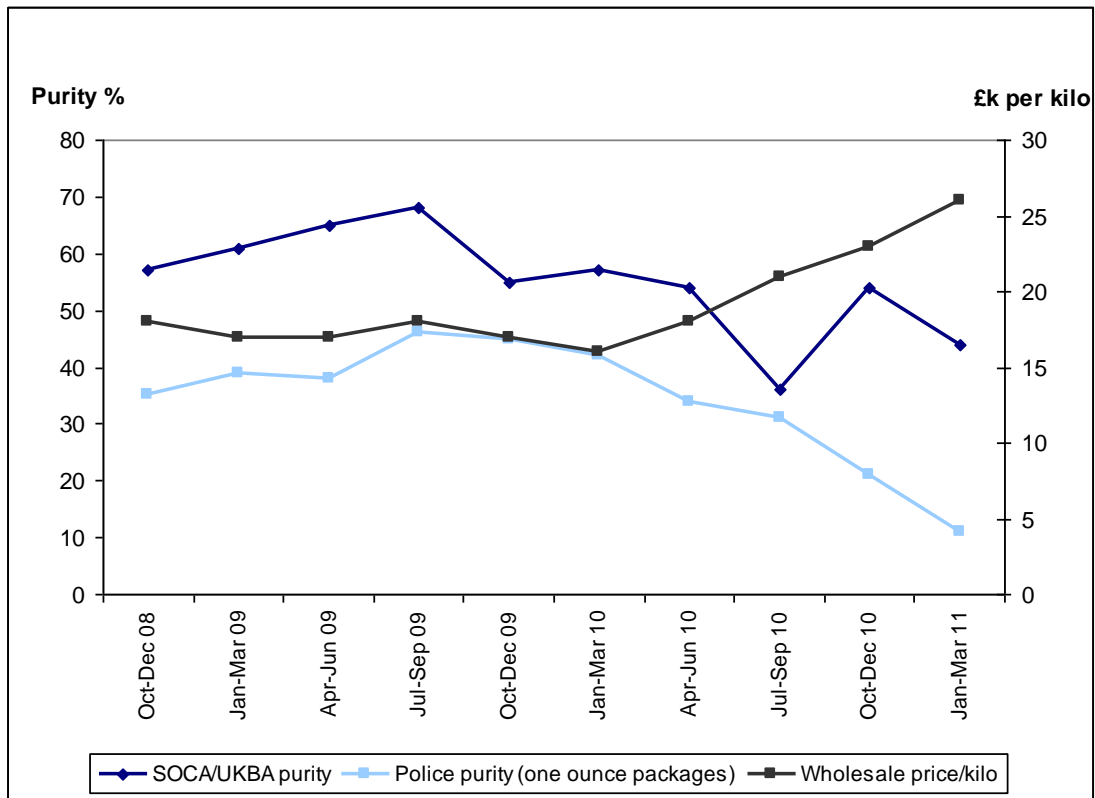
Drug	2003	2004	2005	2006	2007	2008	2009	2010
	£62.00	£45.08	£37.97	£39.09	£31.52	£34.46	£33.11	£42.16
Heroin	€89.63	€66.44	€55.55	€57.35	€46.08	€43.38	€37.19	€49.55

Source: Standard Tables 14 and 16

Most areas of the United Kingdom reported heroin shortages from April 2010 onwards, experiencing low purity at street level and high wholesale prices (Figure 10.3). Data from SOCA ENDORSE³⁴⁰ show that street purity fell from 46% in September 2009 to 32% in September 2010, with suppliers adding more cutting agents to maintain levels of profit. Annually between 18 and 23 tonnes of adulterated and unadulterated heroin is imported in order to supply the UK market. A consequence of this reported shortage has been an increase in wholesale prices; prior to late 2010 UK wholesale prices were commonly up to £19,000 per kilo, however since late 2010 these have increased, commonly up to £25,000 per kilo (personal communication – SOCA).

³⁴⁰ In October 2008 a SOCA initiative known as ENDORSE began. All seizures of heroin, cocaine and amphetamines above 25g were subject to full forensic examination. See: <http://www.soca.gov.uk/threats/drugs/forensic-intelligence>

Figure 10.3: Wholesale (SOCA/UKBA) and street-level (police) purity of heroin and wholesale price in the United Kingdom, 4th quarter 2008 to 1st quarter 2011



Source: SOCA ENDORSE

PART B

Selected Issues

11. Drug-related health policies and services in prison

11.1 Prison systems and prison population: contextual information

11.1.1 Prison estate

The National Offender Management Service (NOMS) is responsible for all prisons in England and Wales while Scotland and Northern Ireland have separate prison administrations. As of 1 October 2011, there are 131 prisons in England and Wales, 119 of which are public sector establishments and 12 are privately managed. There are 13 women's prisons in England and none in Wales. Other specific groups accommodated include young offenders (young males aged 15 to 21 years old) and foreign national prisoners. There are 11 Home Office immigration removal centres in England. Of these, four are operated under a service level agreement by NOMS in the public sector and seven are privately managed.

There are 15 prisons in Scotland, with a design capacity ranging from 104 prisoners to 1,018, two of which are privately managed. In Northern Ireland, there are three prisons with a total capacity of 1,513.

11.1.2 Prison population

On June 30th 2010 there were 85,002 people in prison custody in England and Wales, 73,305 of whom were adults.³⁴¹ Of those adult prisoners in custody, 15% were on remand and 85% were sentenced. The most common offence was violence against the person (28%) followed by drug offences (16%), sexual offences (14%) and robbery (11%). Of all prisoners in custody, five per cent were female and 14% were foreign nationals (including those held in Immigration Removal Centres). Seven per cent of adult sentenced prisoners were sentenced for six months or less.

In Scotland during 2010/11 the average daily number of prisoners was 7,853, 19% of whom were on remand. Of those sentenced, 36% were convicted of non-sexual crimes of violence with 14% convicted of drug offences. The number of receptions to prison during the year was 35,930. Eighteen per cent of directly sentenced receptions to prison during 2010/11 were sentenced to less than three months custody with a further 27% receiving sentences of three months or more and less than six months. Those convicted of shoplifting (n=1,340) were sentenced to the lowest average days of custody with 71% receiving a sentence of less than six months (Scottish Government 2011g). Research looking at the views of prisoners serving short prison sentences (less than six months) found that "the abiding feature of people serving short prison sentences is the presence of a serious drug and/or alcohol problem" (Armstrong and Weaver 2010). The *Criminal Justice and Licensing Act (Scotland) 2010* introduced a presumption against short prison sentences of three months or less which came into effect in February 2011 (the original proposal was for six months but this was amended in parliament).

The prison population in Northern Ireland for the week beginning 28th June 2010 was 1,450, of whom one-third (33%) were on remand.

11.1.3 Health and social needs of prisoners

Health and social needs

Prisoners have a wide range of health problems and have often been socially excluded. A Ministry of Justice led cohort study of prisoners (entitled *Surveying Prisoner Crime*

³⁴¹ See: <http://www.justice.gov.uk/publications/statistics-and-data/prisons-and-probation/oms-quartley.htm>

*Reduction – SPCR*³⁴²), which looked at the problems and needs of newly sentenced prisoners in England and Wales (Stewart 2008)³⁴³ found levels of health and social problems amongst prisoners to be much higher than in the general population. Accommodation problems, unemployment and a lack of educational qualifications were all reported by a higher proportion of prisoners and almost two-thirds (63%) had claimed benefits in the 12 months prior to imprisonment. Twenty-nine per cent of adult prisoners reported a long-standing physical disorder and 63% screened positive for a personality disorder. Over one-third of adult prisoners (37%) reported six to ten anxiety and depression symptoms.

Mental health

The Bradley Review's report of people with mental health problems or learning disabilities in the criminal justice system (Bradley 2009) reported high levels of mental health problems amongst prisoners and suggested that dual diagnosis of substance misuse issues should be considered as the norm.

Substance misuse

In the SPCR cohort study (MOJ 2010d), one-fifth of the sample reported daily use of alcohol with 81% of those consuming ten units or more on a typical drinking day. The majority of respondents (80%) had used illegal drugs at some point in their lifetime with 68% reporting drug use in the last year. Drug use in the four weeks prior to custody was reported by 62% with cannabis (46%), heroin (30%) and crack cocaine (28%) the most commonly reported drugs used. Overall 43% of adult prisoners reported using heroin, crack cocaine or cocaine powder in the four weeks prior to custody. Amongst those reporting use of heroin or crack cocaine in the four weeks before custody, 68% had used both (Stewart 2009)³⁴⁴. The SCPR study also found that 18.7% of heroin users, or 7.5% of the study sample, reported first using heroin while in prison.

In a survey of psychiatric morbidity amongst prisoners³⁴⁵, Singleton et al. (1999) found that dependence on drugs ranged from 41% of female and 43% of male sentenced prisoners to 54% of female and 51% of male remand prisoners.

Twenty-eight per cent of adult and young adult male prisoners surveyed for prison inspections in England and Wales during 2010/11 reported entering prison with a drug problem. Those entering local prisons were more likely to report a drug problem (38%) and nine per cent of respondents reported developing a drug problem while in prison (HMIP 2011).

In Scotland, reported drug use amongst prisoners in the year before imprisonment fell from 82% in 2004 to 67% in 2009 (Figure 11.1).

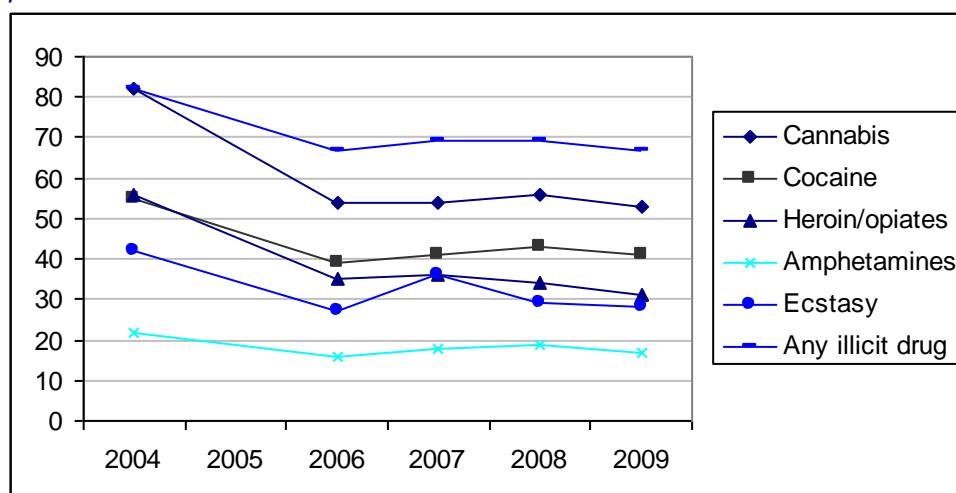
³⁴² The results reported in Stewart (2008) are based on an interim dataset. Results have been updated and are included in the Ministry of Justice's Compendium of Reoffending Statistics. See: <http://www.justice.gov.uk/publications/statistics-and-data/reoffending/compendium-of-reoffending-statistics-and-analysis.htm>

³⁴³ A representative sample of 1,457 newly sentenced prisoners were interviewed between two and four weeks after reception. The Local Inmate Data System was used to select the sample and prisoners were eligible if they had been sentenced for between one month and four years. Fieldwork took place between November 2005 and November 2006 at 49 prisons in England and Wales. A response rate of 60% was achieved. The results are the first from a longitudinal study looking at how prisoners' needs are addressed during and after custody.

³⁴⁴ Ibid.

³⁴⁵ The survey of psychiatric morbidity amongst prisoners was commissioned by the Department of Health. A total of 3,142 prisoners were interviewed (88% response rate) and, of those, 505 took part in a follow-up interview by a psychiatrist or psychologist (76% of those selected for follow-up).

Figure 11.1: Percentage of prisoners in Scotland reporting use of individual drugs in the 12 months prior to imprisonment



Source: Standard Table 12

In the most recent survey, 45% reported being under the influence of drugs at the time of their arrest and 41% stated that their drug use was a problem for them outside of prison. Similarly, 50% stated that they were drunk at the time of their offence and 43% admitted having an alcoholic drink first thing in the morning (SPS 2009). A health needs assessment for alcohol problems published in 2010 showed high levels of alcohol dependency amongst Scottish prisoners (NHS Health Scotland 2011).

Further data on drug use prior to imprisonment in Scotland is provided by addiction prevalence testing carried out on reception to prison³⁴⁶ (ISD 2010). Of the 1,093 addiction prevalence tests carried out at prisoner arrival in 2009/10, 56% were positive for illicit drug use, including illicit use of prescribed drugs, the most common drugs being benzodiazepines (38%), opiates (36%) and cannabis (28%).

Drug-related infectious disease

Data from England and Wales show that, between 2005 and 2008, 24% of prisoners tested positive for hepatitis C and 15% for hepatitis B³⁴⁷ (HPA 2011c). Data show that in 2010 in England and Wales, the prevalence of Hepatitis C was higher amongst those who had ever been in prison (56%) than those who had never been in prison (32%) (ST09).

Women prisoners

The Corston Report on vulnerable women in the criminal justice system claimed there were 'fundamental differences' between male and female offenders and that a different approach is needed (Home Office 2007). Indeed, results from the SCPR cohort study (Stewart 2008) show that women may have different health and social needs than men. Female respondents were more likely than male respondents to report being unemployed in the four weeks prior to custody and to have claimed benefits in the previous 12 months. Large differences in mental health problems were found with women twice as likely as men to have a psychotic order (18% compared to 9%), and more likely than men to be assessed as having a personality disorder (62% compared to 57%). Over half of women (54%) reported

³⁴⁶ A five per cent sample of those entering prison is tested twice a year for the prevalence of illegal drugs. A total of 1,093 prisoners were tested on reception out of 21,011 receptions to prison during 2009/10. This includes prisons run by the Scottish Prison Service and privately run prisons.

³⁴⁷ Between 2005 and 2008, 9,965 prisoners were tested for anti-HCV and 5,175 for HBsAg (the surface antigen of the hepatitis B virus which indicates current infection). Data are taken from 16 laboratories performing testing for 39 prisoners in England (30% of the prison estate).

having six to ten anxiety and depression symptoms compared to one-third of men (34%). Singleton et al. (1999) found similar differences between females and males for probable psychotic disorders and neurotic disorders but females were less likely than males to be assessed as having a personality disorder.

In the SPCR cohort study (Stewart 2008), women (52%) were also more likely than men (40%) to report the use of heroin, crack cocaine or cocaine powder in the four weeks prior to imprisonment. In a study assessing the health needs of women prisoners³⁴⁸ (Plugge et al. 2006), 58% of respondents reported using drugs daily in the six months prior to imprisonment and 38% reported ever having injected drugs. The most commonly reported drugs used in the six months prior to imprisonment were crack cocaine (59.5%) and heroin (52.2%). Stewart (2008) found that women are more likely to report the use of crack cocaine (49%) and heroin (44%) in the year before custody than men (30% for both heroin and crack cocaine).

Other results from Plugge et al. (2006) show that 27% of women prisoners reported having been paid for sex and 16% reported self-harming in the month prior to imprisonment. Six per cent of respondents reported being pregnant on reception to prison.

11.2 Organisation of prison health policies and service delivery

11.2.1 Prison health

Legal framework, management framework and funding

Healthcare is a devolved responsibility in the United Kingdom. Despite prisons in England and Wales being run by the same body, healthcare within prisons is the responsibility of two different administrations.

England and Wales

In April 2003, responsibility for funding healthcare in publicly operated prisons transferred from the Prison Service to the Department of Health in England and the Welsh Government in Wales. In April 2006, Primary Care Trusts (PCTs) in England and Local Health Boards (LHBs) in Wales assumed full responsibility for the commissioning of healthcare within prisons. In England, a National Partnership Agreement (DH and HO 2007) was drawn up, setting out the accountability and commissioning responsibilities for healthcare in prisons. A similar National Partnership Agreement was drawn up in Wales. In England, from April 2011, the commissioning of all substance misuse services in prisons became the responsibility of local commissioning groups, comprising PCTs, local authorities, and prison and probation authorities. In Wales, the responsibility for commissioning non-clinical services remains with NOMS.

Since the transfer of funding responsibility for prisons health services to the Department of Health in England, expenditure³⁴⁹ on health care in publicly run prisons has increased by 78% from €188.1 million (£130.1 million) in 2003/04 to €272.3 million (£231.7 million) in 2010/11 (HC Deb, 7 July 2011, c1340W). Similarly the Welsh Government invested significantly in prison health services in the years immediately following transfer of responsibility, increasing allocations by over 30%. Since 2006 the funding for prison health services in Wales has been mainstreamed and investment therefore a matter for determination by the LHBs.

³⁴⁸ 550 women prisoners were recruited on reception to two women's prisons between June and December 2004, a response rate of 82%. Participants completed a questionnaire on reception, again at one month, and again at three months. Response rates for those still in prison at follow-up were 86% and 93% respectively. Convenience sampling was used to select a number of prisoners to take part in focus groups.

³⁴⁹ Expenditure relates to funding allocations.

In April 2008, in Northern Ireland, the commissioning and delivery of prison healthcare became the lead responsibility of the Health and Social Care service managed by the South Eastern Health and Social Care Trust. However, management, performance and discipline issues with healthcare staff remain the responsibility of Northern Ireland Prison Service (NIPS) (CJI Northern Ireland 2010). A Partnership Board was established with representatives of the Prison Service, the South Eastern Health and Social Care Trust and the Regional Health and Social Care Board with the relationship between the three organisations defined in a Partnership Agreement.

Scotland

Following a feasibility study in 2007 (NHS Scotland and Scottish Prison Service 2007), Ministers approved the transfer of prisoner healthcare from the Scottish Prison Service (SPS) to the NHS. In 2009, the National Programme Board for Prisoners' Healthcare was established for a minimum period of three years to oversee the transition. From 1st November 2011, the NHS will be wholly responsible for providing clinical health services in prison. A SPS Clinical Support Team will be transferred to Healthcare Improvement Scotland, a new body established in April 2011, but responsibility for strategy and liaison will remain at SPS.³⁵⁰

Regulatory Framework

In England and Wales, Her Majesty's Inspectorate of Prisons (HMIP) has a statutory duty to inspect healthcare and substance use in prisons as part of its inspection programme.³⁵¹ Responsibility for the inspection of healthcare provision lies with the Care Quality Commission (CQC) in England and Health Inspectorate Wales (HIW) in Wales. To facilitate cooperation and set out responsibilities, memoranda of understanding have been drawn up between both HMIP and CQC³⁵², and HMIP and HIW.³⁵³

A new performance assessment process was introduced in England in 2007 based on self-assessment against a range of performance indicators and requiring agreement from all those involved in the commissioning and provision of healthcare services in prisons. A set of prison health performance and quality indicators are published annually by the Department of Health, with progress against these indicators assessed every 12 months (DH 2011a). Data on hepatitis B and C and mental health are collected quarterly.

A comparable process is followed in Wales, with Performance and Quality Indicators aligned with the Healthcare Standards in Wales and relevant targets for the wider NHS as well as the Quality and Outcomes Framework for general practice.

A number of prison service instructions (PSIs), prison service orders (PSOs) and standards exist and these feed into the performance indicators (see section 11.4.1).

In Northern Ireland the Partnership Board develops policy and standards for healthcare in prisons and monitors the level and quality of healthcare services provided to prisoners. Local and regional Clinical Governance Committees have existed since 2007 to raise awareness of key clinical governance issues. The Criminal Justice Inspectorate Northern Ireland (CJINI) has the remit to inspect all areas of the criminal justice system apart from the judiciary.

³⁵⁰ See:

http://www.nhshealthquality.org/nhsqis/files/20110224_BMAgendaltem_10_5_Appendix1_PrisonTransferofHealthcareNHSboardpaper.pdf

³⁵¹ See: <http://www.justice.gov.uk/inspectors/hmi-prisons/aboutus.htm>

³⁵² See: <http://www.justice.gov.uk/inspectors/hmi-prisons/docs/mou-healthcare.pdf>

³⁵³ See: <http://www.hiw.org.uk/Documents/477/HMIP%20MoU%20Final%20October%202008.pdf>

Through a memorandum of understanding with HMIP, CJINI may invite HMIP to undertake an inspection of individual prisons.³⁵⁴

Equivalence of care

One of the primary objectives of transferring healthcare to the NHS from Prison Services is to ensure equivalence of care with community healthcare services. This was the major focus of a report published in 1999 by the joint Prison Service and National Health Service Executive Working Group (HM Prison Service and NHS Executive 1999) and the principal aim of the partnership agreements for the delivery of healthcare in public sector prisons in England (DH and HO 2007) and Wales.

The British Medical Journal reported in July 2011 that the UK government has agreed to pay more than €2.3 million (£2 million) in compensation and costs to settle a group action claim by around 500 drug-dependent prisoners and former prisoners who alleged that the treatment they received in prison between 2004 and 2009 “fell below a reasonable standard”. After reaching the High Court, the Ministry of Justice agreed to settle without any admission of liability. This follows an earlier claim in 2006 by 198 prisoners who were subject to rapid detoxification in the late 1990s, which the former Labour Government agreed to settle at a cost of around £1.5 million.³⁵⁵

The Scottish feasibility study on the transfer of responsibility to the NHS states that the transfer would allow Scottish prisons to meet accepted international standards on equivalence of care (NHS Scotland and Scottish Prison Service 2007).

In Northern Ireland, the NIPS Corporate Plan 2008/11 states that “prisoners’ access to health services must be appropriate to their needs and at least equivalent to those services available to the public” (NIPS 2008).

Models of service delivery and healthcare staff in prisons

In England there is a mixed economy of delivery of drug-related health services in prisons. Community based organisations are involved in the delivery of services (in-reach model) but mixed teams, including prison health staff and external specialists, are also utilised (import model). Substitution treatment may be delivered by staff of the local PCT (SQ27 Part 1).

In Wales clinical treatment for drug dependency is delivered as an integral part of the primary care services, i.e. in the main by prison health staff and GPs, but with support from local specialist services. Psychosocial services are provided via a NOMS contract with a third sector organisation.

Due to the predominantly in-reach model used for delivering healthcare in prisons and the transfer of responsibilities to the NHS, it is impossible to estimate accurately the number of healthcare staff working in prisons in the United Kingdom.

However, in Scotland there are currently around 200 nursing staff, clinical managers and health centre managers working in prisons, including NHS in-reach staff but not including administration staff.

11.2.2 Drug-related policies targeting prisoners

National drug policies

The UK Government published its three-pillared Drug Strategy in 2010; *Reducing demand, restricting supply, and building recovery* (HM Government 2010a). Offenders in prison are

³⁵⁴ See: [http://www.justice.gov.uk/inspectorates/hmi-prisons/docs/Protocol_with_CJI_NI_\(2009\).pdf](http://www.justice.gov.uk/inspectorates/hmi-prisons/docs/Protocol_with_CJI_NI_(2009).pdf)

³⁵⁵ BMJ 2011;343:d4438. See: <http://www.bmj.com/content/343/bmj.d4438.full.pdf>

mentioned explicitly in the first two of the three pillars. One action the Government wishes to take in order to reduce demand is to pilot 'drug recovery wings' in prison, which will be recovery-orientated. In the restricting supply section, the commitment to create drug-free environments in prison and increase the number of drug-free wings is made. In addition to the Drug Strategy, the Ministry of Justice's Green Paper, *Breaking the cycle* provides more detail about how the Government plans to tackle offenders' drug use (MOJ 2010c).

In the Scottish Government's Drug Strategy, *The Road to Recovery* (Scottish Government 2008a), a new approach to drug users in prisons is advocated that assists people to build recovery rather than being only punitive in nature. The strategy sets out its aims of reducing the supply of illicit drugs in prison, providing an integrated care pathway including continuity of care on release, and reducing the prevalence and transmission of blood-borne viruses (BBVs).

In the Welsh Substance Misuse Strategy, *Working together to reduce harm*, an explicit aim is to improve treatment options for Welsh prisoners across the prison estate (WAG 2008a) and to improve aftercare measured by a reduction in the number of fatal overdoses post-release.

The Northern Ireland drug strategy, *New strategic direction for alcohol and drugs* (DHSSPSNI 2006), does not explicitly mention treatment of prisoners.

Prison drug strategies

Strategies/policies for addressing drug use amongst offenders exist throughout the United Kingdom.

England and Wales

The National Offender Management Service (NOMS) in England and Wales published its Drug Strategy and associated Action Plan in 2009 (NOMS 2009a; 2009b). The *NOMS drug strategy* in prisons was based on three key elements:

- reducing supply through security measures and drug testing programmes;
- reducing demand, through targeted interventions for low, moderate and severe drug misusers; and
- establishing effective throughcare links to ensure continuity of treatment post-release in order to safeguard the gains made in custody.

An independent review of the prison drug treatment strategy for England, chaired by Lord Patel of Bradford, was published in November 2010 (Patel 2010), the key recommendations of which were:

- a unified cross-Government drug treatment and interventions strategy (prisons & community);
- a national health and criminal justice outcomes model;
- a streamlined commissioning system;
- a national drug treatment and interventions framework (community & prisons);
- an increase in service user and carer engagement; and
- establishing effective links to the wider criminal justice, health and social care systems.

An inter-departmental Offender Substance Misuse Board has been convened to oversee the smooth transition of the transfer of responsibilities from the Ministry of Justice and Home Office to the Department of Health in England. The Board will integrate its work-streams with the emerging policy and delivery landscape of the Public Health and National Health Service in England, the results of the Ministry of Justice Green Paper on rehabilitation and

sentencing of offenders (see section 9.4), and of the recommendations of Lord Patel's review of prison drug treatment (Patel 2010).

Future commissioning of drug services in prisons is expected to be aligned to the recovery goals of the national Drug Strategy and the forthcoming treatment framework, *Building Recovery in Communities* (BRiC), which will replace the current drug treatment framework, *Models of Care* (NTA 2006; see section 5.3.1). The NHS Operating Framework 2011/12 states that "NHS organisations should work with local partners to deliver joined up local commissioning of drug services based on the Prison Drug Treatment Strategy Review Group's outcome framework" (DH 2011b). This outcome framework recommended by the Review Group (Patel 2010) is designed to move away from activity-based outcome measures and instead focuses on four main themes:

- reduced drug use;
- reduced re-offending;
- improved health and social functioning; and
- increased employment and enhanced workforce skills.

Scotland

In Scotland, a strategy framework for managing substance misuse in custody was published by the SPS in 2010 (SPS 2010). The strategic aims are to ensure that:

- a comprehensive range of security measures are in place to reduce the availability and supply of illegal substances and associated paraphernalia entering Scotland's prisons;
- recovery is the explicit aim of all services providing treatment and rehabilitation for prisoners with drug and alcohol problems;
- a range of appropriate treatment and rehabilitation services are available since individual prisoners will require different routes to recovery;
- treatment services integrate effectively with a wider range of prison based services to address fully the complex needs of prisoners with problematic drug and alcohol use;
- addiction testing is deployed with clearly defined purposes to support clinical prescribing, risk management, prisoner progression, and to identify the prevalence of illegal drug use;
- a range of services and support is provided to encourage prisoners to reduce or cease smoking;
- a range of blood-borne virus prevention, treatment, care and support services are available;
- access to information will take into consideration the diversity of prisoners with substance misuse problems, including low ability in reading and comprehension; and
- the principles of recovery are reflected in training for staff and service providers to support the continuous development of a competent, confident, valued and responsive workforce.

Northern Ireland

The Northern Ireland Prison Service's policy on substance misuse (NIPS 2006) lists the following four underpinning principles:

- zero tolerance will apply to all drug and alcohol misuse in prison;
- prisoners will be continually encouraged and challenged to assume responsibility for their own substance misuse behaviour;
- prisoners experiencing drug and alcohol dependency, or suffering health problems as a result, will be offered therapeutic interventions equivalent to those provided in the community but appropriate to a prison environment; and
- discharged prisoners should be offered on-going rehabilitation and support on their return to the community addiction services.

11.3 Provision of drug-related health services in prison

11.3.1 Prevention, treatment, rehabilitation, harm reduction

Drug use assessment

Across the prison systems in the United Kingdom, prisoners receive a healthcare screen on reception to prison including a brief substance misuse assessment. In England, where a substance misuse issue is identified, a substance misuse triage assessment is initiated. Carried out by a competent nurse, pharmacist or doctor, it assesses immediate clinical need enabling pharmacological treatment to commence. In the case of individuals received directly from the courts, this includes medical management on the first night as a means to contain withdrawal symptoms and thereby reduce the risk of suicidal behaviour. A further comprehensive substance misuse assessment is carried out within five days of referral to the Counselling, Assessment, Referral, Advice and Throughcare service (CARATs) team (see below).

There are guidelines in place to ensure regular observation of drug dependant prisoners during the initial stabilisation period (see section 11.4.1).

In Wales an initial first night health screen/risk assessment is completed and rescue medication provided as required. A full assessment is undertaken either on the first night or the following day, and a CARATs assessment within the first five days.

In Scotland a health assessment is carried out on admission to prison and prisoners see a doctor within 24 hours, with clinical addiction needs forming part of comprehensive health provision. In addition core screening is carried out and relevant referrals made to the Enhanced Addiction Casework Service (EACS) under the Integrated Case Management system.

In Scotland during 2009/10, 4,495 prisoners accepted and undertook an Integrated Case Management Substance Misuse Assessment, 94% of all prisoners who were offered an assessment (4,970 individuals) and 12% of all receptions to prison (ISD Scotland 2010).

Drug treatment in prisons

Treatment for drug use is available in prisons across the United Kingdom, both clinical and non-clinical.

England

In England, the final phase of the Integrated Drug Treatment System (IDTS) roll-out began in 2010. IDTS aims to provide better integration of clinical and psychosocial treatment services in prisons, and to provide drug treatment services equivalent to those in the community, and to the standards contained within the *Models of Care* guidance (NTA 2003). The Prison Service Instruction (PSI) for IDTS states that there should be a “full range of evidence based clinical interventions, which should be delivered alongside psychosocial, rehabilitation and educational opportunities” (MOJ 2010e).

Substitution treatment is available for drug users, both for detoxification and maintenance; naltrexone is also provided for assistance in maintaining abstinence. Data show that in 2009/10, 60,067 prisoners received clinical drug treatment in England and Wales, 60% of whom were on a detoxification programme with the remainder on a maintenance (extended prescribing) programme. Table 11.1 shows a decrease in the number and proportion of prisoners receiving detoxification clinical interventions in 2009/10.

Table 11.1: Number of prisoners receiving detoxification and extended prescribing programmes in prisons in England and Wales, 2004/05 to 2009/10

Year	Detoxification		Extended prescribing programmes		Total
	n	%	n	%	
2004/05	No separate reporting of detoxification and maintenance prescribing.				53,903
2005/06					53,773
2006/07					51,520
2007/08	46,291	78.7	12,518	21.3	58,809
2008/09	45,135	69.7	19,632	30.3	64,767
2009/10	36,323	60.5	23,744	39.5	60,067

Source: Offender Health

The CARATs team provides low to medium intensity, non-clinical drug treatment including assessment of need, advice and information, care planning, harm reduction advice, and release planning. They may also provide one-to one sessions and group work to address a client's substance misuse. Prisoners assessed as having a substance misuse problem are provided with a CARATs worker within 24 hours of assessment and all referrals are seen within five days. In 2009/10 there were 66,459 initial assessments carried out by CARATs teams, a similar number to the previous four years but a 13% increase since 2004/05 (Table 11.2).

Table 11.2 Initial assessments carried out by CARAT teams in prisons in England, 2004/05 to 2009/10.

Year	Number of assessments
2004/05	59,000
2005/06	66,010
2006/07	65,670
2007/08	65,820
2008/09	66,600
2009/10	66,459

Source: NOMS

CARATs workers are responsible for co-ordinating the first 28-day psychosocial intervention, which provides intense support during the initial period in custody and can refer clients on to higher-intensity drug treatment programmes post-28 days.

There are a number of accredited psychosocial drug treatment programmes available across the prison estate. These can be categorised as:

- cognitive behavioural therapy (CBT) programmes;
- 12-Step programmes; and
- therapeutic communities.

Data show that in 2009/10, 10,206 prisoners started an accredited psychosocial drug treatment programme.

Funding

In 2006/07 €16.1 million (£11 million) was provided by DH for the prisons IDTS, increasing to €65.2 million (£55.5 million) in both 2010/11 and 2011/12 (HC Deb, 7 July 2011, c1340W). In addition to the funding available for clinical services, €74.4 million (£63.8 million) was allocated in 2011/12 for non-clinical substance misuse interventions comprising CARATs,

drug and alcohol treatment programme and compact-based drug testing (see section 11.3.2) funding.³⁵⁶

Wales

The Integrated Drug Treatment System does not extend to Wales. Substitution treatment is available for detoxification and maintenance, but the latter generally to those already on detoxification/maintenance programmes prior to reception in prison. However the overriding expectation is that treatment is tailored to individual clinical needs. Psychosocial treatment provision is the same as in England.

Scotland

In 2009/10 11,722 one-to-one motivational support sessions were delivered (ISD Scotland 2010).³⁵⁷

In addition SPS also offer overdose awareness and training groups, alcohol and drug group work, stop smoking group work and Nicotine Replacement Therapy (NRT) and take home naloxone training (and supply on release from custody).

Data show that on 11th December 2009, 1,586 prisoners were being prescribed opioid substitution drugs representing 21% of the prison population. This is 88% higher than in 2004 and seven per cent higher than in the previous year (Table 11.3)

Table 11.3: Number and percentage of all prisoners prescribed opioid substitution drugs on a given day in Scottish prisons, 2004 to 2009

Date	Number	%
17 th December 2004	845	14
30 th December 2005	984	16
8 th December 2006	1,228	17
14 th December 2007	1,354	19
12 th December 2008	1,487	19
11 th December 2009	1,586	21

Source: ISD Scotland 2010

Northern Ireland

TDI data show that in Northern Ireland during 2009/10, 177 prisoners entered drug treatment with a mean age of 20 years old. Almost two-thirds (65%) of treatment entrants were under the age of 20 and a similar proportion (66%) were seeking treatment for primary cannabis use.

The Northern Ireland Prison Service's (NIPS) Drug Report provides information on the number of prisoners entering prison with drug dependency.³⁵⁸

Overdose risk assessment

There are protocols in place to manage the risks associated with drug use particularly deaths from overdose or self-harm. A framework for minimising these harms is available in England and Wales in the guidance document, *Clinical management of drug dependence in*

³⁵⁶ See:

http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_12588

1

³⁵⁷ Other interventions delivered by Enhanced Addiction Casework Service (EACS) are monitored internally for contract management purposes but data are not published.

³⁵⁸ See:

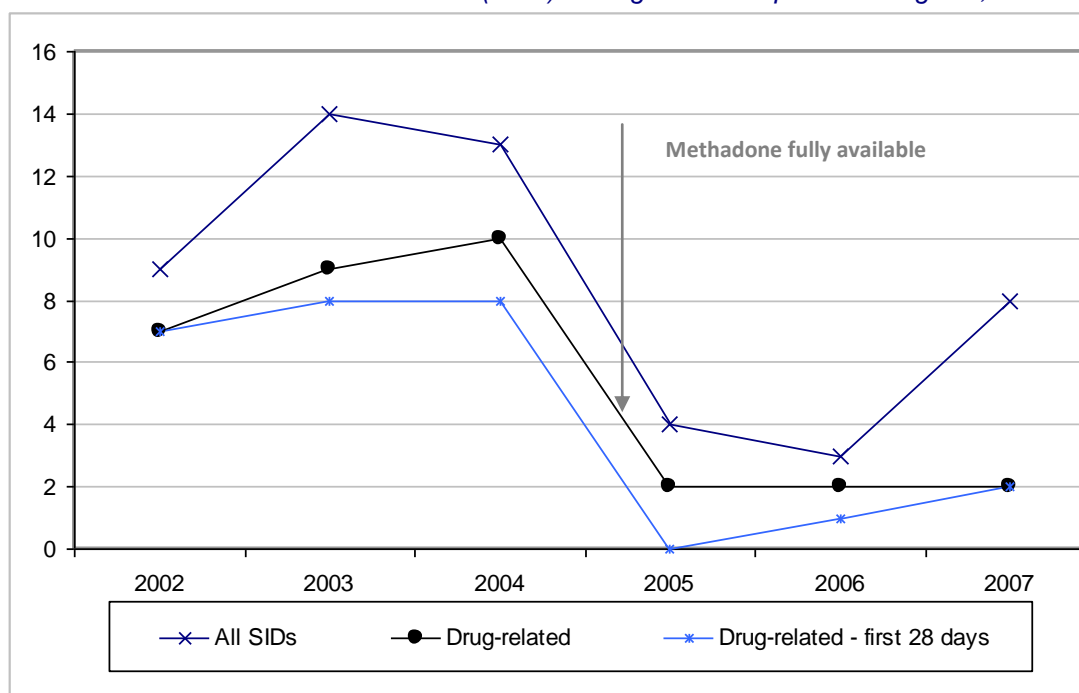
<http://niprisonservice.dev.biznetprojects.co.uk/module.cfm/opt/14/area/Drug%20Report/page/drugseizures/>

the adult prison setting (DH 2006; see section 11.4.1). Furthermore, staff in relevant positions are required to undertake training in resuscitation and the provision of naloxone (see section 11.4.2).

Suicide risk management

A 2003 study of 172 suicides in prisons in England and Wales (Shaw 2003) found that people entering prison while dependent on drugs were twice as likely to kill themselves during the first week of their custody than non-dependent offenders entering prison. The study also found that one half of all the suicides reviewed occurred in the first 28 days of imprisonment. The introduction in 2004-05 of the universal use of methadone for the management of opioid dependence among women in prison appears to be strongly associated with a reduction in deaths related to drug withdrawal (Figure 11.2).

Figure 11.2: Numbers of self-inflicted deaths (SIDs) among women in prison in England, 2002-2007



Source: Marteau, Palmer and Stöver 2010

Other harm reduction interventions in prisons

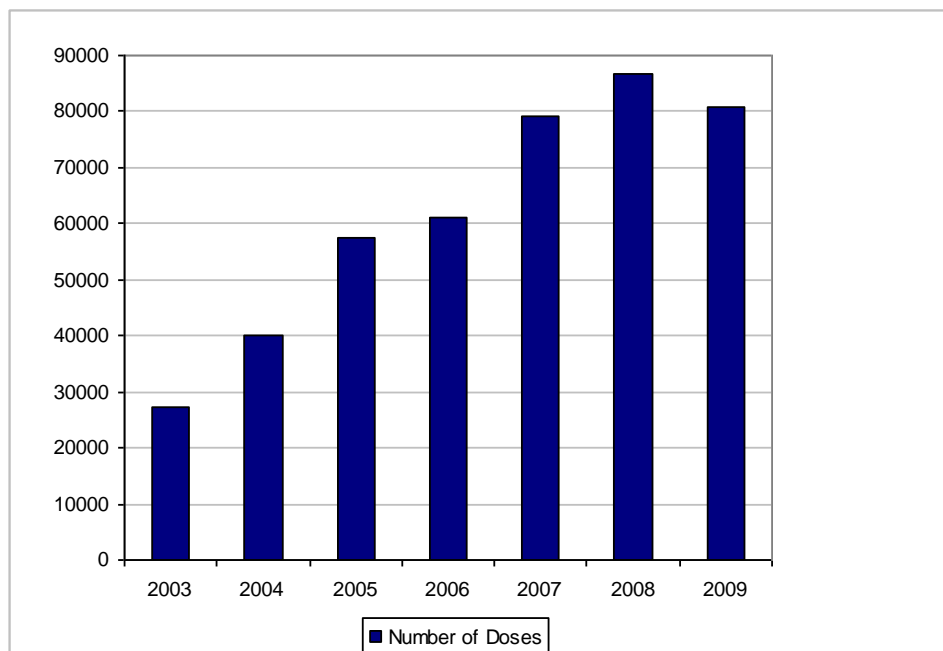
Prison hepatitis B vaccine Programme

UK national immunisation policy states that prisoners should be offered vaccination against hepatitis B. Prison-based vaccination programmes have been successful in improving protection from infection among this high-risk population. The number of hepatitis B vaccine doses delivered to prisoners in England and Wales, reported to the *Prison hepatitis B vaccination monitoring programme*, has increased since the inception of the programme in 2003 (Figure 11.3; HPA 2011c). In 2009, 80,762 doses of hepatitis B vaccine were reported to have been delivered to prisoners in England and Wales. The largest proportion of these doses were delivered in local prisons (26%), compared with other prison types, such as training prisons (18.9%) and Young Offender Institution (YOI) or juvenile establishments (19.6%). Around 55,500 prisoners received at least one dose, while 20,148 prisoners received their third dose.

One of the underlying aims of the prison hepatitis B vaccination programme is to improve vaccine coverage among IDUs, thereby reducing the number of acute cases of hepatitis B

amongst IDUs in the community. Two-thirds of IDUs are reported to be immunised against hepatitis B and the incidence of acute cases of hepatitis B amongst IDUs is reported to have fallen between 2003 and 2008 (HPA 2011c).

Figure 11.3: Hepatitis B vaccine doses delivered to prisoners in England and Wales between 2003 and 2009



Source: HPA 2011c

Blood-borne viral hepatitis action plan for Wales 2010-2015

The *Blood-borne Viral Hepatitis Action Plan for Wales 2010–2015* was approved by the Welsh Government and implementation began in April 2010. Dried blood spot (DBS) testing has been introduced in the five prisons in Wales and a blood-borne virus (BBV) prison nurse specialist has been appointed to work across these prisons. Future proposals include the development of both targeted and generic education and awareness raising tools for use in a variety of settings including the prison environment to improve rates of diagnosis and referral into treatment.

Harm reduction packs

In Scotland, harm reduction packs are available from Addiction Nurses, containing water for injection ampoules, swabs, filters, cooking spoon, citric acid and foil for use by injecting drug users (IDUs). The pack does not contain a needle and syringe but does include priority initiation onto substitute prescription and daily one-to-one support from addiction nurses. There has been an extremely low uptake of this service since its introduction in 2008. The piloting of a needle exchange service within a Scottish prison was an action contained in the *Hepatitis C Phase 2 Action Plan* (Scottish Government 2008e). This has not yet been delivered but the Scottish Government are continuing to investigate the future viability of such a pilot.

Disinfecting tablets

In 2007, disinfecting (bleach) tablets were mandated for provision in all adult prisons in England and Wales via a Prison Service Instruction (PSI 34/2007). Prisoners and staff were provided with information about how to use the tablets to decontaminate materials potentially exposed to infected blood and body fluids e.g. tattoo needles, injecting equipment etc. The impact of this policy is the subject of an independent study by Stirling University, commissioned by the Department of Health, which is due to report in 2011.

Health Promotion Materials

Educational materials concerned with BBVs (hepatitis B, hepatitis C and HIV) specifically targeted at prisoners and prison staff have been developed by the British Liver Trust, in close consultation with Offender Health in England, the HPA, drug and alcohol teams, HIV charities and prison clinics. The resources, which have been well received by prison staff and have received a number of awards, explain modes of BBV transmission, prevention strategies and harm-minimisation practices. All the materials use cartoon graphics and straightforward language to give clear messages such as: 'keep it clean, protect yourself, get tested and, if necessary, get treated' (Figure 11.4).

Figure 11.4: Examples of BBV health promotion materials in use in prisons in England



In Wales a new series of liver health promotion and education materials are being developed within the context of implementing the BBV Action Plan. Prison staff and prisoners are actively engaged in the design. The information and awareness raising will also address other risks to liver health, e.g. obesity and alcohol.

In Scotland a suite of harm reduction and health promotion materials are available to prisoners including booklets and a small wallet containing health promotion, overdose awareness and local and national drug and alcohol service details which is provided in a comprehensive pre-release group or one to one session. Other materials include a DVD resource specifically used for Scottish Prison stop smoking group interventions.

Provision of health services

In England healthcare services are commissioned from a wide range of organisations within the National Health Service (individual primary care practices, mental health trusts), independent charities, profit-making health providers and social enterprise organisations that combine national health and non-profit independent characteristics. The quality of drug treatment services in prisons and the community is overseen by the National Treatment Agency for Substance Misuse (NTA).

Continuity of care

In England, guidance on continuity of care for individuals requiring drug treatment on entering prison, while transferred between prisons and on release from prison, was published in 2009 (DH and MOJ 2009). The relatively extensive duration of dependence means that an episode of treatment needs to be provided across a number of community and prison locations. The Department of Health has assumed responsibility for funding substance misuse services in all prisons and the community in England from April 2011. Procurement of these services is now led by local multi-agency joint commissioning groups. This development is overseen by an Offender Substance Misuse Board that comprises membership from key justice and health organisations, local providers and a service user.

In March 2011, the Home Office published an addendum to the continuity of care document³⁵⁹ setting out changes to the assessment documentation and introducing a minimum dataset to be collected and entered onto DIRweb, a web-based record management system.

In Wales the healthcare services in the public sector prisons are planned and delivered in partnership between the Health Boards and the Prison Service. In the contracted-out prison the services are provided by the main operator.

The UK guidelines on clinical management for drug misuse (DH et al. 2007) include information and guidance on preparing prisoners receiving clinical interventions for release and continuity of care.

Naloxone

Recruitment to the N-ALIVE randomised controlled trial (RCT)³⁶⁰ commenced in 2011 with the aim of reducing DRDs amongst newly released prisoners in the United Kingdom. The pilot trial will demonstrate feasibility by recruiting the first 10% of participants and assessing what happens to the naloxone and participants in the first few months after release. The main trial will aim to answer the question of whether the provision of naloxone to individuals with a history of injecting drug use significantly reduces heroin overdose deaths in the first 12 weeks post-release. The trial will take place in remand prisons in English and Scottish prisons (see section 7.2.2).

The Scottish Government is providing support to the Scottish Prison Service (SPS) to establish a prison-specific naloxone programme. SPS started provision of naloxone and associated training for prisoners in February 2011. All prisons are now offering at-risk prisoners this intervention. Prisoners are identified soon after admission and are trained and supplied with naloxone just before release from prison. Scaling up has been slower than anticipated but on the whole provision has been steadily increasing. SPS no longer monitor provision as this is now done by ISD as part of the national evaluation of naloxone provision. Between February and the end of June this year SPS provided 287 naloxone kits across the prison estate.

³⁵⁹ See: <http://www.homeoffice.gov.uk/publications/crime/reducing-reoffending/continuity-of-care?view=Binary>

³⁶⁰ Funded by the Medical Research Council (MRC), See: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124595.pdf. The aim of the project is to recruit 56,000 participants. In the pilot phase 5,600 participants will be recruited to assess feasibility of the study and qualitative data will also be collected from these participants who give consent. See: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124595.pdf

A pilot naloxone scheme has been running since 2009 in the community and within some prisons. Following an evaluation of the scheme (Bennett and Holloway 2011), it was rolled out nationally from April 2011 (see section 7.2.2).

Evaluation of the Transitional Support Scheme in Wales

The Transitional Support Scheme in Wales provides 'through-the-gate' support to short-term prisoners with substance misuse problems (Maguire and Holloway 2010). An evaluation of the scheme found that it had reached its referral targets and that it had above average rates of contact for a mentoring scheme: 56% had at least one face-to-face contact; 39% had two or more; and 18% six or more. Using data from the Police National Computer, the reconviction rate of those participating in the scheme was found to be no different from a comparison sample although those with two to six contacts were less likely to be reconvicted (71%) than those not in the scheme (83%) or those with less contacts (77%). Examples of good practice identified included: in-reach work; prison gate pick up; assertive outreach; local networking; enhancing offender engagement with support services.

11.3.2 Drug testing

England and Wales

There are two types of drug testing schemes in prisons in England and Wales, mandatory drug testing (MDT) and compact based drug testing (CBDT). MDT is a randomised compulsory security measure; CBDT is a voluntary therapeutic intervention to support abstinence among prisoners.

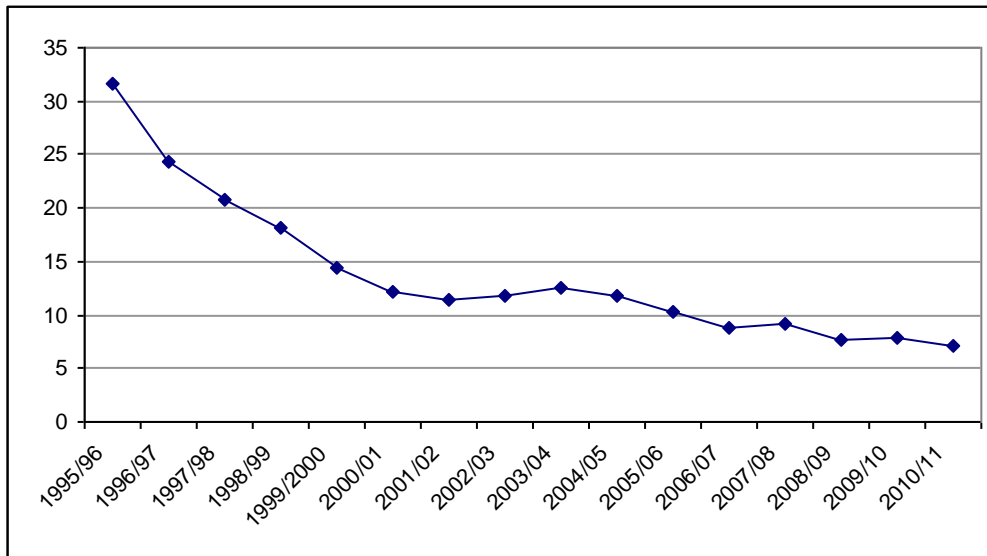
Mandatory drug testing

Powers to require prisoners to provide a sample for drug testing purposes were introduced as part of the *Criminal Justice and Public Order Act 1994*. Urine is the sample matrix used and samples are tested for cannabis, opiates, cocaine, benzodiazepines, methadone, amphetamines, barbiturates, and buprenorphine³⁶¹. LSD is optional. Prisoners can be selected for testing on a random basis, on the basis of suspicion, for risk assessment, on a frequent basis or on reception. Prisoners testing positive are punished and referred to drug treatment services. Those found guilty of administering a Class A drug are to be frequently tested. Policies, procedures and good practice for MDT are contained within a Prison Service Order published in 2005 (HMPS 2005).

Random MDT is used to measure the level of drug misuse amongst prisoners. Each prison in England and Wales with an average population of over 400 must randomly test five per cent of the population each month. Prisons with an average population of under 400 must randomly test ten per cent of the population each month. Data show that 7.1% of prisoners tested positive in 2010/11, a decrease from 7.8% in 2009/10. Figure 11.5 shows a large decrease in the proportion of those testing positive in the random MDT programme since 1995/96.

³⁶¹ Following a review of buprenorphine misuse in prisons (MOJ 2007b), buprenorphine was added to the panel of drugs tested for in 2009.

Figure 11.5: Percentage of mandatory drug test samples testing positive in England and Wales, 1995/96 to 2010/11



Source: HC Deb, 20 June 2011, c104W

A recent costing exercise estimated that mandatory drug testing cost the National Offender Management Service (NOMS) €6.2 million (£5.3 million) in 2010³⁶² (HC Deb, 20 June 2011, c97W). The same exercise developed an efficient operating model for MDT so that from 2012/13 the programme should cost €4.8 million (£4.1 million). NOMS is also undertaking a joint procurement exercise for all drug testing services across the criminal justice system with the aim to achieve further savings on the equipment and laboratory analysis costs. While prison drug treatment funding responsibility has been transferred to DH, NOMS is responsible for the funding and management of MDT in prisons in England and Wales.

There have been some criticisms of MDT on the basis that it is costly, can lead drug users to use more harmful drugs that have shorter detection periods (Bird 2005), is an ineffective deterrent and is open to manipulation by prison staff looking to improve performance (Chambers 2010). However, despite finding that a small but significant number of prisoners report heroin initiation in prison, a review into the MDT programme found it fit for purpose and able to detect changes in drug use over time (Singleton et al. 2005). The HMIP Annual Report 2010/11 found that, across the inspected prisons, MDT positive rates provided an indicator rather than a reliable measure of drug availability (HMIP 2011).

Compact-based drug testing

Compact-based drug testing was established in 2000 after a Public Service Agreement to provide all prisoners with voluntary drug testing by April 2001. Voluntary drug testing is therapeutic in nature and aims to provide an extra incentive for those seeking to become drug free. Various forms of CBDT exist including incentive based drug testing, which allows prisoners to maintain certain privileges if they are drug free. A Prison Service Instruction setting out mandatory actions for the management of CBDT was published in 2009 and will run until the end of 2012 (MOJ 2009b).

Scotland

Mandatory drug testing was abolished in Scottish prisons in 2005 since it was felt that it did little to deter drug use or to encourage drug users into treatment. The Scottish drug strategy (Scottish Government 2008a) states three specific reasons for carrying out drug tests in Scottish prisons:

³⁶² This includes all test types, staff time to collect urine samples, and laboratory analysis costs.

- 1) Clinical management – reception testing and clinical testing during the course of substitution treatment.
- 2) Prison management – to test those suspected of being under the influence of drugs and for prisoners who agree to testing for sentence management.
- 3) Prevalence of drug use – a sample tested on reception and on leaving prison.

Data show that, of the 1,093 addiction prevalence tests carried out on reception to prisons in Scotland during 2009/10, 56% were positive for illegal drugs, a decrease from 71% in 2008/09 and 64% in 2007/08. However, the proportions in individual prisons ranged between 11% and 88%. Benzodiazepines were the most frequently detected drug, 38% tested positive for benzodiazepines with 36% testing positive for opiates (Table 11.4)

Table 11.4: Results of drug testing on reception to and prior to release from Scottish prisons, 2009/10

Drug	% positive tests on reception	% positive tests prior to release
Amphetamines	1	0
Barbiturates	0	0
Benzodiazepines	38	9
Buprenorphine	0	1
Cannabis	28	5
Cocaine	6	0
Methadone	6	0
Opiates	36	8
All illegal drugs	56	17

Source: ISD Scotland 2010

The proportion testing positive for illegal drugs on release from prison fell from 29% in 2008/09 to 17% in 2009/10. Benzodiazepines and opiates were the most commonly detected drugs.

Northern Ireland

Data from the Northern Ireland Prison Service show that, 84% of voluntary drug tests carried out between 1st December 2009 and 30th November 2010 were negative.³⁶³

11.4 Service quality

11.4.1 Guidelines and standards

England and Wales

There are a number of guideline documents and standards for the provision of drug-related services. These range from PSIs and PSOs issued by HMPS to clinical guidelines created in consultation with Government departments and professional organisations. The principal guidelines are:

- DH (Department of Health) (2006). Clinical management of drug dependence in the adult prison setting. This sets out the way in which clinical services in adult prisons should manage drug or alcohol dependence, including universal access to opioid substitution treatment. This guidance applies in England only;
- NOMS (National Offender Management Service) (2006). IDTS The first 28 days: Psychosocial support. This document describes the contribution required of non-clinical services to the Integrated Drug Treatment System;
- NOMS CARATs Service Specification (May 2004) Although all contracts with external providers were originally drawn up against this national specification, much

³⁶³ See:

<http://www.niprisonservice.gov.uk/module.cfm/opt/14/area/Drug%20Report/page/drugseizures/year/2010>

of what is delivered at a local level is agreed based on the guidelines within the revised 2009 CARATs Practice Manual;

- NOMS CARATs Practice Manual (2009) updated policy and guidance to support delivery of CARATs; and
- DH (Department of Health) and MOJ (Ministry of Justice) (2009). Prisons Integrated Drug Treatment System Continuity of Care guidance.

The relevant PSIs/PSOs are:

- Integrated drug treatment system – PSI 45/2010. This PSI describes the operational and regulatory framework for the provision of opioid substitution treatment in English prisons;
- Re-introduction of disinfecting tablets – PSI 34/2007. This PSI confirms that disinfecting tablets will be made available to prisoners in 2007 and explains the arrangements being put in place to ensure that the re-introduction proceeds smoothly;
- Mandatory drug testing – PSO 3601. This instruction specifies revised requirements and procedures for the conduct of mandatory drug testing;
- Compact based drug testing – PSI 31/2009 This instruction sets out mandatory actions on the management of Compact Based Drug Testing programmes (CBDT), including Voluntary Drug Testing (VDT), Incentive Based Drug Testing (IBDT) and Voluntary Testing Units (VTU's) also referred to as drug free wings;
- CARAT services – PSO 3630 – This order describes the required actions on the part of CARATs (Counselling, Assessment, Referral, Advice and Throughcare services) in prisons in England and Wales; and
- Prison drug treatment and self harm – PSI 46/2005 This sets out approaches to drug treatment in prison that addresses the associated risks of self-destructive behaviours.

In Scottish prisons Health Care Standards (HCS) form the basis of clinical intervention:

- HCS 7 relates to BBV services; and
- HCS 10 and accompanying guidance refers to clinical addiction services.

In addition, the Scottish Prison Service provides a framework for the management of substance misuse services in prisons.³⁶⁴

11.4.2 Training

In England, a workforce strategy setting out the knowledge and skills requirements for all groups involved in IDTS was issued in 2007 (NOMS et al. 2007). The strategy sets out a matrix of training needs for different categories of prison workers. All officers working in reception, first night centres and stabilisation units are required to have received training in the recognition of, and response to, drug withdrawal and overdose. All primary and mental healthcare staff are required to undertake training in resuscitation and the provision of naloxone. The strategy also recommends that each prison develop an IDTS workforce plan.

³⁶⁴ See: <http://www.sps.gov.uk/Publications/Publication97.aspx>

12. Drug users with children

Introduction

This chapter provides a summary of the UK evidence, legislation and policies regarding drug users with children. It discusses the evidence around the prevalence and harms associated with parental drug use. It also looks at responses in terms of legislation, government policies and interventions. As much legislation, policies and interventions in the UK focuses on the welfare of children of drug users, this chapter will also discuss the evidence and responses to the needs of these children. Unless otherwise stated, children will refer to those aged 16 years and under.

12.1 Size of the problem

12.1.1 Estimates of parental drug misuse

The primary source of data on drug users with children is treatment data. Treatment data cannot capture the full extent of the problem as not all problem drug users are in treatment. In 2009/10, it was estimated that just over half (57%) of opiate and crack cocaine users (OCUs) were in treatment (see section 5.5.3).

National Drug Treatment Monitoring System (NDTMS) data 2009/10

NDTMS data (see section 5.5) for 2009/10 showed that:

- the majority of clients entering drug treatment had children (71%);
- women were slightly more likely than men to be a parent (73% compared to 70%);
- over half (53%) of clients had some or all of their children living with them (48% had all living with them);
- women were more likely than men to have some or all of their children living with (68% compared to 45%) (Table 12.1).

Table 12.1 Number and percentage of clients starting an episode of treatment in 2009/10 by parental status and residential status of children and by gender

	Total		Male		Female	
Parental status all respondents %	(n)	%	(n)	%	(n)	%
Parents total	49,325	70.7	36,279	70.0	13,046	72.8
Client pregnant, no other children	316	0.5	-	-	316	1.8
Not a parent	20,123	28.8	15,556	30.0	4,567	25.5
Residential status of respondents' children (parents only) %						
All children living with client	10,141	47.9	5,626	40.6	4,515	61.7
Some children living with client	1,077	5.1	629	4.5	448	6.1
Children living with partner	5,111	24.1	4,749	34.3	362	4.9
Children living with other family member	2,271	10.7	1,296	9.4	975	13.3
Children in care	916	4.3	341	2.5	575	7.9
Other	1,655	7.8	1,209	8.7	446	6.1
<i>Base parents only</i>	<i>21,171</i>	<i>100</i>	<i>13,850</i>	<i>100</i>	<i>7,321</i>	<i>100</i>
<i>Base all respondents</i>	<i>69,764</i>	<i>100</i>	<i>51,835</i>	<i>100</i>	<i>17,929</i>	<i>100</i>

Source: NDTMS

Parents in treatment in 2009/10 were more likely to be OCUs than those without children. Of those parents whose primary drug use was known, the majority (55%, n=27,104) were primary heroin users (62% OCU, n=30,366). Of those clients without children, two-thirds (66%, n=13,207) had a drug other than heroin or crack cocaine recorded as their primary drug (33% OCU, n=6,740). The majority of heroin users (whose parental status was known)

had children (82%, n=27,104). This figure was 80% for crack cocaine users (n=3,262) and 58% for other drugs (n=18,495). Of those parents whose age was known, the majority (79%) of parents were aged 25 and over (n=36,183).

Drug Treatment Outcomes Research Study (DTORS)

Baseline data from the DTORS study³⁶⁵ (Jones et al. 2007) of a sample of individuals seeking drug treatment (n=1,792) showed that, in February 2006, nearly half of the respondents had children under 16 years of age (58% of females and 46% of males) (Table 12.2).

- in three-quarters of cases all of their children did not live with them;
- males were less likely than females to have at least one of their children living with them (17% compared to 44% of females);
- the majority of children who were not living with the respondent lived with the other parent (52%; 69% male, 16% female);
- a further 20% of children lived with the family, eight per cent were in care and five per cent lived 'elsewhere';
- older respondents were more likely to have children that did not live with them; 81% of those aged 35 or over compared to 73% in the 25 to 34 age group and 60% of those aged 18 to 24; and
- 92% of primary crack users did not have any of their children living with them, compared to 74% of primary heroin users.

Table 12.2 Percentage of respondents in DTORS study seeking drug treatment in 2006 by parental status, residential status of children and by gender, age and primary drug

	All	Male	Female	18 to 24	25 to 34	35 or over	Heroin	Crack cocaine	Other drug
Parental status all respondents %									
Children under 16	49	46	58	27	53	57	48	58	45
No children under 16	51	54	42	73	47	43	52	42	55
Residential status of respondents' children (parents only) %									
All children with respondent	22	15	38	38	21	19	22	5	37
Some children with respondent	3	2	6	2	5	1	4	3	3
All children elsewhere	75	83	56	60	73	81	74	92	60
<i>Base all respondents</i>	1,792	1,313	479	256	838	684	1,020	208	334
<i>Base parents only</i>	914	630	284	68	455	383	510	121	162

Source: Jones et al. 2007

³⁶⁵ DTORS was a longitudinal, prospective cohort study of treatment outcomes of drug users in England between February 2006 and March 2007. It was conducted with a sample of 1,796 participants who had presented themselves to a Tier 3 or 4 agency for a new episode of drug treatment. They were recruited from 342 drug treatment agencies in 94 Drug Action Team (DAT) areas in England. Participants were selected at random and participation was voluntary. It is reported that the sample broadly represents the drug treatment seeking population. The initial aim was to interview clients as they entered treatment and conduct follow up interviews with them after three months and then again at 12 months. Three and five months after recruitment, 886 clients were re-interviewed. Just over a quarter (28%, n=504) of the original sample were re-interviewed a year later (between 11 to 13 months). A further 245 participants were re-interviewed once only (between six and 12 months after starting treatment). DTORS followed on from the NTORS (National Treatment Outcomes Research Study) longitudinal prospective cohort study of treatment outcomes, which took place between 1995 and 2000.

The proportion of parents in the study who had all of their children living with them increased between baseline and the second follow-up interview (Jones et al. 2009). For all participants the proportion fell from 22% at baseline to 15% at first follow-up. This figure then rose to 34% at the time of the second follow-up interview. The authors suggest that the decrease at first follow-up may be explained by the proportion of participants in residential care at that time (19%). Other findings were:

- 38% of females had all their children living with them at baseline; this dropped to 25% at first follow-up and increased to 54% at second follow-up;
- five per cent of primary crack users had all their children living with them at baseline, increasing to 24% at second follow-up; and
- the proportion of parents in the study who had all of their children living with them increased across all subgroups between baseline and the second follow-up interview.

Scotland

In 2009/10, 42% of clients reporting to the Scottish Drug Misuse Database (SDMD)³⁶⁶ self-reported having dependent children under 16 years of age. This figure has stayed stable for several years (42% 2006/07, 44% 2007/08, 42% 2008/09) (ISD 2010).

Analysis of data from the Drug Outcome Research in Scotland (DORIS) study cohort³⁶⁷, undertaken between 2001 and 2004, reported that 20% of parents, who had entered treatment between 2001 and 2002, had at least one child living with them after eight months in treatment (McKeganey et al. 2008). Retention of children was not related to consumption and severity of drug dependence, unlike many other non-drug outcomes such as health, crime and employment. Women receiving methadone treatment at baseline were four and a half times more likely to retain custody of their children compared to women receiving other forms of treatment. House ownership/tenancy was also linked to retention of children for both male and female parents; however, single parent status was linked with non-retention of children.

Northern Ireland

The extent of problematic parental substance use was examined as a sub-theme of the Belfast Youth Development Study (BYDS).³⁶⁸ Parents of the BYDS cohort were interviewed and asked about their drug use. Findings showed that one per cent of parents reported that they had drug-related problems (Percy et al. 2008).

³⁶⁶ The Scottish Drug Misuse Database (SDMD) records information on drug misusers entering treatment using information collected from a standard reporting tool. It should be noted that, while this is a source of information on children affected by parental substance misuse, the main purpose of the database is not to assess the numbers of children living with substance misusing parents and only parents who are entering treatment will be recorded. Information on children is not reported for all clients, and relies upon honest self disclosure.

³⁶⁷ Prospective cohort study of treatment effectiveness with a cohort of 1,007 PDUs starting a new treatment episode between 2001 and 2002 and aged 15 to 54. Participants were recruited from treatment settings over a 33 month period. It is the largest study of its kind in Scotland and followed a similar methodology to the NTORS study in England (Gossop et al. 2002). Data were collected via face-to-face interviews at baseline (DORIS1) and in three further follow-ups (DORIS2, DORIS3 and DORIS4). A total of 668 participants were interviewed at all four stages of the study (65%) (McKeganey et al. 2008).

³⁶⁸ The Belfast Youth Development Study (BYDS) is a longitudinal community based survey looking at the development of adolescent drug use, tracking a cohort of 4,500 secondary school children from 43 schools in Northern Ireland. In this study, a total of 1,309 family members of the children in the BYDS cohort (consisting of 1,097 parents and 212 older siblings) were interviewed between summer and autumn 2004. A total of 721 individual households participated. Questions included parental lifetime and last year drug use.

Wales

In 2009/10, 26% of clients recorded on the Welsh National Database for Substance Misuse (WNDSM) reported having children under 18 years of age. Of those with children, 66% (n=3,992) indicated that their children were living elsewhere (with other family members or in care). Research undertaken with previous and current injecting drug users in Wales in 2006 indicated that 63% (n=318) were parents having, on average, between two and three children. Only 24% (n=75) had their children living with them. The majority of children not living with their parent(s) were being cared for by another family member (Welsh Government 2011b).

12.1.2 Estimates of children affected by parental drug use

In 2003 the Advisory Council for the Misuse of Drugs (ACMD) reported on the *Hidden Harm* inquiry into the number of children in the United Kingdom affected by parental drug use (see section 12.3.2). The ACMD estimated that between 240,000 and 360,000 children in the UK³⁶⁹ had either one or both parents who were 'problem drug users'.³⁷⁰ In England and Wales³⁷¹ it was estimated that between 200,000 and 300,000 children had parents who were problem drug users (2 to 3% of all children), with a further 41,000 to 59,000 children of problem drug users in Scotland (4 to 6% of all children) (ACMD 2003). This estimate was produced using an extrapolation of drug treatment data sources for clients presenting to treatment between 1996 and 2000. The results are widely thought to be an under-estimate as the assumptions made regarding the number of problem drug users who were not in treatment at that time were not robust and local estimates were not used. Furthermore, presentations to treatment have doubled since 1998 (Manning et al. 2009).

In England in 2003 it was reported that, of those children whose parents had a serious drug problem:

- just over a third were living with their father (37%);
- nearly two-thirds were living with their mother (64%);
- most children not living with their parents were with other relatives; and
- five per cent were living in local authority care (ACMD 2003).

Household survey data

Manning et al. (2009) carried out a secondary analysis of data from a household survey³⁷² in order to estimate levels of parental drug (and alcohol) misuse in the UK.³⁷³ Larger estimates of parental drug use were generated by this study compared to those produced for the *Hidden Harm* (ACMD 2003) report which used treatment data. Using data collected as part of the *2000 National Psychiatric Morbidity Survey* (Singleton et al. 2001) it was estimated that:

- 335,000 children lived with a dependent drug user;
- 72,000 children lived with an injecting drug user (IDU);
- 72,000 lived with a drug user in treatment; and

³⁶⁹ England, Scotland and Wales only. Separate methods and data sources were used for England and Wales and Scotland. Data from Northern Ireland were not available.

³⁷⁰ Problem drug use in the *Hidden Harm* (ACMD 2003) report was defined as "drug use with serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them. The consequences of problem drug use for the user vary enormously from person to person and, for any individual, over time, but are often very serious. The impact on their children is also variable but often very damaging."

³⁷¹ The *Hidden Harm* report estimates that there could be as many as 17,500 children and young people in Wales living in families affected by parental drug misuse.

³⁷² Data from the National Psychiatric Morbidity Survey (NPMS) 2000 were re-analysed in this study to generate estimates for the number of children in England, Scotland and Wales living in households with problem drug users (consisting of a sample of 8,580 adults and 4,783 children).

³⁷³ England, Scotland and Wales.

- 108,000 children lived with an adult who had overdosed.

The study concluded that producing estimates of parental drug use is challenging as most research is limited to retrospective cohort studies. They posit that this is largely because parental substance use is a sensitive issue and drug using parents may be fearful of social services becoming involved if they admit their drug use to researchers. Therefore, it is suggested that the effects of parental drug use have yet to be fully determined and any attempts to generate new data may be restricted by 'social desirability' effects (Manning et al. 2009).

Estimates of the number of children of drug using parents in the Cheshire and Merseyside areas of the North West of England were produced in 2009 using data from the National Drug Treatment Monitoring System (NDTMS) and Drugs Intervention Programme (DIP) (see section 9.3.1) drug monitoring systems (Duffy et al. 2009). Using both data sources, it was estimated that there were 19,029 children of drug using parents (4% of children under 16 years old in the area). Estimates based on the individual data sources ranged from 14,517 using NDTMS data to 24,552 using DIP data (between 3% and 5% of children under 16 years old in the area). The difference in the estimates can be attributed, at least in part, to the way that parental status is recorded within each system, and the benefits and limitations of each dataset are discussed in the report. The residential status of children differed between female and male problem drug users (PDU)s:

- the majority of fathers (57%) stated that their child(ren) lived with a partner;
- around a third of mothers stated that their child(ren) lived with them (32%); and
- around a third (34%) of mothers said their child(ren) lived with a family member.

12.2 Physical, mental and other risks to drug using parents and their children

The Advisory Council on the Misuse of Drugs (ACMD) concluded in its *Hidden Harm* inquiry that while not all parents who misuse drugs are bad parents, parental or carer drug use can reduce the capacity for effective parenting (ACMD 2003). It has been reported that children of drug users can be at increased risk of genetic, developmental, psychological, physical, environmental and social harms (ACMD 2003; ACMD 2007; Barnard and McKeganey 2004; Manning et al. 2009). Specific risks that have been cited in the literature include: physical harm; being exposed to violence; maltreatment; emotional abuse; compromised health and development; being more likely to be placed on the child protection register or taken into care; and becoming problematic drug users themselves later on (ACMD 2003; Forrester 2000; Forrester and Harwin 2008; Manning et al. 2009). It has been suggested that these harms may be due to the interaction of a range of complex factors such as: prenatal exposure to drugs; genetics; and social, cultural and environmental factors associated with drug use (Barnard and McKeganey 2004). Other factors which may lead to poor outcomes for children of drug using parents include: social deprivation; poverty (financing drug use may restrict household budget for other basic necessities); children may not be monitored adequately; exposure to substance use; maladaptive and dysfunctional behaviour; and the lack of a nurturing environment (ACMD 2003; Barnard and McKeganey 2004).

In qualitative studies³⁷⁴ conducted with drug users with children (Klee 1998) it was reported that parents tended to adapt their drug taking habits to fit in with having children. Examples of this included: trying not to sleep in the day; taking themselves away from the children when they were 'coming down' from drugs to avoid conflict; concealing their drug taking and hiding paraphernalia. The authors reported that parents' emotional attachment to their children was very high in the majority of cases. A more recent qualitative study with drug

³⁷⁴ Thematic analysis was carried out on semi-structured interviews with a sample of 240 parents using qualitative data gained as part of three earlier studies.

using parents³⁷⁵ discussed the theme of 'damage limitation' where drug using parents often tried to ensure that their family life appeared as normal as possible and kept their drug taking a secret from their children (Rhodes et al. 2010).

In another qualitative study,³⁷⁶ this time with the children of drug using parents, it was reported that, despite parents trying to hide their drug use and adopting 'protection strategies' (such as those discussed in the two studies above) most children were aware of their parents' drug use at an earlier point in time than their parents realised. The children often kept this knowledge to themselves. They discussed how their parents' drug taking made them feel and described emotions such as: hurt, sadness, anger, rejection and anxiety for the well-being of their parents. The authors raised the point that, as children of drug using parents often keep silent about their parents' addiction, it is likely that there are many children in need of support services that may not be visible to the appropriate service providers (Barnard and Barlow 2003).

However, it is acknowledged that parental substance use does not necessarily result in the children of drug users being harmed (Manning et al. 2009). Furthermore, when harm does occur it is rarely only as a result of substance use, there is often a range of other factors involved such as: poverty; social exclusion; poor physical environment; and family conflict. Drug use alone is not an indication of neglect or child abuse (Klee 1998). The impact parental substance use may have upon their children depends on a range of factors including: the level and nature of drug use; whether a non-drug using adult is also present in the home; and availability of other family members to be 'kinship carers' to the children (McKeganey et al. 2002).

For drug using parents, engaging in drug treatment can be a protective factor for the individual and their families. It has been reported that parents in treatment are generally better able to support their children physically, emotionally and materially and this can lead to a more secure and stable life (NTA 2011i). In an analysis of NDTMS data it is reported that, in England in 2008/09, parents are, in general, more likely to 'do better' in treatment than those without children (NTA 2010c). Parental engagement with treatment services has been shown to be associated with the retention of their children, who had been placed on the 'at risk' register by social services, and also with getting children back after they had been placed in care (Woolfall et al. 2008).

³⁷⁵ In depth qualitative interviews were conducted with 29 drug using parents in the South East of England between 2008 and 2009.

³⁷⁶ The authors conducted a study with 36 children and young people and considered their experiences of growing up with drug dependent parent(s). Qualitative data was collected using semi-structured interviews and opportunistic sampling. Twenty-three children were resident with drug using parent and 13 were not resident with their parents. Four children were resident in a secure unit; four in residential drug rehabilitation for young people. The age ranged from eight to 22 and 56% were female (n=20). The average age was 14.8 years.

12.2.1 Drug using pregnant women

United Kingdom

Inpatient hospital data on effects of maternal use of drugs

During 2009/10, 325 discharges with an ICD-10 code P04.4 related to fetus and newborns affected by maternal use of drugs of addiction and 1,195 discharges with an ICD-10 code P96.1 of neonatal withdrawal symptoms from maternal use of drugs of addiction were recorded in the United Kingdom (Table 12.3).

Table 12.3 Number of inpatient discharges with an ICD-10 code P04.4 or P96.1 in the UK 2007/08, 2008/09 and 2009/10

	Year		
	2007/08	2008/09	2009/10
Discharges with an ICD-10 code P04.4	382	246	325
Discharges with an ICD-10 code P96.1	1,615	1,009	1,195

Inpatient data from Scotland show that in 2008/09, there were 592³⁷⁷ maternities for which drug misuse was recorded,³⁷⁸ a rate of 10.3 per 1,000 maternities. This is an increase from 2007/08, when 504 maternities (8.9 per 1,000) were recorded. This follows a decrease from 2006/07 when 554 maternities (10.2 per 1,000) were recorded. Seventy-one per cent of births were recorded as full-term normal birth-weight compared to 90% of all births and 16% were pre-term compared to eight per cent of all births. Of all the births recording drug misuse between 2004/05 and 2008/09 (n=2,643), 54% (n=1,433) were classed as coming from the most deprived areas, with a further 26% from the next most deprived. Only two per cent (n=58) were from the least deprived areas³⁷⁹ (ISD 2010).

Confidential Enquiries into Maternal Deaths in the UK, 2006-2008

The deaths of 35 substance using women, who died during pregnancy and/or the first six months following delivery were reviewed as part of a confidential enquiry³⁸⁰ (CMACE 2011). The causes of death were: 13 deaths from medical conditions caused by or attributed to drug use; 10 accidental overdoses of drugs of addiction; nine suicides; three accidents caused by drug use. Heroin was the most commonly used drug, but polysubstance use was also common.

Neonatal abstinence syndrome

Dryden et al. (2009), in a retrospective cohort study looking at factors associated with the development of neonatal abstinence syndrome (NAS) amongst babies born to mothers prescribed methadone³⁸¹, found that 46% of babies received pharmacological treatment for NAS. Prescribed methadone dose was independently associated with the likelihood of an infant receiving treatment for NAS. Infants whose mothers were prescribed methadone were more likely than those in the general hospital population to be born prematurely (20% compared to nine per cent) and nearly a quarter (23%) were below average weight.³⁸² The stillbirth rate of 1.3% was almost double that of the hospital as a whole. Despite accounting

³⁷⁷ This is a provisional figure. Data for 2006/07 and 2007/08 have been revised since the publication of the UK Focal Point on Drugs Report 2010. There has been an improvement in the recording of drug misuse in the past five years and therefore care should be taken when making comparisons over time.

³⁷⁸ Defined as ICD-10 codes 035.5, F11, F12, F13, F14, F15, F16, F18 and F19.

³⁷⁹ Using Scottish Index of Multiple Deprivation (SIMD) 2006.

³⁸⁰ Between 2006–2008, 261 women in the UK died directly or indirectly related to pregnancy.

³⁸¹ A retrospective cohort study of infants born to women prescribed methadone and delivered in a single hospital in Glasgow during the period 1st January 2004 to 31st December 2006. Four hundred and fifty infants were delivered to methadone maintained mothers, six were stillborn.

³⁸² Less than the ninth centile.

for only three per cent of hospital births, babies born to drug misusing mothers occupied 18% of bed days for the neonatal unit over the study period.

A study carried out in the Grampian area of Scotland between June 2002 and December 2003³⁸³ found that 75 of the 110 babies born to substance misusing mothers had Neonatal Abstinence Syndrome (NAS) symptoms, an incidence of 68.2% (Scottish Executive 2006b). Of the 26 babies recruited to the study who were initially asymptomatic, 12 developed delayed onset NAS and seven required treatment. The majority of treated infants recruited to the study had ceased treatment at 20 weeks although almost a quarter (24.4%) required longer treatment and follow-up (12 out of 49 infants).

Eye problems

In Hamilton et al. (2010)³⁸⁴ a range of eye problems were reported amongst children who had been exposed to in utero methadone and had been referred to a specialist eye clinic (n=20).³⁸⁵ It was reported that a quarter of the children also had neuro-developmental problems. Ghetau et al. (2009), in a review of the literature on the occurrence of strabismus³⁸⁶ in children of parents misusing substances, found that there are very few studies on the topic but those that do exist, suggest that prevalence of strabismus is much higher in infants exposed pre-natally to substance misuse than in the general population.

12.2.2 Drug-related deaths

Serious case review of child deaths

An analysis was conducted on 189 'serious case reviews' of children who had died as a result of maltreatment and/or neglect between 2005 and 2007 (DCSF 2009). Parental drug misuse featured in 15% of cases (n=28).³⁸⁷ It was reported that many of these families were not previously known to social services, had "poor compliance with services", and were often "in denial about their drug use". Analysis of 268 serious case reviews between 2007 to 2009 showed that in 22% of cases (n=60) parental drug misuse was mentioned as a risk factor in the parents' case files; however, the authors were unable to comment on the particular way in which these factors "affected care giving and the child's safety" (Brandon et al. 2010).

Drug-related deaths reported to NDRDD: parental status of deceased

Data from the National Drug-Related Death Database (NDRDD)³⁸⁸ in Scotland (Graham et al. 2011) reported on drug-related deaths which occurred in 2009 (n=432). In 408 cases (94.4%) the parental status³⁸⁹ of the deceased was known, and of those, just over a third were either a parent or a parental figure to a child under 16 (n=149, 36.5%). It was reported

³⁸³ Opiate using mothers fulfilled the criteria for recruitment to the study. Eligible mothers were identified by their referrers, their own admission of substance misuse, urine screening or by clinical diagnosis in the baby. Of the 110 mothers identified, 72 infants were recruited to the study and assessed by the family health visitor using a modification of the Finnegan score at two, four, eight, 12 and 24 weeks.

³⁸⁴ The case files of 20 children exposed in utero to prescribed methadone and other drugs and who had also been referred to a national paediatric visual electrophysiology service were retrospectively reviewed.

³⁸⁵ These included: including: reduced acuity (95%); nystagmus (70%); and delayed visual maturation (50%); strabismus (35%); and refractive errors (30%).

³⁸⁶ Strabismus is a disorder in which the eyes do not line up in the same direction when focusing.

³⁸⁷ The proportion of families where a risk factor such as domestic violence, substance misuse or neglect is known to be present in the child's caregiving environment is provided.

³⁸⁸ The National Drug-Related Death Database (NDRDD) collects information on the nature and circumstances drug-related deaths in Scotland and details of the deceased individuals, using a wide range of local data sources. Its first year of data, for the calendar year 2009, provided details of 432 DRDs the individual's social circumstances and their previous contact with health and criminal justice services.

³⁸⁹ Parent or a parental figure of child(ren) under 16 years old.

that those parents/parental figures had a combined total of 254 children between them at the time of their death. In 421 cases it was known whether the deceased had children living with them (either their own or otherwise) at the time of their death. Of these, 39 (9.3%) were living with children under 16 years old at the time of their death. A total of 59 children were living with the deceased at the time of death.

12.2.3 Child protection and welfare issues

London: the impact on children (who are long term social work cases) of drug using parents

The cases of 50 families (with a total of 95 children) who were on the child protection register in an inner London borough were examined to explore if a link existed between parental substance misuse³⁹⁰ and child neglect resulting in children being taken into care (Forrester 2000). It was reported that in over half of all cases (52%, n=26) substance use within the family had been flagged as a 'cause for concern' by social workers (principal substance alcohol 24%, n=12; heroin 16%, n=8). Nine out of ten children whose parents used heroin were originally registered on the child protection register due to 'neglect', similar to those with parental alcohol misuse. It was reported that this study was limited due to its small sample size. The authors posited that rating of a case as a 'cause for concern' by social workers was subjective and that "social workers gave very different ratings of concern to alcohol and heroin-using parents even though both were heavily related to neglect."

In a further study Forrester and Harwin (2008) examined the effect of parental substance use (alcohol or drugs) on welfare outcomes for children.³⁹¹ The findings showed that at two year follow-up, 46% of children remained in their previous living arrangement, 26% were residing with other family members (other than parents) and 27% had been taken into formal care. Those children taken into formal care were more likely to have been identified as 'at risk' as a baby and less likely to have a non-substance using parent. Analysis of the other outcomes, i.e. education, emotional/behavioural outcomes and impact on health, indicated that two years after referral 47% of children had no problems in these areas. However, one-third (31%) had continuing problems and 22% had more problems than at referral.

12.3 Policy and legal frameworks

In the UK children of drug using parents are regarded as a vulnerable group, who are at risk of poorer outcomes than children in the general population. Policy and legislation concerning parental drug use is primarily focused on the welfare and safety of the children and meeting the needs of these children. Safeguarding the children of drug using parents is the responsibility of all professionals and services that may come into contact with the family, and as such professionals must act promptly to ensure action (including legal action) is taken if a child is 'suffering or likely to suffer significant harm' (HM Government 2010a).

Whilst it is accepted that parental drug use in itself does not necessarily mean that their children will suffer 'significant harm', drug users in treatment should be routinely asked if they have children and/or parental responsibilities and that this information should be recorded. This is to ensure that wherever it is thought likely that there is a risk to the child(ren) of drug using parents, other support agencies can be made aware of this in a timely manner.

³⁹⁰ Substance misuse in this study refers to heroin and/or alcohol misuse.

³⁹¹ All files being allocated for long term social work in four London boroughs over one year were examined (290 families). Of the 290, 100 families with 186 children involved concerns about parental substance misuse. The authors investigated the outcomes for children two years after referral, specifically focusing on living arrangements, education, emotional/behavioural outcomes and impact on health.

Delivery of joined-up children's services through localised, multi-agency working is a key feature of UK policy and the development of children's plans by each local area is statutory in England, Northern Ireland, Scotland and Wales.

Local Safeguarding Children Boards (LSCBs) made up of representatives from across key children's services are statutory in England and Wales to ensure regular sharing of information and local multi-agency working. Whilst joint multi-agency working across adult services is also an aim of UK policy, it is not covered by law in the same manner as children's services. In Scotland, local Child Protection Committees (CPCs) are the equivalent to LSCBs. In Northern Ireland, a regional Safeguarding Board (SBNI) will be established on 1st April 2012. The SBNI and its local panels will include members from a wide range of organisations across education, justice and local government sectors, along with health, social care and voluntary representation. In line with the rest of the UK, members will be required to adhere to statutory duties to co-operate with each other, safeguard and promote the welfare of children and share information with the SBNI.

In the UK there is a raft of legislation and policy regarding child welfare and the provision of services to families affected by parental substance misuse. Key documents are described in the following sections.

12.3.1 Legal frameworks addressing drug using parents/pregnant women and their children

In the UK there is a legal obligation for children's and adults' services to work together to protect and safeguard children. Drug using parents/pregnant women and their children are covered within the following UK legislation:

- *The Children Act 1989*³⁹² (England and Wales)
- *The Children (Scotland) Act 1995*³⁹³
- *The Children Act 2004*³⁹⁴ (England and Wales)
- *The Children and Young Persons Act 2008*³⁹⁵ (England and Wales)
- *The Children (Northern Ireland) Order 1995*

*Children Act 1989 (England and Wales)*³⁹⁶

When a court is determining the upbringing of a child, Section 1 of the *Children Act 1989* states that "the child's welfare shall be the court's paramount consideration" and that the following should be taken into consideration: the wishes of the child; their physical, educational and emotional needs; and the capability of the child's parents or other carer in meeting those needs. A court should not make any orders with respect to the upbringing of a child "unless it considers that doing so would be better for the child than making no order at all" (The Children Act 1989).

With regard to service provision for children, Section 17 of the Act includes a requirement for service providers to offer family support services for children in need and states that "it shall be the general duty of every local authority to safeguard and promote the welfare of children within their area who are in need; and so far as is consistent with that duty, to promote the upbringing of such children by their families by providing a range and level of services appropriate to those children's needs" (The Children Act 1989).

There is a statutory duty on local authorities to carry out investigations and make assessments where there is a danger of a child suffering, or being likely to suffer, 'significant

³⁹² See: <http://www.legislation.gov.uk/ukpga/1989/41/contents>

³⁹³ See: <http://www.legislation.gov.uk/ukpga/1995/36/contents>

³⁹⁴ See: <http://www.legislation.gov.uk/ukpga/2004/31/contents>

³⁹⁵ See: <http://www.legislation.gov.uk/ukpga/2008/23/contents>

³⁹⁶ The 2008 Act has some additional sections with regard to delivery of social work services and looked after children.

harm'.³⁹⁷ This refers to the threshold that justifies compulsory intervention into family life in the best interests of children and young people. There is no absolute definition of what constitutes significant harm and it could be as a result of one single event or a series of events over time. Parental drug use in itself does not constitute significant harm.

Children Act 2004 (England and Wales)

The *Children Act 2004* introduced the establishment of a Children's Commissioner³⁹⁸ in England and the setting up of Local Safeguarding Children Boards (LSCBs) in England and Wales. These boards bring together representatives from the main agencies responsible for promoting children's welfare, and helping to protect children from abuse and neglect. They must include: a representative of the Local Authority (LA) where the LSCB is located; the police; local probation board; youth offending; the Strategic Health Authority and Primary Care Trust; NHS trust and an NHS foundation trust representing the local hospitals; the Children and Family Court Advisory and Support Service; the governor of any secure training centre or children's prison in the area of the authority. They may also include other relevant representatives who are involved with activities relating to children in the local area. The purpose of the LSCBs is to:

- co-ordinate what each member of the LSCB does for the "purposes of safeguarding and promoting the welfare of children" in local the area; and
- "ensure the effectiveness" of how each LSCB member does this (The Children Act 2004).

LSCBs are responsible for developing monitoring and reviewing child protection policies, procedures and practice. They are also required to provide inter-agency training for staff who work with children and families (DCSF 2010).

Section 11³⁹⁹ of the *Children Act 2004* places a statutory duty on a range of organisations (including those for drug users) that come into contact with children, their parents and family members, to make arrangements to ensure that their service provision safeguards and promotes the welfare of children. All services that work with families (including adult services) must ensure that LSCB's safeguarding procedures are followed at all times. Services must also ensure that staff are trained in safeguarding procedures and there should be clear, written protocols for staff to follow. If staff at a family service suspect that a child is suffering or likely to suffer significant harm, they are obliged to inform social services immediately.

Since 2006 all LAs have been obliged to produce a parenting strategy which identifies the scope of support services that are available locally to cover the broad range of family needs, and each area is required to produce an annual Children and Young People's Plan (CYPP) and conduct a progress review on its priorities and actions each year (DCSF, DH and NTA 2009).

Scotland

In Scotland, local authorities have statutory duties placed on them by the *Social Work (Scotland) Act 1968*. Section 12 of the Act "places a general duty upon local authorities to

³⁹⁷ *The Children Act 1989* defines significant harm as where there is ill treatment or impairment of health or development; 'Ill treatment' includes sexual and emotional abuse as well as physical abuse. 'Health' includes physical and mental health. 'Development' includes physical, intellectual, emotional, social and behavioural development. 'Significant Harm' turns on the question of the harm suffered by a child in respect of its health and development compared with the health and development reasonably expected of another child."

³⁹⁸ The Children's Commissioner has the function of promoting the views and interests of children in England.

³⁹⁹ England. Section 28 for Wales.

promote social welfare in their areas by making available advice, guidance and assistance for certain categories of people in need". The *Children (Scotland) Act 1995* also places a statutory duty upon Local Authorities. Children in need⁴⁰⁰ are covered in Section 22 of the Act. With regard to service provision, Section 22 requires local authorities: "to safeguard and promote the welfare of children who are in need in their area so far as is consistent with that duty; to promote the upbringing of children by their families by providing a range and level of services appropriate to the children's needs. Services may be provided to a child or members of his or her family, and may be in kind, or in exceptional circumstances, in cash. Children in need in an area are likely to include: children of parents who have problems associated with their use of either drugs or alcohol or both, and young people who provide care or support for parents who misuse drugs or alcohol, often termed 'young carers'."

Section 19 of the *Children (Scotland) Act 1995* places a statutory duty on each local authority, in consultation with other relevant agencies, to prepare and publish plans for the provision and development of children's services in their area. The local authority is also required to publish information about the full range of children's services that it provides or purchases, including early education and childcare, social work, adoption, fostering and residential care. The plan should also cover youth justice and youth services.

Northern Ireland

In Northern Ireland the *Children (Northern Ireland) Order 1995* is the key piece of legislation regarding children of drug using parents. The *Children (Northern Ireland) Order 1995* is similar to *The Children Act 1989* (England and Wales) with some minor revisions and differences in the ordering of each Section of the Act. Section 3 of the *Children Order (Northern Ireland) 1995* is equivalent to Section 1 of *The Children Act 1989*. Likewise, Section 18 of the *Children Order 1995* is equivalent to Section 17 of *The Children Act 1989*.

12.3.2 National policies that address drug using parents and their children

United Kingdom

Hidden Harm

The Advisory Council for the Misuse of Drugs' (ACMD) *Hidden Harm* report, published in 2003, was a major catalyst for an increased policy focus on the harms caused by parental substance misuse. The report detailed the findings of an investigation into the number of children in the UK affected by parental drug misuse and the problems these families encounter as a result (ACMD 2003). The aim of the inquiry was to:

- estimate the number of children in the UK affected by parental substance use;
- examine immediate and long term consequences of parental drug use for these children;
- consider the current service provision in terms of health, social care, education, law enforcement and other services;
- identify areas of best policy and practice; and
- make policy and practice recommendations.

⁴⁰⁰ Section 93 (4) defines a child in need as: "Being in need of care and attention because s/he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development unless there are provided for him/her services by a local authority: his/her health or development is likely significantly to be impaired, or further impaired, unless such services are so provided; s/he is disabled; s/he is affected adversely by the disability of any other person in his/her family. For the purposes of support for children in need and their families under Part II of the Act 'child' means a person under the age of 18 years. 'Family', in relation to a child, includes any person who has parental responsibilities for a child and any other person with whom the child has been living."

The authors hoped to highlight a previously 'ignored' and under-researched problem and to "stimulate efforts" by policy makers and service providers to address the needs of a 'hidden' population of people affected by it. The investigation highlighted examples of the potentially negative impact of parental problem drug use on parental capability and also underlined the importance of developing effective and family focussed substance misuse services delivered by trained and appropriately resourced providers. *Hidden Harm* provided the first estimate of the number of children of problem drug users in the UK and it aimed to focus future policy making decisions around the reduction of harm to children affected by parental problem drug use.

Since the publication of *Hidden Harm* there has been an increased focus on the development of policies that address the specific needs of children and families affected by problematic drug (and alcohol) use. Prior to this study there was limited evidence to guide policy and to inform the development of targeted services and interventions (DfES 2005). Since its publication, localised, multi-agency working across a range of children and family support services has been a key aim of government policy (Duffy et al. 2009). Safeguarding children through early intervention, co-ordinated approaches to service delivery and inter-agency working is central to UK policy in this area.

The UK Government published its *Response to Hidden Harm* in 2005 (DfES 2005). It responded to the 48 recommendations made in the *Hidden Harm* report, providing information on how the Government proposed to address the key issues and giving examples of policy and legal developments that were already underway. Since responsibility in this area is devolved, the Scottish Government also published a similar document in response (Scottish Executive 2004) and in Wales a *Framework for Action* was developed (ACMD 2007). In Northern Ireland, a policy response was written into its national drug strategy, the new *Strategic Direction for Alcohol and Drugs 2006-2011*. In 2007, the ACMD published a review of the progress made by the UK Government and the devolved administrations against the original 48 recommendations entitled *Hidden Harm: Three years on* (ACMD 2007). Current national policies addressing parental substance misuse are described in the following pages.

England

Drug strategy 2010: Reducing Demand, Restricting Supply, Building Recovery

The current Drug Strategy (UK Government 2010a) focuses on early intervention for young people and their families. It states that targeted support is necessary for vulnerable young people, including children of drug using parents, to prevent drug use or to intervene at the earliest opportunity. 'Safeguarding' children of drug using parents is a key concern. The strategy states that "where there are concerns about the safety and welfare of children, professionals from both adult and children's services, alongside the voluntary sector, should work together to protect children, in accordance with the statutory guidance *Working Together to Safeguard Children*" (DCSF 2010) (see section 12.4.1). There is a commitment that "all

drug-misusing parents with treatment need are to have ready access to treatment and all problem drug user parents whose children are at risk are to have prompt access to treatment, with assessments taking account of family needs." The importance of adequate training for professionals working with substance using families is highlighted in the strategy. It goes on to say that, following the publication of the *Munro review of social work provision* (Munro 2011 see section 12.4.2), the Government will consider encompassing substance use into the social work degree curriculum.

Every child matters: Change for children

The Every Child Matters policy was published by the Government in 2003. The Green Paper (HM Government 2003) was published alongside Lord Laming's report into the failure of

social services to intervene adequately to prevent the death of an abused child⁴⁰¹ and was a major exigency for the *Children Act 2004*. Following on from the Green Paper, and in tandem with changes to the provision of children's services in England instigated as part of the *Children Act 2004*, the Government published *Every child matters: Change for children* (DfES 2004). This set out a framework underpinning a series of policies and associated guidance documents with the common goal of improving outcomes for children. The focus was on early intervention, a shared sense of responsibility, information sharing and integrated front line services. New and revised initiatives included:

- the development of integrated Children's Services Trusts led by local authorities;
- the production of annual Children's Services Plans;
- a Common Assessment Framework (CAF) for all children who may be in need;
- a new joint inspection process called the Joint Area Review, based on a detailed Outcomes Framework flowing from five key outcomes;
- a set of common core skills and knowledge for all workers with children and young people, linked to a comprehensive workforce development programme; and
- the establishment of Local Safeguarding Children Boards (LSCBs) by every Local Authority in partnership with other responsible agencies (DfES 2005).

Within the Every Child Matters programme, the Government published a document looking at *Young people and drugs* (HM Government 2005). However, the focus was on preventing young people from becoming drug users rather than addressing concerns around parental drug misuse. The current Government have recently launched the 'Early Support, helping every child succeed' programme which follows the principles of the Every Child Matters framework.

Scotland

Hidden Harm

The former Scottish Executive published its *Response to Hidden Harm in 2004* (Scottish Executive 2004). It included a commitment to build on the Government's 2003 *Getting Our Priorities Right* practice guidance (see section 12.4.1) which was developed for use by all practitioners in Scotland who work with children and families affected by substance misuse. In 2006 the Scottish Executive published *Hidden Harm Next Steps: Supporting Children, Working With Parents* (Scottish Executive 2006c). This emphasised the need for all professionals to put the best interests of the child or children first.

National Drug Strategy: the Road to Recovery

The Scottish Government published its drug strategy the *Road to Recovery* in 2008 (Scottish Government 2008a). Chapter five of the strategy, entitled "*Getting it right for substance using families*" outlined a range of actions which aim to improve circumstances for 'children affected by parental substance misuse' (CAPSM). These actions all have a particular focus on prevention and early intervention and also cover the following key themes: improved identification, assessment and information sharing; improved risk management; and, increasing the capacity of support services to improve life chances for vulnerable children.

Getting it right for every child

Work in Scotland is also aligned with wider national change programmes, *Getting it right for every child* (GIRFEC) and the *Early Years Framework* (Scottish Government 2008b). These provide the frameworks within which public agencies can work better together with a focus on improving outcomes for children.

⁴⁰¹ See:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_110711.pdf

Children Affected by Parental Substance Misuse (CAPSM) work programme

A CAPSM steering group was established in 2008 in Scotland to co-ordinate a range of cross-government activities which are currently in progress. They are being delivered through the *Getting it right for every child* national change programme, which aims to focus all services on improving outcomes for children and families. The CAPSM priority work programme for 2010 to 2012 includes a focus on improving the quality and consistency of guidance and national frameworks which local partners work to. A comprehensive review of child protection procedures in Scotland was carried out in 2010 and revised national child protection guidance has been published (Scottish Government 2010b). This guidance includes a strengthened section on CAPSM which sets out national expectations for local partners to put in place CAPSM strategies. The 2003 *Getting our priorities right* guidance (see section 12.4.1) will also be updated to take into account policy developments since then. Inspection of local performance and adherence with national guidance is also being improved and work is underway to further develop the estimates of numbers of children in Scotland potentially affected by parental substance misuse issues. This includes planned updates to child protection statistics from 2012 in order to better identify the factors, such as parental substance misuse, which can lead to a child being classified as 'at risk'. The CAPSM 2010 to 2012 work programme also prioritises work around early intervention, with a particular focus on interventions around pregnancy and pre-conception. Linked to the wider review of child protection procedures in Scotland, the overall CAPSM approach was reviewed in early 2011. A report published in March 2011 made a number of recommendations and key elements of the CAPSM work programme which aim to address these recommendations are:

- a revised draft of the *Getting our Priorities Right* guidance for all practitioners working with substance misuse issues to be consulted on in 2011 (see section 12.4.1);
- the production of a national risk assessment toolkit for child protection and including for CAPSM in 2011 to be piloted and finalised by early 2012;
- a national work programme to improve approaches to performance management and child protection to be developed during 2011; and
- a new group with oversight of child protection public awareness to be established by the Scottish Child Protection Committee Chairs Forum in 2011.

Wales

Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-2018

In 2008 the Welsh Assembly Government published its substance use strategy (WAG 2008a). Within this a specific 'action area' is included on the topic of supporting and protecting families. The aim of this aspect of the strategy is to "reduce the risk of harm to children and adults as a consequence of the substance misusing behaviour of a family member." The strategy emphasises the importance of delivering evidence based family interventions in order to serve the needs of children of substance misusing parents. Access to effective treatment for parents is cited as a key objective which aims to enhance parenting capacity although it is highlighted that services also have a responsibility to ensure the welfare of the children and should work in partnership with other agencies to ensure this. A multi-agency approach to service delivery is a key aim.

Sustainable Social Services: A Framework for Action

In 2011 the Welsh Assembly Government published *Sustainable Social Services: A Framework for Action*, a white paper which seeks to promote a family focused approach which links child and adult services (WAG 2011b).

Northern Ireland

New Strategic Direction for Alcohol and Drugs

In Northern Ireland, and similar to other UK countries, the emphasis for action regarding parental drug use is around services which support children and families (PHA/HSCB 2009).

The national drug strategy *New Strategic Direction for Alcohol and Drugs* (DHSSPSNI 2006) identified children of drug (and alcohol) using parents as a vulnerable group and a commitment was made to develop a hidden harm strategy specifically to address the risks potentially faced by this group. The strategy also discussed an aim to develop integrated multi-agency working in terms of drug prevention, treatment and support. A *Regional Action Plan*⁴⁰² to address *Hidden Harm* was published in 2008 (DHSSPSNI 2008). It set out underlying principles alongside regional action that the Department for Health, Social Services and Public Safety (DHSSPSNI) was committed to undertake. Initial action focused on the development of relationships, structures and processes to promote effective joint working between services. The plan provided guidance to assist in the development of integrated local action plans. Main themes included:

- the need for joint planning/commissioning and integrated working;
- development of specialist services and support for children/young people;
- safeguarding and promoting children's welfare;
- workforce development;
- public awareness; and
- research and evaluation.

A further action plan was published in 2009⁴⁰³ (PHA/HSCB 2009). It aims to "provide direction, guidance, and clarity in addressing hidden harm in Northern Ireland" and gives details of the necessary commissioning requirements. Outcomes of the Action Plan are assessed by a series of agreed performance indicators which link into guidance outlined in *Our Children and Young People – Our Pledge: A 10 Year Strategy for Children and Young People in Northern Ireland 2006-2016*. A hidden harm implementation plan has been developed by the Public Health Agency with the support of the Health and Social Services Boards. Specific resources have been set aside to support children and young people born to substance misusing parents or carers, and to improving training and support to key professionals (such as midwives) (personal communication – Northern Ireland).

Within the wider child protection policy agenda, Health and Social Service Boards (HSSBs) have a duty to plan services for children in need through Children's Service Plans and to establish and ensure the effective functioning of Area Child Protection Committees (ACPCs) in each of the four HSSBs. A *Northern Ireland Children's Services Plan 2008 to 2011* was produced jointly by all four Boards⁴⁰⁴ in 2008, setting out regional priorities for the three years covered by the plan and based upon the ten year strategy for children and young people. This includes a section on drug and alcohol (hidden harm) where a key indicator is the rate of children on the child protection register (CPR) due to parental substance misuse. A key development has been the Joint Agreement between Adult and Children's Services in responding to the needs of parents with mental health issues and/or substance misuse, their children and families.

12.4 Responses addressing drug using parents/pregnant women and their children

12.4.1 Availability of national/local guidelines that target drug using parents/pregnant women and their children

The legal frameworks and policies detailed in section 12.3 are supported by national and local guidelines. The major national guidelines and frameworks for service delivery are

⁴⁰² See: http://www.dhsspsni.gov.uk/regional_hidden_harm_action_plan.pdf and

<http://www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-december-archive-2010/news-dhssps-011210-health-minister-confirms.htm>

⁴⁰³ See;

<http://www.publichealth.hscni.net/sites/default/files/Hidden%20Harm%20Action%20Plan%202010.pdf>

⁴⁰⁴ See: http://www.northernchildrenservices.org/NI_Reg_Chil_Services_plan20082011.pdf

described in the forthcoming pages, although it is common for local areas to publish their own guidance in accordance with national guidelines.

United Kingdom

Drug misuse and dependence: UK guidelines on clinical management

The *UK Guidelines on Clinical Management* (DH et al. 2007) for drug misuse and dependence is a UK-wide guideline that provides a framework from which devolved administrations can develop locally appropriate guidance (see 2010 UK Focal Point Report).⁴⁰⁵ The guidelines have a specific section on pregnancy and neonatal care. It is recommended that pregnant women are 'fast tracked' into treatment at the earliest opportunity. It also recommends that: all women of child bearing age in treatment should be encouraged to have a pregnancy test as some may be unaware that they are pregnant; local multi-disciplinary protocols should be in place between specialist treatment, obstetric, midwifery and primary care services; and local authorities should have a written policy on drug using parents. The guidelines state that substitute prescribing can 'occur at any time in pregnancy' as this is deemed less risky than continued drug use. Detoxification is only recommended in the second trimester of pregnancy, with stabilisation (on an opioid substitute prescription) the preferred option in the first and third stages of pregnancy.

England

The NTA expects local drug treatment services in England to implement care pathways for pregnant drug users. National guidance such as the *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (DH et al. 2007); *Models of Care* (NTA 2006) and *Pregnancy and complex social factors* (National Collaborating Centre for Women's and Children's Health 2010) recommend multi-agency approaches including drug treatment services, maternity and midwifery services and social services. These agencies should all be involved in developing a detailed care plan which sets out the drug treatment (including substitute opioid prescribing) and other support the woman requires through pregnancy and postnatal support (e.g. parenting skills).

Models of Care for Treatment of Adult Drug Misusers: Update 2006

In England, *Models of Care* (NTA 2006) sets out the service framework for the commissioning and provision of drug misuse treatment services⁴⁰⁶ (see 2010 UK Focal Point Report). It requires that local interventions^{are} provided for pregnant women which will "attract and motivate" them into local treatment systems and states that such interventions "may require joint initiatives between specialised drug services and other specialist inpatient units". Pregnant women (and those with 'children at risk') receive a comprehensive assessment to determine the exact nature of their drug (and alcohol problems), and co-existing health problems. A full risk assessment should also be carried out.

NICE guidance: service provision for pregnant women with complex social factors

NICE commissioned guidance entitled *Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors* (National Collaborating Centre for Women's and Children's Health 2010) includes a section on pregnant substance users. The guidance recommends that commissioners and others who are responsible for

⁴⁰⁵ This guideline provides managers, joint commissioners, providers and users of drug treatment services with a four-tiered framework for providing drug treatment. The tiers refer to the level of interventions provided with many agencies providing interventions from a variety of tiers. The degree of individual need and support usually increases with each tier (NTA 2006; see 2010 UK Focal Point Report).

⁴⁰⁶ *Models of Care for Treatment of Adult Drug Misusers* (NTA 2006) is evidence-based guidance on a commissioning framework for drug services. It was developed with the assistance of clinical experts and with reference to the evidence base on effective interventions. It provides guidance on the different types of services needed in a system of care to provide the wide range of interventions required to meet the needs of drug misusers.

organising local antenatal services should “work with local agencies, including social care and third-sector agencies that provide substance misuse services, to coordinate antenatal care by, for example:

- jointly developing care plans across agencies;
- including information about opiate replacement therapy in care plans;
- co-locating services; and
- offering women information about the services provided by other agencies”.

The guidance also recommends that healthcare professionals are trained in dealing with the social and psychological needs of women who misuse substances. It also suggests that both healthcare and non-clinical support staff (such as receptionists) should be trained in how to communicate sensitively with female substance users.

The Children, Young People’s and Maternity National Service Framework

In 2004, the Department of Health published the *Children, Young People’s and Maternity National Service Framework (NSF) for England*. The NSF is a ten-year programme which aims to improve the health and wellbeing of children, including unborn children. It sets out the standards required for the delivery of maternity services and the care of children and young people. Within this framework, the needs of pregnant drug users and their partners are highlighted as requiring specific attention. The National Health Service (NHS) is responsible for its delivery, in association with Children’s Service Trusts and partners (DH and DfES 2004). It is reported that most areas have protocols in place to manage the needs of pregnant drug users, such as the management of neonatal withdrawal and that there is provision of specialist, multi-agency teams which include midwives, obstetricians and drug workers (ACMD 2007).

The Common Assessment Framework

The *Common Assessment Framework (CAF)*, introduced by the *Every Child Matters* programme (see section 12.3.2) in England, is a standardised process which has been designed to be used by professionals working across the whole range of children’s services and which is used to assess the needs of children. Its aim is to facilitate early identification of problems and co-ordinate a network of required support services, linking into more targeted arrangements. It takes into account the environmental factors which may impact on a child’s development including issues around parental substance misuse. There are four main stages of assessment: identifying needs early; assessing those needs; delivering integrated services; and reviewing progress. National guidance is available on implementing the CAF⁴⁰⁷ and local areas provide area-specific guidance.⁴⁰⁸

Local protocols between drug treatment and children/ family services

In 2009 *Joint Guidance on the development of local protocols between drug and alcohol treatment services and local safeguarding and family services* was published (DCSF, DH and NTA 2009). The aim of this cross-government guidance is to ensure drug services are aware of the parental status of their clients so that any at-risk children can be referred to social services if necessary. The overall aim of the protocol is to safeguard children affected by substance use by taking a wider, more preventative approach than just applying the principles of child protection. This involves closer working relationships by a range of agencies involved with families at an earlier stage before problems reach ‘crisis point’. It is aimed at service providers of adult drug/alcohol treatment and family and parenting services within local authorities and aims to establish a co-ordinated, multi-agency approach to the delivery of services for substance using parents and their children. The guidance aims to

⁴⁰⁷ See: <http://www.cwdcouncil.org.uk/caf>

⁴⁰⁸ For example see:

http://www.lincolnshirelscb.org.uk/files/Final_Version_Substance_Using_Parents_September_2008%5B1%5D.pdf

help services develop joint working protocols on a local level. All local authorities are also required to have a *Children and Young People's Plan* (CYPP) which should be reviewed annually. Strategies for family services should feed into these plans and at an operational level a local protocol should be set up to develop links between adult drug treatment services and family and children's services. The guidance states that the protocol should contain details of referral pathways and local treatment services in line with *Models of Care* (NTA 2006) and that it "should include joint referral and treatment arrangements, agreed between adult treatment services, children, parenting and family services and the Local Safeguarding Children's Board" (see section 12.3.1).

Building on the *2009 Joint Guidance* document (DCSF, DH and NTA 2009), further information on developing local protocols between treatment and family support services entitled *Supporting information for the development of joint local protocols between drug and alcohol partnerships, children and family services* was published by the NTA (2011). This publication provides practical examples to help local service providers develop joint protocols between children and family services and drug/alcohol treatment. It is stated that:

"The overarching purpose of the protocol should be agreed by all key partners. The protocol will usually apply to unborn babies, children and young people whose care is deemed to be at risk due to substance misusing parents or carers, and the statement of purpose may include:

- strengthening the relationship between drug and alcohol services and children and family services;
- identification, assessment and referral of drug or alcohol using parents;
- identification, assessment and referral of children who need to be safeguarded;
- referral thresholds and pathways into children and family services;
- referral thresholds and pathways into drug and alcohol treatment services;
- effective joint working arrangements, including sharing of information and data; and
- staff competencies and training".

It is recommended that reference is made to national policy and guidance, including reference to the *2009 Joint Guidance* and *Working Together to Safeguard Children* (DCSF 2010).

Working Together to Safeguard Children: non-statutory practice guidance

A key reference document for supporting local protocols is *Working Together to Safeguard Children* (DCSF 2010). It sets out methods of joint working between organisations and individuals in accordance with the legal requirements of the *Children Act 1989* and the *Children Act 2004* (see 12.3.1) in order to "safeguard and promote the welfare of children and young people" (HM Government and DCSF 2010). It is aimed at: children's services; the Department for Education (DfE); local authorities; statutory agencies; and schools. The document is separated into two parts. The first part is statutory guidance for practitioners and agencies. The second part presents non-statutory guidance for practitioners. Chapter nine "Lessons from research" specifically deals with the issue of parental drug use. The guidance emphasises that the welfare and safety of the child is the responsibility of all professionals and services that have contact with them and as such they must act promptly to ensure action is taken (including court action) if a child is 'suffering or likely to suffer significant harm'.

Laming review of the Protection of Children in England

Care Matters (DCSF 2007) and the *Lord Laming Review of the Protection of Children in England: A Progress Report* (Lord Laming 2009) emphasise the need for inter-agency working in order to safeguard children in families with complex needs, including parental drug users, as well as the need to train and prepare social workers to deal with such cases.

Recommendations in the Lord Laming review included the establishment of a National Safeguarding Delivery Unit to collate best practice on referral and assessment systems for children affected by parental drug use (and other issues), and provide advice to local authorities, health and police on implementation of these systems nationally.

Scotland

Getting our priorities right

In 2003 the Scottish Government⁴⁰⁹ published *Getting our Priorities Right: Good Practice Guidance for Working with Children and Families affected by Substance Misuse* (Scottish Executive 2003). This framework was aimed at practitioners and service providers and suggested ways to work with families affected by parental substance use. It included guidance to help local practitioners decide when children need help and also guidance around parenting, partnership working, information sharing and strengthening services for families; specifically where substance misuse is a factor. Work is currently underway to update the practice guidance and a revised draft will be available for consultation in 2012 (see section 12.3.2).

Getting it right for every child

*Getting it right for every child*⁴¹⁰ is the framework for practitioners involved in the delivery of children's services and child protection, including those addressing the early years of children affected by parental substance misuse. Its aim is to put the child or young person at the centre and develop a shared understanding within and across agencies in order to improve life chances for children and young people. The framework is supported by a number of implementation tools and a national practice model was published in 2011.⁴¹¹

Early Years Framework

The *Early Years Framework* (Scottish Government 2008b) seeks to maximise positive opportunities for children from an early age. The Framework covers the age range of pre-birth to eight and it aims to enable local partners and practitioners in early years services to improve outcomes for children. The Framework has the following key themes: the importance of prevention and early intervention in the early years; helping parents to be the best parents they can be for their children; an emphasis on the importance of pre-birth to three in improving outcomes; and improving play opportunities and access to play.

Framework for maternity care

A *Refreshed Framework for Maternity Care in Scotland* was published in 2011 (Scottish Government 2011h). The framework expects maternity care service providers to tailor services in order to reach and meet the needs of all pregnant women, including those at risk of 'poorer outcomes' such as drug using mothers. The framework provides principles and service descriptors for maternity care from conception until the postnatal period. The principle aim is that: the contribution of maternity care to improving maternal and infant health is strengthened and the inequalities in outcomes between groups are reduced. Central to this aim is the principle that all women have early and direct access to antenatal care. *Evidence into Action: Reducing Antenatal Inequalities Guidance* (Scottish Government 2011i) was published alongside the refreshed framework, providing NHS Boards with practical recommendations for action in order to reach and more effectively manage women in high-risk groups. NHS Boards are encouraged to promote antenatal care through 'all appropriate NHS and local authority services' including treatment services and addiction services.

⁴⁰⁹ Formerly known as the Scottish Executive.

⁴¹⁰ See: <http://www.scotland.gov.uk/Topics/People/Young-People/childrensservices/girfec>

⁴¹¹ See: <http://www.scotland.gov.uk/Topics/People/Young-People/childrensservices/girfec/publications>

Sexual Health and Blood Borne Virus Framework

The Scottish Government's *Sexual Health and Blood Borne Virus Framework* (Scottish Government 2011a) recommends that sexual health assessments should be part of the routine assessment process for clients entering drug and alcohol harm reduction, treatment and rehabilitation services. It goes on to say that particular support is required for pregnant women with a drug or alcohol problem, and their partners, throughout pregnancy and in bringing up their child (see section 7.3.2).

Wales

National Service Framework for Children, Young People and Maternity Services

In Wales, the *National Service Framework for Children, Young People and Maternity Services* (WAG 2005) describes the quality of service provision that children, young people and their families should expect to receive. This includes the all-Wales maternity record which is used to routinely collect data regarding substance use amongst pregnant women, and to ensure that effective screening and services are offered.

Safeguarding Children: Working Together Under the Children Act 2004

This guidance sets out how all agencies and professionals should work together to safeguard and promote children's welfare and protect them from harm, including the harm arising from parental substance misuse. Aimed at managers and practitioners, the guidance states that assumptions about the parenting ability of an individual with substance misuse problems should not be made, but it is important that the implications for children are properly assessed (WAG 2007a).

Good practice guide

As part of the Better Outcomes for Children in Need programme, the Social Services Improvement Agency for Wales (SSIA) published a good practice guide entitled *Promoting good outcomes for children in need where there is parental substance misuse* (SSIA 2007). It urged commissioners of children in need services to work with other local services to ensure that services are commissioned effectively. It also stated that a range of support should be commissioned ranging from lower tier services through to specialist substance misuse services and that these should be underpinned by best practice and supported by the emerging evidence base.

Treatment framework for carers and families of substance misusers

A treatment framework for carers and families of substance misusers in Wales focuses on adults only (WAG 2007e). Nevertheless, the guidance states that "agencies involved with adult service users should be alert to the possibility that there are young carers in the household, and involve the children's commissioning and provider bodies where this is appropriate."

Community prescribing in Wales

The Welsh Government's guidance for *Evidence Based Community Prescribing in the Treatment of Substance Misuse* (Welsh Government 2011e) states that the NICE *Service provision for pregnant women with complex social factors* guidance (National Collaborating Centre for Women's and Children's Health 2010) should be followed in order to "achieve stability for the mother and reduce risks for both the mother and baby". Specifically, this should include: joint care protocols and sharing of information between specialist substance misuse services and the midwifery/obstetric team; sharing of information between specialist substance misuse and the midwifery/obstetric team; early risk assessments and the development of an integrated care plan and support network; routine toxicology testing; appropriate setting for prescribing/dispensing to encourage compliance; and appropriate settings for the provision of maternity care so that easy access to antenatal and postnatal care is facilitated.

Northern Ireland

An inter-agency assessment model has been developed in Northern Ireland which aims to support staff when conducting assessments to identify children's needs. It also aims to help meet those needs when they have been identified. This framework is called UNOCINI (Understanding the Needs of Children in Northern Ireland). The UNOCINI Assessment Framework⁴¹² has been developed to:

- improve the quality of assessment within stakeholder agencies;
- assist in communicating the needs of children across agencies; and
- avoid the escalation of children's needs through early identification of need and effective intervention.

12.4.2 Availability of responses addressing drug using parents and their children

Drug treatment and prevention services for children, adults and families are available across the UK. As per guidance and protocols described in section 12.4.1, treatment agencies are required to work with child protection services to ensure that the needs of children affected by parental substance misuse are addressed.

England

The UK drug strategy states that "the majority of adult and children drug and alcohol services either have or are developing protocols which aim to set out how they can work more effectively together to respond to safeguarding concerns, support parents to stay in treatment and build parenting capacity. Locally, drug and alcohol services should be represented on Local Safeguarding Children Boards" (HM Government 2010a).

In every local area, there should be protocols in place which aim to ensure that the children of drug users are protected from harm and that their needs are met. They should also aim to improve outcomes for treatment service users who are parents. The NTA in partnership with DCSF and DH published guidance on developing these protocols and further guidance was published by the NTA in 2011 (see section 12.4.1; DCSF, DH and NTA 2009; NTA 2011). Since 2006, NTA regional teams have been working with commissioners of treatment services to establish local safeguarding and child protection protocols for parents with drug treatment needs.

According to *Working Together to Safeguard Children* (DCSF 2010) there are a range of adult services provided by health and voluntary organisations which are delivered locally by Drug Action Teams. As specified in the guidance and protocols in section 12.4.1, these services should have arrangements in place to enable children's social care services and substance misuse services referrals to be made in cases where children are suffering 'significant harm' due to parental substance use, in accordance with LSCBs. Where children are not suffering significant harm, referral arrangements also need to be in place to enable children's broader needs to be assessed and responded to (HM Government and DCSF 2010).

Munro review of social work

In a review of social work provision, published in May 2011, it was concluded that services, including those for substance misuse, often concentrate on the needs of the parents and as a result children are often 'invisible' to these services (Munro 2011).

⁴¹² See:

http://www.dhsspsni.gov.uk/microsoft_word_unocini_guidance_revised_june_2011_inc_mh_domain_elements.pdf

Services for pregnant drug users or those with children

In 2003 the ACMD conducted a survey with UK treatment agencies, maternity units and social work services. They reported that specific services for pregnant drug users or those with children were only available in half of the services surveyed and less than one-third provided children's services (ACMD 2003).

Family Drug and Alcohol Courts (FDAC) pilot

In January 2008 a pilot Family Drug and Alcohol Court (FDAC) was set up in London which aimed to address the specific needs of drug using parents and thus improve outcomes for their children. It was the first family drug and alcohol court in England and Wales and consisted of a rehabilitation programme for drug using parents whose children are subject to care proceedings and was led by a judge. In the final evaluation report⁴¹³ it was shown that 39% of children in areas that were served by the FDAC stayed with the family, in comparison to 21% of children in families who were subject to normal care proceedings (Harwin et al. 2011). There was also a positive difference reported in the proportion of mothers who had stopped substance misuse (48% compared to 39%). A greater reduction in substance use was also reported amongst fathers in the evaluation (39% of those in the FDAC group compared to one of the 19 fathers in the other group).

Family Intervention Projects (FIPs)

Since 2006 these projects have been running in around one-third of local authorities. They provide intensive support to families who are assigned an individual key worker (DCSF and DH and NTA 2009).

Scotland

A Learning Partnership for CAPSM was previously established in Angus to improve support across child and adult services for children affected by parental substance misuse, or CAPSM and concluded in early 2011. This was a multi-agency initiative that aimed to identify, support and protect these children. It sought to change the way services, in particular those involved with adults, work with children and families, with a strengthened focus on the principles of *Getting it right for Every Child* and early intervention. The final report reinforced messages around the Getting it right approach. It also reflected on areas of improved working among professionals and raised the profile of children among adult workers

Wales

Since 2000, a crisis intervention service called Option 2 has been running in Cardiff and the Vale of Glamorgan, Wales.⁴¹⁴ Staff work intensively with two or three families for up to 30

⁴¹³ See: <http://www.brunel.ac.uk/research/centres/iccfyr/fdac>. The pilot court has been running in London since January 2008 and will continue until March 2012. The evaluation was conducted with a sample of 55 families with 77 children who entered the FDAC between January 2008 and the end of June 2009. These families were from three pilot local authorities (Camden, Islington and Westminster). A comparison sample of families from areas outside of the pilot local authorities was utilised in the evaluation. This was made up of 31 families with 49 children who were the subject of care proceedings due to parental substance misuse. Over a six-month period a total of 41 FDAC and 19 comparison cases were followed up to their conclusion.

⁴¹⁴ The Option 2 model was based upon key components of an American Intensive Family Preservation (IFP) intervention. It is a therapeutic based model of intervention with families whose children are at a high risk of entering social services care, or having their names placed on the child protection register. Therapeutic behaviour change approaches used with families included motivational interviewing (MI) and solution focused brief therapy (SFBT). MI is a directive counselling style that emphasises the creation of a constructive, empathetic relationship between worker and client by helping individuals to self evaluate their behaviour. SFBT is focussed upon achieving

hours a week over a four week period, with follow up visits at one, six and twelve months post intervention. Booster sessions are available to respond to a crisis or to help parents reinforce their coping skills. Parents are asked to develop goals to reduce risks to their children and to identify behavioural changes which will prevent their child from being taken into care by social services (Forrester et al. 2008). Examples of goals include: drug or alcohol abstinence; improved family relations; developing improved routines for children; dealing with domestic violence; and managing children's behaviour. Several similar interventions which target families with substance use problems using the Option 2 model have been developed across the UK⁴¹⁵ but provision is not provided on a national basis.

Integrated Family Support Services (IFSS)

In Wales, IFSS⁴¹⁶ provides support to vulnerable children and families with complex needs. It is a multi-agency service which provides targeted support to families where there are concerns regarding child welfare and parental substance misuse (drugs and/or alcohol) (WAG 2010f). The scheme is backed by statutory legislation⁴¹⁷. It is a family-centered approach to services which provides early intervention in addition to crisis management. The aim is to provide intensive support to improve parenting capacity as well as social service intervention and to help bridge the gaps between child and adult services by protecting vulnerable children, whilst at the same time helping parents to develop new skills. Four 'pioneer' areas in Wales adopted the scheme in late 2010 and it is reported that some early successes in preventing children being taken into care have been observed. These areas will be evaluated in 2011, and following this it is anticipated that the programme will be rolled out nationally. The evaluation is due for publication in 2012/13. This programme fulfils a commitment in the *Sustainable Social Services: A Framework for Action* (WAG 2011b) White Paper which seeks to promote a family focused approach linking child and adult services (personal communication - Welsh Assembly Government).

12.4.3 Evaluations of interventions addressing drug using parents and their children

Option 2

An evaluation of the Option 2 early intervention service, for families where children are at risk of harm and parents have drug or alcohol problems, was published in 2008 (Forrester et al. 2008). It investigated the differences between children receiving the Option 2 service and a comparison group. It was reported that the service did not reduce the proportion of children entering care but the time spent in care by those children was significantly reduced for varying reasons, that is, they tended to stay in care for a shorter time, they took longer to enter care and a higher proportion returned home after a spell in care. It also found that at the end of the study one-third of children in the comparison group were in care and a quarter of the Option 2 children were in care. It was reported that the Option 2 project brought about significant financial savings in terms of reducing the need for public care and its associated costs. The evaluation did not however, measure the impact of the Option 2 intervention on the welfare of the children and their families.

progress through goal setting and employs a series of questions to help individuals establish clear goals, which are used to facilitate and monitor change over time.

⁴¹⁵ These include: Families First (Middlesbrough, England), Changing Trax (Newcastle, England); DARRT (Conwy, Wales); Changing Trax (Newcastle, England); Children NE (Gateshead and Northumberland, England) and Families Together (Sheffield, England). See: <http://www.option-2.moonfruit.com/#/in-your-area/4549720368> .

⁴¹⁶ See: <http://wales.gov.uk/topics/childrenyoungpeople/parenting/help/ifst/?lang=en>.

⁴¹⁷ "IFST will take place within the context of Core Aim 3 of the local Children and Young People's Plans with the aim that 'every child and young person enjoys the best possible physical and mental, social and emotional health including freedom from abuse, victimisation and exploitation". See: http://www.substancemisuserct.co.uk/staff/parenting/Resources_parental.htm

Families First

The Families First project in Middlesbrough, North East England provides intensive support to families and their children (typically under the age of five, including newborns and pregnant mothers) who have been (or who are at risk of) being placed on the child protection register and being taken into care (Woolfall et al. 2008). It aims to enable the families to change their lives such that the child(ren) can remain safely in the family home. An evaluation of the project found that children of problem drug/ alcohol users who were on the verge of being taken into care were, in the majority of cases, able to stay with their families after the intensive support of the project was given to their parents. The availability of kinship care, usually provided by grandparents, was an important factor in preventing children from being taken into care in the short term for many families. The average cost of the intensive family support provided by the project was much lower than the typical cost of placing a child into care. It was also noted that, in many cases, drug using parents displayed a reduction or cessation of drug use or maintenance of methadone in the 12 month follow up, although causality could not be determined.

Interventions for children and families where there is parental drug misuse

As part of the Department of Health Policy Research Programme, Drugs Misuse Research Initiative (DMRI) phase II⁴¹⁸, Kroll and Taylor (2009) looked at interventions for children and families where there is parental drug misuse.⁴¹⁹ The report concluded that, unless there is evidence presented to the contrary, all children residing with drug using parent(s) should be considered 'children in need'. It was suggested that there is a need for preventative, family focused approaches and that it is important to take into account the views of both parents and their children.

Parental substance misuse: An Islington Perspective

Nagle and Watson (2008) published a discussion paper on the impact of parental substance misuse on children, with a particular focus on the authors' experience of responding to this issue in Islington, London. After recognition of problems within Islington regarding delivery of services to parents with substance use issues, two specialist roles to respond to both substance misuse and childcare were commissioned. The aim of these posts was to improve treatment engagement and retention, and respond to child welfare issues. The authors concluded that the commissioning of the two posts led to a change in culture of attitude across treatment and social work services, bridging the gap between services and enhancing partnership working. It was recommended that this new working strategy could foster improved outcomes for both children and parents, however, there is a continued need for clear guidance on working with substance using parents and their children.

Early Parental Intervention Pilots

In Wales a process evaluation⁴²⁰ examining the delivery of early interventions with substance using parents was carried out on five pilot projects. The intervention focused on parents

⁴¹⁸ Ten projects focusing on areas related to drug treatment and aims to deliver research-based evidence to underpin the development and delivery of effective services and interventions in the field of drug misuse were funded. The value of the programme was around £1.4 million from 2005 to 2008.

⁴¹⁹ The research was conducted from March 2006 to March 2008, in a largely rural, predominantly White area of England, with four sets of interrelated data: case record analysis of the files of 28 children from 14 families on the area child protection register where parental drug misuse was an issue (and a family member had given consent); interviews with 42 children and young people between four and 20 years (average age: 12.6 years) with drug misusing parents; interviews with 40 drug misusing parents and seven grandparents, together with a focus group of parents; and interviews with 60 health and social care professionals from voluntary and statutory sector drug services, statutory child care and primary health care, together with a series of multi-professional focus groups.

⁴²⁰ The evaluation comprised in-depth qualitative interviews with project staff and representatives from external agencies (n=22 and n=20 respectively) and with parents (n=28) and children (n=10).

whose drug use had been identified as having a potential impact on their parenting ability (Wright et al. 2010). The aim of the intervention was to reduce the impact of substance misuse on parenting capacity and enable parents to develop positive and effective parenting skills and greater self-determination. It was reported in the evaluation that whilst the pilot programme provided a valuable service to families, there were some issues in terms of delivering these interventions and addressing the recommendations in *Hidden Harm* (ACMD 2003).

PART C

Bibliography and Annexes

Bibliography

<p>ACMD (Advisory Council on the Misuse of Drugs) (2003). <u>Hidden Harm: Responding to the needs of children of problem drug users</u>. Report of an enquiry by the ACMD. Advisory Council on the Misuse of Drugs, London. Available: http://www.drugs.gov.uk/publication-search/acmd/hidden-harm?view=Binary [accessed 09.05.11]</p>
<p>ACMD (Advisory Council on the Misuse of Drugs) (2007). Hidden harm. <u>Three years on: Realities, challenges and opportunities</u>. Home Office, London. Available: http://www.homeoffice.gov.uk/publications/drugs/acmd1/HiddenHarm20071.pdf [accessed 09.05.11]</p>
<p>ACMD (Advisory Council on the Misuse of Drugs) (2010). <u>Consideration of the use of foil, as an intervention, to reduce the harms of injecting heroin</u>. Advisory Council on the Misuse of Drugs, London. Available: http://www.homeoffice.gov.uk/publications/drugs/acmd1/foil-report?view=Binary [accessed 11.10.10]</p>
<p>Allen, G. (2011). <u>Early Intervention: The Next Steps. An Independent Report to Her Majesty's Government</u>. HM Government, London. Available: http://www.dwp.gov.uk/docs/early-intervention-next-steps.pdf [accessed 27.05.11]</p>
<p>Anderson, D. M. and Carrier, N. C. M. (2011). <u>Khat: Social harms and legislation. A literature review</u>. Home Office, London. Available: http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/occ95?view=Binary [accessed 18.08.11]</p>
<p>The Anti-Social Behaviour Act 2003. <u>The Stationery Office</u>, London. Available: http://www.legislation.gov.uk/ukpga/2003/38/contents [accessed 08.05.11]</p>
<p>Armstrong, S. and Weaver, B. (2010). <u>User Views of Punishment: The Comparative Experience of Short Prison Sentences and Community-Based Punishments</u>. Scottish Centre for Crime and Justice Research, Glasgow. Available: http://www.sccjr.ac.uk/documents/Report%202010_04%20-%20User%20Views%20of%20Punishment.pdf [accessed 16.09.11]</p>
<p>Askew, R., John, P. and Liu, H. (2010). Can policy makers listen to researchers? An application of the design experiment methodology to a local drugs policy intervention. <u>Policy and Politics</u> 38 (4) 583-598.</p>
<p>Ayres, R. M., Eveson, L., Ingram, J. and Telfer, M. (2011). Treatment experience and needs of older drug users in Bristol, UK. <u>Journal of Substance Use</u> (early online access).</p>
<p>Barnard, M. and Barlow, J. (2003). Discovering Parental Drug Dependence Silence and Disclosure. <u>Children and Society</u> 17 45-56.</p>
<p>Barnard, M. and McKeganey, N. (2004). The impact of parental problem drug use on children: what is the problem and what can be done to help? <u>Addiction</u> 99 (5) 552-559.</p>

<p>Bennett, T. and Holloway, K. (2011). <u>Evaluation of the Take Home Naloxone Demonstration Project</u>. Welsh Assembly Government, Cardiff. Available: http://wales.gov.uk/docs/caecd/research/110627naloxonefinalreporten.doc [accessed 01.08.11]</p>
<p>Best, D., Rome, A., Hanning, K. A., White, W., Gossop, M., Taylor, A. and Perkins, A. (2010a). <u>Research for Recovery: A Review of the Drugs Evidence Base</u>. Scottish Government, Edinburgh. Available: http://www.scotland.gov.uk/Publications/2010/08/18112230/0 [accessed 29.09.10]</p>
<p>Best, D., Bamber, S., Battersby, A., Gilman, M., Groshkova, T. et al. (2010b). Recovery and Straw Men: An Analysis of the Objections Raised to the Transition to a Recovery Model in UK Addiction Services. <u>Journal of Groups in Addiction & Recovery</u> 5 (3) 264-288.</p>
<p>Bird, S. (2005). Random mandatory drugs testing of prisoners. <u>The Lancet</u> 365 (9469) 1,451-1,452.</p>
<p>Bird, S. M. and Robertson, J. R. (2011). Toxicology of Scotland's drugs-related deaths in 2000–2007: Presence of heroin, methadone, diazepam and alcohol by sex, age-group and era. <u>Addiction Research and Theory</u> 19 (2) 170–178.</p>
<p>Birdwell, J., Chapman, J. and Singleton, N. (2011). <u>Taking drugs seriously: a DEMOS and UK Drug Policy Commission report on legal highs</u>. UK Drug Policy Commission and DEMOS, London. Available: http://www.ukdpc.org.uk/resources/Taking_Drugs_Seriously.pdf [accessed 05.05.11]</p>
<p>Blagrove, M., Seddon, J., George, S., Parrott, A. C., Stickgold, R., Walker, M. P., Jones, K. A. and Morgan, M. J. (2010). Procedural and Declarative Memory Task Performance and the Memory Consolidation Function of Sleep in Recent and Abstinent Ecstasy/MDMA Users. <u>Journal of Psychopharmacology</u> 25 (4) 465-477.</p>
<p>Bonnell, C., Sorhaindo, A., Strange, V., Wiggins, M., Allen, E., Fletcher, A. et al. (2010a). A pilot whole-school intervention to improve school ethos and reduce substance use. <u>Health Education</u> 110 (4).</p>
<p>Bonnell, C., Sorhaindo, A., Allen, E., Strange, V. and Wiggins, M. (2010b). Pilot multimethod trial of a school-ethos intervention to reduce substance use: Building hypotheses about upstream pathways to prevention. <u>Journal of Adolescent Health</u> 47 (6) 555-563.</p>
<p>Braden, M., McGowan, I. W., McLaughlin, D. F., McKenna, H. P., Keeney, S. and Quinn, B. (2010). Users, carers and professionals experiences of treatment and care for heroin dependency: Implications for practice. A preliminary study. <u>Journal of Substance Use</u> (early online access).</p>
<p>Bradley, K. (2009). <u>The Bradley Report</u>. Department of Health, London. Available: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf [accessed 14.09.11]</p>
<p>Brandon, M., Bailey, S. and Belderson, P. (2010). <u>Building on the learning from serious case reviews: A two-year analysis of child protection database notifications 2007-2009</u>. DfE, London. Available: https://www.education.gov.uk/publications/eOrderingDownload/DFE-RR040.pdf [accessed 05.05.11]</p>

<p>Burgess, A. P., Venables, L., Jones, H., Edwards, R. and Parrott, A. C. (2011). Event related potential (ERP) evidence for selective impairment of verbal recollection in abstinent recreational methylenedioxymethamphetamine (“Ecstasy”)/ polydrug users. <u>Psychopharmacology</u> 216 (4) 545-556.</p>
<p>Carhart-Harris, R. L. and Nutt, D. J. (2010). A web-based survey on mephedrone. <u>Drug and Alcohol Dependence</u> 118 (1) 19-22.</p>
<p>Casey, J., Hay, G., Godfrey, C. and Parrott, S. (2009). <u>Assessing the scale and impact of illicit drug markets in Scotland</u>. Scottish Government Social Research. Available: http://www.scotland.gov.uk/Publications/2009/10/06103906/0 [accessed 28.10.09]</p>
<p>CCEA (Council for the Curriculum, Examinations and Assessments) (2011). <u>Development Key Stage 3 Non Statutory Guidance for Personal Development</u>. Council for the Curriculum, Examinations and Assessments, Belfast. Available: http://www.nicurriculum.org.uk/docs/key_stage_3/areas_of_learning/non_statutory/k_s3_PD_ns_guidance_Aug2011.pdf [accessed 05.09.11]</p>
<p>Centre for Drug Misuse Research (2006). <u>Estimating the Prevalence of Problem Opiate and Problem Cocaine Use in Northern Ireland</u>. Drug and Alcohol Information and Research Unit, Department of Health, Social Services and Public Safety Northern Ireland, Belfast. Available: http://www.dhsspsni.gov.uk/opiate_cocaine.pdf [accessed 21.05.10]</p>
<p>Chambers, M. (2010). <u>Coming Clean: Combating Drug Misuse in Prisons</u>. Policy Exchange, London. Available: http://www.policyexchange.org.uk/images/publications/pdfs/Coming_Clean_-_Jun_10.pdf [accessed 15.09.10]</p>
<p>Chaplin, R., Flatley, J. and Smith, K. (Eds.) (2011). <u>Crime in England and Wales 2010/11: Findings from the British Crime Survey and police recorded crime (First Edition)</u>. Home Office, London. Available: http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb1011/hosb1011?view=Binary [accessed 19.08.11]</p>
<p>Chatwin, C. (2011). User involvement in the illegal drugs field: what can Britain learn from European experiences? <u>Safer Communities</u> 9 (4) 51-59.</p>
<p>The Children (Northern Ireland) Order 1995. Her Majesty’s Stationery Office, London. Available: http://www.legislation.gov.uk/nisi/1995/755/contents/made [accessed 05.05.11]</p>
<p>The Children (Scotland) Act 1995. Her Majesty’s Stationery Office, London. Available: http://www.legislation.gov.uk/ukpga/1995/36/contents [accessed 05.05.11]</p>
<p>The Children Act 1989. Her Majesty’s Stationery Office, London. Available: http://www.legislation.gov.uk/ukpga/1989/41/contents [accessed 05.05.11]</p>
<p>The Children Act 2004. The Stationery Office, London. Available: http://www.legislation.gov.uk/ukpga/2004/31/contents [accessed 05.05.11]</p>
<p>CJI (Criminal Justice Inspectorate) Northern Ireland (2010). <u>Northern Ireland Prison Service Corporate Governance Arrangements</u>. Criminal Justice Inspectorate (Northern Ireland) Available: http://www.niprisonservice.gov.uk/module.cfm/opt/5/area/Publications/page/publicati</p>

ons/archive/false/download/true/id/495 [accessed 17.03.11]
CMACE (Centre for Maternal and Child Enquiries) (2011). <u>Saving Mothers' Lives Reviewing maternal deaths to make motherhood safer: 2006–2008. The Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom.</u> Centre for Maternal and Child Enquiries. Available: http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2010.02847.x/pdf [accessed 05.05.11]
Cole, C., Jones, L., McVeigh, J., Kicman, A., Syedc, Q. and Bellis, M. (2010). Adulterants in illicit drugs: a review of empirical evidence. <u>Drug Testing and Analysis</u> 3 (2) 89-96.
Constantinou, N., Morgan, C. J. A., Battistella, S., O'Ryan, D., Davis, P. and Curran, V. H. (2010). Attentional bias, inhibitory control and acute stress in current and former opiate addicts. <u>Drug and Alcohol Dependence</u> 109 (1-3) 220-225.
Cooper, R. (2011). <u>Respectable Addiction: A qualitative study of over the counter medicine abuse in the UK.</u> School of Health and Related Research (SchHARR) University of Sheffield, Sheffield. Available: http://www.pprrt.org.uk/Documents/respectable_addiction_richard_cooper_2011.pdf [accessed 10.10.11]
Corkery, J. M., Schifano, F., Oyefeso, A., Ghodse, A. H., Tonia, T., Naidoo, V. and Button, J. (2010). 'Bundle of fun' or 'bunch of problems'? Case series of khat-related deaths in the UK. <u>Drugs: Education, Prevention, and Policy</u> (early online access)
Cornish, R., Macleod, J., Strang, J., Vickerman, P. and Hickman, M. (2010). Risk of death during and after opiate substitution treatment in primary care: Prospective observational study in UK General Practice Research Database. <u>British Medical Journal</u> 341 (7779) 5475.
The Criminal Justice and Licensing Act (Scotland) 2010. Available: http://www.legislation.gov.uk/asp/2010/13/contents [accessed 05.05.11]
Cusick, L., Brooks-Gordon, B., Campbell, R. and Edgar, F. (2011). 'Exiting' drug use and sex work: Career paths, interventions and government strategy targets. <u>Drugs: Education, Prevention, and Policy</u> 18 (2) 145-156.
Dargan, P., Albert, S. and Wood, D. M. (2010). Mephedrone use and associated adverse effects in school and college/university students before the UK legislation change. <u>QJM: An International Journal of Medicine</u> 103 (11) 875-879.
Davies, R. and Cameron, J. (2010). Self-identified occupational competencies, limitations and priorities for change in the occupational lives of people with drug misuse problems. <u>British Journal of Occupational Therapy</u> 73 (6) 251-260.
Day, E. and Strang, J. (2010) Outpatient versus inpatient opioid detoxification: A randomised controlled trial. <u>Journal of Substance Abuse Treatment</u> 40 (1) 56-66.
DCSF (Department for Children, Schools and Families) (2007). <u>The Children's Plan: Building brighter futures.</u> Department for Children, Schools and Families, London. Available: https://www.education.gov.uk/publications/eOrderingDownload/The_Childrens_Plan .

pdf [accessed 20.07.11]
DCSF (Department for Children, Schools and Families) (2009). <u>Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-07</u> . Department for Children, Schools and Families, London. Available: https://www.education.gov.uk/publications/eOrderingDownload/DCSF-RR129(R).pdf [accessed 27.05.11]
DCSF (Department for Children, Schools and Families) (2010). <u>Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children</u> . Department for Children, Schools and Families, London. Available: https://www.education.gov.uk/publications/eOrderingDownload/00305-2010DOM-EN.PDF [accessed 27.05.11]
DCSF and DH/NTA (2009). <u>Joint Guidance on Development of Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services</u> . Department for Children, Schools and Families, London. Available: http://webarchive.nationalarchives.gov.uk/20100202100434/http://www.dcsf.gov.uk/everychildmatters/download/?id=7211 [accessed 05.05.11]
DfE (Department for Education) (2010). <u>The Importance of Teaching The Schools White Paper 2010</u> . Department for Education, London. Available: https://www.education.gov.uk/publications/eOrderingDownload/CM-7980.pdf [accessed 05.05.11]
DfES (Department for Education and Skills) (2005). <u>Government Response to Hidden Harm: the Report of an Inquiry by the Advisory Council on the Misuse of Drugs</u> . Department for Education and Skills, London. Available: https://www.education.gov.uk/publications/eOrderingDownload/DfES-1208-2005.pdf [accessed 05.05.11]
DH (Department of Health) (2001). <u>The Government Response to the Advisory Council on the Misuse of Drugs Report into Drug Related Deaths</u> . Department of Health, London. Available: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4015217 [accessed 13.05.11]
DH (Department of Health) (2002a). <u>Mental health policy implementation: dual diagnosis and good practice</u> . Department of Health, London. Available: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009058 [accessed 12.05.11]
DH (Department of Health) (2002b). <u>Models of care for substance misuse treatment: promoting quality, efficiency and effectiveness in drug misuse treatment services</u> . Department of Health, London. Available: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008118 [accessed 12.05.11]
DH (Department of Health) (2003). <u>Dangerousness of Drugs - A guide to the risks and harms associated with substance misuse</u> . Department of Health, London. Available: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4086293.pdf [accessed 23.07.11]

<p>DH (Department of Health) (2004). <u>Hepatitis C Action Plan for England</u>. Department of Health, London. Available: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084521 [accessed 20.05.11]</p>
<p>DH (Department of Health) (2006). <u>Clinical management of drug dependence in the adult prison setting</u>. Department of Health, London. Available: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063064 [accessed 05.04.11]</p>
<p>DH (Department of Health) (2010). <u>Attitudes to Mental Illness 2010 Research Report</u>. Department of Health, London. Available: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_114795 [accessed 01.09.11]</p>
<p>DH (Department of Health) (2011a). <u>Prison Health Performance and Quality Indicators 2011: Guidance notes</u>. Department of Health, London. Available: http://offenderhealth.org.uk/default.aspx?id=2587&tabid=1110 [accessed 17.03.11]</p>
<p>DH (Department of Health) (2011b). <u>The operating framework for the NHS in England 2011/12</u>. Department of Health, London. Available: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122736.pdf [accessed 10.08.11]</p>
<p>DH (Department of Health) and DfES (Department for Education and Skills) (2004). <u>National Service Framework for Children, Young People and Maternity Services</u>. Department of Health, London. Available: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4090523.pdf [accessed 05.05.11]</p>
<p>DH (Department of Health) (England) and the devolved administrations (2007). <u>Drug Misuse and Dependence: UK Guidelines on Clinical Management</u>. Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive, London. Available: http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf [accessed 09.05.11]</p>
<p>DH (Department of Health) and HO (Home Office) (2007). <u>National Partnership Agreement between the Department of Health and the Home Office for the accountability and commissioning of health services for prisoners in public sector prisons in England</u>. Department of Health, London. Available: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_064097.pdf [accessed 17.03.11]</p>
<p>DH (Department of Health) and MOJ (Ministry of Justice) (2009). <u>Prisons Integrated Drug Treatment System Continuity of Care guidance</u>. Department of Health, London. Available: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_064097.pdf [accessed 11.04.11]</p>
<p>DH (Department of Health) and NTA (National Treatment Agency for Substance Misuse) (2007). <u>Reducing Drug-related Harm: An Action Plan</u>. Available: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_074846.pdf [accessed 27.10.11]</p>

<p>DHSSPSNI (Department of Health, Social Services and Public Safety Northern Ireland) (2006). <u>New Strategic Direction for Alcohol and Drugs (2006 – 2011)</u>. Department of Health, Social Services and Public Safety Northern Ireland, Belfast. Available: http://www.dhsspsni.gov.uk/nsdad-finalversion-may06.pdf [accessed 05.05.11]</p>
<p>DHSSPSNI (Department of Health, Social Services and Public Safety Northern Ireland) (2007). <u>Action Plan for the Prevention, Management and Control of Hepatitis C in Northern Ireland</u>. Department of Health, Social Services and Public Safety Northern Ireland, Belfast. Available: http://www.dhsspsni.gov.uk/hepatitisc-actionplan-2007.pdf [accessed 20.09.11]</p>
<p>DHSSPSNI (Department of Health, Social Services and Public Safety Northern Ireland) (2008). <u>Regional Hidden Harm Action Plan</u>. Department of Health, Social Services and Public Safety Northern Ireland, Belfast. Available: http://www.dhsspsni.gov.uk/regional_hidden_harm_action_plan.pdf [accessed 03.03.11]</p>
<p>DHSSPSNI (Department of Health, Social Services and Public Safety Northern Ireland) (2010). <u>New Strategic Direction for Alcohol and Drugs: NSD Update</u>. Department of Health, Social Services and Public Safety Northern Ireland, Belfast. Available: http://www.dhsspsni.gov.uk/nsd_update_report_-_april_2010.pdf [accessed 09.09.11]</p>
<p>Dibben, C., Atherton, I., Doherty, J. and Baldacchino, A. (2010). Differences in 5-year survival after a 'homeless' or 'housed' drugs-related hospital admission: a study of 15-30-year olds in Scotland. <u>Journal of Epidemiology Community Health</u> (early online access).</p>
<p>Dodsworth, J. (2011) Pathways through Sex Work: Experiences and Adult Identities Childhood. <u>British Journal of Social Work</u> (early online access).</p>
<p>The Drugs Act 2005. The Stationery Office, London. Available: http://www.legislation.gov.uk/ukxi/2005/3053/contents/made [accessed 05.05.11]</p>
<p>Drugscope (2010). <u>Pathways to employment in London: A guide for drug and alcohol services</u>. Drugscope, London. Available: http://www.ldan.org.uk/ [accessed 05.05.11]</p>
<p>Drugscope (2011). Housing for recovery. Findings from a survey on access to housing on behalf of the Recovery Partnership. Drugscope, London. Available: http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/RecoveryPartnershipHousingPullout.pdf [accessed 21.09.11]</p>
<p>Drummond, C. (2004). <u>The effectiveness and cost effectiveness of cognitive behaviour therapy for opiate misusers in methadone maintenance treatment: a multicentre, randomised, controlled trial. Executive Summary</u>. DMRI, Department of Health, London. Available: http://dmri.lshtm.ac.uk/docs/drummond_es.pdf [accessed 15.09.11]</p>
<p>Dryden, C., Young, D., Hepburn, M. and Mactier, H. (2009). Maternal methadone use in pregnancy: factors associated with the development of neonatal abstinence syndrome and implications for healthcare resources. <u>BJOG: An International Journal of Obstetrics and Gynaecology</u> 116 (5) 665–671.</p>

<p>Duffy, P., Shaw, C., Woolfall, K., McVeigh, J. and Beynon, C. (2009). Estimating the numbers of children of problematic drug users and their residential circumstances to inform United Kingdom research, policy and practice. <u>Drugs: Education, Prevention and Policy</u> 17 (5) 470-484.</p>
<p>Durham, M. (2011). Ivory wave: the next mephedrone? <u>Emergency Medicine Journal</u> (early online access).</p>
<p>DWP (Department for Work and Pensions) (2011). <u>Welfare Reform Bill 2010-11</u>. Department for Work and Pensions, London. Available: http://services.parliament.uk/bills/2010-11/welfarereform.html [accessed 05.05.11]</p>
<p>Ershce, K. D., Barnes, A., Jones, S. P., Morein-Zamir, S., Robinns, T. W. and Bullmore, E. T. (2011). Abnormal structure of frontostriatal brain systems is associated with aspects of impulsivity and compulsivity in cocaine dependence. <u>Brain: A Journal of Neurology</u> 134 2013-2024.</p>
<p>Fisk, J. E., Murphy, P. N., Montgomery, C. and Hadjiefthyvoulou, F. (2011). Modelling the adverse effects associated with ecstasy (MDMA) usage. <u>The Open Addiction Journal</u> 4 30-31.</p>
<p>Fletcher, A., Bonell, C. and Sorhaindo, A. (2010). We don't have no drugs education: The myth of universal drugs education in English secondary schools? <u>International Journal of Drug Policy</u> 21 (6) 452-458.</p>
<p>Foëx, B. A., Subramanian, G. and Butler, J. M. (2010). Ecstasy overdose and memory loss. <u>Emergency Medicine Journal</u> 27 733.</p>
<p>Forrester, D. (2000). Parental Substance Misuse and Child Protection in a British Sample: A Survey of Children on the Child Protection Register in an Inner London District Office. <u>Child Abuse Review</u> 9 (4) 235-246.</p>
<p>Forrester, D. and Harwin, J. (2008). Parental Substance Misuse and Child Welfare: Outcomes for children two years after referral. <u>British Journal of Social Work</u> 38 1518–1535.</p>
<p>Forrester, D., Pokhrel, S., McDonald, L., Copello, A., Binne, C., Jensch, G., Waissbein, C and Giannou, D (2008). <u>Final Report on the evaluation of 'Option 2'</u>. Welsh Assembly Government, Cardiff. Available: http://wales.gov.uk/topics/housingandcommunity/research/safety/option2/?lang=en [accessed 07.10.11]</p>
<p>Freel, R., Quigley, D. and Toner, S. (2011). <u>Perceptions of Crime: Findings from the 2009/10 Northern Ireland Crime Survey Research and Statistical Bulletin 2/2011</u>. Department of Justice, Belfast. Available: http://www.dojni.gov.uk/index/statistics-research/stats-research-publications/perceptions_of_crime_-_findings_from_the_2009-10_northern_ireland_crime_survey.pdf [accessed 05.05.11]</p>

<p>Frontier Economics (2011). <u>Specialist drug and alcohol services for young people - a cost benefit analysis</u>. Department for Education, London. Available: https://www.education.gov.uk/publications/eOrderingDownload/DFE-RR087.pdf</p>
<p>Fuller, E. (2011). <u>Smoking, drinking and drug use among young people in England in 2010</u>. NHS Information Centre for Health and Social Care (ICNHS), London. Available: http://www.ic.nhs.uk/webfiles/publications/003_Health_Lifestyles/Smoking%20drinking%20drug%20use%202010/Smoking_drinking_and_drug_use_among_young_people_in_England_2010_Full_report.pdf [accessed 28.07.11]</p>
<p>Galavani, S. and Forrester, D. (2011a). <u>Social Work Services and Recovery from Substance Misuse: A Review of the Evidence</u>. Scottish Government, Edinburgh. Available: http://www.scotland.gov.uk/Publications/2011/03/18085806/0 [accessed 25.03.11]</p>
<p>Galavani, S. and Forrester, D. (2011b). <u>Social Work Services and Recovery from Substance Misuse: A Review of the Evidence. Practitioners' Briefing</u>. Scottish Government, Edinburgh. Available: www.adsw.org.uk/doc_get.aspx?DocID=416 [accessed 25.03.11]</p>
<p>Galvani, S. and Hughes, N. (2010). Working with Alcohol and Drug Use: Exploring the Knowledge and Attitudes of Social Work Students. <u>British Journal of Social Work</u> 40 946-962.</p>
<p>Ghetau, E., Bloor, R. and Firth, A. Y. (2009). Identification of strabismus in children born to mothers misusing substances during pregnancy: A clinical and research challenge. <u>Drugs: education, prevention and policy</u> 16 (1) 88-93.</p>
<p>Glasgow Addiction Services (2011). <u>Persistent Offender Project: An analysis of the costs and benefits</u>. Available: http://www.glasgow.gov.uk/NR/rdonlyres/C38FBB8E-A20F-4B57-962C-A876CD098B2B/0/GASPersistentOffenderProjectAnalysisofcosts.pdf [accessed 14.09.11]</p>
<p>Goodman, A. (2010). Substance use and common child mental health problems: examining longitudinal associations in a British sample. <u>Addiction</u> 105 (8) 1484-1496.</p>
<p>Gordon, L., Tinsley, L., Godfrey, C. and Parrott, S. (2006). <u>The economic and social costs of Class A drug use in England and Wales, 2003/04</u>. In Singleton, N., Murray, R. and Tinsley, L (eds). <u>Measuring different aspects of problem drug use: methodological developments</u>. Home Office Online Report. Home Office, London. Available: http://www.homeoffice.gov.uk/rds/pdfs06/rdsolr1606.pdf [accessed 05.05.11]</p>
<p>Gorodetzky, H., Sahakian, B. J., Robbins, T. W. and Ersche, K. D. (2010). Differences in decision-making styles in stimulant-dependent and opiate-dependent individuals. <u>Psychiatry Research</u> 186 437-440.</p>
<p>Gossop, M. Stewart, D., Treacy, S. and Marsden, J. (2002). A prospective study of mortality among drug misusers during a 4-year period after seeking treatment. <u>Addiction</u> 97 (1) 39-47.</p>

<p>Graham, L. Matthews, S., Dunbar, J. K. and Stoner, N. (2011). <u>The National Drug Related Deaths Database (Scotland) Report 2009</u>. Information Services Division, National Health Service Scotland, Edinburgh. Available: http://www.drugmisuse.isdscotland.org/publications/local/NDRDD_2009.pdf [accessed 06.02.11]</p>
<p>GROS (General Register Office for Scotland) (2010). <u>Drug Related Deaths in Scotland in 2009</u>. The General Register Office for Scotland, Edinburgh. Available: http://www.gro-scotland.gov.uk/statistics/theme/vital-events/deaths/drug-related/drd2009/index.html [accessed 27.10.11]</p>
<p>GROS (General Register Office for Scotland) (2011). <u>Drug Related Deaths in Scotland in 2010</u>. The General Register Office for Scotland, Edinburgh. Available: http://www.gro-scotland.gov.uk/statistics/theme/vital-events/deaths/drug-related/2010/index.html [accessed 27.10.11]</p>
<p>Gyngell, K. (2011). <u>Breaking the Habit</u>. Centre for Policy Studies, Surrey. Available: http://www.cps.org.uk/cps_catalog2/breaking%20the%20habit.pdf [accessed 15.09.11]</p>
<p>Hadjiefthyvoulou, F., Fisk, J. E., Montgomery, C. and Bridges, N. (2011). Prospective memory functioning among ecstasy/polydrug users: evidence from the Cambridge Prospective Memory Test (CAMPROMPT). <u>Psychopharmacology</u> (early online access).</p>
<p>Hamilton, R., McGlone, L., MacKinnon, J. R., Russell, H.C., Bradnam, M.S. and Mactier, H. (2010). Ophthalmic, clinical and visual electrophysiological findings in children born to mothers prescribed substitute methadone in pregnancy. <u>British Journal of Ophthalmology</u>. (early online access)</p>
<p>Harwin, J., Ryan, M., Tunnard, J., Pokhrel, S., Alrouh, B., Matias, C. and Momenian-Schneider (2011). <u>The Family Drug & Alcohol Court (FDAC) Evaluation Project Final Report (executive summary)</u>. Brunel University, London. Available: http://www.brunel.ac.uk/7067/FDAC/FDACEVALUATIONFINALREPORTEXECUTIVESUMMARYMay2011.pdf [accessed 24.05.11]</p>
<p>HAS (Health Advisory Service) (2001). <u>Substance misuse and mental health co-morbidity (dual diagnosis)</u>. Standards for Mental Health Services. Health Advisory Service, London. Available: http://www.dualdiagnosis.co.uk/uploads/documents/originals/Health%20Advisory%20Service%20-%20Standards%20for%20Dual%20Diagnosis%20Servi.pdf [accessed 26.09.11]</p>
<p>Hay, G. and Bauld, L. (2008). <u>Population estimates of problematic drug users in England who access DWP benefits: A feasibility study</u>. Department for Work and Pensions, London. Available: http://research.dwp.gov.uk/asd/asd5/WP46.pdf [accessed 26.09.11]</p>
<p>Hay, G., Gannon, M., McKeganey, N., Hutchinson, S. and Goldberg, D. (2004). <u>Estimating the national and local prevalence of problem drug misuse in Scotland</u>. Centre for Drug Misuse Research, University of Glasgow and Scottish Centre for Infection and Environmental Health, Glasgow. Available: http://www.drugmisuse.isdscotland.org/publications/abstracts/prevalence3.htm [accessed 21.05.10]</p>

<p>Hay, G., Gannon, G., MacDougall, J., Millar, T., Eastwood, C. and McKeganey, N. (2006). <u>Local and national estimates of the prevalence of opiate use and/or crack cocaine use</u> (2004/05). In Singleton, N., Murray, R. and Tinsley L. Measuring different aspects of problem drug use: methodological developments. Home Office Online Report 16/06. Home Office, London. Available: http://rds.homeoffice.gov.uk/rds/pdfs06/rdsolr1606.pdf [accessed 21.05.10]</p>
<p>Hay, G., Gannon, M., MacDougall, J., Millar, T., Eastwood, C. and McKeganey, N. (2007). <u>National and regional estimates of the prevalence of opiate use and/or crack cocaine use 2005/06: a summary of key findings</u>. Home Office Online Report 21/07. Home Office, London. Available: http://rds.homeoffice.gov.uk/rds/pdfs07/rdsolr2107.pdf [accessed 21.05.10]</p>
<p>Hay, G., Gannon, M., MacDougall, J., Millar, T., Williams, K., Eastwood, C. and McKeganey, N. (2008). <u>National and regional estimates of the prevalence of opiate use and/or crack cocaine use 2006/07: a summary of key findings</u>. Home Office Research Report 9. Home Office, London. Available: http://rds.homeoffice.gov.uk/rds/pdfs08/horr09.pdf [accessed 21.05.10]</p>
<p>Hay, G., Gannon, M., Casey, J. and McKeganey, N. (2009). <u>Estimating the National and Local Prevalence of Problem Drug Misuse in Scotland</u>, Executive Report. University of Glasgow, Glasgow. Available: http://www.drugmisuse.isdscotland.org/publications/local/Prevalence_2009.pdf [accessed 21.05.10]</p>
<p>Hay, G., Gannon, M., Casey, J. and Millar, T. (2010a). <u>Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2008/09: Sweep 5 report</u>. University of Glasgow, Glasgow. Available: http://www.nta.nhs.uk/uploads/glasgowprevalencestudysweep5-technicalreport2008-09[0].pdf [accessed 07.10.10]</p>
<p>Hay, G., Gannon, M., Casey, J. and Millar, T. (2010b). <u>National and regional estimates of the prevalence of opiate and/or crack cocaine use 2008–09: a summary of key findings</u>. National Treatment Agency for Substance Misuse, London. Available: http://www.nta.nhs.uk/uploads/summaryprevalenceestimates2008-2009.pdf [accessed 21.09.2010]</p>
<p>Hay, G., Gannon, M., Casey, J. and Millar, T. (2011a). <u>National and regional estimates of the prevalence of opiate and/or crack cocaine use 2009-10: a summary of key findings</u>. National Treatment Agency for Substance Misuse, London. Available: http://www.nta.nhs.uk/uploads/prevalencesummary0910.pdf [accessed 05.09.11]</p>

<p>Hay, G., Gannon, M., Casey, J. and Millar, T. (2011b). <u>Estimates of the prevalence of opiate and/or crack cocaine use 2009-10: Sweep 6 report</u>. National Treatment Agency for Substance Misuse, London. Available: http://www.nta.nhs.uk/uploads/prevalencestats2009-10fullreport.pdf [accessed 05.09.11]</p>
<p>Health Protection Scotland (HPS) (2010). <u>Scotland's Hepatitis C Action Plan Phase II: Progress Report Year Two (2009/10)</u>. Available: http://www.hepcscotland.co.uk/media/50321/happii-second-yr-annual-report-2010-11.pdf [accessed 01.12.10]</p>
<p>Heather, N., Paton, J. and Ashton, H. (2011). Predictors of response to brief intervention in general practice against long-term benzodiazepine use. <u>Addiction Research and Theory</u> (early online access)</p>
<p>HM (Her Majesty's) Government (2003). <u>Every Child Matters: Green Paper</u>. Her Majesty's Government, London. Available: http://www.education.gov.uk/consultations/downloadableDocs/EveryChildMatters.pdf [accessed 05.05.11]</p>
<p>HM (Her Majesty's) Government (2005). <u>Every Child Matters: Change for Children Young People and Drugs</u>. Her Majesty's Government, London. Available: http://www.capic.org.uk/documents/every-child-matters-change-for-children-young-people-and-drugs.pdf [accessed 05.05.11]</p>
<p>HM (Her Majesty's) Government (2008). <u>Drugs: protecting families and communities. The 2008 drug strategy</u>. Her Majesty's Government, London. Available: http://webarchive.nationalarchives.gov.uk/20100419081707/http://drugs.homeoffice.gov.uk/publication-search/drug-strategy/drug-strategy-2008 [accessed 29.03.09]</p>
<p>HM (Her Majesty's) Government (2010a). <u>Drug Strategy 2010. Reducing demand, restricting supply, building recovery</u>. Her Majesty's Government, London. Available: http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-strategy/drug-strategy-2010?view=Binary [accessed 09.05.11]</p>
<p>HM (Her Majesty's) Government (2010b). <u>Drug Strategy 2010: Summary of the consultation responses. A report of the drug strategy consultation document</u> Her Majesty's Government. Available: http://www.homeoffice.gov.uk/publications/consultations/cons-drug-strategy-2010/consultation-responses?view=Binary [accessed 13.09.11]</p>
<p>HM (Her Majesty's) Government (2011a). <u>The Government's Response to the Reports by Sir Peter North CBE QC and the Transport Select Committee on Drink and Drug Driving</u>. Her Majesty's Government, London. Available: http://www.dft.gov.uk/pgr/roadsafety/drivinglaws/govtresponse/pdf/report.pdf [accessed 09.05.11]</p>
<p>HM (Her Majesty's) Government (2011b). <u>No health without mental health. A cross-government mental health outcomes strategy for people of all ages</u>. Department of Health, London. Available: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766 [accessed 18.04.11]</p>

<p>HM (Her Majesty's) Government and DCSF (2010). <u>England: Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children</u>. Her Majesty's Government, London. Available: http://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00305-2010 [accessed 03.03.11]</p>
<p>HMIP (Her Majesty's Inspectorate of Prisons) (2011). <u>Annual Report 2010-11</u>. HMIP, London. Available: http://www.justice.gov.uk/downloads/publications/corporate-reports/hmi-prisons/hmip-annual-report-2010-11.pdf [accessed 12.10.11]</p>
<p>HM Prison Service and NHS Executive. (1999). <u>The future organisation of prison healthcare</u>. HM Prison Service and NHS Executive, London. Available: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4106031.pdf [accessed 15.03.11]</p>
<p>HMPS (Her Majesty's Prison Service) (2005). <u>Mandatory Drug Testing. PSO 3601</u>. Her Majesty's Prison Service, London. Available: http://pso.hmprisonservice.gov.uk/PSO_3601_mandatory_drugs_testing.doc [accessed 11.04.11]</p>
<p>Hoare, J. and Moon, D. (Editor) (2010). <u>Drug Misuse Declared: Findings from the 2009/10 British Crime Survey. England and Wales</u>. Home Office, London. Available: http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb1310/ [accessed 16.09.10]</p>
<p>Holloway, K. and Bennett, T. (2011). Prescription drug misuse among university staff and students: A survey of motives, nature and extent. <u>Drugs: Education, Prevention, and Policy</u> (early online access)</p>
<p>Home Office (2002). <u>Updated Drug Strategy 2002</u>. Home Office, London. Available: http://www.ukcia.org/research/UpdatedDrugStrategy2002.pdf [accessed 05.09.11]</p>
<p>Home Office (2007). <u>The Corston Report: Executive summary</u>. Home Office, London. Available: http://webarchive.nationalarchives.gov.uk/+http://www.homeoffice.gov.uk/documents/corston-report/corston-exec-summary?view=Binary [accessed 17.03.11]</p>
<p>Home Office (2010a). <u>Drug Interventions Programme Operational Handbook</u>. Home Office, London. Available: http://www.homeoffice.gov.uk/publications/crime/reducing-reoffending/DIP-Operational-Handbook?view=Binary [accessed 31.08.11]</p>
<p>Home Office (2010b). <u>Drug-misusing offenders: results from the 2009 cohort for England and Wales</u>. Home Office, London. Available: http://webarchive.nationalarchives.gov.uk/20110218135832/rds.homeoffice.gov.uk/rds/pdfs10/misc0410.pdf [accessed 10.06.11]</p>
<p>Home Office (2011a). <u>Drug Interventions Programme: Introducing locally funded drug testing on arrest (and associated interventions)</u>. Home Office, London. Available: http://www.homeoffice.gov.uk/publications/crime/reducing-reoffending/Introducing-Locally-Funded-DTOA?view=Binary [accessed 31.08.11]</p>

<p>Home Office (2011b). <u>How to conduct an evaluation of DIP in your area</u>. Home Office, London. Available: http://www.homeoffice.gov.uk/publications/crime/reducing-reoffending/DIP-Impact-Toolkit?view=Binary [accessed 31.08.11]</p>
<p>Hough, M., Clancy, A., McSweeney, T. and Turnbull, P.J. (2003) <u>The Impact of Drug Treatment and Testing Orders on offending: two year reconviction results</u>. Home Office Research Findings No. 184. Home Office, London. Available: http://webarchive.nationalarchives.gov.uk/20110220105210/http://rds.homeoffice.gov.uk/rds/rf2003.html [accessed 31.08.11]</p>
<p>House of Commons Transport Committee (2010). <u>Drink and drug driving law</u>. House of Commons, London. Available: http://www.publications.parliament.uk/pa/cm201011/cmselect/cmtran/460/460.pdf [accessed 09.05.11]</p>
<p>HPA (Health Protection Agency) (2010). <u>Tuberculosis in the UK: Annual report on tuberculosis surveillance in the UK, 2010</u>. Health Protection Agency, London. Available: http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1287143594275 [accessed 17.10.11]</p>
<p>HPA (Health Protection Agency) (2011a). <u>Health Protection Agency, Health Protection Services and Microbiology Services. Unlinked Anonymous Monitoring Survey of Injecting Drug Users in Contact with Specialist Services</u>. Health Protection Agency, London. Available: www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1202115519183 [accessed 17.10.11]</p>
<p>HPA (Health Protection Agency) (2011b). <u>Anonymous Unlinked anonymous HIV and viral hepatitis monitoring among IDUs: 2011 update</u>. Health Protection Report . Health Protection Agency, London. Available: http://www.hpa.org.uk/hpr/archives/2011/hpr3011.pdf [accessed 17.10.11]</p>
<p>HPA (Health Protection Agency) (2011c). <u>Health protection in prisons: 2009-2010 report</u>. Health Protection Agency, London. Available: http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1296682990869 [accessed 06.06.11]</p>
<p>HPA (Health Protection Agency), HPS (Health Protection Scotland), Public Health Wales, and Public Health Agency Northern Ireland. (2011). <u>Shooting Up: Infections among people who inject drugs in the United Kingdom 2010</u>. Health Protection Agency, London. Available: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/InjectingDrugUsers/GeneralInformation/idu_ShootingUp/ [accessed 31.10.11]</p>
<p>HPS (Health Protection Scotland) (2010). <u>Enhanced Surveillance of Mycobacterial Infections (ESMI) in Scotland: 2010 tuberculosis annual report for Scotland</u>. HPS Weekly Report Volume 44 No. 2010/5015 December 2010, HPS, Online publication. Available: http://www.documents.hps.scot.nhs.uk/ewr/pdf2010/1050.pdf [accessed 17.10.11]</p>
<p>Hughes, K., Bellis, M., Calafat, A., Blay, N., Kokkevi, A., Boyiadji, G., Mendes, M. and Bajcarova, L. (2011). Substance use, violence, and unintentional injury in young holidaymakers visiting Mediterranean destinations. <u>Journal of Travel Medicine</u> 18 (2) 80-89</p>

<p>ISD (Information Services Division) Scotland (2010). <u>Drug misuse statistics 2010</u>. Information Services Division, National Health Service Scotland, Edinburgh. Available: http://www.drugmisuse.isdscotland.org/publications/10dmss/10dmss.pdf [accessed 15.03.11]</p>
<p>ISD (Information Services Division) Scotland (2011). <u>Injecting Equipment Provision in Scotland, 2009/10</u>. Information Services Division, National Health Service Scotland, Edinburgh. Available: http://www.drugmisuse.isdscotland.org/publications/local/injecting_provision2011.pdf [accessed 27.07.11]</p>
<p>James, D., Adams, R. D., Spears, R., Cooper, G., Lupton, D.J., Thompson, J. P. and Thomas, S. H. L. (2010). Clinical characteristics of mephedrone toxicity reported to the UK National Poisons Information Service. <u>Emergency Medicine Journal</u> (early online access)</p>
<p>Johnsen, S. and Teixeira, L. (2010). <u>Staircases, Elevators and Cycles of Change 'Housing First' and Other Housing Models for Homeless People with Complex Support Needs Crisis London</u>. Available: http://www.york.ac.uk/inst/chp/publications/PDF/HousingModelsReport.pdf [accessed 05.05.11]</p>
<p>Jones, A., Donmall, M., Millar, T., Moody, A., Weston, S. Anderson, T. et al. (2009). <u>The Drug Treatment Outcomes Research Study (DTORS): Final outcomes report 3rd Edition</u>. Home Office Research Report 24. Home Office, London. Available: http://www.dtors.org.uk/reports/DTORS_Final_Main.pdf [accessed 28.05.11]</p>
<p>Jones, A., Weston, S., Moody, A., Millar, T., Dollin, L., Anderson, T. and Donmall. M. (2007). <u>The drug treatment outcomes research study (DTORS): baseline report. Research Report 3</u>. Home Office, London. Available: http://www.dtors.org.uk/reports/BaselineMain.pdf [accessed 22.05.11]</p>
<p>Jones, L., Bates, G., Bellis, M., Beynon, C., Duffy, P., Evans-Brown, M., Mackridge, A., McCoy, E. et al. (2011a). <u>A summary of the health harms of drugs</u>. Department of Health, London. Available: http://www.nta.nhs.uk/uploads/healthharmsfinal-v1.pdf [accessed 26.08.11]</p>
<p>Jones, L., Bates, G., Bellis, M., Beynon, C., Duffy, P., Evans-Brown, M., Mackridge, A., McCoy, E. et al. (2011b). <u>A summary of the health harms of drugs. Technical document</u>. Department of Health, London. Available: http://www.nta.nhs.uk/uploads/healthharmstechnicalfinal-v12.pdf [accessed 26.08.11]</p>
<p>Keaney, F., Gossop, M., Dimech, A., Guerrini, I., Butterworth, M., Al-Hassani, H. and Morinan, A. (2011). Physical health problems among patients seeking treatment for substance use disorders: A comparison of drug dependent and alcohol dependent patients. <u>Journal of Substance Use</u> 16(1) 27-37.</p>
<p>Kerr, J., Tompkins, C., Tomaszewski, W., Dickens, S., Grimshaw, R. et al. (2011). <u>The Dedicated Drug Courts Pilot evaluation process study</u>. Available: http://www.justice.gov.uk/publications/docs/ddc-process-evaluation-study.pdf [accessed 10.06.11]</p>

<p>King, R. and Best, D. (2011). Cognitive functioning and cognitive style among drug users in maintenance substitution treatment. <u>Drugs: Education, Prevention, and Policy</u> (early online access).</p>
<p>Klee H. (1998). Drug-using parents: analysing the stereotypes. <u>International Journal of Drug Policy</u> 9 (6) 437-448.</p>
<p>Klein (2011). Khat deaths – or the social construction of a non-existent problem? A response to Corkery et al. 'Bundle of fun' or 'bunch of problems'? Case series of khat-related deaths in the UK. <u>Drugs: education, prevention and policy</u> (early online access)</p>
<p>Kothari, G., Hardy, G. and Rowse, G. (2010). The therapeutic relationship between therapists and substance-using clients: A qualitative exploration. <u>Journal of Substance Use</u> 15(4) 257-271.</p>
<p>Kouimtsidis, C., Reynolds, M., Coulton, S. and Drummond, C. (2011). How does cognitive behaviour therapy work with opioid-dependent clients? Results of the UKCBTMM study. <u>Drugs: Education, Prevention and Policy</u> (early online access)</p>
<p>Kroll, B. and Taylor, A. (2009). <u>Interventions for children and families where there is parental drug misuse</u>. Department of Health, London Available: http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Good%20Practice/interventionsforkidssummary.pdf [accessed 03.03.11]</p>
<p>Leach, D. and Oliver, P. (2011). Drug-related deaths following release from prison: a brief review of the literature with recommendations for practice. <u>Current Drug Abuse Review</u> (early online access)</p>
<p>Leeds Safeguarding Children Board (2010). <u>Think Family: Valuing Parents and Improving Safeguarding for Children and Young People. Leeds joint working protocol for parents with substance misuse, mental health or dual diagnosis problem, to improve outcomes for children and young people living in these families</u>. Leeds Safeguarding Children Board, Leeds. Available: http://www.leedslscb.org.uk/documents/Local-Protocols/Think%20family_Aug%202010[1].pdf [accessed 07.05.11]</p>
<p>Linden, I. (2010). The effect of personal use and family history on the attitudes of medical students toward alcohol and drug users. <u>Journal of Substance Use</u> 15 (6) 377-389.</p>
<p>Litchfield, J., Maronge, A., Rigg, T., Rees, B., Harshey, R. and Keen, J. (2010). Can a targeted GP-led clinic improve outcomes for street sex workers who use heroin? <u>British Journal of General Practice</u> 60 (576) 514-6.</p>
<p>Lloyd, C. (2010). <u>Sinning and sinned against: The stigmatisation of problem drug users</u>. United Kingdom Drug Policy Commission, London. Available: http://www.ukdpc.org.uk/resources/Stigma_Expert_Commentary_final.pdf [accessed 07.05.11]</p>
<p>Long, C. G., Hall, L., Dolley, O. and Hollin, C. R. (2011). Substance-abusing women in a medium secure psychiatric setting: characteristics and psychometric test performance. <u>Journal of Substance Use</u> (early online access)</p>

<p>Long, C., Fulton, B., Fitzgerald, K-A. and Hollin, C. (2010). Group substance abuse treatment for women in secure services. <u>Mental Health and Substance Use: dual diagnosis</u> 3 (3) 227-237.</p>
<p>Lord Laming (2009). <u>The Protection of Children in England: a progress report</u>. The Stationery Office, London. Available: https://www.education.gov.uk/publications/eOrderingDownload/HC-330.pdf [accessed 28.06.11]</p>
<p>MacGregor, S (2011). The impact of research on policy in the drugs field. <u>Methodological Interventions Online</u> 6(1) 41-57. Available: http://www.pbs/plym.ac.uk/mi/pdf/09-06-11/7.%20Article%20-%20MacGregor%2041-57%20(Proofed).pdf [accessed 10.08.11]</p>
<p>Mackay, K., Taylor, M. and Bajaj, N. (2011). The adverse consequences of mephedrone use: a case series. <u>The Psychiatrist</u> 35 203-205.</p>
<p>Mackridge, A., Beynon, C., McVeigh, J., Whitfield, M. and Chandler, M. (2010). Meeting the health needs of problematic drug users through community pharmacy: A qualitative study. <u>Journal of Substance Use</u> 15 (6) 367-376.</p>
<p>MacLeod, P. and Page, L. (2011). <u>2009/10 Scottish Crime and Justice Survey: Drug Use</u>. Scottish Government, Edinburgh. Available: http://www.scotland.gov.uk/Publications/2011/01/21134813/0 [accessed 07.02.11]</p>
<p>Maguire, M. and Holloway, K. (2010). <u>Evaluation of the Transitional Support Scheme (TSS)</u>. Welsh Assembly Government, Cardiff. Available: http://wales.gov.uk/docs/dsjlg/research/101109tssfinreporten.pdf [accessed 14.09.11]</p>
<p>Manning, V., Best, D. W., Faulkner, N. and Tothertington, E. (2009). New estimates of children living with substance misusing parents: results from UK national household surveys. <u>BMC Public Health</u> 9 337.</p>
<p>Marsden, J., Eastwood, B., Wright, C., Bradbury, C., Knight, J. and Hammond, P. (2011). How best to measure change in evaluations of treatment for substance use disorder. <u>Addiction</u> 106 (2) 294-302.</p>
<p>Maskell, P.D., De Paoli, G., Seneviratne, C., Pounder, D.J. (2011a). Mephedrone (4-Methylmethcathinone)-Related Deaths. <u>Journal of Analytical Toxicology</u> 35 (3) 188-191.</p>
<p>Maskell, P. D., De Paoli, G., Seetohul, L. N. and Pounder, D. J. (2011b). Phenazepam is currently being misused in the UK. <u>BMJ</u> (early online access)</p>
<p>Marteau, D., Palmer, J. and Stöver, H. (2010). Introduction of the Integrated Drug Treatment System (IDTS) in English Prisons. <u>International Journal of Prisoner Health</u> 6 (3) 117-124.</p>
<p>Matheson, C. et al. (2010) Management of drug misuse: an 8-year follow-up survey of Scottish GPs. <u>British Journal of General Practice</u> 60 (4) 517-520.</p>
<p>Matheson, C., Pitcairn, J., Bond, C et al. (2003). General practice management of illicit drug users in Scotland: A national survey. <u>Addiction</u> 98 (1) 119-126.</p>

Matthew, J. (2010). <u>Melting the Iceberg of Scotland's Drug and Alcohol Problem: Report of the Independent Enquiry</u> . University of Glasgow, Glasgow. Available: http://www.projectstrada.org/v1/index.php?option=com_attachment&task=download&id=226 [accessed 09.05.2011]
Mayet, S., Manning, V., Williams, A., Loaring, J. and Strang, J. (2010). Impact of training for healthcare professionals on how to manage an opioid overdose with naloxone: Effective, but dissemination is challenging. <u>International Journal of Drug Policy</u> (early online access)
McAuley, A. and Best, D. (2011). A quantitative exploration of risk factors associated with drug-related deaths involving heroin, alcohol or methadone in the West of Scotland. <u>Addiction Research and Theory</u> 1–9 (early online access)
McAuley, A. and Forsyth, A. J. (2011). The impact of drug-related death on staff who have experienced it as part of their caseload: An exploratory study. <u>Journal of Substance Use</u> 16 (1) 68–78.
McCambridge, J., Hunt, C., Jenkins, R. and Strang, J. (2011). Cluster randomised trial of the effectiveness of Motivational Interviewing for universal prevention. <u>Drug and Alcohol Dependence</u> . (early online access)
McCarthy, T. and Galvani, S. (2010) Alcohol and other Drugs – Essential Information for Social Workers. A BASW Pocket Guide. Luton: University of Bedfordshire. http://ranzetta.typepad.com/files/guide-for-social-wrkers.pdf [accessed 15.07.11]
McCrystal, P. and Percy, A. (2011). Patterns of substance use among young people attending colleges of further education in Northern Ireland. <u>Drugs: Education, Prevention, and Policy</u> 18 (1) 69–76.
McDonald, S. A., Hutchinson, S. J., Mills, P. R., Bird, S. M., Cameron, S., Dillon, J. F. and Goldberg, D. J. (2011). The influence of hepatitis C and alcohol on liver-related morbidity and mortality in Glasgow's injecting drug user population. <u>Journal Viral Hepatitis</u> (early online access)
McElrath, K. (2002). Prevalence of Problem Heroin Use in Northern Ireland. Department of Health, Social Services and Public Safety. Available: http://www.dhsspsni.gov.uk/heroin_use_ni.pdf [accessed 31.08.11]
McElrath, K. and O'Neill. (2010). Experiences with mephedrone pre- and post-legislative controls: Perceptions of safety and sources of supply. <u>International Journal of Drug Policy</u> 22 (2)120-12.
McKeganey, N., Barnard, M. and McIntosh, J. (2002). Paying the Price for their Parents' Addiction: meeting the needs of the children of drug-using parents. <u>Drugs: Education, Prevention and Policy</u> 9 (3) 233.
McKeganey, N., Bloor, M., McIntosh, J. and Neale, J. (2008). <u>Key findings from the Drug Outcome Research in Scotland (DORIS) study</u> . University of Glasgow Centre for Drug Misuse Research, Glasgow. Available: http://www.gla.ac.uk/departments/drugmisuse/staff/profneilmckeganey/#Publications

<p>Measham F, Moore K, Newcombe R, Welch Z. (2010). Tweaking, bombing, dabbing, and stockpiling: the emergence of mephedrone and the perversity of prohibition. <u>Drugs and Alcohol Today</u> 10 14-21.</p>
<p>Measham, F., Wood, D. M, Dargan, P. I. and Moore, K. (2011). The rise in legal highs: prevalence and patterns in the use of illegal drugs and first- and second-generation 'legal highs' in South London gay dance clubs. <u>Journal of Substance Use</u> 16 (4) 263-272.</p>
<p>Merrall, E. L., Kariminia, A., Binswanger, I. A., Hobbs, M. S., Farrell, M., Marsden, J., Hutchinson, S. J. and Bird, S. M. (2010). Meta-analysis of drug-related deaths soon after release from prison. <u>Addiction</u> 105 (9) 1545-1554.</p>
<p>Merrall, E.L., Bird, S.M. and Hutchinson, S.J. (2011). Mortality of those who attended drug services in Scotland 1996-2006: Record-linkage study. <u>International Journal of Drug Policy</u> (early online access)</p>
<p>Miller, P., McKenzie, S., Lintzeris, N., Martin, A. and Strang, J. (2010). The community impact of RIOTT, a medically supervised injectable maintenance clinic in south London. <u>Mental Health and Substance Use: dual diagnosis</u> 3 (3) 248-259.</p>
<p>The Misuse of Drugs Act 1971. Her Majesty's Stationery Office, London. Available: http://www.legislation.gov.uk/ukpga/1971/38/contents [accessed 05.05.11]</p>
<p>MOJ (Ministry of Justice) (2007a). <u>Criminal statistics 2006, England and Wales. Supplementary tables, Vol. 5: Proceedings at all Courts</u>. Ministry of Justice, London. Available: http://www.justice.gov.uk/publications/docs/crim-stats-2006-vol5.zip [accessed 10.06.11]</p>
<p>MOJ (Ministry of Justice) (2007b). <u>A survey of buprenorphine misuse in prisons</u>. Ministry of Justice, London. Available: http://www.justice.gov.uk/publications/docs/survey-buprenorphine.pdf [accessed 11.04.11]</p>
<p>MOJ (Ministry of Justice) (2008). <u>Criminal statistics 2007, England and Wales. Supplementary tables, Vol. 5: Proceedings at all Courts</u>. Ministry of Justice, London. Available: http://www.justice.gov.uk/publications/docs/crim-stats-2007-vol5a.zip [accessed 10.06.11]</p>
<p>MOJ (Ministry of Justice) (2009a). <u>Criminal statistics 2008, England and Wales. Supplementary tables, Vol. 5: Proceedings at all Courts</u>. Ministry of Justice, London. Available: http://www.justice.gov.uk/publications/docs/criminal-statistics-2008-v5.zip [accessed 10.06.11]</p>
<p>MOJ (Ministry of Justice) (2009b). <u>Compact Based Drug Testing. PSI 31/2009</u>. Ministry of Justice, London. Available: psi.hmprisonservice.gov.uk/psi_2009_31_compact_based_drugs_testing.doc [accessed 11.04.11]</p>
<p>MOJ (Ministry of Justice) (2010a). <u>Criminal statistics 2009, England and Wales. Statistics Bulletin</u>. Available: http://www.justice.gov.uk/publications/docs/criminal-statistics-annual.pdf [accessed 10.06.11]</p>

<p>MOJ (Ministry of Justice) (2010b). <u>Criminal statistics 2009, England and Wales. Supplementary tables, Vol. 5: Proceedings at all Courts.</u> Ministry of Justice, London. Available: http://www.justice.gov.uk/publications/docs/volume5-proceedings-at-all-courts-b.zip [accessed 22.03.11]</p>
<p>MOJ (Ministry of Justice) (2010c). <u>Breaking the cycle: Effective punishment, rehabilitation and sentencing of offenders.</u> Ministry of Justice, London. Available: http://www.justice.gov.uk/consultations/docs/breaking-the-cycle.pdf [accessed 24.03.11]</p>
<p>MOJ (Ministry of Justice) (2010d). <u>Compendium of Reoffending Statistics and Analysis</u> Ministry of Justice Statistics Bulletin, November 2010. Ministry of Justice, London. Available: http://www.justice.gov.uk/publications/statistics-and-data/reoffending/compendium-of-reoffending-statistics-and-analysis.htm [accessed 17.10.11]</p>
<p>MOJ (Ministry of Justice) (2010e). <u>Integrated Drug Treatment System. PSI 45/2010.</u> Ministry of Justice, London. Available: www.justice.gov.uk/downloads/guidance/.../psipso/psi_2010_45_IDTS.doc [accessed 24.03.11]</p>
<p>MOJ (Ministry of Justice) (2011a). <u>Criminal statistics 2010, England and Wales. Supplementary tables, Vol. 5: Proceedings at all Courts.</u> Ministry of Justice, London. Available: http://www.justice.gov.uk/publications/statistics-and-data/criminal-justice/criminal-annual.htm [accessed 09.09.11]</p>
<p>MOJ (Ministry of Justice) (2011b). <u>National Offender Management Service Annual Report 2010/11: Management Information Addendum.</u> Ministry of Justice, London. Available: http://www.justice.gov.uk/downloads/publications/statistics-and-data/hmps/noms-annual-report-2010-11-addendum.pdf [accessed 31.08.11]</p>
<p>MOJ (Ministry of Justice) (2011c). <u>Family Justice Review Interim Report.</u> Ministry of Justice, London. Available: http://www.justice.gov.uk/downloads/publications/policy/moj/family-justice-review-interim-rep.pdf [accessed 02.06.11]</p>
<p>Morgan, C. J. A. and Curran H. V. (2011). Ketamine use: a review on behalf of the Independent Scientific Committee on Drugs (ISCD). <u>Addiction</u> (early online access)</p>
<p>Morgan, C. J. A., Muetzelfeldt, L., Muetzelfeldt, M., Nutt, D. J. and Curran, H. V. (2010). Harms associated with psychoactive substances: findings of the UK National Drug Survey. <u>Journal of Psychopharmacology</u> 24 147-153.</p>
<p>Mulchandani, R., Hand, T., and Panesar, L. K. (2010). Drug seizures in England and Wales, 2009/10. Home Office, London. Available: http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/police-research/hosb1710/hosb1710?view=Binary [accessed 27.10.11]</p>
<p>Mullin, A., McAuley, R. J., Watts, D. J., Crome, I. B. and Bloor, R. N. (2008). Awareness of the need for safe storage of Methadone at home is not improved by the use of protocols on recording information giving. <u>Harm Reduction Journal</u> 5 (15). Available: http://www.harmreductionjournal.com/content/pdf/1477-7517-5-15.pdf [accessed 05.05.11]</p>

Munro, E. (2011). <u>The Munro Review of Child Protection: Final Report A child-centred system</u> . Department for Education, London. Available: http://www.education.gov.uk/munroreview/downloads/8875_DfE_Munro_Report_TA_GGED.pdf [accessed 02.06.11]
Nagle, A. and Watson, G. (2008). Parental substance misuse: An Islington perspective. <u>Child Abuse Review</u> 17 444-453.
National Collaborating Centre for Women's and Children's Health (2010). <u>Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors</u> . Royal College of Obstetricians and Gynaecologists, London. Available: http://www.nice.org.uk/nicemedia/live/13167/50861/50861.pdf [accessed 05.05.11]
NOMS (National Offender Management Service) (2007). <u>Re-Introduction of Disinfecting Tablets, Prison Service Instruction PSI 34/2007</u>
Neale, J., Nettleton, S. and Pickering, L. (2010) What is the role of harm reduction when drug users say they want abstinence? <u>International Journal of Drug Policy</u> . (early online access)
NHS Health Scotland (2011). <u>Prison health needs assessment for alcohol problems</u> . NHS Health Scotland. Available: http://www.ohrn.nhs.uk/resource/policy/PrisonHealthNeedsAssessmentAlcohol.pdf [accessed 26.08.11]
NHS National Services Scotland (2011). <u>National Drug and Alcohol Waiting Times Report, April to June 2011</u> . NHS National Services Scotland, Edinburgh. Available: http://www.drugmisuse.isdscotland.org/wtpilot/2011-09-27-DATWT-Report.pdf?19378298522 [accessed 11.10.11]
NHS Scotland and Scottish Prison Service (2007). <u>Report of The Prison Healthcare Advisory Board</u> . NHS Scotland and Scottish Prison Service, Edinburgh. Available: http://www.scotland.gov.uk/Resource/Doc/924/0063020.pdf [accessed 17.03.11]
NICE (National Institute for Health and Clinical Excellence) (2011). <u>Psychosis with coexisting substance misuse</u> . Clinical guidelines CG120. National Institute for Health and Clinical Excellence, London. Available: http://guidance.nice.org.uk/CG120 [accessed 28.04.11]
Niewiarowski, S., Gogbashian, A., Afaq, A., Kantor, R. and Win, Z. (2010). Abdominal x-ray signs if intra-intestinal drug smuggling. <u>Journal of Forensic and Legal Medicine</u> 17 (4) 198-202.
NIPS (Northern Ireland Prison Service) (2006). <u>Northern Ireland Prison Service Policy on Alcohol and Substance misuse</u> . Northern Ireland Prison Service, Belfast. Available: www.niprisonservice.gov.uk/.../Alcohol%20and%20Substance%20Misuse%20press%20release.pdf [accessed 23.03.11]
NIPS (Northern Ireland Prison Service) (2008). <u>Corporate Plan 2008/11</u> . Northern Ireland Prison Service, Belfast. Available: http://www.niprisonservice.gov.uk/module.cfm/opt/5/area/Publications/page/publications/archive/false/ [accessed 17.03.11]

<p>NISRA (Northern Ireland Statistics & Research Agency) (2008). <u>Young Person's Behaviour and Attitudes Survey 2007: Topline Results</u>. Northern Ireland Statistics and Research Agency, Belfast. Available: http://www.csu.nisra.gov.uk/YPBAS%202007%20Topline%20Results%20Weighted.pdf [accessed 17.08.11]</p>
<p>NISRA (Northern Ireland Statistics & Research Agency) (2011). <u>Young Person's Behaviour and Attitudes Survey 2010: Topline Results</u>. Northern Ireland Statistics and Research Agency, Belfast. Available: http://www.csu.nisra.gov.uk/YPBAS%202010%20Topline%20Results%20(Weighted).pdf [accessed 18.08.11]</p>
<p>NOMS (National Offender Management Service), HMPS (Her Majesty's Prison Service) and DH (Department of Health) (2007). <u>Integrated Drug Treatment System Workforce Strategy</u>. National Offender Management Service, London. Available: www.nta.nhs.uk/uploads/ids_workforce_strategy.doc [accessed 11.04.11]</p>
<p>NOMS (National Offender Management Service) (2009b). <u>The National Offender Management Service Drug Strategy 2008-2011: Action Plan</u>. National Offender Management Service, London. Available: http://www.justice.gov.uk/publications/docs/noms-drugs-action-plan.pdf [accessed 31.03.11]</p>
<p>North, P. (2010). <u>Report of the review of drink and drug driving law</u>. Department for Transport, London. Available: http://northview.independent.gov.uk/docs/NorthReview-Report.pdf [accessed 05.05.2011]</p>
<p>Notley, C., Scaife, V., O'Brien, M., McEune, R., Biggart, L. and Millings, A. (2011). Vulnerable young people and substance-use information-seeking: perceived credibility of different information sources and implications for services. <u>Journal of Substance Use</u> (early online access).</p>
<p>NTA (National Treatment Agency for Substance Misuse) (2006). <u>Models of Care for Treatment of Adult Drug Misusers</u>. National Treatment Agency for Substance Misuse, London. Available: http://www.nta.nhs.uk/uploads/nta_modelsofcare_update_2006_moc3.pdf [accessed 09.06.10]</p>
<p>NTA (National Treatment Agency) (2010a). <u>Substance misuse among young people: the data for 2009-10</u>. National Treatment Agency for Substance Misuse, London. Available: www.nta.nhs.uk/yp-the-data-2009-10.aspx [accessed 10.04.11]</p>
<p>NTA (National Treatment Agency for Substance Misuse) (2010b). <u>Statistics from the National Drug Treatment Monitoring System (NDTMS), 1 April 2009 – 31 March 2010</u>. National Treatment Agency for Substance Misuse, London. Available: http://www.nta.nhs.uk/uploads/ndtmsannualreport2009-10finalversion.pdf [accessed 14.09.11]</p>
<p>NTA (National Treatment Agency for Substance Misuse) (2010c). <u>Women in drug treatment: what the latest figures reveal</u>. National Treatment Agency for Substance Misuse, London. Available: http://www.nta.nhs.uk/uploads/ntawomenintreatment22march2010.pdf [accessed 01.06.11]</p>

NTA (National Treatment Agency for Substance Misuse) (2011a). <u>The transition to Public Health England: Action Plan for the NTA 2011-12</u> . National Treatment Agency for Substance Misuse, London. Available: http://www.nta.nhs.uk/action-plan11-12.aspx [accessed 10.06.11]
NTA (National Treatment Agency for Substance Misuse) (2011b). <u>Building recovery in communities: A consultation for developing a recovery-orientated framework to replace Models of Care</u> . National Treatment Agency for Substance Misuse, London. Available: http://www.nta.nhs.uk/uploads/bricquestionnaire[0].pdf [accessed 05.05.11]
NTA (National Treatment Agency for Substance Misuse) (2011c). <u>Recovery-orientated drug treatment</u> . National Treatment Agency for Substance Misuse, London. Available: http://www.nta.nhs.uk/uploads/rodt_an_interim_report_july_2011.pdf [accessed 24.08.11]
NTA (National Treatment Agency for Substance Misuse) (2011d). <u>Addiction to medicine</u> . National Treatment Agency for Substance Misuse, London. Available: http://www.nta.nhs.uk/uploads/addictiontomedicinesmay2011a.pdf [accessed 10.06.11]
NTA (National Treatment Agency for Substance Misuse) (2011e). <u>Statistics from the National Drug Treatment Monitoring System (NDTMS), 1 April 2010 – 31 March 2011</u> . NTA, London. Available: http://www.nta.nhs.uk/uploads/statisticsfromndtms201011vol1thenumbers.pdf [accessed 11.10.11]
NTA (National Treatment Agency for Substance Misuse) (2011f). <u>Drug-Related Deaths: Setting up a local review process</u> . National Treatment Agency for Substance Misuse, London. Available: http://www.nta.nhs.uk/uploads/drug_related_deaths_setting_up_a_local_review_process.pdf [accessed 06.02.11]
NTA (National Treatment Agency for Substance Misuse) (2011g). <u>The NTA overdose and naloxone training programme for families and carers</u> . National Treatment Agency for Substance Misuse, London. Available: http://www.nta.nhs.uk/uploads/naloxonereport2011.pdf [accessed 01.08.11] 01.06.11]
NTA (National Treatment Agency for Substance Misuse) (2011h). <u>Employment and housing: resource pack for needs assessment. A supplement to the 2009 needs assessment guidance and the interim treatment planning guidance for 2011-12</u> . National Treatment Agency for Substance Misuse, London. Available: http://www.nta.nhs.uk/uploads/employmenthousingvfinal.pdf [accessed 01.02.11]
NTA (National Treatment Agency for Substance Misuse) (2011i). <u>Supporting information for the development of joint local protocols between drug and alcohol partnerships, children and family services</u> . National Treatment Agency for Substance Misuse, London. Available: http://www.nta.nhs.uk/uploads/20110531ypsupportinginformationfinal.pdf [accessed

01.08.11]
Nutt, D., King, L. A., Saulsbury, W. and Blakemore, C. (2007). Development of a rational scale to assess the harm of drugs of potential misuse. <u>The Lancet</u> 369 1047–53.
Nutt, D. J., King, L. A. and Phillips, L. D. (2010). Drug harms in the UK: a multicriteria decision analysis. <u>The Lancet</u> 379 (9752) 1558-1565.
NWPHO (North West Public Health Observatory). (2011). Topography of Drinking Behaviours in England. Synthetic estimates of numbers and proportions of abstainers, lower risk, increasing risk and higher risk drinkers in local authorities in England. Centre for Public Health, Liverpool. Available: http://lape.org.uk/downloads/alcholestimates2011.pdf [accessed 20.09.11]
OFMDFMNI (Office of the First Minister and Deputy First Minister for Northern Ireland) (2006). <u>Our Children and Young People – Our Pledge: A 10 year strategy for children and young people in Northern Ireland, 2006-2016</u> . Office of the First Minister and Deputy First Minister for Northern Ireland, Belfast. Available: http://www.ofmdfmi.gov.uk/index/equality/children-young-people/children-and-young-people-strategy.htm [accessed 21.05.11]
Omand, D. (2010). <u>Report of the 2010 NDPB Review of the Advisory Council on the Misuse of Drugs</u> . Home Office, London. Available: http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/acmd1/2010-ndpd-review-acmd [accessed 10.05.11]
ONS (Office for National Statistics) (2011). <u>Deaths related to drug poisoning in England and Wales, 2010</u> . Office for National Statistics, Newport. Available: http://www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/2010/stb-deaths-related-to-drug-poisoning-2010.html [accessed 24.08.11]
Parkin, S. and Coomber, R. (2011). Public injecting drug use and the social production of harmful practice in high-rise tower blocks (London, UK): A Lefebvrian analysis. <u>Health and Place</u> 17 717-726.
Patel, L. (2010). <u>The Patel Report: Reducing drug related crime and rehabilitating offenders</u> . Department of Health, London. Available: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_119850.pdf [accessed 16.09.11]
Pearson, M. and Coomber, R. (2010). The challenge of external validity in policy-relevant systematic reviews: a case study from the field of substance misuse. <u>Addiction</u> 105 (1) 136-145.
Percy, A., Thornton, M. and McCrystal, P. (2008). The extent and nature of family alcohol and drug use: Findings from the Belfast Youth Development Study. <u>Child Abuse Review</u> 17 371-386.

<p>PHA/HSCB (2009). <u>Hidden Harm Action Plan. Responding to the needs of children born to and living with parental alcohol and drug misuse in Northern Ireland</u>. Public Health Agency, London. Available: http://www.publichealth.hscni.net/sites/default/files/Hidden%20Harm%20Action%20Plan%202010.pdf [accessed 12.04.11]</p>
<p>PHIRB (Public Health Information and Research Branch) (2010). <u>Statistics from the Northern Ireland Drug Addicts Index</u>. Department of Health, Social Services and Public Safety, Belfast. Available: http://www.dhsspsni.gov.uk/addicts_index_report_09.pdf [accessed 21.04.11]</p>
<p>PHIRB (Public Health Information and Research Branch) (2011). <u>Statistics from the Northern Ireland Drug Addicts Index</u>. Department of Health, Social Services and Public Safety, Belfast. Available: http://www.dhsspsni.gov.uk/addicts_index_report_2010.pdf [accessed 21.04.11]</p>
<p>Pinto, H., Maskrey, V., Swift, L., Rumball, D., Wagle, A. and Holland, R. (2010). The SUMMIT Trial: A field comparison of buprenorphine versus methadone maintenance treatment. <u>Journal of Substance Abuse Treatment</u>. 39 (4) 340-352.</p>
<p>Plugge, E., Douglas, N. and Fitzpatrick, R. (2006). <u>The health of women in prison study findings</u>. University of Oxford. Available: http://www.publichealth.ox.ac.uk/research/prison/2007-02-13.6702780065 [accessed 27.10.11]</p>
<p><u>The Police and Criminal Evidence Act 1984</u>. Her Majesty's Stationery Office, London. Available: http://www.legislation.gov.uk/ukpga/1984/60/contents [accessed 05.05.11]</p>
<p>Povey, D., Hand, T., Rishiraj, A. S. and Mulchandani, R. (2010). <u>Police powers and procedures, England and Wales 2008/09</u>. Home Office Statistical Bulletin 06/10. Home Office, Available: http://webarchive.nationalarchives.gov.uk/20110220105210/http://rds.homeoffice.gov.uk/rds/police-powers.html [accessed 14.07.10]</p>
<p>Povey, D., Smith, K., Hand, T. and Dodd, L. (2009). <u>Police powers and procedures, England and Wales, 2007/08</u>. Home Office Statistical Bulletin. Home Office, London. Available: http://www.homeoffice.gov.uk/rds/pdfs09/hosb0709.pdf [accessed 15.10.09]</p>
<p>Povey, Mulchandani, R., Hand, T. and Panesar, L. (2011). <u>Police powers and procedures, England and Wales, 2009/10</u>. Home Office Statistical Bulletin. Home Office, London. Available: http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/police-research/hosb0711/ [accessed 10.06.11]</p>
<p>Powell, A. G. M. T., Crozier, J. E. M., Hodgson, H. and Galloway, D. J. (2011a). A case of septicaemic anthrax in an intravenous drug user. <u>BMC Infectious Diseases</u> 11 (1) 21</p>
<p>Powell, C., Christie, M., Bankart, J., Bamber, D. and Unell, I. (2011b). Drug treatment outcomes in the criminal justice system: what non self-report measures of outcome can tell us. <u>Addiction Research and Theory</u> 19 (2) 148-160.</p>

<p><u>The Proceeds of Crime Act 2002</u>. The Stationery Office, London. Available: http://www.legislation.gov.uk/ukpga/2002/29/contents [accessed 19.11.11]</p>
<p>PSNI (Police Service of Northern Ireland) (2004a). <u>Recorded Crimes and Clearances. 1st April 2003 – 31st March 2004</u>. PSNI Statistics: Annual Statistical Report. Statistical Report No. 1. Police Service of Northern Ireland, Belfast. Available: http://www.psni.police.uk/recorded_crime_2003-04.pdf [accessed 14.07.10]</p>
<p>PSNI (Police Service Northern Ireland) (2004b). <u>Drug Seizures and Arrests 2002/03</u>. Police Service Northern Ireland, Belfast. Police Service Northern Ireland, Belfast. Available: http://www.psni.police.uk/drugs_seizures_and_arrests_2003-04.pdf [accessed 07.08.10]</p>
<p>PSNI (Police Service of Northern Ireland) (2006a). <u>Recorded Crimes and Clearances. 1st April 2005 – 31st March 2006</u>. PSNI Statistics: Annual Statistical Report. Statistical Report No. 1. Police Service of Northern Ireland, Belfast. Available: http://www.psni.police.uk/recorded_crime_2005-06.pdf [accessed 14.07.10]</p>
<p>PSNI (Police Service Northern Ireland) (2006b). <u>Drug Seizures and Arrests 2004/05</u>. Police Service Northern Ireland, Belfast. Available: http://www.psni.police.uk/drugs_seizures_and_arrests_2004-05.pdf [accessed 07.08.10]</p>
<p>PSNI (Police Service of Northern Ireland) (2008a). <u>Recorded Crimes and Clearances. 1st April 2007 – 31st March 2008</u>. PSNI Statistics: Annual Statistical Report. Statistical Report No. 1. Police Service of Northern Ireland, Belfast. Available: http://www.psni.police.uk/stats1_recorded_crime.pdf [accessed 07.08.10]</p>
<p>PSNI (Police Service of Northern Ireland) (2008b). <u>Drug Seizures and Arrests. 1st April 2007 – 31st March 2008</u>. PSNI Statistics: Annual Statistical Report. Statistical Report No. 4. Police Service of Northern Ireland, Belfast. Available: http://www.psni.police.uk/drug_seizures_and_arrests_summary_2007-08.pdf [accessed 20.10.10]</p>
<p>PSNI (Police Service of Northern Ireland) (2010a). <u>Recorded Crimes and Clearances. 1st April 2009 – 31st March 2010</u>. PSNI Statistics: Annual Statistical Report. Statistical Report No. 1. Police Service of Northern Ireland, Belfast. Available: http://www.psni.police.uk/1._recorded_crime_200910.pdf [accessed 14.07.10]</p>
<p>PSNI (Police Services Northern Ireland) (2010b). <u>Drug seizures and arrests, 1st April 2009 – 31st March 2010</u>. Police Service Northern Ireland. Available: http://www.psni.police.uk/4._drug_seizures_and_arrests_summary_200910_final.pdf [accessed 27.10.11]</p>
<p>PSNI (Police Service of Northern Ireland) (2011a). <u>Police recorded crime in Northern Ireland 2010/11</u>. Police Service Northern Ireland. Available: http://www.psni.police.uk/1._10_11_recorded_crime.pdf [accessed 09/06/11]</p>

<p>PSNI (Police Services Northern Ireland) (2011b). <u>Drug seizures and arrests, 1st April 2010 – 31st March 2011</u>. Police Service Northern Ireland. Available: http://www.psni.police.uk/drugs_new_format_201011.pdf [accessed 04.06.11]</p>
<p>Public Health Wales (2010). <u>Guidance to reduce unplanned dropout from and promote re-engagement with substance misuse treatment services – both sides of the story</u>. Available: http://www2.nphs.wales.nhs.uk:8080/BloodBorneVirusesDocs.nsf/3dc04669c9e1eaa880257062003b246b/bee22a0587b6a00d802576f0003ccd13/\$FILE/Influences%20and%20implications%20of%20unplanned%20drop%20out.pdf [accessed 17.10.11]</p>
<p>RCPsych (Royal College of Psychiatrists) (2011). <u>Our invisible addicts</u>. College Report CR165. Royal College of Psychiatrists, London. Available: http://www.rcpsych.ac.uk/files/pdfversion/CR165.pdf [accessed 24.08.11]</p>
<p>Reed, K., Bond, A., Witton, J., Cornish, R., Hickman, M. and Strang, J. (2011). <u>The changing use of prescribed benzodiazepines and z-drugs and of over-the-counter codeine-containing products in England: a structured review of published English and international evidence and available data to inform consideration of the extent of dependence and harm</u>. Kings College, London. Available: http://www.kcl.ac.uk/iop/depts/addictions/research/drugs/Thechanginguseofprescribedbenzodiazepinesandz-drugsandofover-the-countercodeine-containingproducts.pdf [accessed 18.05.11]</p>
<p>Rhodes, T., Bernays, S. and Houmøller, K. (2010). Parents who use drugs: Accounting for damage and its limitation. <u>Social Science and Medicine</u> 71 (8) 1489-1497.</p>
<p>Riley, S., Thompson, J. and Griffin, C. (2010). Turn on, tune in, but don't drop out: The impact of neo-liberalism on magic mushroom users' (in)ability to imagine collectivist social worlds. <u>International Journal of Drug Policy</u> 21 445-451.</p>
<p><u>The Road Traffic Act 1988</u>. Her Majesty's Stationery Office, London. Available: http://www.legislation.gov.uk/ukpga/1988/52/contents [accessed 05.05.11]</p>
<p>Roberts, M. (2011). <u>By their fruits...Applying payment by results to drug recovery</u>. United Kingdom Drug Policy Commission, London. Available: http://www.ukdpc.org.uk/resources/UKDPC_PbR.pdf [accessed 10.06.11]</p>
<p>Roderique-Davies, G. and Shearer, D. (2010). Estimated lifetime drug use, impulsivity, and psychopathology in recreational ecstasy users. <u>Journal of Substance Use</u> 15 (3) 215-225.</p>
<p>Roe, S. (2005). <u>Drug Misuse Declared: Findings from the 2004/05 British Crime Survey</u>. Home Office, London. Available: http://rds.homeoffice.gov.uk/rds/pdfs05/hosb1605.pdf [accessed 11.02.11]</p>
<p>Rolles, S. and Measham, F. (2011). Questioning the method and utility of ranking drug harms in drug policy. <u>International Journal of Drug Policy</u> 22 (4) 243-246.</p>

<p>SACDM (Scottish Advisory Committee on Drug Misuse) (2005). <u>Scottish Advisory Committee on Drugs Misuse (SACDM) Working Group on Drug Related Deaths: Report and Recommendations</u>. Scottish Advisory Committee on Drug Misuse, Edinburgh. Available: http://www.scotland.gov.uk/Publications/2005/08/04154654/46563 [accessed 13.05.11]</p>
<p>SAP (Sentencing Advisory Panel) (2010). <u>Sentencing for Drug Offences</u>. Sentencing Advisory Panel, London. Available: http://www.drugscope.org.uk/OneStopCMS/Core/CrawlerResourceServer.acpx?resource=C20F6BE6-4F43-469B-B294-CACAAAD3D6CC&mode=link&guid=c03a022d79f642c4b87d4dad4acad3db [accessed 05.05.11]</p>
<p>Schifano, F., Albanese, A. Fergus, S., Stair, J. L. and Deluca, P. Corazza, O., Davey, Z., Corkery, J., Siemann, H. and Scherbum, N, et al. (2010). Mephedrone (4-methylmethcathinone; 'meow meow'): chemical, pharmacological and clinical issues. <u>Psychopharmacology</u> 214 (3) 593-602.</p>
<p>Schulte, S. J., Meier, P. S., Stirling, J. and Berry, M. (2010). Dual diagnosis competency among addiction treatment staff: training levels, training needs and the link to retention. <u>European Addiction Research</u> 16 78-84.</p>
<p>Scott, J. (2010). The availability of injecting paraphernalia in the UK following the 2003 law change to permit supply. <u>Drugs: education, prevention and policy</u> 17 (3) 205–215.</p>
<p>Scottish Executive (2003). <u>Getting Our Priorities Right - Good Practice Guidance for Working with Children and Families Affected by Substance Misuse</u>. Scottish Executive, Edinburgh. Available: http://www.scotland.gov.uk/Resource/Doc/47032/0023960.pdf [accessed 05.05.11]</p>
<p>Scottish Executive (2004). <u>Hidden Harm: Scottish Executive Response to the Report of the Inquiry by the Advisory Council on the Misuse of Drugs</u>. Scottish Executive, Edinburgh. Available: http://www.scotland.gov.uk/Publications/2004/10/20120/45470 [accessed 05.05.11]</p>
<p>Scottish Executive (2006a). <u>Hepatitis C Action Plan for Scotland Phase I: September 2006 – August 2008</u>. Scottish Executive, Edinburgh. Available: http://www.scotland.gov.uk/Publications/2006/09/15093626/0 [accessed 21.05.10]</p>
<p>Scottish Executive (2006b). <u>Neonatal Abstinence Syndrome. A new intervention: A community based, structured health visitor assessment</u>. Scottish Executive, Edinburgh. Available: http://www.scotland.gov.uk/Resource/Doc/146679/0038382.pdf [accessed 05.05.11]</p>
<p>Scottish Executive (2006c). <u>Hidden Harm Next Steps: Supporting Children, Working With Parents</u>. Scottish Executive, Edinburgh. Available: http://www.scotland.gov.uk/Resource/Doc/114027/0027764.pdf [accessed 05.05.11]</p>
<p>Scottish Government (2008a). <u>The Road to Recovery. A New Approach to Tackling Scotland's Drug Problem</u>. Scottish Government, Edinburgh. Available: http://www.scotland.gov.uk/Publications/2008/05/22161610/0 [accessed 15.05.09]</p>

<p>Scottish Government (2008b). <u>The Early Year's Framework</u>. Scottish Government, Edinburgh. Available: http://www.scotland.gov.uk/Publications/2009/01/13095148/0 [accessed 15.05.11]</p>
<p>Scottish Government (2008c). <u>Achieving Our Potential: A Framework to tackle poverty and income inequality in Scotland</u>. Scottish Government, Edinburgh. Available: http://www.scotland.gov.uk/Publications/2008/11/20103815/0 [accessed 05.05.11]</p>
<p>Scottish Government (2008d). <u>Equally Well Implementation Plan</u>. Scottish Government, Edinburgh. Available: http://www.scotland.gov.uk/Publications/2008/11/20103815/0 [accessed 05.05.11]</p>
<p>Scottish Government (2008e). <u>Hepatitis C Action Plan for Scotland Phase II: May 2008 - March 2011</u>. Scottish Government, Edinburgh. Available: http://www.scotland.gov.uk/Publications/2008/05/13103055/17 [accessed 10.05.11]</p>
<p>Scottish Government (2010a). <u>Criminal Justice Social Work Statistics 2009/10</u>. Scottish Government, Edinburgh. Available: http://scotland.gov.uk/Resource/Doc/933/0109857.pdf [accessed 17.10.11]</p>
<p>Scottish Government (2010b). <u>National Guidance for Child Protection in Scotland</u>. Scottish Government, Edinburgh. Available: http://www.scotland.gov.uk/Publications/2010/12/09134441/0 [accessed 05.09.11]</p>
<p>Scottish Government (2011a). <u>Sexual Health and Blood Borne Virus Framework 2011-2015</u>. Scottish Government, Edinburgh. Available: http://www.scotland.gov.uk/Resource/Doc/356286/0120395.pdf [accessed 01.09.11]</p>
<p>Scottish Government (2011b). <u>Scotland's People Annual Report. Results from 2009/2010 Scottish Household Survey</u>. Scottish Government, Edinburgh. Available: http://www.scotland.gov.uk/Publications/2011/08/17093111/2 [accessed 09.09.11]</p>
<p>Scottish Government (2011c). <u>Recorded crime in Scotland 2010/11. Statistical Bulletin</u>. Scottish Government, Edinburgh. Available: http://www.scotland.gov.uk/Resource/Doc/933/0120682.pdf [accessed 15.09.11]</p>
<p>Scottish Government (2011d). <u>Reconviction rates in Scotland: 2007-08 and 2008-09 offender cohorts</u>. Scottish Government, Edinburgh. Available: http://www.scotland.gov.uk/Resource/Doc/356580/0120513.pdf [accessed 01.09.11]</p>
<p>Scottish Government (2011e). <u>Criminal proceedings in Scotland 2009/10</u>. Scottish Government, Edinburgh. Available: http://www.scotland.gov.uk/Resource/Doc/338582/0111403.pdf [accessed 31.08.11]</p>
<p>Scottish Government (2011f). <u>Drug Treatment and Testing Orders: Guidance for schemes</u>. Scottish Government, Edinburgh. Available: http://www.scotland.gov.uk/Resource/Doc/353029/0118820.pdf [accessed 31.08.11]</p>
<p>Scottish Government (2011g). <u>Prison statistics Scotland 2010-11</u>. Scottish Government, Edinburgh. Available: http://www.scotland.gov.uk/Publications/2011/08/19154230/0 [accessed 27.10.11]</p>

<p>Scottish Government (2011h). <u>Refreshed Framework for Maternity Care in Scotland. The Maternity Services Action Group</u>. Scottish Government, Edinburgh. Available: http://www.scotland.gov.uk/Resource/Doc/337644/0110854.pdf [accessed 05.05.11]</p>
<p>Scottish Government (2011i). <u>Reducing Antenatal Health Inequalities: Outcome Focused Evidence into Action Guidance</u>. Scottish Government, Edinburgh. Available: http://www.scotland.gov.uk/Publications/2011/01/13095621/0 [accessed 27.10.11]</p>
<p>Scottish Parliament (2011). S3W-39212, written answers (24 February).</p>
<p>SDF (Scottish Drugs Forum) (2011). <u>Annual Report 2010</u>. Scottish Drugs Forum, Glasgow. Available: http://www.sdf.org.uk/sdf/files/SDF%20Annual%20Report%202009.2010.Web.pdf [accessed 05.05.11]</p>
<p>Seddon, T. (2011a). Explaining drug policy: Towards an historical sociology of policy change. <u>International Journal of Drug Policy</u> (early online access)</p>
<p>Seddon, T. (2011b). What is a problem drug user? <u>Addiction Research and Theory</u> 19 (4) 334–343.</p>
<p>Segrott, J. (2008). <u>Assessing the potential of the Cardiff Strengthening Families Programme 10-14 (UK) as a national programme for Wales</u>. Cardiff Institute of Society, Health and Ethics. Cardiff University, Cardiff. Available: http://www.mystrongfamily.org/downloads/PDFs/SFP-CardiffEvaluation.pdf [accessed 02.05.11]</p>
<p>Senbanjo, R., Wolff, K. and Marshall, J. (2007). Excessive alcohol consumption is associated with reduced quality of life among methadone patients. <u>Addiction</u> 102 (2) 257-263.</p>
<p>Senbanjo, R., Hunt, N. and Strang, J. (2010). Cessation of groin injecting behaviour among patients on oral opioid substitution treatment. <u>Addiction</u> 106 (2) 376-382.</p>
<p>Sentencing Council (2011). <u>Drug Offences Guideline: Public Consultation</u>. Sentencing Council. Available: http://www.sentencingcouncil.judiciary.gov.uk/docs/Drug_Offences_Guideline_Public_Consultation_.pdf [accessed 30.08.11]</p>
<p>Shah, A. D., Wood, D. M. and Dargan, P. I. (2011). Survey of ICD-10 coding of hospital admissions in the UK due to recreational drug toxicity. <u>Quarterly Journal of Medicine</u> 104 779–784.</p>
<p>Shaw, C. (2010). The effectiveness of an innovative model of community opiate detoxification provided on a supported one-to-one basis. <u>Journal of Substance Use</u> 15 (5) 340-351.</p>
<p>Shaw, J., Appleby, L. and Baker, D. (2003). <u>Safer Prisons</u>. Department of Health and HM Prison Service, London. Available: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4034301.pdf [accessed 15.07.11]</p>

<p>Singleton, N. (2010). <u>Attitudes to Drug Dependence Results from a Survey of People Living in Private Households in the UK</u>. UK Drug Policy Commission (UKDPC), London. Available: http://www.ukdpc.org.uk/resources/UKDPC_Attitudes_to_drug_dep_report.pdf [accessed 05.05.11]</p>
<p>Singleton, N. (2011a). <u>Getting Serious about Stigma in Scotland: The problem with stigmatising drug users</u>. UK Drug Policy Commission (UKDPC), London. Available: http://www.sdrconsortium.org/assets/files/UKDPCFullScottishReportFinal.pdf [accessed 09.02.11]</p>
<p>Singleton, N. (2011b). Crying wolf? A response to Corkery et al. 'Bundle of fun' or 'bunch of problems'? Case series of khat-related deaths in the UK. <u>Drugs: education, prevention and policy</u> (early online access)</p>
<p>Singleton, N., Bumpstead, R., O'Brien, Lee, A. and Meltzer, H. (2001). <u>Psychiatric Morbidity Among Adults Living in Private Households, 2000</u>. Her Majesty's Stationery Office (HMSO), Norwich. Available: http://www.ons.gov.uk/ons/rel/psychiatric-morbidity/psychiatric-morbidity-among-adults-living-in-private-households/2000/index.html [accessed 11.02.11]</p>
<p>Singleton, N., Meltzer, H., Gatward, R. (1999). <u>Psychiatric morbidity among prisoners: Summary report</u>. Office for National Statistics, Newport. Available: http://www.statistics.gov.uk/downloads/theme_health/Prisoners_PsycMorb.pdf [accessed 15.03.11]</p>
<p>Singleton, N., Pendry, E., Simpson, T., Goddard, E., Farrell, M. et al. (2005). <u>The impact of mandatory drug testing in prisons</u>. Home Office online report 03/05. Available: http://www.druglibrary.stir.ac.uk/documents/rdsolr0305.pdf [accessed 11.04.11]</p>
<p>Smith, A., Thurston, M. and Green, K. (2011). Proximity, sociability and excitement: exploring the normalisation of sensible drug use among 15-16-year-olds in north-west England and north-east Wales. <u>Journal of Youth Studies</u> 14 359-379.</p>
<p>Smith, G., Farrell, M., Bunting, B., Houston, J. and Shevlin, M. (2010). Patterns of polydrug use in Great Britain: Findings from a national household population survey. <u>Drug and Alcohol Dependence</u> (early online access).</p>
<p>Smith, K. and Flatley, J. (2011). <u>Drug Misuse Declared: Findings from 2010/11 British Crime Survey</u>. Home Office Statistical Bulletin. Available: http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb1211/hosb1211?view=Binary [accessed 30.08.11]</p>
<p>SOCA (Serious Organised Crime Agency) (2009). <u>Annual Report 2008/09</u>. Serious Organised Crime Agency, London. Available: http://www.soca.gov.uk/about-soca/library/doc_download/53-serious-organised-crime-agency-annual-report-2008-2009.pdf [accessed 17.10.11]</p>
<p>Social Services Improvement Agency (SSIA) (2007). <u>What works in promoting good outcomes for children in need where there is parental substance misuse?</u> SSIA, Cardiff. Available: http://www.gni.org.uk/docs/What_works_in_promoting_good_outcomes.pdf [accessed 05.09.11]</p>

<p>The Social Work (Scotland) Act 1968. Her Majesty's Stationery Office, London. Available: http://www.legislation.gov.uk/ukpga/1968/49 [accessed 05.05.11]</p>
<p>SPS (Scottish Prison Service) (2009). <u>Scottish Prisoner Survey 2009</u>. Scottish Prison Service, Edinburgh. Available: http://www.sps.gov.uk/Publications/Publication79.aspx [accessed 15.03.11]</p>
<p>SPS (Scottish Prison Service) (2010). <u>SPS strategy framework for the management of substance misuse in custody</u>. Scottish Prison Service: Edinburgh. Available: http://www.sps.gov.uk/Publications/Publication97.aspx [accessed 17.08.10]</p>
<p>Stead, J., Lloyd, G., Baird, A., Brown, J., Riddell, S. and Weedon, E. (2011). <u>All Wales School Liaison Core Programme (AWSLCP) evaluation report</u>. Welsh Government, Cardiff. Available: http://wales.gov.uk/docs/caecd/research/110314allwaleschoolliasoncoreprogramm een.doc [accessed 14.09.11]</p>
<p>Stewart, D. (2008). <u>The problems and needs of newly sentenced prisoners: Results from a national survey</u>. Ministry of Justice, London. Available: http://webarchive.nationalarchives.gov.uk/+http://www.justice.gov.uk/docs/research-problems-needs-prisoners.pdf [accessed 08.03.11]</p>
<p>Stewart, D. (2009). Drug use and perceived treatment need among newly sentenced prisoners in England and Wales. <u>Addiction</u> 104 243-247.</p>
<p>Stewart, D., Gossop, M. and Trakada, K. (2007). Drug dependent parents: Childcare responsibilities, involvement with treatment services, and treatment outcomes. <u>Addictive Behaviours</u> 32 (8) 1657-1668.</p>
<p>Stirling, J. and McCoy, L. (2010). Quantifying the Psychological Effects of Ketamine: From Euphoria to the k-Hole. <u>Substance Use and Misuse</u> 45 (14) 2428-2443.</p>
<p>Street, K., Whitlingum, G., Gibson, P., Cairns, P. and Ellis, M. (2008). Is adequate parenting compatible with maternal drug use? A 5-year follow-up. <u>Child: Care, Health and Development</u> 34 (2) 204-206.</p>
<p>Sumnall, H. R., Measham, F., Brandt, S. D. and Cole, J. C. (2011). Salvia divinorum use and phenomenology: results from an online survey. <u>Journal of Psychopharmacology</u> (early online access)</p>
<p>Sykes, W., Coleman, N., Desai, P., Groom, C., Gure, M. and Howarth, R. (2010). <u>Perceptions of the social harms associated with khat use</u>. Home Office Research Report 44. Available: http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/horr44/ [accessed 08.04.11]</p>
<p>Tanner, G. R. Bordon, N. Conroy, S. and Best D. (2011). Comparing methadone and Suboxone® in applied treatment settings: the experiences of maintenance patients in Lanarkshire. <u>Journal of Substance Use</u> (early online access).</p>
<p>Templeton, L. (2010). Meeting the needs of children with the 5-step method. <u>Drugs: Education, Prevention, and Policy</u> 17 (1) 113-128</p>

<p>WAG (Welsh Assembly Government) (2008a). <u>Working Together to Reduce Harm. The Substance Misuse Strategy for Wales 2008-2018</u>. Welsh Assembly Government, Cardiff. Available: http://new.wales.gov.uk/topics/housingandcommunity/safety/publications/strategy0818/?lang=en [accessed 05.05.11]</p>
<p>WAG (Welsh Assembly Government) (2008b) <u>Working Together to Reduce Harm. The Substance Misuse Strategy. Three-year Implementation Plan 2008-11</u>. Welsh Assembly Government, Cardiff. Available: http://new.wales.gov.uk/topics/housingandcommunity/safety/publications/strategy0818/?lang=en [accessed 05.05.11]</p>
<p>WAG (Welsh Assembly Government) (2009). <u>Substance misuse in Wales 2008/09</u>. Welsh Assembly Government, Cardiff. Available: http://wales.gov.uk/docs/dsilg/publications/commsafety/091006submisuse0809en.pdf [accessed 21.05.11]</p>
<p>WAG (Welsh Assembly Government) (2010a). <u>Substance Misuse Annual Report 2010</u>. Welsh Assembly Government, Cardiff. Available: http://new.wales.gov.uk/topics/housingandcommunity/safety/substancemisuse/publications/annualreport10/?lang=en [accessed 09.05.11]</p>
<p>WAG (Welsh Assembly Government) (2010b). <u>Working Together to Reduce Harm - Substance Misuse Annual Report 2010</u>. Welsh Assembly Government, Cardiff. Available: http://wales.gov.uk/docs/dsilg/publications/commsafety/101118smannreporten.doc [accessed 05.05.11]</p>
<p>WAG (Welsh Assembly Government) (2010c). <u>All Wales School Liaison Core Programme (AWSLCP)</u>. Welsh Assembly Government, Cardiff. Available: http://wales.gov.uk/docs/dsilg/research/101231AWSLCPreporten.pdf [accessed 05.05.11]</p>
<p>WAG (Welsh Assembly Government) (2010d). <u>Blood Borne Viral Hepatitis Action Plan for Wales 2010-2015</u>. Welsh Assembly Government, Cardiff. Available: http://wales.gov.uk/docs/phhs/publications/100226actionplanen.pdf [accessed 11.05.11]</p>
<p>WAG (Welsh Assembly Government) (2010e). <u>Drug Interventions Programme: Wales Annual Report</u>. Welsh Assembly Government, Cardiff. Available: http://wales.gov.uk/topics/housingandcommunity/safety/substancemisuse/publications/dipannreport2009-10/?lang=en [accessed 31.08.11]</p>
<p>WAG (Welsh Assembly Government) (2010f). <u>Integrated Family Support Services: Statutory Guidance and Regulations</u>. Welsh Assembly Government, Cardiff. Available: http://wales.gov.uk/docs/caecd/publications/100922ifssguidenceen.pdf [accessed 18.04.11]</p>
<p>WAG (Welsh Assembly Government) (2011a). <u>Drug Related Deaths in Wales 2010 – Annual Report of the Systematic Review of Drug Related Deaths in Wales</u>. Welsh Assembly Government, Cardiff. Available: http://wales.gov.uk/docs/dsilg/research/110308drdreport2010en.pdf [accessed 05.05.11]</p>

<p>WAG (Welsh Assembly Government) (2011b). <u>Sustainable Social Services: A Framework for Action</u>. Welsh Assembly Government, Cardiff. Available: http://wales.gov.uk/topics/health/publications/socialcare/guidance1/services/?lang=en [accessed 11.04.11]</p>
<p>Walker, A., Flatley, J., Kershaw, C. and Moon, D. (2009). <u>Crime in England and Wales 2008/09</u>. Available: http://webarchive.nationalarchives.gov.uk/20110220105210/http://rds.homeoffice.gov.uk/rds/crimeew0809.html [accessed 11.08.11]</p>
<p>Webb, T., Sniehotta, F. and Michie, S. (2010). Using theories of behaviour change to inform interventions for addictive behaviours. <u>Addiction</u> 105 (11) 1879</p>
<p>Welsh Government (2011a). <u>Substance Misuse Treatment Framework (SMTF) Prevention and Education of Volatile Substance Abuse (VSA)</u>. Welsh Government, Cardiff. Available: http://wales.gov.uk/docs/dsijg/publications/commsafety/110518vsaen.pdf [accessed 01.09.11]</p>
<p>Welsh Government (2011b). <u>Substance misuse in Wales 2010/11</u>. Welsh Government, Cardiff. Available: http://wales.gov.uk/topics/housingandcommunity/safety/substancemisuse/stats/?lang=en [accessed 28.10.11]</p>
<p>Welsh Government (2011c). <u>Substance Misuse Treatment Framework (SMTF) Guidance for Evidence Based Psychosocial Interventions in the Treatment of Substance Misuse</u>. Welsh Government, Cardiff. Available: http://wales.gov.uk/docs/dsijg/publications/commsafety/110628psychosocialen.pdf [accessed 20.07.11]</p>
<p>Welsh Government (2011d). <u>Substance Misuse Treatment Framework (SMTF) Guidance for the Provision of Evidence Based Tier 4 Services in the Treatment of Substance Misuse</u>. Welsh Government, Cardiff. Available: http://wales.gov.uk/docs/dsijg/publications/commsafety/110628tier4servicesen.pdf [accessed 20.07.11]</p>
<p>Welsh Government (2011e). <u>Substance misuse treatment framework (SMTF) guidance for evidence based community prescribing in the treatment of substance misuse</u>. Welsh Assembly Government, Cardiff. Available: http://wales.gov.uk/docs/dsijg/publications/commsafety/110628prescribingen.pdf [accessed 17.08.11]</p>
<p>Welsh Government (2011f). <u>Drug Related Deaths in Wales 2010 – Annual Report of the Systematic Review of Drug Related Deaths in Wales</u>. Welsh Assembly Government, Cardiff. Available: http://wales.gov.uk/docs/dsijg/research/110308drdreport2010en.pdf [accessed 05.05.11]</p>
<p>Welsh Government (2011g). <u>Substance misuse treatment framework (SMTF) service framework for needle and syringe programmes in Wales</u>. Welsh Government, Cardiff. Available: http://wales.gov.uk/docs/dsijg/publications/commsafety/110628needleen.pdf [accessed 16.08.11]</p>

Welsh, J., Precey, G. and Lambert, P. (2008). Parents of children at risk – A multi-agency initiative to address substance misuse amongst parents whose children are at risk of neglect. <u>Child Abuse Review</u> 15 454-462.
Winstock, A., Mitcheson, L., Ramsey, J., Davies, S., Puchnarewicz, M. and Marsden, J. (2011a). Mephedrone: use, subjective effects and health risks. <u>Addiction</u> (early online access)
Winstock, A. R., Mitcheson, L. R., Deluca, P. Davey, Z., Corazza, O. and Schifano, F. (2011b). Mephedrone, new kid for the chop? <u>Addiction</u> 106 (1) 154–161.
Wood, D., Who, S., Alldus, G., Huggett, D., Nicolaou, M., Chapman, K., Oakley, M., Bessim, E., Julian, K., Sturgeon, K., Ramsey, J. D. and Dargan, P. I. (2010a). The development of the recreational drug outreach educational concept 'Drug Idle'. <u>Journal of Substance Use</u> 15 (4) 237-245.
Wood, D. M., Davies, S., Greene, S. L., Button, J., Holt, D. W., Ramsey, J., and Dargan, P. I. (2010b). Case series of individuals with analytically confirmed acute mephedrone toxicity. <u>Clinical Toxicology</u> 48 (9) 924-927
Wood, D., Beaumont, P., May, D. and Dargan, P. (2010c). Recreational drug use presentations during a large outdoor festival event: Reduction in hospital emergency department transfer where medical physicians are present. <u>Journal of Substance Use</u> 15 (6) 434-441.
Wood, D. M., Stribley, V., Dargan, P. I., Davies, S., Holt, D. W. and Ramsey, J. (2010d). Variability in the 3,4-methylenedioxymethamphetamine content of 'ecstasy' tablets in the UK. <u>Emergency Medical Journal</u> (early online access)
Wood, D. M., Conran, P. and Dargan, P. I. (2011). ICD-10 coding: poor identification of recreational drug presentations to a large emergency department. <u>Emergency Medicine Journal</u> 28 (5) 387-389.
Woolfall, K. and Sumnall, H. (2010). Evaluating interventions for children of substance using parents: A review of outcome measures. <u>Addiction research and theory</u> 18 (3) 326-343.
Woolfall, K. (2006a). Services working to meet the needs of children of drug using families. Liverpool John Moores University, Liverpool.
Woolfall, K. (2006b). An evaluation of PSS IMPACT: Addressing the needs of children of drug and alcohol using parents. Liverpool John Moores University, Centre for Public Health, Liverpool. Available: http://www.cph.org.uk/showPublication.aspx?pubid=398 [accessed 23.09.11]
Woolfall, K., Sumnall, H. R. and McVeigh, J. (2008). <u>Addressing the needs of children of substance using parents. An evaluation of Families First's Intensive Intervention</u> . Liverpool John Moores University, Liverpool. Available: http://www.cph.org.uk/showPublication.aspx?pubid=455 [accessed 03.03.11]

Wright, S., Gray, P., Watts, E., McAteer, L., Hazel, N. et al. (2010). Evaluation of Early Parental Intervention Pilot Projects. Final Report to the Welsh Assembly Government. Swansea University, Wales. Available: <http://wales.gov.uk/docs/dsijq/research/100809researchepipen.pdf> [accessed 05.10.11]

List of tables used in the text

Table	Page
Table 1.1: Labelled public expenditure on drugs by COFOG category in England, 2006/07 to 2010/11	34
Table 1.2: Labelled public expenditure in Northern Ireland, 2008/09 to 2010/11	35
Table 1.3: Labelled public expenditure in Wales, 2006/07 to 2010/11	35
Table 2.1: Percentage of 16 to 59 year olds reporting lifetime, last year and last month use of individual drugs in England and Wales, 2010/11	38
Table 2.2: Percentage of 16 to 64 year olds reporting lifetime, last year and last month use of individual drugs in Northern Ireland, 2009/10 by gender	41
Table 2.3: Percentage of 16 to 24 year olds and 16 to 34 year olds reporting last year use of individual drugs in England and Wales, 2010/11 by gender	43
Table 2.4: Percentage of recent cannabis users reporting daily use in England and Wales 2010/11 by age and gender	43
Table 2.5: Percentage of 16 to 24 year olds and 16 to 34 year olds reporting last year use of individual drugs in Scotland, 2009/10 by gender	44
Table 2.6: Percentage of pupils aged 11 – 15 years reporting lifetime, last year and last month use of individual drugs in England in 2010 by gender	46
Table 2.7: Percentage of pupils reporting last year use of drugs in England, 2010 by age and gender	46
Table 2.8: Percentage of pupils aged 11 – 15 years reporting lifetime, last year and last month use of individual drugs in Wales in 2009/10 by gender	48
Table 2.9: Percentage of pupils reporting last year use of drugs in Wales, 2009/10 by age and gender	48
Table 2.10: Lifetime, last year and last month use of individual drugs amongst schoolchildren in Northern Ireland, 2007 and 2010	49
Table 2.11: Percentage of respondents in a clubbers' survey reporting lifetime, last year and last month use of certain individual drugs, 2010	52
Table 4.1: Estimates of OCU, opiate use, crack cocaine use and drug injecting and rates per 1,000 population aged 15 to 64 in England, 2009/10	65
Table 4.2: Estimated number of OCUs, opiate users, crack cocaine use and drug injectors aged 15 to 64 in England, 2004/05, 2005/06, 2006/07, 2008/09 and 2009/10	65
Table 4.3: Prevalence rate per 1,000 population of opiate and/or crack cocaine users by age group in England, 2009/10	66
Table 4.4: Estimated number of opiate and/or crack cocaine users by age group in England, 2006/07, 2008/09 and 2009/10	66
Table 4.5: Estimates of problem drug use in the United Kingdom: number and rate per 1,000 population aged 15 to 64	67

Table 4.6: Estimates of injecting drug use in the United Kingdom: number and rate per 1,000 population, aged 15 to 64	67
Table 4.7: Estimates of problem drug use: number and rate per 1,000 population, aged 15 to 64 in the United Kingdom	68
Table 4.8: Estimates of injecting drug use: number and rate per 1,000 population, aged 15 to 64 in the United Kingdom	68
Table 5.1: Presentations by centre type in the United Kingdom, 2003/04 to 2009/10	80
Table 5.2: Presentations to treatment by primary drug and centre type in the United Kingdom, 2009/10	81
Table 5.3: Presentations to treatment by primary drug and country in the United Kingdom 2009/10	82
Table 5.4: Opiate and crack cocaine users in drug treatment in England 2005/06, 2006/07, 2008/09 and 2009/10	90
Table 6.1: Inpatient discharges recording poisoning by drugs in the UK 2007/08 to 2009/10 by drug	99
Table 6.2: Drug mentions on death certificates in the United Kingdom, 2002 to 2010	111
Table 7.1: Syringe provision: number of visits and syringes issued in Northern Ireland, 2001/02 to 2010/11	121
Table 9.1: Recorded crime: Drug offences in the United Kingdom by offence type and country, 2004/05 to 2010/11	140
Table 9.2: Number of persons arrested for drug offences in England and Wales, and Northern Ireland, 2003/04 to 2009/10	140
Table 9.3: Drug offences where the offender was found guilty or issued a caution in the United Kingdom, 2002 to 2009 by individual drug	141
Table 9.4: One year reconviction rates and frequency rates for cohorts of drug offenders in Scotland, 1997/98 to 2008/09	145
Table 9.5: Number and percentage of offenders receiving each disposal for drug offence type in England and Wales, 2010	146
Table 9.6: Average sentence length (months) for offenders given immediate custody in England and Wales, 2010 by offence type and drug class	146
Table 9.7: Reasons for termination of DTTOs in Scotland, 2004/05 to 2009/10	148
Table 10.1: Number of seizures of drugs by law enforcement agencies in England and Wales, 2004 to 2009/10	154
Table 10.2: Number of seizures of drugs by law enforcement agencies in England and Wales, 2004 to 2009/10	155
Table 10.3: Number of seizures of drugs by police in Northern Ireland, 2005/06 to 2010/11	155
Table 10.4: Quantity of seizures of drugs by police in Northern Ireland, 2005/06 to 2010/11	156

Table 10.5: Law enforcement agencies: Mean price of illegal drugs in the United Kingdom, 2005 to 2010	158
Table 10.6: Mean percentage purity of certain drugs seized by police in England and Wales, 2003 to 2010	159
Table 10.7: Purity-adjusted price of cocaine powder per gram in the United Kingdom, 2003 to 2010: indexed to 2003	159
Table 10.8: Purity-adjusted price of heroin per gram in the United Kingdom, 2003 to 2010: indexed to 2003	160
Table 11.1 Number of prisoners receiving detoxification and extended prescribing programmes in prisons in England and Wales, 2004/05 to 2009/10	172
Table 11.2: Initial assessments carried out by CARAT teams in prisons in England, 2004/05 to 2009/10.	172
Table 11.3: Number and percentage of all prisoners prescribed opioid substitution drugs on a given day in Scottish prisons, 2004 to 2009	173
Table 11.4: Results of drug testing on reception to and prior to release from Scottish prisons, 2009/10	180
Table 12.1: Number and percentage of clients starting an episode of treatment in 2009/10 by parental status and residential status of children and by gender	182
Table 12.2: Percentage of respondents in DTORS study seeking drug treatment in 2006 by parental status, residential status of children and by gender, age and primary drug	183
Table 12.3: Number of inpatient discharges with an ICD-10 code P04.4 or P96.1 in the UK 2007/08, 2008/09 and 2009/10	188

List of figures used in the text

Figure	Page
Figure T.1: Trends across heroin indicators in the UK, 2003 to 2010; indexed to 2003	17
Figure T.2: Trends across crack cocaine indicators in the UK, 2003 to 2010; indexed to 2003	18
Figure T.3: Trends across cocaine powder indicators in the UK, 2003 to 2010; indexed to 2003	19
Figure T.4: Trends across ecstasy indicators in the UK, 2003 to 2010; indexed to 2003	20
Figure T.5: Drug possession offences and drug use in England and Wales, 2003 to 2009; indexed to 2003	21
Figure T.6: Trends across cannabis indicators on the UK, 2003 to 2010; indexed to 2003	22
Figure 2.1: Percentage of 16 to 59 year olds reporting last year use of individual drugs in England and Wales, 1996 to 2010/11	40
Figure 2.2: Percentage of 16 to 34 year olds reporting last year use of individual drugs in the UK from 2003/04 to 2009/10	42
Figure 2.3: Percentage of 16 to 24 year olds reporting last year use of individual drugs in England and Wales, 1996 to 2010/11	44
Figure 2.4: Drug use amongst schoolchildren in England, 2001 to 2010	47
Figure 2.5: Recent use of some individual drugs amongst schoolchildren in England, 2001 to 2010	47
Figure 2.6: Percentage of positive tests for illegal drugs in the British Armed Forces, 2000 to 2010	51
Figure 5.1: Number of clients presenting to treatment with primary use of 'other stimulants' and percentage of all primary stimulants in the United Kingdom 2003/04 to 2009/10	83
Figure 5.2: Number and percentage of primary heroin presentations reporting secondary use of crack cocaine in the United Kingdom, 2003/04 to 2009/10	83
Figure 5.3: Number of reports of secondary alcohol use amongst primary heroin users and proportion of all heroin clients reporting secondary alcohol use in the United Kingdom, 2003/04 to 2009/10	84
Figure 5.4: Trends in the number of clients presenting for treatment for individual drugs in the United Kingdom, 2003/04 to 2009/10	86
Figure 5.5: Numbers of under 18s in treatment for individual Class A drugs in England, 2005/06 to 2009/10	87
Figure 5.6: Number of opioid users in prescribing treatment in England, 2005/06 to 2009/10	88
Figure 6.1: Trends in the prevalence of HIV infection among recently initiated injecting drug users* in England, Wales & Northern Ireland**, 2000 to 2010	93

Figure 6.2: Percentage of recently initiated injecting drug users* with antibodies to hepatitis C in England, Wales and Northern Ireland**, 1998 to 2010	95
Figure 6.3: Psychiatric inpatient discharges with a diagnosis of drug misuse in Scotland, 2001/02 to 2008/09; rate per 100,000 population	98
Figure 6.4: Drug-related deaths in the United Kingdom, 1996 to 2010: EMCDDA definition	109
Figure 6.5: Comparison of total number of deaths using three definitions in the United Kingdom, 1996 to 2010	109
Figure 6.6: Number of deaths by age group in the United Kingdom, 1998 to 2010; EMCDDA definition	110
Figure 8.1: Percentage of adults reporting people using or dealing drugs to be a problem in their area in England and Wales, 1992 to 2010/11	131
Figure 9.1: Number of cannabis offences by sanction type in England and Wales, 2003 to 2009	142
Figure 9.2: Average sentence length (months) for offenders given immediate custody for drug importation offences in England and Wales, 2006 to 2010	147
Figure 10.1: The percentage of seized tablets analysed by the Forensic Science Service (FSS) containing MDMA, piperazines and cathinones by quarter in England and Wales, 2005 to 2010.	157
Figure 10.2: Price and purity of cocaine powder in England and Wales, 2003 to 2010: indexed to 2003	160
Figure 10.3: Wholesale (SOCA/UKBA) and street-level (police) purity of heroin and wholesale price in the United Kingdom, 4th quarter 2008 to 1st quarter 2011	161
Figure 11.1: Percentage of prisoners in Scotland reporting use of individual drugs in the 12 months prior to imprisonment	165
Figure 11.2: Numbers of self-inflicted deaths (SIDs) among women in prison in England, 2002-2007	174
Figure 11.3: Hepatitis B vaccine doses delivered to prisoners in England and Wales between 2003 and 2009	175
Figure 11.4: Examples of BBV health promotion materials in use in prisons in England	176
Figure 11.5: Percentage of mandatory drug test samples testing positive in England and Wales, 1995/96 to 2010/11	179

List of Abbreviations used in the Text

2-DPMP	desoxypropiradol
3-TFMP	3-trifluoromethylphenylpiperazine
A&E	Accident and Emergency
ACMD	Advisory Council on the Misuse of Drugs
AD(H)D	Attention Deficit (Hyperactive) Disorder
ADPs	Alcohol and Drug Partnerships
ADSW	Association of Directors of Social Work
AIDS	Acquired Immunodeficiency Syndrome
AMI	Attitudes to Mental Illness
AOR	Adjusted Odds Ratio
ATS	Amphetamine Type Stimulants
AWSLCP	All Wales School Liaison Core Programme
BBV	Blood-borne Virus
BCR	Bin Chute Room
BCS	British Crime Survey
BHIVA	British HIV Association
BME	Black and Minority Ethnic
BMJ	British Medical Journal
BMT	Buprenorphine Maintenance Therapy
BPS	British Psychological Society
BRiC	Building Recovery in Communities
BYDS	Belfast Youth Development Study
BZP	Benzylpiperazine
CAF	Common Assessment Framework
CAMPROMPT	The Cambridge Prospective Memory Test
CARAT	Counselling, Assessment, Referral, Advice and Through-care Services
CBD	Cannabidiol
CBDT	Compact Based Drug Testing
CBT	Cognitive Behavioural Therapy
CCDAAG	Carrickfergus Community Drug and Alcohol Advisory Group
CCEA	Council for Curriculum, Examinations and Assessments
CCTV	Closed Circuit Television
CFL	Choices for Life
CI	Confidence Interval
CJAs	Community Justice Authorities
CJINI	Criminal Justice in Northern Ireland
CMO	Chief Medical Officer
COFOG	United Nations Classification of the Functions of Government
COSLA	Convention of Scottish Local Authorities
CQC	Care Quality Commission
CRC	Capture, Re-Capture
CSPs	Community Safety Partnerships
D2PM	Diphenyl-2-pyrrolidinylmethanol
DAATs	Drug and Alcohol Action Teams
DACTs	Drug and Alcohol Co-ordination Teams
DAIRU	Drug and Alcohol Information and Research Unit
DATs	Drug Action Teams
DBS	Dried Blood Spot testing
DCSF	Department for Children, Schools and Families
DD	Dual-Diagnosis
DDC	Dedicated Drug Courts
DfE	Department for Education
DfT	Department for Transport

UNITED KINGDOM FOCAL POINT REPORT 2011

DH	Department of Health
DHSSPSNI	Department of Health, Social Services and Public Safety Northern Ireland
DIP	Drug Interventions Programme
DMD	Drug Misuse Database
DNA	Deoxyribonucleic acid
DORIS	Drug Outcome Research in Scotland
DRD	Drug-Related Deaths
DRR	Drug Rehabilitation Requirement
DSD	Drug Strategy Definition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSRG	Drug Strategy Research Group
DTOC	Drug Testing on Charge
DTTO	Drug Treatment and Testing Order
DWP	Department for Work and Pensions
EACS	Enhanced Addiction Casework Service
EDDRA	Exchange on Drug Demand Reduction Action
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESA	Employment and Support Allowance
ESF	European Social Fund
EU	European Union
FASA	Forum for Action on Substance Abuse
FDAC	Family Drug and Alcohol Court
FE	Further Education
FSS	Forensic Science Service
FTT	Finger Tapping Test
FUEL	Fermanagh Underage Entertainment Life
GBL	Gamma-butyrolactone
GHB	Gamma-hydroxybutyrate
GIRFEC	Getting It Right For Every Child
GMR	General Mortality Register
GP	General Practitioner
GROS	General Register Office for Scotland
HBsAG	Hepatitis B surface Antigen
HBSC	Health Behaviour in School Age Children Survey
HC	House of Commons
HCS	Health Care Standards
HCV	Hepatitis C Virus
HEAT	Health Improvement, Efficiency, Access, Treatment Targets
HIV	Human Immunodeficiency Virus
HIW	Health Inspectorate Wales
HM	Her Majesty
HMIP	Her Majesty's Inspectorate of Prisons
HMPS	Her Majesty's Prison Service
HO	Home Office
HPA	Health Protection Agency
HPS	Health Protection Scotland
HRD	Harm Reduction Database
ICD-10	International Statistical Classification of Diseases and Related Health Problems-tenth edition
IDTS	Integrated Drug Treatment System
IDUs	Injecting Drug Users
IEP	Injecting Equipment Provision
IFSS	Integrated Family Support Services
IQ	Intelligence Quotient

IRISS	Institute for Research and Innovation in Social Services
ISD	Information Services Division
JT	Jacobson and Truax survey
KPIs	Key Performance Indicators
LGBT	Lesbian, Gay, Bisexual, Transgender
LHB	Local Health Board
LLW	Learning for Life and Work
LSD	Lysergic Diethylamide Acid
MDMA	3,4-Methyldioxy-n-methylamphetamine
MDMQ	Melbourne Decision-Making Questionnaire
MDT	Mandatory Drug Testing
MHRA	Medicines and Healthcare products Regulatory Agency
MI	Motivational Interviewing
MIM	Multiple Indicator Method
MMT	Methadone Maintenance Therapy
MOD	Ministry of Defence
MOJ	Ministry of Justice
MP	Member of Parliament
MRC	Medical Research Council
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus Aureus
MSIMC	Medically Supervised Injectable Maintenance Clinic
N-ALIVE	NALoxone InVEstigation
NAR	National Assessment Resource
NCCMH	National Collaborating Centre for Mental Health
NDRD	National Drug-Related Deaths
NDRDD	National Drug-Related Deaths Database
NDTMS	National Drug Treatment Monitoring System
NESI	Needle Exchange Surveillance Initiative
NHS	National Health Service
NICE	National Institute for Clinical and Health Excellence
NICS	Northern Ireland Crime Survey
NIPS	Northern Ireland Prison Service
NISRA	Northern Ireland Statistics and Research Agency
NOMS	National Offender Management Service
NPIS	National Poisons Information Service
NPRI	National Research Prevention Initiative
np-SAD	National Programme on Substance Abuse Deaths
NSD	New Strategic Direction for Alcohol and Drugs
NSPs	Needle and Syringe Programmes
NTA	National Treatment Agency for Substance Misuse
OCU	Opiate and/or crack cocaine user
OFMDFMI	Office of the First Minister and Deputy First Minister of Northern Ireland
OI	Offender's Index
ONS	Office for National Statistics
OSA	Occupational Self Assessment
OST	Opioid Substitution Treatment
OTC	Over The Counter
p2w	Progress2work
PbR	Payment by Results
PCR	Polymerase Chain Reaction
PCT	Primary Care Trust
PDI	Partnership Drugs Initiative
PDMU	Personal Development and Mutual Understanding

PDU	Problem Drug Use(rs)
PHA	Public Health Agency
PHE	Public Health England
PHIRB	Public Health Information and Research Branch
PM	Prospective Memory
PND	Penalty Notices for Disorder
POM	Prescription Only Medicine
PSA(s)	Public Service Agreements
PSHE	Personal, Social and Health Education
PSIs	Prison Service Instructions
PSNI	Police Service of Northern Ireland
PSOs	Prison Service Orders
RBMT	Rivermead Behavioural Memory Test
RCP	Royal College of Physicians
RCPsych	Royal College of Psychiatrists
RCT	Randomised Controlled Trial
RIOTT	Randomised Injectable Opioid Treatment Trial
RNA	Ribonucleic acid
SACDM	Scottish Advisory Committee on Drugs Misuse
SALSUS	Scottish Schools Adolescent Lifestyle and Substance Use Survey
SCDEA	Scottish Crime and Drug Enforcement Agency
SCJS	Scottish Crime and Justice Survey
SCL-90-R	The Symptom Checklist-90-R
SCVS	Scottish Crime and Victimisation Survey
SDF	Scottish Drugs Forum
SDMD	Scottish Drugs Misuse Database
SDRC	Scottish Drugs Recovery Consortium
SFA	Scottish Football Association
SIMD	Scottish Index of Multiple Deprivation
SMR	Special Mortality Register
SMRs	Standardised Mortality Ratio
SOCA	Serious and Organised Crime Agency
SP	Scottish Parliament
SPCR	Surveying Prisoner Crime Reduction
SPS	Scottish Prison Service
SQ	Standard Questionnaire
SR	Systematic Review
SRU	Scottish Rugby Union
ST	Standard Table
TDI	Treatment Demand Indicator
THC	delta-9-tetrahydrocannabinol
THN	Take-Home-Naloxone
TOP	Treatment Outcomes Profile
UAM	Unlinked Anonymous Monitoring survey
UK	United Kingdom
UKBA	United Kingdom Border Agency
UKCBTMM	United Kingdom Cognitive Behaviour Therapy study in Methadone Maintenance treatment
UKDPC	United Kingdom Drug Policy Commission
UN	United Nations
US	United States of America
VAS	Visual Analogue Scales
VCS	Voluntary and Community Sector
VCSE	Voluntary, Community and Social Enterprise

VDT	Voluntary Drug Testing
VSA	Volatile Substance Abuse
VTUs	Voluntary Testing Units
WA	Written Answer
WAG	Welsh Assembly Government
WHO	World Health Organisation
YPBAS	Young Person's Behaviour and Attitudes Survey
YPSAL	Young People, Sport and Leisure Questionnaire

List of Standard Tables and Structured Questionnaires

Number	Title	Source
ST01	Basic results and methodology of population surveys on drug use	England and Wales - British Crime Survey (BCS) Scotland – Scottish Crime and Justice Survey (SCJS) Northern Ireland – Northern Ireland Crime Survey (NICS); Drug Prevalence Survey
ST02	Methodology and results of school surveys on drug use	England – Smoking, Drinking and drug use amongst school children in England Scotland – Scottish Adolescent Lifestyle and Substance Use Survey (SALSUS) Northern Ireland – Young Persons Behavioural and Attitudes Survey (YPBAS)
ST05	Acute/direct drug-related deaths	General Mortality Registers (GMRs) for England and Wales, Scotland and Northern Ireland
ST06	Evolution of acute/direct drug-related deaths	General Mortality Registers (GMRs) for England and Wales, Scotland and Northern Ireland
ST07	National prevalence estimates on problem drug use	Home Office; NHS ISD Scotland; DHSSPSNI; Welsh Assembly Government
ST08	Local prevalence estimates on problem drug use	Home Office; NHS ISD Scotland
ST09	Prevalence of hepatitis B/C and HIV infection among injecting drug users	Health Protection Agency (HPA); Health Protection Scotland (HPS); National Public Health Service for Wales (NPHSW); Communicable Disease Surveillance Centre Northern Ireland
ST10	Syringe availability	Northern Ireland Needle & Syringe Exchange Scheme (NSES)
ST11	Arrests/reports for drug law offences	Ministry of Justice; Scottish Government; Northern Ireland Office; Police Service of Northern Ireland (PSNI)
ST12	Drug use among prisoners	Scottish Prison Service
ST13	Number and quantity of seizures of illicit drugs	Home Office; Her Majesty's Revenue & Customs (HMRC); Scottish Government; Scottish Crime and Drug Enforcement Agency (SCDEA); Police Service of

UNITED KINGDOM FOCAL POINT REPORT 2011

		Northern Ireland (PSNI)
ST14	Purity at street level of illicit drugs	Forensic Science Service (FSS); LGC Forensics Ltd
ST15	Composition of tablets sold as illicit drugs	Forensic Science Service (FSS)
ST16	Price in Euros at street level of illicit drugs	Serious Organised Crime Agency (SOCA)
ST24	Access to treatment	National Drug Treatment Monitoring System (NDTMS) in England
SQ25	Universal prevention	Consultation with relevant UK government officials
SQ26	Selective and indicated prevention	Consultation with relevant UK government officials
SQ27	Treatment programmes	Consultation with relevant UK government officials
SQ28	Social reintegration	Consultation with relevant UK government officials
SQ31	Treatment as an alternative to imprisonment	Consultation with relevant UK government officials
SQ32	Policy and institutional framework	Consultation with relevant UK government officials
ST34	TDI data	National Drug Treatment Monitoring System (NDTMS) in England, the Scottish Drug Misuse Database, the Welsh National Database for Substance Misuse; and the Northern Ireland Drug Misuse Database

Appendix A: United Kingdom prevalence estimates from population surveys

By combining data from the British Crime Survey (BCS) 2009/10, the Northern Ireland Crime Survey (NICS) 2008/09 and the Scottish Crime and Justice Survey (SCJS) 2009/10, estimates of drug use have been produced for the United Kingdom.

Table A.1: percentage of 16 to 59 year olds reporting having used individual drugs in lifetime, last year and last month in the United Kingdom, 2009/10

	BRITISH CRIME SURVEY 2009/10	NORTHERN IRELAND CRIME SURVEY 2008/09	SCOTTISH CRIME AND JUSTICE SURVEY 2009/10	UNITED KINGDOM ESTIMATE
Lifetime prevalence				
Any illicit drug	36.4	27.5	33.5	35.9
Amphetamines	11.7	7.4	10.5	11.5
Cannabis	30.6	20.6	30.5	30.3
Cocaine	8.8	4.6	9.1	8.7
Ecstasy	8.3	7.9	10.2	8.5
Heroin	0.7	0.8	1.2	0.8
LSD	5.3	4.4	6.3	5.4
Magic mushrooms	7.4	5.1	7.3	7.3
Last year prevalence				
Any illicit drug	8.6	6.7	9.8	8.7
Amphetamines	1.0	0.6	1.3	1.0
Cannabis	6.6	5.0	8.3	6.7
Cocaine	2.5	1.1	2.9	2.5
Ecstasy	1.6	1.1	2.6	1.7
Heroin	0.1	0.1	0.4	0.1
LSD	0.2	0.4	0.3	0.2
Magic mushrooms	0.4	0.2	0.5	0.4
Last month prevalence				
Any illicit drug	5.0	3.8	5.8	5.0
Amphetamines	0.3	0.1	0.5	0.3
Cannabis	3.9	2.8	4.9	4.0
Cocaine	1.1	0.5	1.0	1.1
Ecstasy	0.6	0.5	0.9	0.6
Heroin	0.1	0.0	0.3	0.1
LSD	0.1	0.2	0.1	0.1
Magic mushrooms	0.1	0.1	0.1	0.1
<i>Net response</i>	26,199	2,204	8,814	

Table A.2: Percentage of 16 to 34 year olds reporting having used individual drugs in lifetime, last year and last month in the United Kingdom, 2009/10

	BRITISH CRIME SURVEY 2009/10	NORTHERN IRELAND CRIME SURVEY 2008/09	SCOTTISH CRIME AND JUSTICE SURVEY 2009/10	UNITED KINGDOM ESTIMATE
Lifetime prevalence				
Any illicit drug	44.4	38.4	43.5	44.1
Amphetamines	14.3	11.8	14.1	14.2
Cannabis	38.8	30.7	39.8	38.6
Cocaine	13.4	9.0	14.6	13.4
Ecstasy	12.7	15.1	16.5	13.1
Heroin	0.8	1.0	1.6	0.9
LSD	5.5	6.9	7.0	5.7
Magic mushrooms	8.2	7.5	9.2	8.3
Last year prevalence				
Any illicit drug	15.5	13.8	17.5	15.6
Amphetamines	1.8	1.4	2.6	1.9
Cannabis	12.0	10.4	14.9	12.2
Cocaine	4.8	2.6	5.9	4.8
Ecstasy	3.2	2.9	5.5	3.4
Heroin	0.1	0.0	0.6	0.1
LSD	0.3	1.0	0.7	0.4
Magic mushrooms	0.8	0.4	1.6	0.9
Last month prevalence				
Any illicit drug	8.9	8.0	10.6	9.0
Amphetamines	0.6	0.2	1.0	0.6
Cannabis	6.8	5.8	8.9	6.9
Cocaine	2.1	1.3	2.3	2.1
Ecstasy	1.3	1.4	1.9	1.4
Heroin	0.1	0.0	0.5	0.1
LSD	0.1	0.6	0.2	0.1
Magic mushrooms	0.2	0.3	0.9	0.3
<i>Net response</i>	<i>8,945</i>	<i>805</i>	<i>2,870</i>	

Table A.3: Percentage of 16 to 24 year olds reporting having used individual drugs in lifetime, last year and last month in the United Kingdom, 2009/10

	BRITISH CRIME SURVEY 2009/10	NORTHERN IRELAND CRIME SURVEY 2008/09	SCOTTISH CRIME AND JUSTICE SURVEY 2009/10	UNITED KINGDOM ESTIMATE
Lifetime prevalence				
Any illicit drug	40.7	35.2	38.2	40.3
Amphetamines	10.0	7.8	9.1	9.9
Cannabis	34.7	27.5	33.9	34.4
Cocaine	11.7	6.6	12.7	11.6
Ecstasy	10.0	12.2	14.4	10.4
Heroin	0.5	1.2	0.8	0.5
LSD	2.4	3.4	3.6	2.5
Magic mushrooms	5.7	5.8	6.7	5.8
Last year prevalence				
Any illicit drug	20.0	18.2	20.2	20.0
Amphetamines	2.4	2.2	2.3	2.4
Cannabis	16.1	13.8	17.4	16.1
Cocaine	5.6	2.9	6.6	5.6
Ecstasy	4.3	4.4	6.3	4.5
Heroin	0.1	0.0	0.3	0.1
LSD	0.5	2.2	0.6	0.6
Magic mushrooms	1.2	0.7	1.9	1.2
Last month prevalence				
Any illicit drug	11.6	10.2	11.7	11.6
Amphetamines	0.7	0.5	0.9	0.7
Cannabis	9.2	6.7	10.4	9.2
Cocaine	2.6	1.7	2.6	2.6
Ecstasy	1.9	2.2	2.2	1.9
Heroin	0.1	0.0	0.3	0.1
LSD	0.2	1.2	0.3	0.2
Magic mushrooms	0.3	0.7	1.1	0.4
<i>Net response</i>	3,429	286	1,157	

Appendix B: United Kingdom treatment presentations by primary drug

Table B.1: Number and percentage of all drug treatment presentations by primary drug in the United Kingdom, 2003/04 to 2009/10

Drug	2003/04		2004/05		2005/06		2006/07		2007/08		2008/09		2009/10	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Amphetamines	3,474	3.7	3,731	3.6	4,134	3.5	4,622	3.8	4,416	3.5	4,315	3.2	3,701	3.0
Benzodiazepines	1,929	2.1	2,503	2.4	2,297	1.9	2,226	1.8	2,512	2.0	2,480	1.9	2,453	2.0
Cannabis	9,849	10.7	14,801	14.1	18,793	15.8	19,108	15.6	20,938	16.4	22,884	17.1	24,112	19.6
Cocaine powder	3,739	4.0	5,093	4.9	6,890	5.8	8,372	6.9	10,215	8.0	11,446	8.5	9,362	7.6
Crack cocaine	4,980	5.4	5,842	5.6	6,857	5.8	7,096	5.8	7,453	5.9	7,985	6.0	5,517	4.5
Opiates	66,012	71.4	70,179	67.0	77,580	65.1	77,849	63.7	78,803	61.9	82,016	61.2	74,815	60.8
Other	2,494	2.7	2,662	2.5	2,540	2.1	2,890	2.4	3,011	2.4	2,834	2.1	3,152	2.6
<i>Sub Total</i>	92,477	100	104,811	100	119,091	100	122,163	100	127,348	100	133,960	100	123,112	100
Not Known	7,186		12,970		9,355		6,045		4,655		5,430		4,781	
Total	99,663		117,781		128,446		128,208		132,003		139,390		127,893	

Source ST34

UNITED KINGDOM FOCAL POINT REPORT 2011

Table B.2: Number and percentage of first ever drug treatment presentations by primary drug in the United Kingdom, 2003/04 to 2009/10

Drug	2003/04		2004/05		2005/06		2006/07		2007/08		2008/09		2009/10	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Amphetamines	1,455	5.1	1,619	4.1	1,812	3.9	2,045	4.3	1,976	4.4	1,640	3.8	1,415	3.3
Benzodiazepines	675	2.3	1,226	3.1	1,153	2.5	916	1.9	1,285	2.9	1,074	2.5	1,270	3.0
Cannabis	5,289	18.6	8,653	22.1	11,506	24.8	11,325	24.0	12,251	27.2	12,214	28.0	13,969	32.5
Cocaine powder	1,683	5.8	3,016	7.7	4,197	9.1	4,951	10.5	5,980	13.3	6,581	15.1	5,345	12.4
Crack cocaine	1,722	6.0	2,589	6.6	3,116	6.7	2,900	6.1	2,822	6.3	2,922	6.7	1,998	4.6
Opiates	16,656	57.8	20,464	52.3	23,021	50.0	21,561	45.7	19,126	42.5	17,892	41.0	17,377	40.4
Other	1,329	4.6	1,525	3.9	1,528	3.3	1,468	3.1	1,573	3.5	1,360	3.1	1,617	3.8
<i>Sub Total</i>	<i>28,809</i>	<i>100</i>	<i>39,092</i>	<i>100</i>	<i>46,333</i>	<i>100</i>	<i>45,166</i>	<i>100</i>	<i>45,013</i>	<i>100</i>	<i>43,683</i>	<i>100</i>	<i>42,991</i>	<i>100</i>
Not Known	1,056		3,405		3,292		1,999		1,588		1,365		1,933	
Total	29,865		42,497		49,625		47,165		46,601		45,048		44,924	

Source: ST34

