European Monitoring Centre for Drugs and Drug Addiction

UK Focal Point On Drugs

2012 NATIONAL REPORT (2011 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 on the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2011

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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 Mark Edginton at the Department of Health (mark.edginton@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 2011 or the first half of 2012**.** 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 2013.

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Simon Brandt, Mark Robinson, Lisa Jones, Harry Sumnall and David Seddon at the ***Centre for Public Health at Liverpool John Moores University***.

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Technical Notes

Standard Tables

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

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

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

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

References to Specific Drugs

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

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

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 63.1 million according to the 2011 census which took place on Sunday 27th March. Eighty-four per cent (53.0 million) live in England, eight per cent (5.3 million) in Scotland, five per cent (3.1 million) in Wales and three per cent (1.8 million) in Northern Ireland.

Summary

PART A: New Developments and trends

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

Drug Classification

In 2012 , desoxypipradrol and other pipradrol-related compounds were classified as class B by generic definition. Phenazepam and derivatives of pipradrol were classified as Class C. Methoxetamine and its simple derivatives became the first drugs to be controlled under the provisions within the *Police and Social Responsibility Act* allowing the Home Secretary to invoke a temporary class drug order.

National Action Plans and strategies

May 2012 saw the introduction of the Government Action Plan on New Psychoactive Substances (NPS).This outlines actions on supply and demand reduction in addition to promoting research into new substances.

Northern Ireland published their *New Strategic Direction for Alcohol and Drugs Phase 2 – 2011-2016*, which focuses on reducing drug and alcohol related harm.

In October 2011, the Scottish Drugs Strategy Delivery Commission (DSDC) published its first year report highlighting the action taken by the government, particularly in relation to the local partnership delivery system.

Chapter 2. Drug use in the general population

Results from surveys carried out in 2010/11 in Scotland and Northern Ireland and in 2011/12 in England and Wales indicate that prevalence of drug use amongst the general population has remained stable since 2009/10 with cannabis again the most commonly used drug.

The *Crime Survey for England and Wales (CSEW)* 2011/12 suggests there has been a decrease in last year mephedrone use amongst adults and young people since the previous survey.

School pupils

After a sharp decline between 2009 and 2010, drug use amongst school pupils in England remained relatively stable between 2010 and 2011. The most commonly used substances are cannabis and volatile substances.

Drug use amongst club goers

Data from the self-selecting Mixmag/Guardian survey reports that ecstasy remains the most popular stimulant (68%) amongst clubbers followed by cocaine (42%). Mephedrone preference appears to have dropped substantially amongst respondents, decreasing from 51% to 20%. However, other research conducted in ‘gay friendly’ clubs in London suggest

that mephedrone is the most commonly used drug in that setting (41%) and this has increased substantially from a similar survey carried out in the previous year (27%).

Chapter 3. Prevention

Universal prevention

A review of Personal, Social, Health and Economic (PSHE) education was published in 2011. School based drug education is a central component of universal drug prevention action in the United Kingdom. England introduced reforms in school to address drug and alcohol use risk factors and further committed to improve the quality of PSHE. In addition, the Association of Chief Police Officers and the Department for Education have issued guidance for schools in dealing with drug incidents.

Scotland has redesigned *Choices for Life*, an interactive online education programme and launched a new website.

Mass media and campaigns

National drug information campaigns continue across the UK. In England, the FRANK service has been re-launched In Scotland 'Know the score' continues, and further investment has been provided for training and resources on New Psychoactive Substances (NPS). Wales report further increases in use of their DAN 24/7 service.

Community prevention

In England the diversion and prevention programme *Positive Futures continues* to target "at risk" 10 to 19 year olds and the government has announced support of a database to house information and evidence regarding the effectiveness and impact of prevention initiatives.

In Scotland, further investment has been provided to the *Inspiring Scotland 14 to 19 fund*, aimed at assisting vulnerable young people.

Chapter 4. Problem drug use

Estimates of problematic drug use

In England new estimates are being calculated for the 2010/11 period, and are anticipated to be published in 2013. In Scotland, there were an estimated 59,600 problematic opioid and/or illicit benzodiazepine users in 2009/10, an increase from 2006 (n=55,328).

Combining the 2009/10 estimates for England, Wales and Northern Ireland with the most recent estimate of opiate use for Northern Ireland (2004), it is estimated that there are around 383,534 problematic drug users in the UK. This is equivalent to an approximate rate of 9.38 per 1,000 population aged 15-64. The UK estimate has remained stable since the 2007 estimate.

The combined UK rate for people who inject drugs (PWID) is 3.27 per 1,000 population aged 15-64 (133,112 individuals).

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

Strategy and Policy

The Pooled Treatment Budget (PTB) in England remains at £406.7m for 2012/2013, with the formula for the allocation of the money now including a recovery element based upon the number of people leaving treatment free from dependency and not representing within six months. Eight Payment by Results (PbR) pilots went live in England in April 2012. The pilots will run for two years and a large-scale evaluation is running alongside the pilots.

Data from Scotland for April to June 2012 show that the target on waiting times (90% of people accessing treatment within three weeks) was achieved ahead of schedule.

Treatment system

A number of treatment guidelines and reports have been published in the 2011 and 2012. In England, the Department of Health has launched a pilot to run from 2012 to 2015 exploring supervised Injectable Opioid Treatment (IOT).

Treatment Demand indicator

There has been an overall decrease in the total number of presentations to treatment in the UK between 2009/10 and 2010/2011. Whilst primary opiate users still make up the majority of presentations to treatment, the overall number presenting with primary opiate use has decreased, as has the number presenting with primary cocaine powder use. Presentations for primary cannabis use, after increasing since 2003/04 decreased between 2009/10 and 2010/11. However, cannabis now accounts for one-fifth of all treatment presentations and one-third of first ever presentations.

Chapter 6. Health correlates and consequences

Drug-related deaths

Using the EMCDDA definition, drug-related deaths in the UK dropped by eight per cent in 2011 compared to 2010 (1,785 and 1,930 respectively) with a large decrease in the number of deaths mentioning heroin/morphine and an increase in deaths mentioning methadone. There were four times as many deaths mentioning tramadol in 2011 as in 2003.

Drug-related infectious disease

According to the Unlinked Anonymous Monitoring (UAM) survey, the prevalence of HIV amongst PWID in England, Wales and Northern Ireland remains relatively stable at 1.2%. Based on results of people underdoing voluntary HIV testing, in 2010 in Scotland the prevalence of HIV was 0.4%

Amongst UAM survey participants in England, Wales and Northern Ireland, the prevalence of hepatitis C was relatively stable at 47% in 2010 compared to 43% in 2011. Within England, there were marked variations between regions with the highest prevalence occurring in the North West.

PWID surveyed at needle exchanges across Scotland recorded a hepatitis C prevalence level of 53% in 2011, a decrease from 57% in 2010.

Chapter 7. Responses to health correlates and consequences

Information provision

Action to raise awareness in relation to the health harms of drugs continue across the UK. In December 2011, the Welsh Government held a national 'overdose awareness day' to raise awareness of prevention techniques and to acknowledge the deceased.

There are systems to explore the circumstances around drug-related deaths within each UK country and both Scotland and wales have published the findings of their recent reviews.

Naloxone

In England the Advisory Council on the Misuse of Drugs (ACMD) published a review of naloxone in 2012 concluding that it is safe and efficacious and any potential risks of use are outweighed by its benefits.

In 2012 a trial of the impact of naloxone on drug-related deaths amongst newly released prisoners was initiated in England

'Take home naloxone' is currently available in Scotland and Wales while Northern Ireland is piloting a take-home naloxone scheme.

Strategy and guidance

In 2011, Scotland published their strategy *Sexual Health and Blood-borne Virus Framework 2011-2015*, in addition to quality standards for HIV services and quality indicators for hepatitis C services.

NICE are expected to publish guidance on increasing the uptake of hepatitis B and C testing amongst high risk groups in late 2012.

Needle and Syringe programs

Needle and syringe programmes continue to be widely available across the UK with activity data routinely published in Scotland and Northern Ireland and data from the Harm Reduction Database in Wales due to be published later in 2012.

Chapter 8. Social correlates and social reintegration

Housing

In 2011/12, nine per cent of people presenting to treatment in England reported being homeless, with a further 15% reporting that they were experiencing an urgent housing problem. In Wales, eight per cent of those taken onto the Drug Interventions Programme caseload in 2010/11 reported homelessness with approximately 25% living in temporary

accommodation. Homelessness amongst people entering into treatment in Scotland has dropped from 16% in 2009/10 to 12% in 2011.

Employment

The majority of those presenting to treatment are unemployed, although was a decrease between 2009/2010 and 2010/2011 in the number of unemployed clients in England Scotland and Northern Ireland from 66% to 59%.

Between February 2011 and May 2011 the number of people in the UK claiming Incapacity Benefit or Severe Disablement Allowance (IBSDA) with drug abuse as their main condition, decreased from 34,940 to 34,080.

Families

The percentage of new clients reporting to the Scottish Drugs Misuse Database that they had a dependent under the age of 16 living with them, has remained relatively stable at 41% in 2010/11.

In Northern Ireland in 2010/2011, 14% of those presenting to treatment reported living with a child, a decrease from 20% in 2009/2010.

Reintegration

In 2010/11, £33.1 million was spent on housing-related support services for drug users funded through the Supporting People programme in England.

On March 28 2011, conditions within Employment and Support Allowance were introduced to enable people in residential treatment for drug or alcohol dependency to be automatically treated as having limited capability for work supporting the continuity of benefit payments whilst in treatment.

The Department for Communities and Local Government (DCLG) have published a financial framework for the Troubled Families Programme in England to incentivise and encourage local authorities, through Payment-by-Results (PbR), to work with 'troubled families' by providing intensive support.

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

Drug-offences

Drug-related crime in the UK decreased by one per cent in 2011/2012 although there were country differences with both Northern Ireland and Scotland experiencing increases, and England and Wales a decrease. Arrests for drug offences in England and Wales increased by three per cent from the previous year and Northern Ireland experienced an increase of eight per cent. There was a four per cent increase during 2010 in the number of people found guilty or cautioned at court for drug offences in the United Kingdom. Apart from cannabis, convictions for almost all drugs decreased or remained stable, with offences related to ecstasy reducing by 50%.

Prevention of drug-related crime

In England 2011/2012, approximately 88,000 drug-misusing offenders were supported into treatment and recovery services through the Drug Interventions Program (DIP), an increase from 60,000 the previous year. Data from Wales shows that there were 2,937 referrals to DIP.

An assessment by the National Treatment Agency for substance misuse (NTA) on the value for money of drug treatment and recovery systems estimated that they may have prevented 4.9 million crimes in 2010/11 and saved society £960 million.

Interventions in the criminal justice system

In January 2012, the Sentencing Council in England and Wales published a definitive guideline on sentencing for drug offences that uses a matrix to assess both the role of the offender (culpability) and the quantity of drug involved (category of harm) in setting an appropriate sentence.

Both the number of people commencing and completing Drug Rehabilitation Requirements in England and Wales decreased, however this is thought to be reflective of the shift in Police initiatives in diverting offenders from charge and focusing on maximising completion rates. The numbers of people undertaking and completing Drug Treatment and Testing Orders (DTTO) in Scotland also decreased in 2010/2011.

Drug use in prison

In Scotland, data from 2011 suggests that the numbers of people reporting drug use in prison in the last month, ever having injected drugs and injecting with the last month have all experienced decreases since 2009. Seventeen per cent of exiting prisoners in Scotland and seven per cent of randomly sampled prisoners in England and Wales tested positive to drugs in 2011/2012.

Chapter 10. Drug Markets

Availability

In 2011/2012 in England and Wales, three-quarters of people aged 16-59 years reported that it was easy to obtain drugs. In Scotland there was a continued decrease in the numbers of people reporting ever being offered drugs. The proportion of school children in England having been offered drugs remains stable in 2011 at 29% (28% in 2010), with Scotland reporting a decrease in 2010. In all populations, cannabis continues to be the most commonly offered drug.

Seizures

The numbers of seizures within the UK decreased in 2010/2011, with cannabis seizures responsible for 77% of all UK seizures in this period. Overall, seizures from England and Wales accounted for 87% of the total seizures, Scotland for 11% and Northern Ireland for one per cent, although proportions varied by individual drug.

Decreases in quantities of drugs seized were experienced in powder cocaine, ecstasy and a slight decrease in cannabis plants. Increases were seen in quantities of seized ketamine,

cannabis resin and cannabis herb, with the herbal cannabis increase wholly attributable to a 50% increase in the quantity seized by police (United Kingdom Border Agency figures remain stable). There is evidence of a stabilisation in the number of cannabis farm discoveries.

Price/purity

Following a reported reduction in the supply of heroin in late 2010 and early 2011 heroin purity has decreased and purity-adjusted price has increased. The mean purity of cocaine has increased in 2011 and the mean MDMA content in ecstasy tablets has increased substantially from 49mg to 71mg.

Data from law enforcement suggest that at a wholesale level heroin, cannabis herb and resin have all reportedly increased in price, with cocaine powder remaining stable in 2011. At the street level, most drug prices have remained stable with cannabis appearing to be the only increase. Non-law enforcement data reports that at the street level powder cocaine, heroin and ecstasy have increased whilst high quality cannabis has decreased.

Chapter 11. Residential rehabilitation for drug users

Residential rehabilitation is recognised as an important part of an integrated pathway across the UK and all local partnerships are expected to provide access to such services as appropriate. There are an estimated 121 residential rehabilitation units in the UK and a further 18 independent hospitals offering residential rehabilitative programmes. Most units have a minimum stay of less than six months.

The most common programmes used within residential rehabilitation units in the UK, are 12-Step, Cognitive Behavioural Therapy (CBT), Therapeutic Communities (TCs) and Faith-Based approaches. However, many describe themselves as offering eclectic/integrated approaches, which combine two or more common, and/or bespoke approaches. Many residential rehabilitation units will also offer further support for those with additional health needs, such as mental health needs and a small number will accommodate families within the unit.

Guidelines relevant to residential rehabilitation units have been produced by NICE, the NTA and the devolved administrations. They focus on improving quality and provision, creating greater consistency and supporting commissioning. Treatment frameworks and models have been developed by England and Wales. Each devolved administration has a regulatory body, which will inspect residential rehabilitation units to ensure that they comply with their regulations. In order to provide services legally, residential units must also register with the regulatory body within their country.

Chapter 12 - Recent trends of drug-related public expenditure

It is estimated that, in 2010/11, labelled drug-related expenditure in the UK amounted to £1.1 billion. Since 2005/06, labelled drug-related expenditure has decreased by 0.5% in real terms, largely due to the mainstreaming of certain drug specific funding elements. Labelled drug-related expenditure accounted for 0.19% of public sector expenditure on services in 2005/06 and 0.17% in 2010/11.

The estimate of unlabelled expenditure, which includes law enforcement costs for drug law offences, drug-related crime, drug-related health costs, personal social services and drug-

related welfare benefits totalled £6.3 billion in 2010/11, the majority of which (70%) was law enforcement expenditure.

Overall it is estimated that drug-related expenditure in the UK amounted to £7.4 billion in 2010/11, 42% (£3.1 billion) of which was proactive government expenditure with the remainder being reactive. This accounts for 1.1% of all public sector expenditure on services in 2010/11 and is 0.49% of GDP.

It is recommended that, before further estimations of drug-related public expenditure are undertaken, a consensus is sought on the definitions and methodology guiding the estimates and the rationale for undertaking such a study.

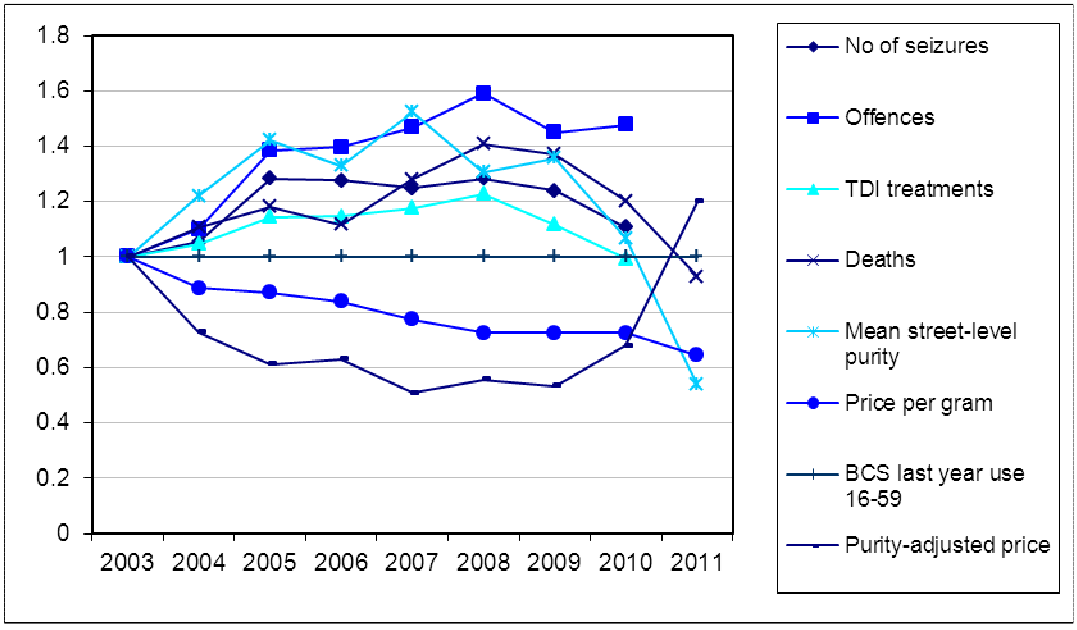
Trends by Individual Drug

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. Inpatient hospital discharge data are only available on a comparable basis from 2007/08 so have not been included in the figures. Where data are for financial year e.g. 2003/04, data 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 prevalence of use are for England and Wales. Price data have not been adjusted for inflation. 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 2011; indexed to 2003*



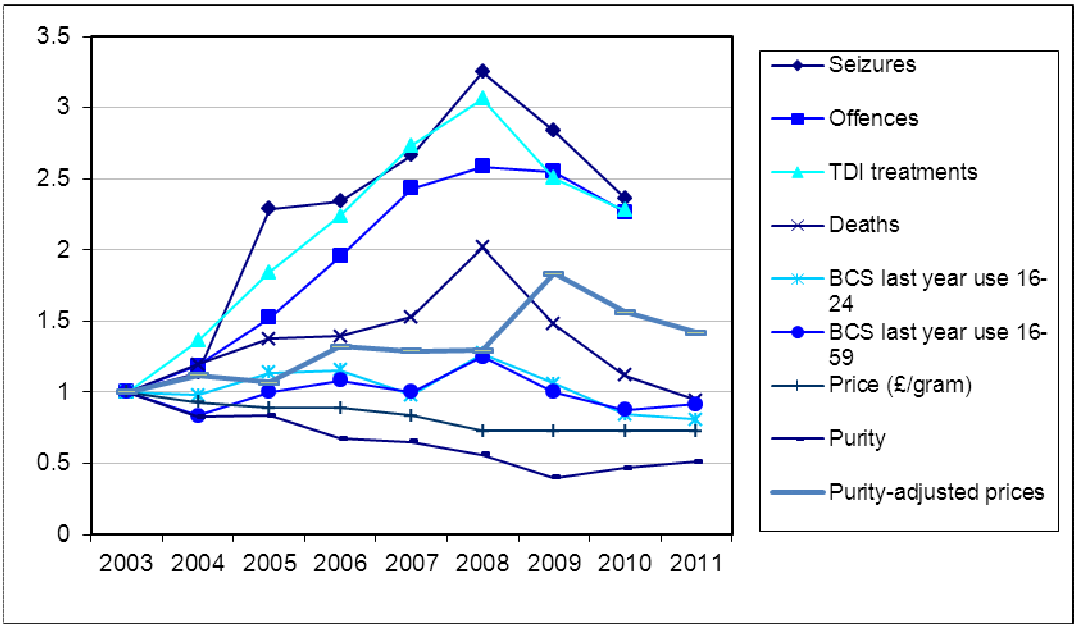
Following reports of a reduction in the availability of heroin in late 2010, there have been noticeable decreases in almost all heroin indicators. Seizures data from England and Wales show that between 2009/10 and 2010/11 the quantity of heroin seized halved from 1,516 kg to 732 kg. The exception to the trend is purity-adjusted price, which increased substantially between 2010 and 2011 due wholly to a large decrease in purity; prices decreased according to law enforcement sources (ST14 & ST16). The Treatment Demand Indicator (TDI) showed a decrease in heroin presentations to below 2003/04 levels with a steady decline since 2008/09. This may be a reflection of the number of heroin users retained in treatment (ST34) and the changing epidemiology of heroin use with decreases in the number of younger people with heroin problems. Data from England show that, of the 153,033 opioid users in prescribing treatment in 2010/11, two-thirds (65%) had been receiving prescribing treatment for over 12 months (ST24). There are also signs of a decrease in injecting risk behaviour; 25% of primary heroin users presenting to treatment in 2010/11 reported current injecting compared to 34% in 2007/08. In addition, there was a

reduction in the percentage of people who inject drugs reporting that they had shared needles from 28% in 2005 to 17% in 2011 (HPA 2011; see section 6.2.4). However, estimates of problem opiate use and injecting drug use have not yet been completed for 2010/11 so the extent to which decreases in treatment demand reflect a reduction in the number of individuals with opiate problems is unclear.

Hospital inpatient data also show a decrease between 2009/10 and 2010/11 with 21% fewer individuals hospitalised as a result of heroin poisoning in 2010/11 (n=2,500) compared to 2009/10 (n=3,155). Similarly deaths have decreased; by 23% between 2010 (n=1,061) and 2011 (n=820) and by 32% since 2009 (n=1,210) (ST06). Over the same period, however, the number of hospital discharges and deaths for other opioids has increased (see section 4.5).

Cocaine powder

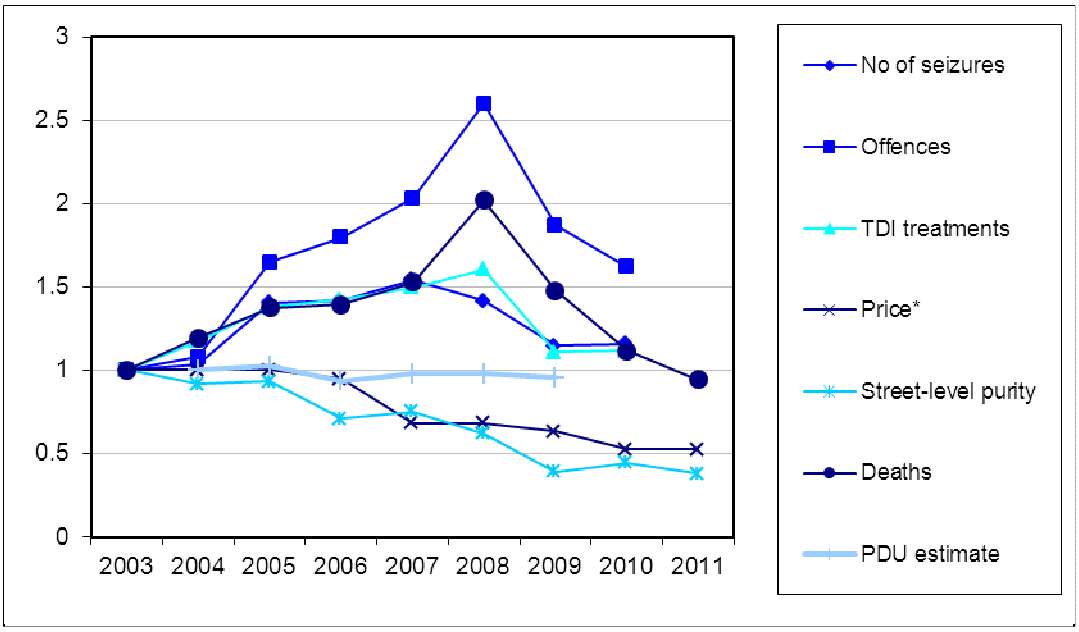
Figure T.2: *Trends across cocaine powder indicators in the UK, 2003 to 2011; indexed to 2003*



Following a peak in 2008, almost all cocaine powder indicators have decreased. Last year use has decreased to below 2003 levels with seizures (ST16) and offences (ST11) also decreasing after large increases between 2004 and 2008. The number of individuals presenting to treatment for primary cocaine powder use decreased again in 2010/11, although the number is still higher than in 2006/07 for both all and first ever treatment presentations (ST34). After a sharp rise in cocaine mentions on death certificates between 2007 and 2008, the number of deaths has decreased to below 2003 levels (see section 6.4.1). Despite this, the number of inpatient hospital discharges recording cocaine poisoning increased by 13% between 2009/10 (n=1,986) and 2010/11 (n=2,247) after a large decrease in 2009/10, although the number is still at a lower level than in 2007/08 (n=2,477) and 2008/09 (n=2,627). Whether the low purity of cocaine powder in 2009, when it reached a mean purity of 20.3% had an effect on the number of poisonings in 2009/10 is unclear, particularly as the increases in purity since then have been relatively small. Nevertheless, the general trend across the indicators is downwards. The downward trend in cocaine powder indicators has coincided with an increase in the use of new psychoactive substances (see supplementary chapter on new psychoactive substances).

Crack cocaine

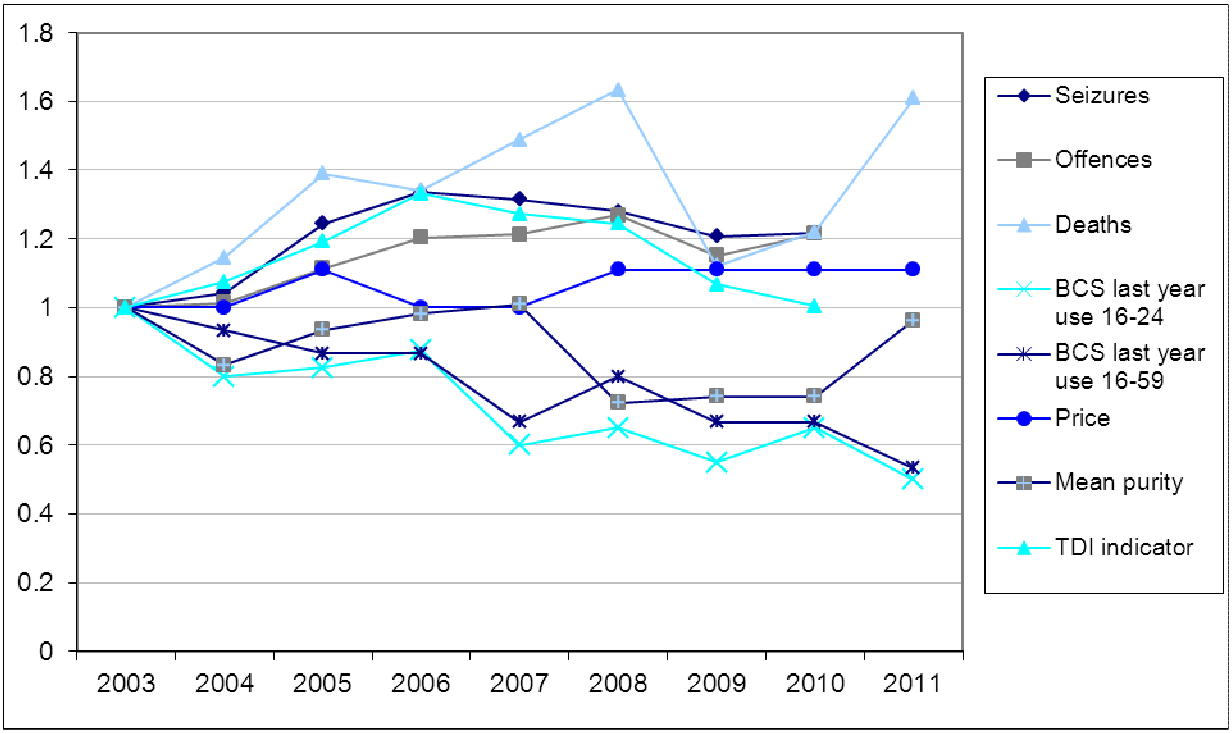
Figure T.3: *Trends across crack cocaine indicators in the UK, 2003 to 2011; indexed to 2003*



Similar to the trend in cocaine powder, most crack cocaine indicators decreased after a peak in 2008. The exceptions are price and purity, which decreased from 2005 onwards. Deaths mentioning cocaine decreased to below 2003 levels, offences have decreased and the number of TDI treatments is lower than in 2005. All of the decrease in primary crack cocaine treatment presentations occurred between 2008/09 and 2009/10 with a decrease in the number of primary heroin presentations reporting secondary use of crack cocaine over the same period. While the number of primary crack cocaine presentations remained stable between 2009/10 and 2010/11, there was a decrease in the number of heroin users reporting secondary use of crack cocaine, although decreases in overall heroin presentations meant that the proportion reporting secondary crack cocaine use increased. There is a high positive correlation between the number of seizures and TDI treatments (r=0.92), similar to heroin (r=0.89), perhaps reflecting the role of the criminal justice system (CJS) in referring opiate and crack cocaine users into treatment. Indeed for the first time, in 2010/11 CJS referrals were at the same level of self-referrals (29%) and a special analysis carried out on 2008/09 TDI data showed that primary crack cocaine users were the group most likely to be referred via the CJS. Offences data show a similar trend to seizures data. As with heroin (r=0.84) and amphetamines (r=0.85), a strong positive correlation is observed between crack cocaine offences and cocaine deaths (r=0.93).

Amphetamines

Figure T.4: *Trends across amphetamine indicators in the UK, 2003 to 2011; indexed to 2003*



It is difficult to obtain a clear picture of the situation with amphetamines. Prevalence of last year use decreased substantially across all age groups since the end of the 1990s and continued after 2003 with a decrease in last year use between 2010/11 and 2011/12 from 1.0% to 0.8% amongst adults aged 16 to 59 years old. However, use was over one per cent in the North East (1.6%) and South West (1.2%) and in Wales (1.3%). Amongst 16 to 24 year olds, there was a decrease between the 2006/07 and 2007/08 surveys from 3.5% to 2.4%, since when use has been relatively stable. Amongst groups with high levels of drug use such as those who visit nightclubs, amphetamine use is relatively low: 12% reported recent use of amphetamine in the Mixmag/Guardian survey compared to 54% reporting ecstasy use, 42% reporting cocaine powder use and 25% reporting ketamine use (see section 2.5.2).

Prevalence of use is the only indicator that shows a downward trend since 2003. Purity has been changeable with decreases in 2008 to 2010 but an increase back to 2003 levels in 2011. Purity is still low, at around 10%, although there have been reports of seizures of high purity amphetamine (up to 98% in 2011) (ST14). While seizures of amphetamine increased until 2006/07, there were subsequent decreases until 2009/10, since when the number of amphetamine seizures remained stable at around 7,200. In terms of quantity seized, there was a large decrease between 2009/10 and 2010/11 in England and Wales from 1,326 kg to 710 kg, which is less than half the amount seized in 2003 (1,580 kg) (Coleman 2011).

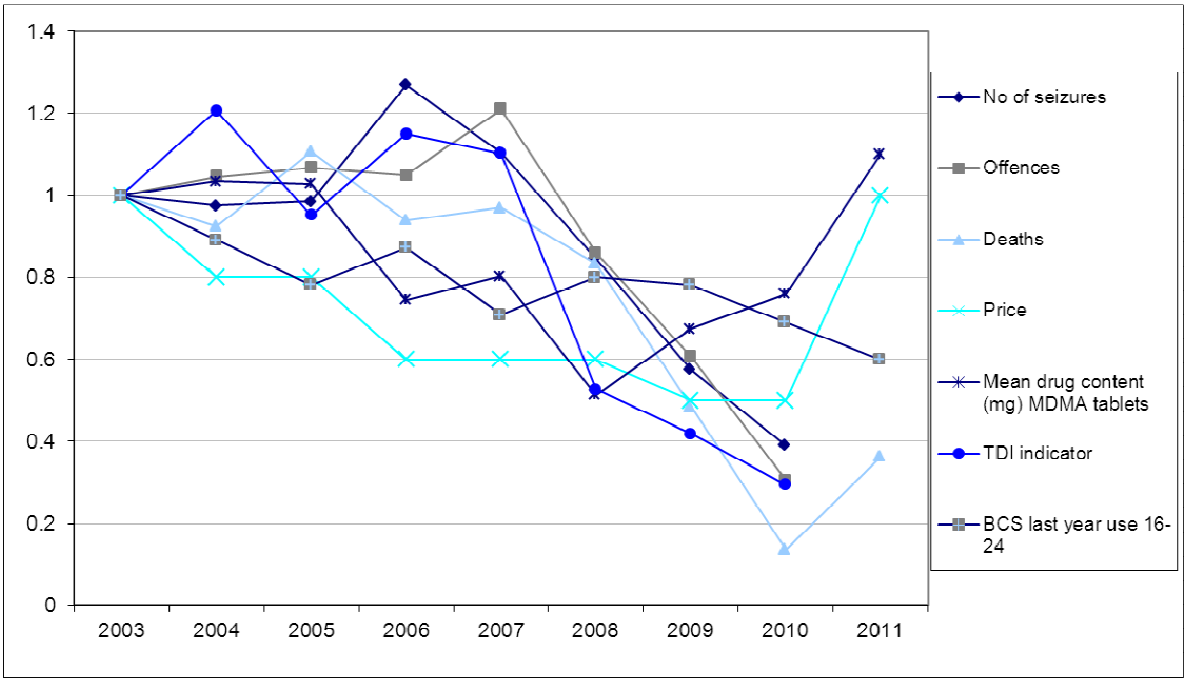
There have also been decreases in the number of presentations to treatment for primary amphetamine use since 2006/07 with a 14% decrease between 2008/09 and 2009/10 and the number presenting to treatment in 2010/11 (n=3,486) at the same level as in 2003/04 (n=3,474). In addition, the proportion of primary amphetamine users reporting current injecting decreased from 17.2% in 2008/09 to 13.2% in 2010/11. It is not possible to identify amphetamine poisonings using the ICD-10 coded hospital data.

Despite indications that use of amphetamines and the number seeking treatment for amphetamine use are decreasing, there was a large increase in the number of deaths mentioning amphetamines between 2010 and 2011 from 50 to 66, although numbers are relatively small compared to deaths mentioning opiates. This follows a large decrease between 2008 and 2009 from 68 deaths to 46 deaths. The number of offences related to amphetamines is also elevated compared to 2003 with over 7,000 offences recorded per year.

The literature on problem drug use has primarily focussed on opiates and/or crack cocaine while research on drug use in recreational settings has tended to focus on ecstasy, cocaine powder and, latterly, new psychoactive substances. Since the end of the 1990s, there has been less focus on amphetamine use and, consequently, less is known about current patterns of use. With current prevalence at around two per cent in the UK, there are still significant health and social harms that merit further investigation.

Ecstasy

Figure T.5: *Trends across ecstasy indicators in the UK, 2003 to 2011; indexed to 2003*



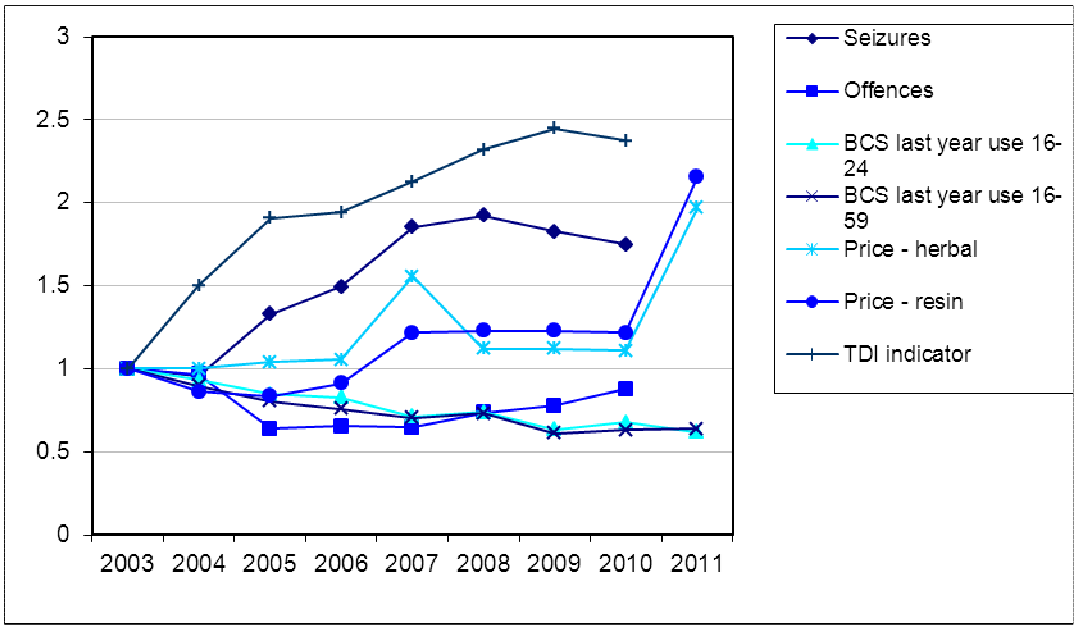
In 2008 all ecstasy indicators were below 2003 levels. However, since 2010 there has been an increase in three out of the four indicators where 2011 data are available suggesting a possible return of high purity ecstasy (Daly 2011). Most notably, there has been a large increase in both the mean MDMA content of tablets (ST14) and the price (both street-level and wholesale) of ecstasy (ST16). Mean content increased from 49mg of MDMA per tablet in 2010 to 71mg of MDMA per tablet in 2011, a level that now exceeds the mean MDMA content of 67mg per tablet in 2004. There is a positive correlation (r=0.76) between purity and street-level price with the average price now at the same level as in 2003 (£5.00 per tablet). Street-level prices from non-law enforcement sources also report an increase in the price of ecstasy between 2010 and 2011 (see section 10.4.3). The wholesale price increased from £2,500 per 10,000 tablets in 2010 to £4,000 per 10,000 tablets in 2011. There has also been an increase in the percentage of analysed drug tablet seizures that contain MDMA from 11% of all analysed tablets to 43%, although this is well below the percentage in 2003, when almost all analysed tablets contained MDMA.

The number of deaths mentioning ecstasy also increased between 2010 and 2011 from nine to 24, although this is still well below the number in 2003 (66) with the mean drug content of ecstasy positively correlated with the number of deaths (r=0.75).

While there have been decreases in ecstasy use since 2003/04, the decreases in the past two years are not statistically significant. The number of seizures in the UK decreased substantially between 2007/08 and 2010/11 but data for 2011/12 are not yet available. While the quantity of ecstasy tablets seized increased in England and Wales between 2009/10 and 2010/11, it is still substantially lower than in 2003 (357,000 compared to 6.9 million in 2003). Convictions for ecstasy offences have also decreased substantially since 2007 and are one-third of the number in 2003. In addition, the number of people presenting to treatment continues to decrease from 857 in 2007/08 to 229 in 2010/11.

Cannabis

Figure T.6: *Trends across cannabis indicators in the UK, 2003 to 2011; indexed to 2003*



Last year cannabis use has decreased since 2003, although it has remained stable in the last few years (ST01). Despite this, the number of individuals presenting to drug treatment for primary cannabis use has more than doubled since 2003/04 from 9,849 to 23,378. Primary cannabis users now account for one-fifth (20%) of all presentations to treatment and one-third (32%) of first ever presentations (ST34). The majority (79%) of primary cannabis users presenting to treatment are young people under the age of 25 years old, although data from England and Wales suggest that young cannabis users may be less likely to use cannabis daily or almost daily compared to users aged 35 to 54 years old (ST01). Nevertheless, in England and Wales it is estimated that there were 107,017 daily or almost daily cannabis users aged 16 to 24 in 2011/12. This suggests that around 11% of daily or almost daily cannabis users aged 16 to 24 years old received treatment in 2010/11. While the increase in cannabis treatment may be a result of increased cannabis-related problems, it may also reflect the growth in young people's services over the past five years.

In terms of the cannabis market, changes in the price of cannabis should be treated with caution since they are mostly an artefact of the change in deal size, on which the price is based. The increase in the number of seizures since 2004 is mostly due to the introduction

of the cannabis warning, an administrative penalty that allows the police to deal with cannabis possession offences quickly. Over the period since its introduction, the number of cannabis offences being dealt with by a caution or in court (and thus showing up in offences data) has decreased while the number of people being dealt with by the police has increased (see section 9.2.4). There are, however, indications that cannabis possession offences have been dealt with more punitively in recent years with a 24% increase in the number of offences being dealt with by a caution or in court between 2007 and 2010.
While the number of cannabis seizures has increased, the quantity of cannabis seized has decreased, mainly of cannabis resin but also of herbal cannabis. The number and quantity of seized cannabis plants, however, increased substantially from 2005 onwards as a result of increasing domestic cultivation. Nevertheless, herbal cannabis was still imported in significant quantities over this period, with an average of 19 tonnes per year seized by the UK Border Agency since 2005 compared to an average of 22 tonnes per year between 2001 and 2004.

No data on cannabis potency are available.

PART A

New developments and trends

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 for the control and supply of drugs that are considered dangerous or otherwise harmful when misused. This Act divides such drugs into three Classes (A, B and C) to broadly reflect their relative harms and sets maximum criminal penalties for possession, supply and production in relation to each class. Drugs in Class A include cocaine, ecstasy, LSD, magic mushrooms, heroin, methadone, methylamphetamine and injectable amphetamine. Class B drugs include amphetamine, barbiturates, cannabis and, since April 2010, synthetic cathinone derivatives including mephedrone, as well as, since 13th June 2012, pipradrol related compounds including desoxypipradrol (2-DPMP) and diphenylprolinol (D2PM). Class C drugs include anabolic steroids, tranquillisers, ketamine, benzodiazepines and, since December 2009, over 140 synthetic cannabinoids, as well as piperazines (such as 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 (TCDOs) enabling law enforcement activity against those trafficking and supplying temporary class drugs. Methoxetamine became the first drug subject to a TCDO in the UK on 5th April 2012.[1]

The United Kingdom Government is responsible for setting the overall strategy and for its delivery in the devolved administrations only in matters where it has reserved power (SQ32). A new drug strategy was launched in December 2010 (HM Government 2010) replacing that of the previous government, which was published in 2008 (HM Government 2008). 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 contained actions and outcomes, at both the regional and local level, to achieve its overarching aims (DHSSPSNI 2006a). A review of the NSD was conducted in 2010, and, after consultation, a revised strategy, the *New Strategic Direction for Alcohol and Drugs Phase 2 – 2011-2016,* was published in late 2011.

[1] See the European Legal Database on Drugs (ELDD) for further information about the legal framework http://www.emcdda.europa.eu/eldd.

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

Labelled public expenditure on drugs is about £1.1 billion per annum. Since 2007, data on labelled public expenditure on drugs have been provided to the UK Focal Point annually from government departments and the devolved administrations. The last estimate of the economic and social costs of Class A drug use in England and Wales was for 2003/04, with an estimated cost of around £15.4 billion (Gordon et al. 2006). Using a similar methodology, it is estimated that the economic and social costs of illicit drug use in Scotland was £3.5 billion in 2006 (Casey et al. 2009). New UK estimates are due to be published in autumn 2012.

1.2 Legal Framework

Drugs controlled under the *Misuse of Drugs Act 1971* (MDA) 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 relative 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 Changes to the Misuse of Drugs Act 1971(MDA)

2-DPMP and related compounds

On 13 June 2012, following acceptance of the Advisory Council on the Misuse of Drugs' (ACMD) advice (ACMD 2011a), desoxypipradrol (2-DPMP) and other pipradrol-related compounds, including diphenylprolinol (D2PM) and diphenylmethylpyrrolidine, became Class B drugs by generic definition. Simple derivatives (esters or ethers) of pipradrol became Class C drugs alongside the main drug. The drug control order came into force following Parliament's approval.

Phenazepam

By the same order, and also on the ACMD's recommendation, phenazepam was added to the list of benzodiazepines which are controlled Class C drugs.

Anabolic steroids

In 2011, the ACMD provided government with advice on anabolic steroids (see UK Focal Point Report 2011). The government accepted the advice and the legislation pertaining to recommendation two and four of the advice[2] (to remove the words 'medicinal product' from the MDA and to make the importation of anabolic steroids restricted to personal custody) came into effect on 23rd April 2012.

1.2.2 Temporary Class Drugs

Since 15th November 2011, the Home Secretary has had the power to make a temporary class drug order (TCDO) where, following consultation with or a recommendation from the ACMD to make a TCDO, there is sufficient concern about the physical harm or harm potential of a new psychoactive substance (NPS), which is being or is likely to be misused, to the public. The importation, exportation, production and supply of a drug subject to a TCDO is unlawful. While the personal possession of a temporary class drug is not an

[2] See: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130262.pdf

offence, the police have the power to seize and destroy any drug suspected of being subject to a TCDO. The order can last for a maximum of 12 months.

The terms of engagement between the ACMD and Government under the temporary control power are set out in a new joint working protocol published on 15th November 2011[3] (see UK Focal Point Report 2011).

Methoxetamine

In March 2012, the Government referred methoxetamine to the ACMD for advice under the temporary control power. The ACMD provided initial advice on methoxetamine within 15 working days, recommending that the drug be subject to a TCDO within 15 working days. The Government accepted the ACMD's advice and the *Misuse of Drugs Act 1971 (Temporary Class Drug) Order 2012* came into force on 5th April 2012, making methoxetamine and its simple derivatives temporary class drugs. The rapid collection of information and data on methoxetamine was aided by drugs early warning systems, which are described in a supplementary chapter.

In October 2012, the ACMD (2012a) provided full advice on methoxetamine to the Home Secretary recommending that the drug be controlled as Class B alongside closely related analogues of ketamine and phencyclidine by way of a generic definition.

Synthetic cannabinoids

In October 2012, the ACMD (2012b) published a further consideration of synthetic cannabinoids recommending that the generic definition covering synthetic cannabinoids be extended to include recently identified non-controlled synthetic cannabinoids.

1.2.3 Advisory Council on the Misuse of Drugs

Work programme 2012/13

The Home Secretary wrote to the ACMD in March 2012 setting out the Government's priorities for the ACMD's 2012/13 work programme.[4] The letter requests the ACMD's work on Recovery and NPS, as well as its review of khat, remain priorities. New referrals consist of a review of the available evidence on the harms of ketamine, which was last formally reviewed in 2004, and its classification under the *Misuse of Drugs Act 1971*, as well as a request for the ACMD to input into, and be consulted by, the Department of Transport's technical advisory panel about the impairing levels of certain controlled drugs within the context of a new drug impaired driving offence (*Crime and Courts Bill*) (see section 1.2.4).

In its response to the Home Secretary's letter, the ACMD set out a timeline for delivery of its work priorities, bringing forward the completion of its review of khat from the end of the year to autumn 2012. In addition to the work reported elsewhere in this chapter, a report on polysubstance misuse is due for publication in 2013, after the ACMD has completed a review of cocaine, which is to be published in December 2012. Further, the ACMD is considering tramadol with a view to providing advice by the end of 2012, and has agreed to provide further advice on ketamine within a year.

At the request of the Inter Ministerial Group on Drugs, chaired by the Minister for Crime Prevention, the ACMD has set up a standing committee on Recovery. The committee has been commissioned to provide evidence-based advice for ministers on the best ways to deliver the recovery ambitions of the *2010 Drug Strategy*. The committee aims to identify enabling factors and barriers to recovery, and recommend solutions. It will also identify gaps

[3]See: http://www.homeoffice.gov.uk/publications/agencies-public-bodies/acmd1/workingprotocol
[4]See: http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/hs-acmd-priorities-2012-2013?view=Html

in evidence and make recommendations on how an evidence base on recovery may be developed. The first output of the Recovery Committee will be a brief report that reviews the evidence to identify the various contributors (or barriers) to recovery, such as employment and treatment. The Committee then aims to produce a series of short reports on specific aspects of recovery.

Consideration of novel psychoactive substances

In October 2011, the ACMD published its report on the consideration of NPS (ACMD 2011b). The report set out evidence on the use, harms and societal impact of these substances and explored possible legislative, health and social responses to the issue. Thirteen recommendations were made including: strengthening the EU response; developing chemical standards; improving analytical capability and providing resources for research; exploring the possibility of analogue legislation; using the full powers of the Medicines and Healthcare products Regulatory Agency (MRHA), consumer protection regulations and the Advertising Standards Agency; and developing demand reduction strategies (see also section 6.3.5 and supplementary chapter).

The Government responded to the recommendations in an addendum to the *Drug Strategy Annual Review* document including an Action Plan on new psychoactive substances (see section 1.3.1 and supplementary chapter on NPS).

1.2.4 Proposed revisions to the legal framework

Drug driving law

In the UK, it is already an offence to drive while unfit through drugs. Under the current law, a person who, when driving or attempting to drive, or in charge of a mechanically propelled vehicle on a road or other public place, is unfit to drive through drink or drugs is guilty of an offence (Section 4, *Road Traffic Act 1988*).

In May 2012, it was announced that, as part of the *Crime and Courts Bill*, a specific offence of driving while under the influence of drugs would be created. Under the proposed legislation it will automatically be an offence to drive a motor vehicle if you have certain controlled drugs in your body in excess of specified limits. The penalty for the new offence will be identical to the drink drive offence; a maximum of six months' imprisonment and/or a fine of up to £5,000, and an automatic driving ban of at least 12 months. It is anticipated that the new offence, along with the regulations setting out the types and levels of specified drugs, will be in place by middle of 2014. The specified drugs covered by the offence and the specified limits for each will be determined following advice from an expert panel and a public consultation.[5] There will be a statutory defence for those who have used specified drugs by taking prescribed drugs in line with medical advice. Further information on drug driving can be found on the Department for Transport's website.[6]

1.2.5 Commentary and research

Emergency department presentations and mephedrone control

An analysis of the number of emergency department presentations for mephedrone pre- and post- control shows that there were 58 presentations in the year preceding control and 55 in the year following control (Wood et al. 2011a). Presentations peaked in the two months preceding the ban to 31 and fell significantly in the six months after. The authors suggest that this demonstrates that the control of mephedrone was effective. However, the effect that imminent control had on consumption patterns is not discussed and the graph presented

[5] See: http://rnn.cabinetoffice.gov.uk/Press-Releases/Government-crack-down-on-drug-driving-menace-679ce.aspx
[6] See: http://www.dft.gov.uk/topics/road-safety/drink-and-drug-driving

appears to show a relatively normal distribution with the number of presentations at the same level in the second and third period post-control as the second and third period pre-control. Furthermore, it would be prudent to consider the impact of a substance's legality on the likelihood of presenting to health services. These issues are highlighted in a response to the article authors from the head of the Welsh Emergency Department Investigation of Novel Substances (WEDINOS) Group, Dr. David Caldicott.[7]

1.3 National action plan, strategy, evaluation and coordination

1.3.1 National action plans and strategies

Action Plan on new psychoactive substances

In May 2012, the Government published an Action Plan on new psychoactive substances (NPS) as part of its Annual Review of the Drug Strategy (HM Government 2012; see section 1.3.2) and in response to the ACMD's 2011 report (ACMD 2011b; see section 1.2.3). Actions under the heading of reducing demand include highlighting the potential risks and harms of these substances, improving the quality of drug education and working with partners to enhance knowledge and evidence on NPS. Under the heading of 'making it difficult to obtain and supply NPS', actions include improving the understanding of the threat, making full use of the legislative framework, strengthening the enforcement response and bolstering the global response. Another action is to promote research into NPS.

Further information about actions to tackle the supply and use of NPS is contained in a supplementary chapter in this report.

Northern Ireland

In December 2011, an updated substance misuse strategy framework was published by the Department of Health, Social Services and Public Safety (DHSSPS) Northern Ireland. The *New Strategic Direction for Alcohol and Drugs Phase 2* will run between 2011 and 2016 (DHSSPS 2011) and continues on much the same basis as the previous NSD published in 2006 (DHSSPS 2006a). However, during the review stage a number of emerging issues were identified and addressed including: the use of prescription and over-the-counter medicines; the emergence of new psychoactive substances; families and hidden harm; the recovery agenda; and mental health, suicide, self-harm, and sexual and domestic abuse. In addition, the NSD Phase II aims to take a population level approach to addressing alcohol misuse rather than the previous focus on individual behavioural change related to binge drinking.

Based around five pillars, the overall aim of the NSD is to reduce the level of alcohol and drug-related harm in Northern Ireland. A number of key priorities are identified in the strategy including targeting those at risk or vulnerable, both children and adults. The outcomes expected in the short-term and medium/long term are also set out within the document.

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

England

The *Annual Review of the Drug Strategy*, published in May 2012 (HM Government 2012), sets out the progress made in implementing the strategy under each of the three pillars: recovery; restricting supply; and reducing demand. It also describes the actions that will be taken in the coming year in each of the pillars. An annex to the review sets out an action plan to tackle NPS (see section 1.3.1).

[7] See: http://emj.bmj.com/content/early/2011/10/27/emermed-2011-200747/reply

Scotland

The Scottish Drugs Strategy Delivery Commission (DSDC)[8] published its first year report in October 2011 (DSDC 2011). It assessed progress against the three priority areas identified for the first year: children affected by parental substance misuse; care, treatment and recovery; and governance and accountability of the delivery system. Overall, the DSDC reported that there has been "considerable productive activity from Government and within the ADP[9] delivery system." A summary of the DSDC's findings for each of the three priority areas and their recommendations for further action can be found in the relevant sections of this report (sections 1.3.4, 5.2.2 and 8.3.4 respectively). General recommendations contained in the report include: a more closely aligned process between alcohol and drugs; improve institutional memory; and identify barriers to local delivery of national strategies.

Wales

Progress of the Welsh Government's substance misuse strategy continues to be monitored via the National Strategy Implementation Board. To support the Board, the Welsh Government has commissioned the University of Glamorgan to carry out an external evaluation of the strategy. The process evaluation is due to be published in late 2012 and will inform the new three year substance misuse implementation plan, which is currently under consultation.

The Welsh Government has revised its Key Performance Indicators for substance misuse to ensure that they are more outcomes focused rather than activity based. Further information about the implementation of the strategy is available from the *Welsh Government's Substance Misuse Annual Report 2011* (Welsh Government 2012a). An implementation plan for 2011-12 has been published setting out actions and target dates for implementation of the actions (Welsh Government 2012b).

Northern Ireland

The *New Strategic Direction* strategy published in Northern Ireland in 2011 contains an annex setting out the range of outcomes under five key pillars: prevention and early intervention; treatment and support; community safety and anti-social behaviour; monitoring, evaluation and research; and workforce development (DHSSPS 2011).

1.3.3 Other drug policy developments

Parliamentary Inquiries on drug issues

House of Lords inquiry into the EU drugs strategy

In 2011, the House of Lords EU Select Committee carried out a review of European drug policy. Evidence was taken from a wide range of organisations and individuals and the final report was published in early 2012. The main conclusion was that there should continue to be an EU drugs strategy but that it should have a different focus than the current strategy. In particular, it was felt that the twin aims of reducing the demand for and supply of drugs were too broad and the new strategy should focus on clearer and more realistic objectives. Other recommendations were to improve co-operation against drug trafficking and to improve understanding of the effectiveness of supply reduction initiatives and the human rights implications of such initiatives. The report also highlighted the good work of the EMCDDA and recommended enhancing its work in the collection, analysis and dissemination of drugs data.

[8] The DSDC was set up in 2009 and superseded the Scottish Advisory Committee on Drug Misuse (SACDM), created in 1994. The DSDC is independent from government and helps monitor the implementation of Scotland's drug strategy and whether it is achieving its aims.

[9] Alcohol and Drug Partnership.

The Government published its response to the House of Lords Inquiry in May 2012 (Home Office 2012a).

Home Affairs Select Committee review of UK drug policy

In November 2011, the House of Commons Home Affairs Select Committee announced that it would undertake a review of drug policy in 2012. The aim was to examine the effectiveness of the *2010 Drug Strategy*. A call for written evidence closed in February 2012 and a number of organisations and individuals submitted evidence, which is available online.[10] The committee has been receiving oral evidence throughout 2012, the transcripts of which are also available online. A final report from the committee is expected in late 2012.

1.3.4 Co-ordination arrangements

Scotland

The DSDC's first year report (see section 1.3.2) stated that investment in Scotland's Alcohol and Drug Partnership (ADP) structure is significant and the ring-fenced money shows the high priority the Scottish Government gives to substance use (DSDC 2011).

Local outcomes

In Scotland, the Scottish Government, COSLA, and NHS Scotland published ADP Planning and Reporting Guidance for 2012-15, which aims to support the embedding of outcomes based planning and reporting at local level, to help ADPs to self-assess their performance and to articulate their contribution to their local Single Outcome Agreement (SOA) and Community Planning Partnership, as well as contributing to the overall progress in supporting alcohol and drug prevention, support and treatment. This guidance identified nationally agreed core outcomes and indicators which all ADPs are expected to deliver against.

Wales

The Welsh Government has undertaken a review of the Substance Misuse Area Planning Boards established in 2010. Revised guidance has been issued and includes strengthened financial and governance arrangements and a requirement to produce a regional outcome based commissioning strategy.

1.3.5 Commentary and research

In their report *A Fresh Approach to Drugs* (UKDPC 2012a), the UK Drug Policy Commission[11] pull together the findings of six year's work analysing the evidence for a range of different aspects of drug policy. They conclude that, while there have been policy successes, for example harm-reduction approaches have kept rates of HIV amongst injecting drug users low and the numbers of people receiving treatment has steadily increased, there remain large areas of expenditure, such as enforcement and much prevention, for which there is little evidence of effectiveness. In addition, the authors state that some policies may have negative unintended consequences. Drug policy, it is argued, cannot fully address the problems caused by drugs because the debate has become polarised and 'toxic', with areas of evidence essentially off-limits. The authors use, as an example, the lack of recognition within policy that drug use is not invariably harmful and that users may perceive benefits from use, which are amongst the reasons for use. They therefore conclude that in this age of austerity, and in the light of the challenges posed by new psychoactive substances, there is a need for a fresh approach to drug policy.

[10] See: http://www.parliament.uk/business/committees/committees-a-z/commons-select/home-affairs-committee/inquiries/parliament-2010/drugs/inquiry-timeline/

[11] The UKDPC is an independent charity that commissions research and collects evidence about what works in drug policy.

As part of this fresh approach, the UKDPC suggest a clearer distinction should be made between the goals of policy and the tools (e.g. prevention, treatment and enforcement) to deliver it. They propose considering drug policy in terms of two high-level challenges. Firstly, looking at how society and government can enable and support individuals to behave responsibly; tackling underlying causes of drug use, providing the information and skills necessary for people to make sensible choices about drug use and ensuring that when drug use does occur it is undertaken in a way that minimizes the harm to users and others. Secondly, focusing on how society and government can enable and promote recovery from entrenched drug problems, for individuals and communities.

In support of this approach, they identify a number of key opportunities for policy ranging from tackling the structural problems, such as social inequalities and feelings of exclusion and disenfranchisement that increase the risk of drug problems, through providing evidence-based prevention programmes to support less risky choice and continuing the development of more recovery-oriented treatment systems, to involving local communities in law enforcement and reducing the sanctions for drug possession. The UKDPC also highlight the need to address how drug policy is made and delivered in order to develop and implement more cost-effective policies. In particular they stress the need for better evidence and, alongside a number of other recommendations concerning the structures and processes for policy development and evaluation, suggest the establishment of a body to collect and promote the evidence.

A poll of members of the UK and Scottish Parliaments and the Welsh Assembly commissioned by the United Kingdom Drug Policy Commission (UKDPC 2012b) found that the majority of participants disagreed with the statement that current policies are effective in tackling the problems caused by illegal drugs.[12] Members of the UK parliament were most likely to disagree (77%) compared to 67% of members of the Welsh Assembly and 60% of members of the Scottish Parliament. At least two-thirds of politicians in each body thought that the process of making policy about illegal drugs should make more use of evidence and research than it currently does. Only a minority of respondents, between one-quarter and one-third believed that changes to the drug laws should be considered to make possession of drugs for personal use a non-criminal offence.

1.4 Economic Analysis

1.4.1 Public expenditures

Labelled drug-related public expenditure has been reported for the UK from 2005/06 to 2010/11. A selected issue on the topic can be found in Chapter 12 of this report and includes updated estimates for unlabelled expenditure for the first time since 2007. Current government policy devolves responsibility for spending decisions to the local level as part of the localism agenda. Therefore, the future provision of comparable labelled expenditure in England may not be possible. This may be exacerbated by the mainstreaming of drug-specific budgets, for example removing the ring-fence from the pooled treatment budget from April 2013 and making it part of a wider public health grant, which may make it difficult to monitor drug-related expenditure (see section 5.2.1 and 12.3). The funding arrangements for drugs for 2012/13 and the proposed changes from 2013/14 are set out in a document

[12] Self-completion postal and on-line questionnaires were sent to the ComRes panel of parliamentarians. One hundred and fifty MPs participated (50% of those approached) out of the total 650 members in the Houses of Parliament, 55 (50% of those approached) out of 129 MSPs and 31 (60% response rate) out of 60 AMs. The ComRes panels are configured as far as possible to be representative of all parliamentarians but exclude those holding positions in government. The data were weighted to reflect the composition of the relevant body. A series of statements were provided and participants responded on a five point scale indicating whether they agreed or disagreed.

from the National Treatment Agency as part of its submission to the Home Affairs Select Committee's Inquiry (see section 1.3.3).[13]

1.4.2 Budget[14]

England

Data show that the major elements of drug funding in England remain unchanged in 2012/13 in cash terms with the adult pooled treatment budget providing the largest component of labelled drug-related expenditure at £381 million. The significant investment in prison drug treatment continues with £114 million available for the current year. Estimates of the contribution from local mainstream funds (£216 million) are from 2010/11 since the requirement for Drug Action Teams to provide a detailed breakdown of expenditure through part 4 of the treatment plan no longer exists.

Wales

For 2012/13, both the Substance Misuse Action Fund (£22.3m) allocated to Community Safety Partnerships and the ring-fenced Local Health Boards (£17.1m) revenue funding has remained unchanged. The capital funding provided via the Substance Misuse Action Fund to Substance Misuse Area Planning Boards to improve the access and availability of substance misuse services across Wales has decreased slightly from £6.1m to £5.7m.

Northern Ireland

Approximately £8 million is allocated each year to the implementation of the *NSD Phase 2* and additional funding of around £7 million is provided through the mental health budget for the provision of treatment and support services.

Scotland

The Scottish Government drug misuse budget for 2011-12 was (£31.9 million). This included record ring-fenced funding for drug treatment which was protected and maintained at £28.6 million. This was allocated to Alcohol and Drug Partnerships (ADPs) via NHS Boards for frontline drug services, in line with the national drugs strategy, to enable them to deliver nationally agreed core outcomes and local outcomes on alcohol and drugs. In addition, £3.2 million was provided to support the operation of ADPs. Funding of £600,000 has been provided from 2010/11 to 2011/12 for the rollout of the national naloxone programme.

The figures for drug treatment refer only to the ring-fenced funding provided to NHS Boards and are not the complete picture of Scottish Government spend on drug misuse, i.e. in 2011-12 the Scottish Government also provided £9.1 million to Community Justice Authorities (CJAs) for drug-related criminal justice interventions, comprised of £7.2 million nationwide for the Drug Treatment and testing Order (DTTO) programme and £1.9 million for two dedicated drugs courts, one based in Glasgow and one in Fife. In addition, the Scottish Government also provided £22.7 million from the Justice portfolio to support the Scottish Crime and Drug Enforcement Agency (SCDEA) in 2011/12.

1.4.3 Social costs

The Home Office is revising the social and economic costs of drug use as part of a wider project on the cost of organised crime. The work is due to be completed in autumn 2012.

1.4.4 Commentary and research

Implication of public service reform and financial austerity on drug services

A study by the United Kingdom Drug Policy Commission (UKDPC) looked at the potential impact of public service reform and financial austerity on the delivery of drug services in

[13] See: http://www.nta.nhs.uk/uploads/hasc2012-funding12-1313-14.pdf
[14] Figures provided here are nominal values and have not been adjusted for inflation.

England (UKDPC 2012c). The research utilised a number of methods including semi-structured interviews, a national survey of police forces and Drug Action Teams, and workshops. Key findings included a lack of understanding of how the National Health Service (NHS) structural reforms, the move to localism, austerity measures and the national drug strategy will fit together and how reforms in one area will affect other areas. While study participants saw opportunities to work more efficiently across sectors such as housing, employment and education and to integrate responses to alcohol and drugs, there were some concerns about the potential risks for disinvestment, fragmentation and bureaucracy. Furthermore, despite valuing partnership working, the resources and staff required for such collaboration led around one-third of police respondents to report that they expected to work less with community groups and local councils in the next 12 months.

Other concerns voiced by participants included the lack of robust evidence or detail underpinning the changes, a lack of knowledge about who is responsible for the collection of evidence to support the evaluation of policies and the implications for accountability systems. In addition, the potential for groups perceived as 'undeserving', such as drug users, to be neglected given the removal of the ring-fence and assimilation into wider public health budgets caused concern. The study provides six proposals for national policy makers and a further five for those working at the local level to address these issues.

The research also found that services for young people appeared to be being differentially affected by the changes at local level and an extension to the project looked at these issues in more detail. The report (UKDPC 2012d) described how young people's services, that historically received funding through a wide range of funding streams, were particularly vulnerable to cuts in this period of austerity and change. It highlighted the way that cuts to generic services, such as youth clubs, can have a knock-on effect on substance misuse problems because of their role in prevention and early identification of problems and referral to more specialist services, as well as the support they provide after discharge from specialist care. This is often not recognised and the report suggests that this may pose a risk to the continuation of the positive trends in reductions in substance misuse in the longer term.

2. Drug use in the general population and specific groups

2.1 Introduction

The *Crime Survey for England and Wales (CSEW)*[15] provides estimates of the prevalence of drug use in the general population in England and Wales. Scotland[16] and Northern Ireland[17] also undertake similar surveys. Combining data from surveys undertaken in 2010/11, the UK Focal Point estimates that 35.6% of the adult population in the United Kingdom, aged between 16 and 59, had used an illicit drug at some point in their lifetime. In England and Wales, for which the most complete time series data are available, prevalence of last year use of any illicit drug had been fairly stable at around 12% from 1998 to 2003/04, decreasing year on year to 9.6% in 2007/08; and then falling again to 8.6% in 2009/10. Since then, prevalence had stabilised and was 8.9% in 2011/12.

Males were 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.[18] In England, for which the longest time series are available, drug use increased between 1998 and 2003, but has fallen since then.

Cannabis continued to be the most commonly used drug throughout the UK with prevalence rates close to those of any drug. The use of other drugs was considerably lower. Since the mid-1990s the *Crime Survey for England and Wales* (known as the *British Crime Survey* until 2010/11) shows that the use of cocaine powder increased, with a corresponding decline in amphetamines over the same period, although use has decreased since 2008/09. Some

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

[16] 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 CSEW although questions on drug use are asked of all those aged over 16 years. The latest published results are for 2010/11. Surveys were carried out as part of the former BCS in 1982 and 1988; as the independent *Scottish Crime Survey* in 1993, 1996, 2000, 2003; as the SCVS in 2004, 2006; and as the SCJS in 2008/09 and 2009/10. Findings from the 2010/11 survey were published in 2012. The survey asks questions about drug use using Computer Assisted Personal Interviewing (CAPI).

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

[18] Amongst the school age population the main sources of information on drug use prevalence are surveys undertaken in schools. In England, a survey of the prevalence of drug use, smoking and drinking amongst young people (11 to 15 year old school children) has been undertaken annually since 1998. In Scotland, the *Scottish Schools Adolescent Lifestyle and Substance Use Survey* (SALSUS) is undertaken every two years, the most recently published data are for 2010. The *Young Person's Behaviour and Attitudes Survey* was undertaken in Northern Ireland in 2000 for the first time and repeated in 2003, 2007 and 2010.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 2009/10. The *Young Person's Behaviour and Attitudes Survey* was undertaken in Northern Ireland in 2000 for the first time and repeated in 2003, 2007 and 2010.

questions on new psychoactive substances have been added to the last three surveys and data show a statistically significant decrease in reported mephedrone use amongst both adults and young people between the 2010/11 survey and the 2011/12 survey.

2.2 Drug use in the general population

Prevalence of drug use throughout this chapter is measured using the following recall periods: lifetime (ever use); last year (recent use); last month (current use). These terms are used interchangeably.

2.2.1 UK estimate[19]

By combining data from the 2010/11 BCS[20] (Smith and Flatley 2011), the 2010/11 Scottish Crime and Justice Survey (SCJS) (Scottish Government 2012a) and the 2010/11 Northern Ireland Drug Prevalence Survey (NACD and PHIRB 2012), the Focal Point has produced a United Kingdom estimate for 16 to 59 year olds (Table A.1, Appendix A) showing that:

- 35.6% had used drugs in their lifetime (ever);
- 8.8% had used drugs in the last year (recent use); and
- 4.8% had used drugs in the last month (current use).

Prevalence levels were lowest in Northern Ireland for all recall periods. Recent and current use was at a similar level in England and Wales as in Scotland.

Trends in drug use

Between 2006/07[21] and 2010/11 estimated lifetime use of any drug in the United Kingdom, amongst 16 to 59 year olds, has remained stable (35.4% and 35.6% respectively). Over the same time period, recent and current drug use has steadily decreased. In 2006/07, last year use of any drug was reported as 10.2%, decreasing to 8.8% in 2010/11. A similar pattern was observed in last month use of any drug which had decreased from 6.0% in 2006/07 to 4.8% in the 2010/11 UK estimate (Table A.4, Appendix A).

2.2.2 England and Wales: the Crime Survey for England and Wales

The latest findings from the 2011/12 *CSEW*[22] (Home Office 2012b) show that, for adults aged 16 to 59 years, 36.5% had ever used drugs; 8.9% had used drugs recently; and 5.2% currently use drugs) (Table 2.1). This equates to approximately twelve million, three million and one and a half million people respectively.

Cannabis continued to be the most commonly reported drug across all recall periods, with cocaine and ecstasy the next most popular drugs in terms of recent and current use. As in previous years, amphetamines remained the second most commonly used drug ever; this may be due to high levels of use in the late 1990s.

[19] Data used for the UK estimate are for ages 16 to 59 years old, with the exception of the Northern Ireland data which are for ages 16 to 64 years old.
[20] Known as the Crime Survey for England and Wales (CSEW) from 2011/12.
[21] See: UK Focal Point Reports 2008, 2010 and 2011 for earlier UK estimates.
[22] The fieldwork for the survey was carried out between April 2011 and March 2012. A total of 26,663 individuals completed the drugs module of the 2011/12 CSEW. The overall response rate for the survey was 76% and, within this, the response rate for the self-completion drugs module was 92%.

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, 2011/12*

	Lifetime use			Last Year use			Last Month use		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug	43.1	30.0	36.5	12.4	5.5	8.9	7.3	3.0	5.2
Amphetamines	14.5	8.6	11.5	1.1	0.6	0.8	0.4	0.2	0.3
Cannabis	37.4	24.6	31.0	9.7	4.1	6.9	5.9	2.4	4.1
Cocaine	13.0	6.3	9.6	3.3	1.1	2.2	1.5	0.5	1.0
Ecstasy	11.7	5.5	8.6	2.1	0.8	1.4	0.8	0.3	0.5
LSD	7.8	2.8	5.3	0.3	0.1	0.2	0.1	0.0	0.1
Magic mushrooms	10.7	4.3	7.5	0.7	0.2	0.5	0.2	0.0	0.1
Opiates	1.7	0.6	1.1	0.4	0.1	0.3	0.3	0.1	0.2
Base	*12,291*	*14,372*	*26,663*	*12,215*	*14,276*	*26,491*	*12,198*	*26,460*	*26,460*

Source: Standard Table 01

New psychoactive substances

Questions on some new psychoactive substances were added to the BCS in October 2009 with mephedrone added for the 2010/11 survey. In 2011/12, last year use of mephedrone was recorded at 1.1% amongst adults aged 16 to 59 years old (1.5% males and 0.7% females), a significant decrease from 1.4% in the previous survey. Use of all other NPS was low (see supplementary chapter on NPS) (Table 2.2).

Table 2.2: *Percentage of 16 to 59 year olds reporting last year use of recently classified drugs and khat, England and Wales, 2010/11 to 2011/12*

	2010/11	2011/12
Mephedrone	1.4	1.1*
GBL/GHB	0.0	0.1*
BZP	0.1	0.1
Spice (and other cannabinoids)	0.2	0.1
Khat	0.2	0.2
Base	*27,450*	*26,834*

**Statistically significant change*

Source: Home Office 2012b

Factors related to drug use

Analysis of the 2011/12 CSEW showed a relationship between drug use and certain personal and lifestyle factors.[23] For example:

- single adults had higher levels of recent drug use than other marital groups (17.4% of single adults had used drugs recently compared to 3.2% of married adults);
- those who consumed alcohol frequently had higher levels of recent drug use than those who consumed alcohol less frequently, 12.4% of adults who had drunk alcohol more than three times a week in the past month compared to 7.1% who drank alcohol less than one day a week;
- those who visit nightclubs and pubs frequently are more likely to be recent drug users, 30.7% of those visiting a nightclub four or more times in the last month had used drugs recently compared to 6.5% of those who had not visited a nightclub in the last month and

[23] It should be noted that whilst these comparisons provide useful information many of these factors are interrelated or relate to other factors, such as age or sex, which also have an association to the likelihood of drug use and indeed may be responsible for these observed associations.

23.9% of those who had been to a pub nine or more times in the past month compared to 5.2% of those who had not been to a pub; and
- recent drug use was higher amongst those who were unemployed (19.8%) than those who were employed (8.0%).

Onset and desistance of drug use

An analysis of data from the 2011/12 CSEW looked at the onset and desistance of use of three individual drugs;[24] cocaine powder; ecstasy; and cannabis. The mean age at which cocaine powder users reported first using the drug was older (21.2 years old) than when ecstasy (20.1 years old) and cannabis users (17.7 years old) reported first using the respective drugs. Amongst those reporting that they had ever used the individual drugs but had not done so in the last year, the average duration of use was 4.4 years for cocaine powder, 3.9 years for ecstasy, and 6.2 years for cannabis. Around one-third (32.5%) of those who had ever used cocaine powder but had not done so in the last year reported that they had used the drug for less than one year compared to 31.9% amongst ecstasy users and 27.3% amongst cannabis users.

Frequency of drug use

The CSEW asks a question on the frequency of cannabis use for those who have used cannabis in the last year. However, even in a survey with a large sample size such as the CSEW[25] and asking the question of all those who had used cannabis in the last year, rather than just the last month[26], the number of users in each category was small. Therefore, caution should be taken when interpreting the data, particularly when looking at trends.

In 2011/12, 10.3% of recent cannabis users aged 16 to 34 years old and aged 16 to 24 years old reported being daily or almost daily cannabis users (Table 2.3). Although young people aged between 16 and 24 were most likely to be recent cannabis users, they were less likely than adults aged between 35 and 54 to report daily or almost daily use of cannabis. Those aged 35 to 44 years old were most likely to report daily or almost daily cannabis use.

Table 2.3: *Percentage of recent cannabis users reporting daily or almost daily use in England and Wales 2011/12 by age and gender*

Age	Male	Female	Total
16 to 24 years	13.9	3.4	10.3
25 to 34 years	11.7	5.9	10.3
35 to 44 years	18.2	15.4	17.5
45 to 54 years	19.5	10.3	16.2
55 to 59 years	4.3	12.5	9.7

Source: Standard Table 01

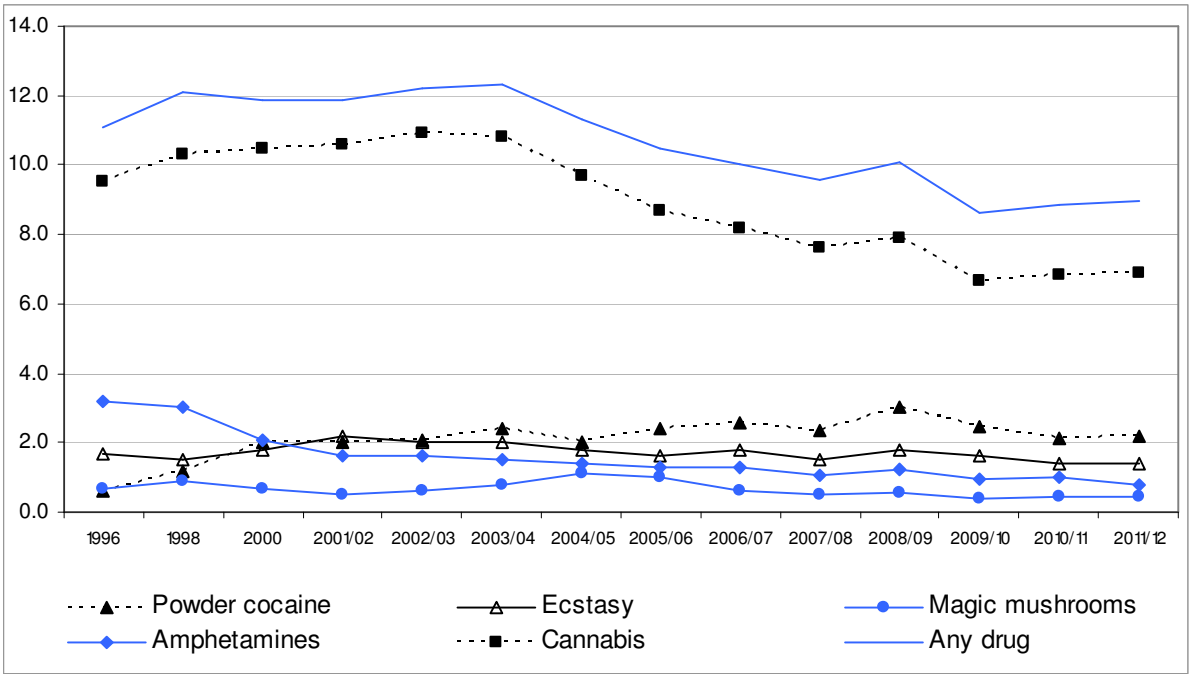
Trends in drug use

Data show that, compared with 1996, lifetime use of almost all individual drugs was higher in 2011/12 (except anabolic steroids where reported use was lower, and LSD and tranquilisers which have been stable). This was expected as, over time, more people will enter this group. In terms of recent and current drug use, there was a steady decrease in the use of any drug between 2003/04 and 2009/10 driven mostly by a decrease in cannabis use (recent use fell from 10.8% in 2003/04 to 6.6% in 2009/10). Between the 2010/11 and 2011/12 surveys, use

[24] See: http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/drugs-misuse-dec-1112-tabs/onset-tabs
[25] Sample size for adults aged 16 to 59 was 26,663 in 2011/12.
[26] As recommended by the European Model Questionnaire (EMQ). See: http://www.emcdda.europa.eu/attachements.cfm/att_58103_EN_Handbook%20for%20surveys%20on%20drug%20use%20amongst%20the%20general%20population%20-%202002.pdf

of almost all individual drugs remained stable. The exception was amphetamine use, which decreased from 1.0% to 0.8%. Since data collection began in 1996, the use of amphetamines has decreased significantly from 3.2% with cocaine powder use increasing significantly over the same time period from 0.6% to 2.2%. However, reported cocaine powder use in 2011/12 was lower than in 2008/09 when prevalence of use was 3.0% (Figure 2.1).

Figure 2.1: *Percentage of 16 to 59 year olds reporting last year drug use of individual drugs in England and Wales, 1996 to 2011/12*



Source: Standard Table 01

2.2.3 Scottish Crime and Justice Survey: Drug Use 2010/11[27] adults aged 16 and over

Results from the 2010/11 *Scottish Crime and Justice Survey (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 (Scottish Government 2012a). Latest data show that amongst adults aged 16 years and over in Scotland:

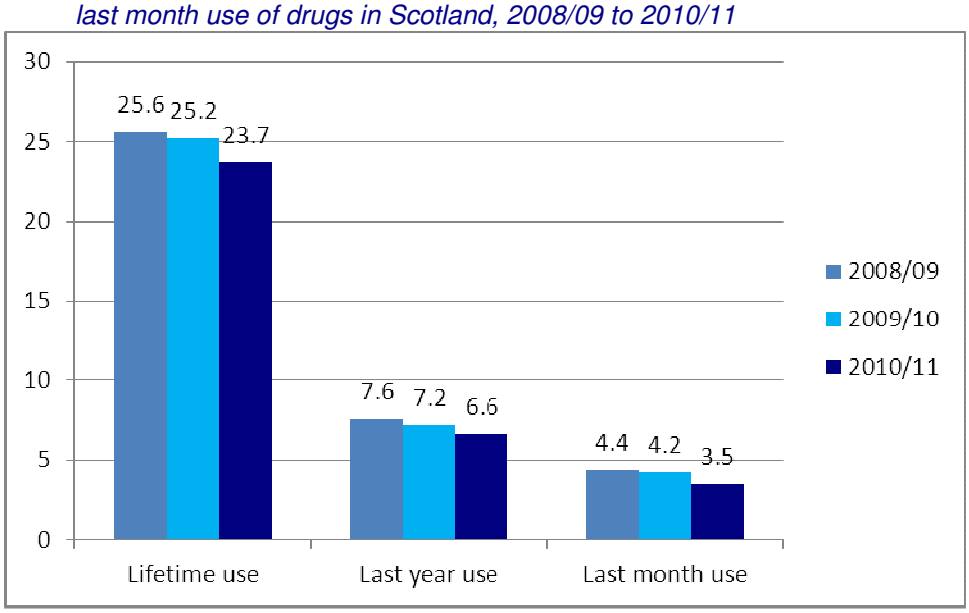
- 23.7% reported that they had taken illicit drugs in their lifetime (ever used);
- 6.6% reported recent (last year) drug use; and
- 3.5% reported current (last month) drug use.

Trends in drug use

Lifetime drug use was lower in 2010/11 than in both 2009/10 and 2008/09 (23.7% in 2010/11 compared to 25.2% in 2009/10 and 25.6% in 2008/09). Decreases were also reported in recent use between 2008/09 and 2010/11 and in current use between both 2008/09, 2009/10 and 2010/11. (Figure 2.4).

[27] The survey fieldwork for the SCJS was conducted between 1st April 2010 and 31st March 2011. The final sample size for the survey was 13,010 with a response rate of 67%. Of those who participated in the full survey, 10,999 (84.5%) answered the self-completion section, including questions on drug use which was administered using CASI.

Figure 2.2: *Percentage of respondents aged 16 years and over reporting lifetime, last year, and last month use of drugs in Scotland, 2008/09 to 2010/11*



Source: Scottish Government 2012a

Factors related to drug use

Associations between drug use and socio-economic, experiential and area factors were investigated using simple one-to-one relationships.[28] Those working in routine and manual occupations (9.6%) were significantly more likely to report using illicit drugs in the last year than those in managerial and professional occupations, those who were not working or who were long-term unemployed (each 4.8%), and those in intermediate occupations (5.9%).

Those living in private rented accommodation (14.5%) were significantly more likely to report having used drugs in the last year compared with those in social rented housing (10.0%) with both groups significantly more likely to report illicit drug use than those who were owner-occupiers (4.1%). Respondents living in urban areas (7.2%) were significantly more likely to have used drugs recently than those living in rural areas (4.4%). Those living in the 15 per cent most deprived areas of Scotland were significantly more likely to be recent drug users than those living elsewhere (9.0% compared to 6.3%). Victims of crime[29] (11.7%) were significantly more likely to have used drugs recently than non-victims (5.5%).

Polydrug use

Just over one-third of current drug users[30] (34.3%) reported ever having used another drug (polydrug[31] use) whilst under the influence of the drug that they used most often in the previous month. In response to a separate question, the majority of current drug users (84.6%) reported drinking alcohol at some point in their lives while under the influence of the drug they had used most often in the last month.

[28] 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.
[29] As measured by the SCJS 2010/11.
[30] Those who reported use of at least one illicit drug in the last month (3.5% of adults).
[31] 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.

New psychoactive substances

Questions on some new psychoactive substances (NPS)[32] were added to the SCJS in 2010/11. Last year use of any NPS was reported by 1.8% of adults aged 16 and over. Recent use was 0.7% and last month use was 0.2%. Mephedrone was the most commonly reported of these drugs, with 1.2% reporting ever use, 0.7% recent use and 0.2% having used it in the last month. Younger adults (aged 16 to 24) were the age group most likely to be recent mephedrone users (3.6%), with younger males more likely to have used mephedrone in the last year than females (4.9% compared to 2.2%). Use of all other NPS was low (see supplementary chapter on NPS). Including these new substances made very little difference to the overall prevalence of use so they have not been added in to the prevalence figures described above. Amongst recent illicit drug users, 11% had used one or more of the new drugs in the last year, most commonly mephedrone (reported by 9.9% of drug users).

2.2.4 Scottish Crime and Justice Survey 2010/11: Drug Use amongst adults aged 16 to 64[33]

To closer align the SCJS data with the EMCDDA reporting requirements on age, a standard table reporting the prevalence of self-reported drug use amongst adults aged 16 to 64 in Scotland has been submitted (ST01). Data show that, in 2010/11:

- 29.2% reported that they had taken illicit drugs at some point in their lives;
- 8.2% reported recent drug use; and
- 4.3% reported current drug use (Table 2.4).

As in previous years, cannabis had the highest prevalence rates across all recall periods. In terms of recent (last year) use, cocaine (2.4%), followed by ecstasy and amphetamines (1.7% and 1.2% respectively) were the next most commonly used drugs. A slightly higher proportion of 16 to 64 year olds had ever used amphetamines (9.8%) compared to either ecstasy or cocaine (9.0% and 8.9% respectively).

[32] Specifically BZP, GBL, khat, synthetic cannabinoids and mephedrone.

[33] Results reported here have been taken from ST01 provided on an EMCDDA basis and refer to 16 to 64 year olds. Therefore, data differ slightly from the published SCJS report (Scottish Government 2012a) which presents data for adults aged 16 and over. A technical report is available: http://www.scotland.gov.uk/Topics/Statistics/Browse/Crime-Justice/Publications/publications/SCJStechreport201011 It is also worth noting that this age range is slightly different from that covered by the CSEW (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 2.4: *Percentage of 16 to 64 year olds reporting lifetime, last year and last month use of individual drugs in Scotland, 2010/11, by gender*

	Lifetime use			Last Year use			Last Month use		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug	34.8	23.8	29.2	11.6	5.0	8.2	6.4	2.3	4.3
Amphetamines	12.5	7.1	9.8	1.7	0.7	1.2	0.8	0.2	0.5
Cannabis	32.4	21.1	26.7	10.0	4.2	7.0	5.6	2.0	3.8
Cocaine	11.8	6.0	8.9	3.4	1.4	2.4	1.3	0.4	0.9
Ecstasy	12.3	5.8	9.0	2.8	0.8	1.7	1.2	0.3	0.7
Ketamine	2.2	0.9	1.5	0.3	0.3	0.3	0.2	0.0	0.1
LSD	9.1	3.3	6.2	0.5	0.1	0.3	0.3	0.0	0.1
Magic mushrooms	9.5	3.6	6.5	0.5	0.3	0.3	0.2	0.1	0.1
Opioids	1.8	0.7	1.3	0.4	0.2	0.3	0.3	0.2	0.3
Base	*3,514*	*4,718*	*8,232*	*3,514*	*4,718*	*8,232*	*3,514*	*4,718*	*8,232*

Source: Standard Table 01

Trends in drug use

Reported recent drug use amongst adults aged 16 to 64 years old, which was stable between 2008/09 and 2009/10, decreased between 2009/10 and 2010/11 (from 9.0% to 8.2%) and has also decreased for the most commonly used drugs cannabis, cocaine and ecstasy.

2.2.5 Northern Ireland Drug Prevalence Survey 2010/11: Drug use amongst adults aged 15-64 years[34]

In Northern Ireland over one-quarter of respondents (27.3%) reported having ever used an illegal drug. The most commonly ever used drug was cannabis, reported by 24.0% of respondents. Other findings were that:

- recent drug use was highest in the 15 to 24 age group (13.4%) and lowest amongst older adults (aged 55 to 64) at 0.3%; and
- drug use was substantially higher amongst males than females, 9.2% of males aged 15 to 64 reported recent use of any drug compared to 3.9% of females (Table 2.5).

[34] The questionnaire and methodology are based on the EMCDDA's European Model Questionnaire (EMQ) http://www.emcdda.europa.eu/html.cfm/index19541EN.html. The questionnaires were administered through face-to-face interviews, using Computer Assisted Personal Interview (CAPI) with respondents aged between 15 and 64 years old who are normally resident in households in Northern Ireland (and Ireland, not reported here). People outside these age ranges and those who did not live in private households (e.g. those living in prisons, nursing homes etc.) were not surveyed. The survey was carried out between October 2010 and May 2011 and a total of 2,535 individuals from Northern Ireland took part (a further 5,134 individuals also participated in the survey in Ireland). The response rate for the survey was 67% in Northern Ireland and 60% in Ireland.

Table 2.5: *Percentage of 15 to 64 year olds reporting lifetime, last year and last month use of individual drugs in Northern Ireland 2010/11, by gender*

	Lifetime use			Last Year use			Last Month use		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug	32.3	22.4	27.3	9.2	3.9	6.6	5.1	1.6	3.3
Amphetamines	8.1	4.6	6.3	1.5	0.8	1.1	0.5	0.2	0.3
Cannabis	29.2	18.8	24.0	7.4	2.7	5.1	4.4	1.1	2.7
Cocaine	8.8	4.5	6.7	2.1	0.9	1.5	0.9	0.2	0.5
Ecstasy	11.1	6.5	8.8	1.9	0.4	1.1	0.5	0.1	0.3
LSD	6.9	3.3	5.1	0.3	0.1	0.2	0.1	0.0	0.0
Magic mushrooms	8.6	3.0	5.8	0.2	0.1	0.2	0.0	0.0	0.0
Heroin	0.6	0.1	0.4	0.2	0.0	0.1	0.0	0.0	0.0
Base	*1,161*	*1,372*	*2,533*	*1,161*	*1,372*	*2,533*	*1,161*	*1,372*	*2,533*

Source: Standard Table 01

Trends in drug use

Lifetime use and last month use of any drug amongst 15 to 64 year olds remained fairly stable between 2006/07 and 2010/11, while recent use of any drug decreased from nine per cent in 2006/07 to seven per cent in 2010/11. Recent cannabis use decreased from seven per cent in 2006/07 to five per cent 2010/11.

2.3 Drug use amongst young adults

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

2.3.1 UK Estimate

By combining data from surveys undertaken in 2010/11 (as described in section 2.2.1), it is estimated that in the United Kingdom:

- 43.4% of 16 to 34 year olds and 39.6% of 16 to 24 year olds had ever used drugs;
- 15.6% of 16 to 34 year olds and 20.2% of 16 to 24 year olds had used drugs recently; and
- 8.4% of 16 to 34 year olds and 10.7% of 16 to 24 year olds were current drug users (Table A.2, Appendix A).

The rates for current use were slightly lower than the corresponding figures in the UK estimate from 2009/10 (9.0% for 16 to 34 year olds and 11.6% for 16 to 24 year olds).[35] However, recent use amongst 16 to 24 year olds was essentially stable compared with 2009/10 when it was 20.0%. Amongst 16 to 34 year olds, recent use had also remained stable at 15.6% (see UK Focal Point Report 2011).

2.3.2 England and Wales: the Crime Survey for England and Wales 2011/12

Recent drug use is 15.6% amongst 16 to 34 year olds and 19.3% amongst 16 to 24 year olds (Table 2.6). Amongst the 25 to 34 year old age group, recent use of any drug is lower (12.3%) than amongst 16 to 24 year olds (19.3%). Recent cannabis use is also much lower amongst 25 to 34 year olds (9.2% compared to 15.7% for 16 to 24 year olds). The difference between age groups is most pronounced amongst females where more than twice as many 16 to 24 year olds are recent cannabis users compared to 25 to 34 year olds (10.8% compared to 4.8%). Cocaine is the only individual drug where usage is at the same level for both age groups (ST01).

[35] Caution must be taken when commenting on trends due to the nature of the combined estimate and the assumptions underlying the estimates.

Table 2.6: *Percentage of 16 to 24 year olds and 16 to 34 year olds reporting last year use of individual drugs in England and Wales, 2011/12 by gender*

	16-24 year olds			16-34 year olds		
	Male	Female	Total	Male	Female	Total
Any drug	24.1	14.2	19.3	20.8	10.1	15.6
Amphetamines	2.1	1.9	2.0	1.8	1.1	1.4
Cannabis	20.4	10.8	15.7	16.8	7.6	12.3
Cocaine	5.6	2.7	4.2	6.1	2.1	4.2
Ecstasy	4.3	2.3	3.3	3.9	1.7	2.8
LSD	0.7	0.3	0.5	0.5	0.2	0.3
Magic mushrooms	1.8	0.6	1.2	1.4	0.3	0.9
Base	*1,656*	*1,840*	*3,496*	*4,331*	*5,272*	*9,691*

Source: Standard Table 01

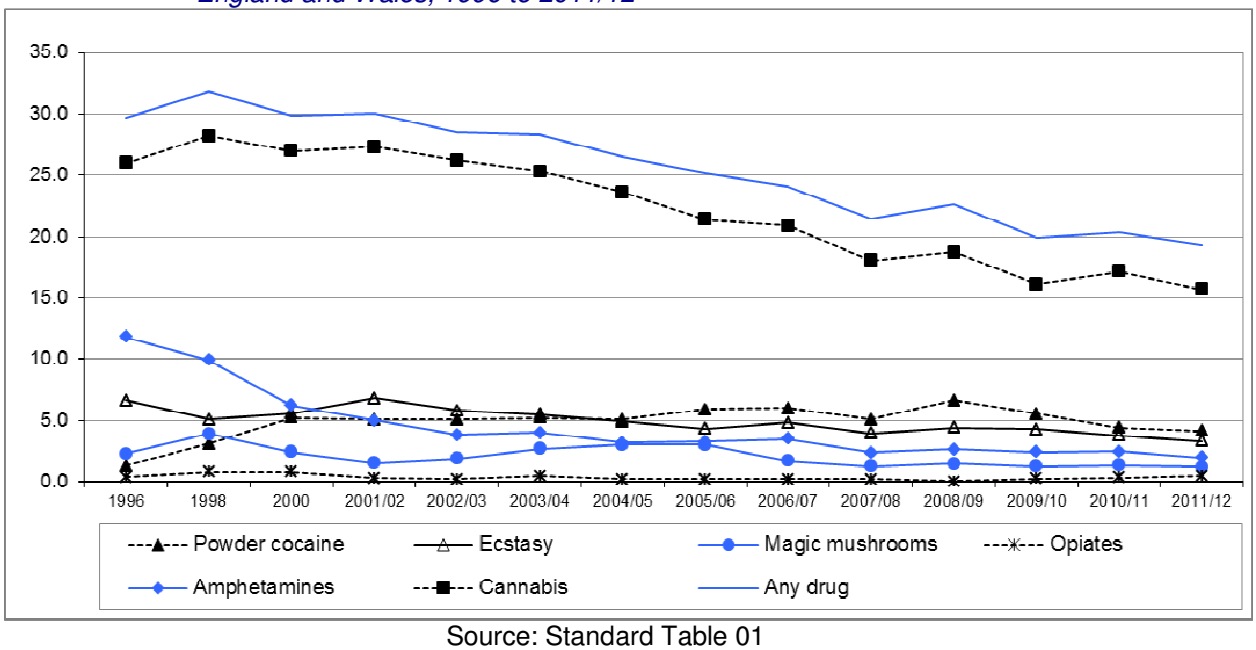
Trends in drug use

Recent drug use amongst 16 to 24 year olds remained stable in 2011/12 (Figure 2.2). Recent cannabis use was 15.7% in 2011/12, the lowest level since the survey began.

Use of any drug in the past year had decreased significantly since 1996. There had also been a decrease in prevalence of use of cannabis, ecstasy, magic mushrooms and amphetamines over the same time period (Figure 2.3). Since 1996, the only drug for which prevalence of use was higher compared to 1996 was cocaine powder, which increased from 1.3% in 1996 to 4.2% in 2010/11. However, last year cocaine powder use had decreased from a peak of 6.6% in 2008/09.

In addition to the drugs reported separately for the EMCDDA, data from the 2011/12 CSEW show that recent mephedrone use had fallen amongst young people aged 16 to 24, from 4.4% in 2010/11 to 3.3.%. However, it was still relatively high; at the same level as ecstasy, the third most commonly used drug in the survey. Ketamine was added to the survey in 2006/07 and recent use amongst young people aged 16 to 24 years old had increased since 2008/09 from 0.8% to 1.8%.

Figure 2.3: *Percentage of 16 to 24 year olds reporting last year use of individual drugs in England and Wales, 1996 to 2011/12*



Source: Standard Table 01

2.3.3 Scottish Crime and Justice Survey 2010/11

In 2010/11 cannabis continued to be the most commonly used drug amongst young adults in Scotland followed by cocaine and ecstasy (Table 2.7). As is the case amongst all adults, drug use was more common amongst males than females. Drug use amongst young people aged 16 to 24 years old (20.3%) was around three times as high as amongst all adults (6.6%).

Table 2.7: *Percentage of 16 to 24 year olds and 16 to 34 year olds reporting last year use of individual drugs in Scotland, 2010/11 by gender*

	16-24 year olds			16-34 year olds		
	Male	Female	Total	Male	Female	Total
Any drug	26.8	13.6	20.3	21.7	10.5	16.2
Amphetamines	5.8	1.7	3.8	3.7	1.5	2.6
Cannabis	24.4	12.1	18.4	18.7	9.0	14.0
Cocaine	7.5	4.1	5.8	7.4	3.3	5.4
Ecstasy	8.0	2.0	5.0	6.4	1.9	4.2
Ketamine	1.4	1.3	1.4	0.8	0.8	0.8
LSD	0.7	0.3	0.5	1.1	0.2	0.6
Magic mushrooms	1.2	0.8	1.0	1.2	0.7	1.0
Opioids	0.5	0.0	0.3	0.6	0.4	0.5
Base	*438*	*530*	*968*	*1,006*	*1,426*	*2,432*

Source: Standard Table 01

Trends in drug use

Amongst 16 to 24 year olds, prevalence of recent drug use remained stable between 2009/10 and 2010/11 (20.2% and 20.3% respectively), although it had decreased since 2008/09 when it stood at 23.5%. Amongst 16 to 34 year olds, recent use had fallen steadily since 2008/09 (from 19.0% in 2008/09 to 17.5% in 2009/10 and to 16.2% in 2010/11). Amongst 16 to 24 year olds and 16 to 34 year olds, prevalence decreased for the most commonly used drugs; cannabis, cocaine and ecstasy between 2009/10 and 2010/11.

2.3.4 Northern Ireland Drug Prevalence Survey 2010/11

In Northern Ireland, 13.4% of 15 to 24 year olds and 11.8% of 15 to 34 year olds reported recent use of any illegal drug. Males were more likely than females to report recent drug use and cannabis was the most frequently reported drug by both genders and age groups (Table 2.8). Mephedrone use in the last year was reported by 3.1% of 15 to 24 year olds and 2.2% of 15 to 34 year olds (NACD and PHIRB 2012). Recent use of 'other' legal highs was reported by 3.3% of 15 to 24 year olds and 2.0% of 15 to 34 year olds (see supplementary chapter on NPS).

Table 2.8: *Percentage of 15 to 24 year olds and 15 to 34 year olds reporting last year use of individual drugs in Northern Ireland, 2010/11 by gender*

	15-24 year olds			15-34 year olds		
	Male	Female	Total	Male	Female	Total
Any drug	17.2	9.4	13.4	15.7	7.9	11.8
Amphetamines	0.6	2.5	1.5	1.3	1.8	1.5
Cannabis	15.8	5.5	10.8	13.5	5.2	9.4
Cocaine	3.5	2.6	3.1	2.9	2.0	2.5
Ecstasy	4.7	0.6	2.7	3.4	0.7	2.0
LSD	0.6	0.6	0.6	0.5	0.3	0.4
Magic mushrooms	0.6	0.5	0.6	0.3	0.2	0.3
Base	*159*	*187*	*346*	*395*	*460*	*855*

Source: Standard Table 01

2.3.5 Other studies on drug use amongst young adults

The North West England Longitudinal Study (Aldridge, Measham and Williams 2011) aimed to assess how attitudes and behaviours towards the new availability of drugs had developed and changed over time amongst 'ordinary' young people in England in the 1990s.[36] Surveys included questions in four main sections: personal characteristics; drugs; last use of drugs; and alcohol and were changed slightly for each collection sweep. Nine in 10 respondents reported having drunk alcohol in the first data sweep and in all data sweeps, cannabis was the most commonly used illicit drug. Data showed that self-reported lifetime use of drugs rose from around one-third (36.3%) at age 14 to around two-thirds (64.3%) at age 18. By age 22, lifetime use had increased to 75.8%. Lifetime prevalence was broadly similar at age 27 but with a small decrease (72.0%). The authors suggested that this was due to biographical reconstruction or forgetting. Past year and past month prevalence remained consistent from the age of 18 to 22 and substantially decreased from just over half (52.1%) at age 22 to just over one-third at the age of 27 (34.1%). A drug pathways analysis carried out at ages 18, 22 and 27, identified drug status groups that respondents could be classified as depending on their drug use. Drug abstainers were identified at each age (age 18: n=157 30%, age 22: n=113 24%, age 27: n=40 18.6%) and the number of abstainers declined from age 18 to age 27. As respondents progressed through adulthood, attitudes towards drug use and the perceived risks shifted from concerns over immediate risks when participants were in their teenage years, to concerns of long-term effects, such as 'come downs' once participants were adults. Strategies were adopted to increase pleasure and reduce any problems associated with drug use. This included taking cannabis or valium to counteract the 'come down' from cocaine and ecstasy. Participants who had become parents were more likely to avoid drug taking. The normalisation of recreational drug use refers to the use of certain drugs, primarily cannabis, but also nitrates, amphetamines, LSD and ecstasy. The authors argued that, since the first data sweep, the concept of normalisation had been discussed more widely. The authors noted that the survey under-represented the more drug-involved and it was not possible to generalise the findings to the wider population.

2.4 Drug use in the school and youth population

2.4.1 England

Data from *Smoking, drinking and drug use amongst young people in England* (Fuller 2012) show that in 2011, 16.8% of pupils aged 11 to 15 years old had ever taken drugs, 11.8% had used drugs recently, and 6.0% had used drugs in the last month (Table 2.9). Cannabis was the most prevalent drug with 7.6% using it in the last year. Volatile substances[37] were the second highest, with 3.5% of pupils having used them recently. Recent use of all other drugs was below one per cent. In general, use of drugs was higher amongst boys, but in general this did not reach statistical significance. However, boys were significantly more likely to

[36] Using clustered non-random sampling, eight co-educational, State secondary schools in the metropolitan north-west of England were selected as representative of Merseyside and Greater Manchester. The study consisted of seven data collection sweeps. The first, in 1991, included 776 survey returns from respondents (aged 14). Four further data collection sweeps were conducted each year until 1995 when the modal cohort age was 18. Survey returns in 1995 dropped to 529. In addition to the surveys, in 1994 (age 17), 86 interviews were conducted (46 female and 40 male). The sixth data collection sweep took place in 1999 (age 22). Survey returns totalled 465 and a further 86 interviews were conducted. The final data collection sweep took place in 2004 and 2005 (ages 27 and 28) with a total of 217 surveys returned and 19 interviews conducted. Due to the high attrition rate in the final data collection sweep, interviews were conducted in greater depth than in the sixth sweep. The majority of the sample of 217 at the final sweep comprised those who had attended a secondary school with a 'middle-class' catchment area (71.9%), compared to those who had attended a secondary school with a 'working-class' catchment area (28.1%). Almost all of the respondents described their ethnicity as White (95.4%).

[37] Glue, gas, aerosols or solvents.

report cannabis use in the past year, but although volatile substance use appeared higher amongst girls across all recall periods, this was not statistically significant.

Table 2.9: *Percentage of pupils aged 11 to 15 years reporting lifetime, last year and last month use of individual drugs in England in 2011, by gender*

	Lifetime use			Last Year use			Last Month use		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug	17.6	16.0	16.8	12.7	10.8	11.8	7.2	4.8	6.0
Amphetamines	1.1	0.5	0.8	1.0	0.4	0.7	0.5	0.2	0.4
Cannabis	10.3	7.3	8.8	8.9	6.3	7.6	5.2	2.9	4.0
Cocaine powder	1.5	0.6	1.1	1.1	0.5	0.8	0.5	0.2	0.4
Crack cocaine	0.9	0.3	0.6	0.5	0.2	0.4	0.3	0.0	0.2
Ecstasy	1.2	0.8	1.0	1.1	0.6	0.8	0.5	0.1	0.3
LSD	0.7	0.3	0.5	0.6	0.3	0.5	0.4	0.1	0.2
Magic mushrooms	1.3	0.8	1.1	1.1	0.6	0.9	0.6	0.2	0.4
Ketamine	0.6	0.6	0.6	0.5	0.5	0.5	0.2	0.2	0.2
Opioids	1.3	0.6	1.0	0.8	0.5	0.7	0.5	0.2	0.3
Volatile substances	7.1	8.3	7.7	3.1	3.9	3.5	1.3	1.4	1.4
Base	*3,183*	*3,308*	*6,491*	*3,183*	*3,308*	*6,491*	*3,183*	*3,308*	*6,491*

Source: Fuller 2012

Type of drug by age

At younger ages, pupils are more likely to have taken volatile substances than cannabis. However, at age 13, whilst volatile substances were still the most common recently used drugs (at 4.7%) the use of cannabis increased substantially from 0.3% at age 12 to 3.7% at age 13 (Table 2.10). Prevalence then increased sharply to 10.4% at the age of 14 and 18.8% at 15. Volatile substances were the second most commonly used drug at older ages with ecstasy (2.3%), magic mushrooms (2.1%) and cocaine powder (1.8%) the next most commonly reported drugs at age 15. Amongst pupils reporting recent drug use, 71% had only taken one type of drug with the remaining 29% having taken two or more types of drug. Older pupils were more likely to report taking more than one drug; 36% of 15 year old pupils reported doing so compared to 21% of 11 to 13 year olds.

Table 2.10: *Percentage of pupils aged 11 to 15 years reporting last year use of individual drugs in England in 2011, by age*

	11yrs	12yrs	13yrs	14yrs	15yrs
Any drug	2.7	3.4	9.4	14.3	23.3
Amphetamines	0.0	0.2	0.	1.1	1.8
Cannabis	0.2	0.3	3.7	10.4	18.8
Cocaine powder	0.0	0.2	0.6	1.0	1.8
Crack cocaine	0.0	0.1	0.5	0.4	0.7
Ecstasy	0.0	0.2	0.1	1.0	2.3
LSD	0.0	0.1	0.5	0.8	0.7
Magic mushrooms	0.1	0.2	0.9	0.7	2.1
Ketamine	0.0	0.0	0.3	0.6	1.3
Opioids[38]	0.3	0.1	0.5	0.7	1.4
Volatile substances	1.9	2.5	4.7	3.1	4.8
Base	*1,034*	*1,329*	*1,308*	*1,267*	*1,553*

Source: Standard Table 02

Frequency of use

Seven per cent of recent drug users reported using drugs on most days with over one-third (35%) using drugs at least once a month. Just under one-third (30%) of recent drug users

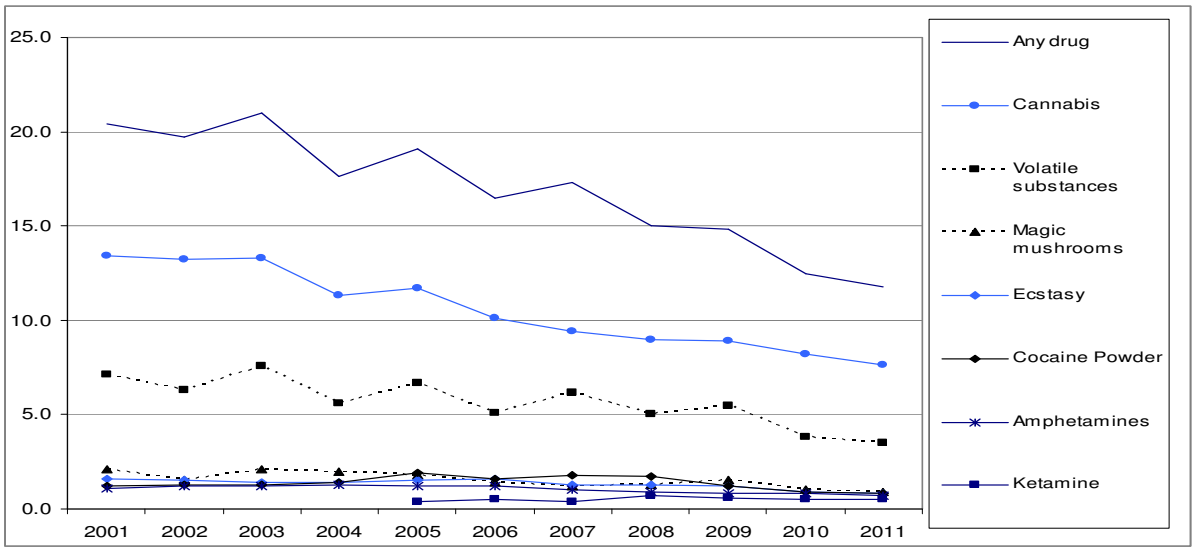
[38] Heroin and methadone.

had only ever taken drugs once. Those who had used Class A drugs recently were most likely to report taking drugs most days (17%) and at least once a month (60%).[39] Amongst pupils who had only used cannabis in the last year, four per cent reported using most days with one-third (33%) using at least once a month (Fuller 2012).

Trends in drug use

Since 2003, there was a general decline in recent and current drug use amongst the school population in England with a large decrease in recent use between 2009 and 2010 from 14.8% to 12.5% and stable use between 2010 and 2011. This downward trend in overall drug use results from marked declines in in the use of several of the most commonly used drugs. In 2003 recent use of cannabis was reported by 13.3% of pupils whereas in 2011 it was 7.6%. There had also been a decline in recent use of other drugs, particularly in the use of any stimulant, which decreased from 6.1% in 2003 to 2.5% in 2011. The use of volatile substances had also decreased in that time from 7.6% to 3.5% (Figure 2.4).

***Figure 2.4**: Recent use of some individual drugs amongst schoolchildren in England, 2001 to 2011*



Source: Fuller 2012

2.4.2 Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)

SALSUS was last carried out in 2010[40] and results were published in 2011 (NHS Scotland 2011, Table 2.11).The key findings were:

- one-fifth of 15 year olds (21%) and five per cent of 13 year olds had ever used drugs;
- just under one-fifth of 15 year olds (19%) and four per cent of 13 year olds had used drugs in the last year;
- cannabis was the most commonly used drug for both ages and across all recall periods;
- 15 year old boys were more likely than girls to be recent (21% compared to 16%) and current drug users (14% compared to 9%);
- at age 13 drug use was similar for boys and girls (last year use was the same at 4%; and last month use was 3% for boys compared to 2% for girls); and

[39] Frequency of drug use refers to all drugs not just Class A drugs.
[40] Fieldwork was conducted between September 2010 and February 2011. A total of 37,307 pupils in years S2 and S4 (aged mainly 13 and 15 respectively) completed the questionnaire and the overall response rate (both class and pupil response rate) was 62%.

- recent mephedrone[41] use was reported by one per cent of 13 year olds (both sexes) and two per cent of 15 year olds (3% of 15 year old boys and 2% of 15 year old girls).

Table 2.11: *Percentage of 13 and 15 year olds reporting last year use of individual drugs in Scotland, 2010 by gender and age*

	13 year olds			15 year olds		
	Male	Female	Total	Male	Female	Total
Any drug	4	4	4	21	16	19
Amphetamines	1	0	1	3	1	2
Cannabis	3	2	3	19	14	17
Cocaine powder	1	1	1	4	3	3
Crack cocaine	1	1	1	2	1	1
Ecstasy	1	1	1	3	2	3
LSD	1	0	1	2	1	1
Magic mushrooms	1	1	1	3	1	2
Opiates (opioids)	1	1	1	2	1	1
Volatile substances*	1	2	1	3	2	3
Mephedrone	1	1	1	3	2	2
Base	*9,586*	*9,375*	*19,011*	*8,908*	*8,593*	*17,567*

*gas, glue or other solvents

Source: NHS Scotland 2011

Amongst 13 year olds, recent use of all drugs apart from cannabis was around one per cent with the exception of volatile substances use amongst females, which at two per cent was the same level as cannabis use amongst girls. At the age of 15, ecstasy, cocaine powder and volatile substances were the second most commonly used drugs at three per cent. For all three drugs, a slightly higher percentage of boys than girls had used them in the past 12 months. Around half of pupils who had used drugs said they had used them outdoors (45% of 15 year olds and 49% of 13 year olds). The next most common place to take drugs was at someone else's home (33% of 15 year olds and 20% of 13 year olds). Girls were more likely than boys to report drinking alcohol the last time they used drugs (52% compared to 36%).

Frequency of use

One per cent of 15 year olds and less than one per cent of 13 year olds reported that they took drugs most days. Of those who had taken drugs, it was most common to report only haven taken drugs once.

Other factors related to drug use

Amongst 15 year olds, pupils from the most deprived areas were more likely to report current drug use than those from the least deprived areas, 13% compared to 10% (4% compared to 2% for 13 year olds). The survey included a behavioural screening questionnaire[42] and analysis showed that current drug users were significantly more likely to have an abnormal score for: emotion; conduct; hyperactivity/inattention; pro-social behaviour; and peer relationships than pupils who had never taken drugs.

[41] Added to the survey in 2010.

[42] The survey incorporated a self-completion version of the Goodman Strengths and Difficulties questionnaire (SDQ) (http://www.sdqinfo.com/), which is used to identify behavioural problems in four to 17 year olds. The SDQ asks about 25 attributes and pupils' scores were grouped as 'normal', 'borderline' and 'abnormal'.

Attitudes and beliefs about drug use

Fifteen year old current drug users were more likely to believe 'drug use is exciting' (65%) than recent but not current drug users (39%) or non-drug users (7%). A similar pattern was reported amongst 13 year olds (56%, 26% and 4% respectively). Around one-quarter (26%) of 15 year old current drug users felt that 'people my age who use drugs need help and advice' compared to just over three-quarters (76%) of those who had never taken drugs (38% and 81% respectively for 13 year olds).

Trends

Current drug use decreased for both 13 year olds and 15 year olds between 2002 and 2006, although changes to the fieldwork period may have influenced the findings.[43] Between 2006 and 2008 drug use remained relatively stable. Whilst drug use amongst boys remained stable between 2008 and 2010, there had been a decline in prevalence amongst girls: from 11% in 2008 to nine per cent in 2010 amongst 15 year old girls; and from three per cent to two per cent amongst 13 year old girls.

2.4.3 Northern Ireland

Topline results from the Young Person's Behaviour and Attitudes Survey (YPBAS)[44] in Northern Ireland were reported in the UK Focal Point Report 2011 showing that, amongst 12 to 16 year olds:

- lifetime use of any drug was 15.2%;
- last year use was 11.3%; and
- last month use of any drug was 7.1% (see UK Focal Point Report 2011).

Data presented were for pupils aged 12 to 16 years.[45] In general, older pupils were more likely to have taken drugs in the last year or last month than younger pupils and, for most drugs, recent prevalence increased with age (Table 2.12). Key findings were that:

- until the age of 15 years old, solvents were the most commonly used drug;
- cannabis was the most commonly used drug amongst older pupils, with 17% of 16 year olds reporting recent use and 10% in the last month; and
- solvents and cocaine powder were the second most commonly reported drugs by 16 year olds followed by ecstasy.

[43] A change in the fieldwork period should be taken into account when comparing results from 2006 with those from 2002 and 2004. The 2006 survey was carried out in the autumn term while the previous two surveys were conducted in the spring term. This resulted in a lower age profile for 2006 survey participants. As age has been identified as a key factor influencing the prevalence of drug use, caution should be taken when interpreting trends (see section 1.4, p.17 NHS Scotland 2011 and ISD Scotland 2007).

[44] The survey fieldwork took place between 18th October and 19th November 2010. Forty-four per cent of schools agreed to take part. A total of 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. A technical report including the full survey questionnaire is available at: http://www.csu.nisra.gov.uk/YPBAS%202010%20Technical%20Report.pdf

[45] These data have been calculated specifically for ST02 and differ from the published findings in the YPBAS report.

Table 2.12: *Last year and last month use of individual drugs amongst schoolchildren in Northern Ireland in 2010 by age*

	Last Year					Last Month				
	12yr	13yr	14yr	15yr	16yr	12yr	13yr	14yr	15yr	16yr
Any drug	4.8	6.7	9.3	13.5	21.1	3.3	4.9	6.0	7.5	12.5
Amphetamines	0.5	0.6	1.3	1.7	3.2	0.3	0.4	0.7	0.6	1.5
Cannabis	0.3	1.7	4.1	7.5	16.5	0.2	1.3	2.0	4.2	9.8
Cocaine powder	1.3	1.2	1.4	2.2	4.6	0.8	0.9	0.8	0.7	2.1
Crack cocaine	0.3	0.9	1.4	0.7	1.4	0.3	0.7	0.6	0.6	0.8
Ecstasy	0.3	1.0	1.2	1.9	4.3	0.3	0.7	0.6	0.4	1.9
LSD	0.8	0.8	1.2	0.7	1.4	0.5	0.4	0.6	0.0	1.0
Mag.mushrooms	0.5	1.0	1.0	1.4	3.7	0.3	0.8	0.3	0.3	1.7
Heroin	0.5	0.6	0.9	0.9	0.8	0.3	0.4	0.4	0.6	0.3
Solvents	2.9	4.2	4.8	4.9	4.6	2.0	2.9	3.2	2.0	2.2
Tranquillisers	0.3	0.4	0.7	0.7	2.4	0.3	0.3	0.6	0.4	1.0
Poppers	0.5	0.3	1.5	0.9	1.5	0.2	0.3	1.0	0.6	1.0
An.Steroids	0.6	0.7	0.7	0.6	0.7	0.3	0.6	0.6	0.1	0.5
Base	712	756	669	663	584	712	756	669	663	584

Source: Standard Table 02

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

ESPAD

The *2011 European School Survey Project for Alcohol and other Drugs (ESPAD),* published in 2012 (Hibell et al. 2012), is a comparative study across a number of European and other countries, including the United Kingdom.[46] The sample size is much smaller than the school surveys carried out in England and Scotland and the school response rate was very low so data should be treated with caution. Around one-quarter (27%) of UK respondents aged 15 to 16[47] reported that they had ever used drugs, a large reduction from the first year of the survey in 1995 when the figure was 42%. Cannabis was the most frequently used drug, one-quarter of pupils reported lifetime use and 13% current use. Cannabis use had decreased since 1995 for both measures (41% lifetime and 24% current). Overall, boys were more likely (29%) than girls (24%) to have used illicit drugs (Atkinson et al. 2012).

2.5 Drug use amongst specific groups in the adult population

2.5.1 Ethnic Minorities

Even large household surveys, such as the Crime Survey for England and Wales, have an insufficient sample size to properly consider prevalence of drug use by ethnicity taking account of the variety of ethnic groups and the different age structures of the populations. Ad-hoc studies combining several years of survey data are sometimes undertaken (Hoare and Moon 2010; see UK Focal Point Report 2011) or one-off studies of particular ethnic groups but there were none to report in 2012.

[46] The survey was carried out in 36 European countries (n= circa 100,000) in 2011. It has also been conducted in 1995, 1999, 2003 and 2007 and is used to collect comparable European-wide data on substance use amongst school pupils aged 15 to 16 and to examine trends (see: www.espad.org). The UK has taken part in the study since its inception in 1995. Data were collected in 74 schools (participation rate of 6%) which were selected at random and stratified so that each UK country was represented in the sample in proportion to their respective populations. A total of 1,712 pupils responded to the survey.

[47] Equivalent to approximately 403,000 individuals in this age group across the UK.

2.5.2 Drug use amongst clubbers

A follow-up study to a survey conducted in two 'gay-friendly' dance clubs in London[48] in 2010 (Measham et al. 2011a) was carried out one year later to establish if levels of mephedrone use in those clubs had changed in that time and also to identify the drug of choice amongst respondents (Wood et al. 2012a). It was reported that 12 months after the previous survey was conducted, and fifteen months after legislative control, there was a significant increase in the number of clubbers who had taken or planned to take mephedrone on the night of the survey. Nearly two-thirds (63%) of respondents reported that they had already taken drugs that day and/ or were planning to do so on the night of the survey. Mephedrone was the drug most commonly used on the survey night with 41% stating that they had already taken it or were planning to do so that night (compared to 27% in the previous year). GHB or GBL was the next most frequently used drug (24%) followed by cocaine (17%). Clubbers were also asked to identify their favourite drug and mephedrone was the most commonly cited, by one-fifth of respondents. Cocaine (14.9%) and GHB or GBL were the next favourite drugs (12.0%). The authors concluded that this may provide some evidence to suggest that, in the short term at least, legislation does not necessarily reduce the demand for a particular substance, nor in some cases the levels of use. They recommended that further research is conducted to investigate the complex relationships between drug policy, markets, use and legislation.

In a further publication from the same survey conducted in 2011, Wood et al (2012b) reported that the use of novel substances was limited in this particular club scene and only mephedrone had established itself as a commonly used recreational drug with participants. Over half (53%) of respondents had used mephedrone in the past month which was more than for cocaine and ecstasy (44.6% and 26.9%) but there was limited use of other new psychoactive substances (NSP) such as methoxetamine (1.6%), 1-benzylpiperazine (0.6%), spice 0.6%) and pipradols (0.6%).

Emerging trends in Northern England

As part of a two year project[49] to monitor emerging drug trends in the night-time economy, a survey was conducted on a Friday night in four towns and city centres in northern England (Measham et al. 2011b). The authors reported high levels of self-reported drugs use amongst participants, particularly of mephedrone with one in 20 having tried it in the past month and one in ten in the past year.[50] Those who reported mephedrone use were significantly more likely to also use ecstasy, cocaine and amphetamines than those who did not report mephedrone use. The authors reported the use of a range of unidentified synthetic white powders amongst respondents, for which users employed a generic, slang name "bubble". The authors were unable to identify the use of any specific emergent substances amongst these participants.

[48] The survey was carried out in two gay friendly clubs in South London on four nights in July 2011 using opportunistic sampling. The vast majority of participants (85%) were male. A total of 312 individuals provided responses about drug taking. The mean age was 29.7 years old. Researchers recorded information from participants on a two-page survey which followed a similar format to the survey carried out 12 months earlier in the same two clubs (Measham et al. 2012; see UK Focal Point Report 2011).

[49] See also Measham et al. 2011c www.ldaat.org/files/emerging_trends_report.pdf and Moore et al. 2011 http://www.ldaat.org/files/emerging_trends_second_report.pdf for data tables and further details. A third report was due for publication in September 2012. Fieldwork was carried out on a convenience sample of adults on a Friday night in November 2010. Participants were stopped at random in four town and city centres in Lancashire in the north of England and asked about their drug use.

[50] The survey was conducted in November 2010 prior to the classification of mephedrone under the *Misuse of Drugs Act 1971*.

The Mixmag/ Guardian survey

A survey of drug users (predominantly clubbers 65%)[51] found that the most commonly used drug in the last year was cannabis (68%) (Winstock 2012) (Table 2.13). The next most commonly used drugs were ecstasy (54%), followed by cocaine powder (42%), nitrous oxide (27%), ketamine (25%) and mephedrone (20%). Fifteen per cent of all respondents and one-fifth of all respondents aged 18 to 25 had taken an 'unknown white powder' in the past 12 months.

Table 2.13: *Percentage of all respondents in the Mixmag/Guardian survey (n=7,700) reporting lifetime, last year and last month use of certain individual drugs, 2011*

	Lifetime	Last year	Last month
Cannabis	91.1	68.2	53.4
Ecstasy	75.0	53.7	33.7
Cocaine powder	69.4	41.8	22.3
Nitrous oxide	49.6	27.2	n.i
Ketamine	47.8	24.5	9.3
Mephedrone	42.7	19.5	7.2
Amphetamine	52.9	11.8	4.2
Magic mushrooms	53.1	13.9	4.8
Methoxetamine	4.9	4.2	2.4

Source: Winstock 2012

Regular clubbers (defined as at least once in the past month) typically reported higher recent and current drug use when compared to all respondents. Cannabis use for this group was reported as 69% for recent use and 60% for current use (compared to 68% and 53% respectively). This was also the case with cocaine powder (54% recent use and 30% current use); nitrous oxide (43% recent use and 10% current use); ketamine (40% recent use 10% current use); mephedrone (30% recent use and 13% current use); and methoxetamine (6% recent use and 4% current use).

2.5.3 Drug use in the Lesbian, Gay, Bisexual and Transgender (LGBT) community

In 2011, a survey of self-reported drug use amongst gay and bisexual men in Britain[52] (Guasp 2012) reported that in the last 12 months:

- just over half of respondents (51%) reported they had taken drugs;
- just under one-third (31%) had used amyl nitrate (poppers);

[51] The 'Global Drug Survey' is an online, cross-sectional, self-reported, self-selecting survey and as such it is not representative of the general population. The survey was hosted by the Guardian newspaper and Mixmag dance music magazine. A total of 7,700 responses were received from the UK (52% of the total global responses, n=15,500). Of the total respondents, n=5,000 were clubbers (> 4 times a year) and 22.6% reported that they never go clubbing. In the UK, 70% of respondents were male and the age of respondents ranged from 18 to 'over 60' years of age. The average age of respondents was 28.3 years old, with 70% aged between 18 and 29 years old. Fifteen per cent of responses were from the over 40 age group. The survey collected data on drug users' experiences during a four week period between November and December 2011. The survey was advertised on social media sites and via the Guardian and Mixmag. In previous years this survey was hosted solely by Mixmag a dance music magazine aimed at clubbers. As a result of the wider advertising in 2011 there has been a wider spread of participants who are not clubbers. These results are preliminary and may be subject to change.
See: http://globaldrugsurvey.com/about and http://globaldrugsurvey.com/run-my-survey/methods and http://www.guardian.co.uk/society/2012/mar/15/guardian-mixmag-drug-survey-drugs and http://www.guardian.co.uk/society/datablog/2012/mar/15/global-drug-survey-us-uk

[52] In 2011, responses to a health needs survey were received from 6,861 gay (92%) and bisexual (8%) British men (85% English, 9% Scottish and 6% Welsh). The age range was from 16 to 85 years with the majority of respondents (77%) aged between 20 and 50 (8% aged 20 or younger and 15% aged over 50). See: www.stonewall.org.uk/gaymenshealth.

- just over one-fifth (21%) had used cannabis;
- one in six (15%) had taken cocaine;
- 11% had taken ecstasy;
- one in twelve (8%) had taken ketamine or mephedrone;
- amphetamine, GHB and tranquilizer use was four per cent for each; and
- two per cent had taken methamphetamine.

A survey conducted[53] in Northern Ireland (Rooney 2012) with participants from the LGBT community also reported that drug use was higher amongst this group than levels reported in general population[54] surveys with nearly two-thirds (62%) reporting lifetime use of any drug. In the previous 12 months:

- over one-third reported use of any drug (37%), 28% in the last month;
- over one-quarter (27%) had used cannabis, 14% in the last month;
- one-quarter had used amyl nitrate (poppers); and
- 12% had taken cocaine and 10% had taken ecstasy.

A survey conducted in England amongst lesbian, gay and bisexual people between 2009 and 2011[55] reported current drug use amongst 35% of the respondents (Buffin et al. 2012). The majority of respondents (80%) completed the survey at Gay Pride events[56] at various locations across the country. One-fifth (21%) of respondents had taken one substance in the last month and 15% had taken two or more. The most commonly used drugs in the last month were cannabis (20%) and amyl nitrate (18%), followed by cocaine powder (8%) and ecstasy (7%). Similar to the general population, drug use tended to be higher amongst younger age groups; however last month use of any drug did not decrease with age as greatly as is typically observed in the general population.

An analysis of drug use by sexual orientation was carried out using data from the 2007/08 and 2008/09 British Crime Survey (Hoare and Moon 2010; see UK Focal Point Report 2010). Comparisons of drug use amongst the LGBT community and the general population should be treated with caution if data are not age standardised. The BCS analysis uses age-standardised data and a common methodology so it is more appropriate to use these data for commenting on differences in drug use prevalence by sexuality.

[53] An online survey was advertised by various LGBT organisations and on the Gaydar and Pink Sofa. Are these websites? If so needs to say that. A total of 941 responses were received, 63% from males. The majority of responses were from 15 to 34 year olds (61% of female responses and 54% of male responses), this is a higher proportion of younger respondents than the general population survey (Northern Ireland Drug Prevalence survey 2010/11 NACD and PHIRB 2012) which reported that 42% of female and 43% of male respondents were aged between 15 to 34 years old.

[54] It should be noted that the majority of responses were from 15 to 34 year olds (61% of female responses and 54% of male responses),this is a higher proportion of younger respondents than the general population survey (Northern Ireland Drug Prevalence survey 2010/11 NACD and PHIRB 2012) which reported that 42% of female and 43% of male respondents were aged between 15 to 34 years old.

[55] A total of 4,206 responses were received.

[56] A further 14% completed the survey online, five per cent completed a postal survey and 0.2% (n=9) completed the survey at a sexual health conference for men who have sex with men (MSM). The sample was recruited using convenience methods and was self-selecting. It is noted that the age profile of the respondents is younger than that for the general population and so care should be taken when making comparisons. The setting for the completion of the survey e.g. at Gay Pride events may also have influenced the prevalence levels.

2.5.4 Older drug users

A secondary analysis of a national household survey[57] was conducted and the results were compared to local data from a community health survey (conducted in inner London) to examine levels of drug use amongst older drug users.[58] It was reported that, whilst drug use amongst the over 50s was typically lower than levels reported in younger age groups, prevalence levels had increased over time (Fahmy et al. 2012). Cannabis was the most commonly reported drug in both surveys examined in this analysis. In the household survey (England) recent use amongst respondents aged 50 to 64 years was 1.8% and for those over 65 years of age it was 0.4%. Figures for the community health survey (inner London) were higher at 9.0% for 50 to 64 year olds and 1.1% in the over 65's. Lifetime prevalence rates for cannabis use amongst 50 to 64 year olds were 11.4% in the household survey (England) and 42.8% in the community health survey (inner London). Amongst the over 65's it was 1.7% in the household survey (England) and 9.4% in the community health survey (inner London). The authors reported that since 1993 there had been around a ten-fold increase in the lifetime prevalence rates of cannabis, amphetamine, cocaine and LSD use amongst 50 to 64 year olds.

2.6 Drug use amongst specific groups in the school age population

2.6.1 England

Data from the 2011 survey of *Smoking, drinking and drug use in England* (Fuller 2012; see section 2.4.1) show that pupils who had ever truanted or had been excluded from school were more likely to have used Class A drugs in the last year than those who had not; eight per cent compared to one per cent. Although this pattern is similar to previous years, there has been an overall downward trend in the prevalence of drug use amongst truants/excludees since 2006 when it was 14%. Truants/excludees were also more likely to report using drugs at least once a month (8% compared to 1%).

2.7 Research

The association between childhood intelligence and drug use as a teenager and in later life was investigated using data from a longitudinal cohort study[59] (White and Batty 2011). It was reported that higher IQ at the age of five years old was positively associated with an increased lifetime use of cannabis at 16 years of age. It was also positively associated with recent cannabis use (in the past 12 months) at 30 years of age. There was a positive association with IQ at 10 years of age and the likelihood of ever using cannabis; also with recent cannabis, cocaine, amphetamines, ecstasy and polydrug use at the age of 30. It was reported that the associations were stronger in women and results were independent from

[57] Using data from the 2007 English Adult Survey of Psychiatric Morbidity (APMS) (McManus et al. 2009) and the South East London Community Health (SELCoH) survey (carried out in 2008-10 in the boroughs of Lambeth and Southwark). Secondary analyses were also carried out using data from the 1993, 2000 and 2007 APMS for 50 to 64 year olds and using data from the 2000 and 2007 APMS for 65 to 74 year olds.

[58] See: http://www.slam.nhs.uk/research/biomedical-research-centre/about-the-brc/core-facilities/south-east-london-community-health-(selcoh)-survey.aspx and http://www.kcl.ac.uk/innovation/groups/selcoh/about/selcohfindings.aspx

[59] Data were obtained from the 1970 British Cohort Study, a longitudinal study of 16,571 children born in England, Wales and Scotland between 5th and 11th April 1970. Participants were enrolled at birth and followed up at ages five, 10 (n=14,874), 16 (n=11,622) and 29 to 30 (n=11,261). In this study data were analysed to investigate: IQ levels at ages 5 and 10; lifetime cannabis and cocaine use at age 16; parental social class, and levels of psychological distress at age 16; recent (last 12months) cannabis, cocaine, amphetamine, ecstasy and polydrug use (more than 3 drugs) at age 30; social class, highest educational attainment and gross monthly income at age 30.T16) to 7,946. Data were analysed using χ^2, analysis of variance and multivariate logistic regression.

psychological distress experienced as a teenager, parental social class and income at age 30.[60]

It was reported that at 16 years of age, seven per cent of males and six per cent of females had used cannabis. The mean IQ scores of these individuals at the age of 10 were significantly higher than for those who self-reported that they had never used cannabis. Lifetime cocaine use at age 16 was 0.7% for boys and 0.6% for girls.[61] With the exception of recent amphetamine use in men, significantly higher childhood IQ scores were recorded for both men and women who had recently used all types of drugs at age 30.

[60] The authors adjusted significance levels to take into account: levels of psychological distress as a teenager; parental social class; the individuals' monthly income; and highest level of education. This was found to have no influence on the results.

[61] There was a non-significant difference in mean child IQ scores for those who reported cocaine use at age 16 and those who had never used cocaine.

3. Prevention

3.1 Introduction

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

Policies have been embedded in, or complemented by, a much wider framework of social action to create the capacity of both individuals and communities to resist drugs, including policies for children and young people aimed at enabling them to reach their full potential. In England, the *Children's Plan* aims to facilitate this (DCSF 2007). The devolved administrations take a similar approach, in Wales through *Children and Young People: Rights to Action* (WAG 2004a). The GIRFEC (Getting It Right For Every Child) programme[62] provides the methodology for delivering the Scottish Government's three social policy frameworks: the *Early Years Framework; Achieving our Potential;* and *Equally Well* (Scottish Government 2008b;c;d), which aim to develop the prevention and early intervention agenda. In Northern Ireland, *Our Children and Young People – Our Pledge: A 10 year strategy for children and young people in Northern Ireland, 2006-2016* (OFMDFMNI 2006) sets a framework for addressing the needs of young people. Improved education and early interventions for young people and families (especially those most at risk) and improved public information about drugs are priority areas.

Universal drug prevention initiatives are an important area of policy. Communication programmes, such as 'Talk to FRANK'[63] in England and 'Know the Score'[64] in Scotland, provide factual information and advice to young people and their families. In Northern Ireland, the Public Health Agency[65] develops public information campaigns for various target groups and settings, and in Wales a bilingual (Welsh and English) helpline, 'Dan 24/7'[66] 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. A review of PSHE in England was published in 2011 (DfE 2011a).

In England and Wales, all local areas are expected to produce *Children and Young People's Plans* for all services for children and young people, including prevention and treatment. The *Common Assessment Framework (CAF)*[67] 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.

[62] See: http://www.scotland.gov.uk/Topics/People/Young-People/childrensservices/girfec.
[63] See: http://www.talktofrank.com/
[64] See: http://knowthescore.info/
[65] See: http://www.publichealth.hscni.net/
[66] See: http://www.dan247.org.uk
[67] See: http://www.cwdcouncil.org.uk/caf

Communities are provided with assistance to build the capacity to resist drugs through a range of initiatives which are delivered by local partnerships. There are specific interventions targeting young people in deprived communities such as Positive Futures[68] in England and the Integrated Families Support Service (IFSS) in Wales. In Scotland, a number of projects receive time limited funding from the Scottish Government in partnership with Lloyds TSB Partnership Drugs Initiative (PDI)[69], targeting children with, or at risk of, problem drug use 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 Environmental Prevention

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

3.2.1 Illicit drugs, alcohol and tobacco policies in the UK

Across the United Kingdom there are a range of policies and strategy documents concerned with licit substances such as tobacco and alcohol. In some UK countries, such as Wales and Northern Ireland, there are global strategies which cover both illicit and licit substances. A summary of the situation across the UK is given below and a reference list of the key strategy documents is provided in Table 3.1.

UK/England

There is a drug strategy which covers illicit (and some licit) drugs. There are separate strategies for alcohol and tobacco in England, aspects of the alcohol strategy apply to all UK countries, such as taxation, but others (including crime, policing, licensing, pricing) only apply to England and Wales. *Healthy lives, healthy people: a Tobacco Control Plan for England* was published in 2011. The plan sets out national ambitions to reduce smoking rates in England by the end of 2015.

Wales

In Wales there is a global strategy which equally covers illicit drugs and alcohol. Wales also has a tobacco strategy.

Scotland

Scotland has an illicit drugs strategy and also has separate alcohol and tobacco strategies.

Northern Ireland

There is a global strategy equally covering illicit drugs and alcohol. Northern Ireland also has a tobacco strategy.

[68] See: http://www.posfutures.org.uk/index.asp?m=793&t=Home
[69] See: http://www.ltsbfoundationforscotland.org.uk/index.asp?tm=16

Table 3.1: *UK strategy documents for alcohol, tobacco and illicit drugs*

Country	Substance(s) covered	Reference
UK/England	Illicit drugs	HM (Her Majesty's) Government (2010). Drug Strategy 2010. Reducing demand, restricting supply, building recovery. Her Majesty's Government. http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-strategy/drug-strategy-2010?view=Binary
	Alcohol	HM (Her Majesty's) Government (2012). The Government's Alcohol Strategy. Home Office. http://www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol-strategy
England	Tobacco	HM (Her Majesty's) Government (2011). Healthy Lives, Healthy People: A Tobacco Control Plan for England. Department of Health. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124960.pdf
Wales	Illicit drugs and alcohol	WAG (Welsh Assembly Government) (2008). Working Together to Reduce Harm. The Substance Misuse Strategy for Wales 2008-2018. Welsh Assembly Government. http://new.wales.gov.uk/topics/housingandcommunity/safety/publications/strategy0818/?lang=en WAG (Welsh Assembly Government) (2008) Working Together to Reduce Harm. The Substance Misuse Strategy. Three-year Implementation Plan 2008-11. Welsh Assembly Government. http://new.wales.gov.uk/topics/housingandcommunity/safety/publications/strategy0818/?lang=en WAG (Welsh Government) (2012). Working Together to Reduce Harm. The Substance Misuse Strategy One-year Implementation Plan 2011-12. Welsh Government. http://wales.gov.uk/docs/dsjlg/publications/commsafety/120125implan1112.pdf
	Tobacco	WAG (Welsh Government) (2012). Tobacco Control Action Plan for Wales. Welsh Government. http://wales.gov.uk/docs/phhs/publications/120202planen.pdf Welsh Government (2012). Tobacco Control Delivery Plan. Welsh Government. http://wales.gov.uk/docs/phhs/publications/120202tableen.doc
Scotland	Illicit drugs	Scottish Government (2008). The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem. Scottish Government. http://www.scotland.gov.uk/Publications/2008/05/22161610/0
	Alcohol	Scottish Government (2009). Changing Scotland's Relationship with Alcohol Framework for Action. Scottish Government. http://www.scotland.gov.uk/Publications/2009/03/04144703/0
		Scottish Government (2012) Changing Scotland's Relationship with Alcohol: A Framework for Action - Progress Report. Scottish Government. www.scotland.gov.uk/Resource/0038/00388540.pdf
	Tobacco	Scottish Government (2008). Scotland's Future is Smoke Free: A Smoking Prevention Action Plan Scottish Government. http://www.scotland.gov.uk/Publications/2008/05/19144342/0
Northern Ireland	Illicit drugs and alcohol	Department of Health, Social Services and Public Safety (DHSSPSNI) (2011). New Strategic Direction for Alcohol and Drugs Phase 2 2011-2016. A Framework for Reducing Alcohol and Drug-Related Harm in Northern Ireland. DHSSPSN. http://www.dhsspsni.gov.uk/nsdad-finalversion-may06.pdf
	Tobacco	Department of Health, Social Services and Public Safety (DHSSPSNI) (2012). Ten-Year Tobacco Control Strategy of Northern Ireland. DHSSPSNI. http://www.dhsspsni.gov.uk/tobacco_strategy_-_final.pdf

3.3 Universal prevention

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

3.3.1 School

England

Reforms in schools to address risk factors that can lead to substance misuse have been introduced (HM Government 2012a). These reforms include exclusion trials[70] and a review of alternative education provision for excluded pupils which Local Authorities now have a statutory obligation to provide. The Government has consulted on a review of Personal, Social, Health and Economic (PSHE) education (which includes drug education). In the next 12 months the Government has pledged to improve the quality of PSHE education in schools with the aim of providing young people with knowledge of the potential risks of taking drugs and the confidence to resist pressure to take them.

The Association of Chief Police Officers (ACPO) and the Department for Education (DfE) have issued non-statutory guidance for schools for dealing with drug incidents (DfE and ACPO 2012). The guidance does not cover drug education. It recommends that schools should have a written drug policy and a sample framework is included within the report. It includes suggested headings for areas that should be covered by the policy and is intended for schools to use as a guide to help them develop their own individual policies. It is also recommended that pupils affected by drug misuse should have early access to support services and that a senior member of school staff should have overall responsibility for drug policy and any necessary liaison with the police and local support services.

Scotland

Choices for Life[71]

Following a re-design and re-launch in late 2011 (see UK Focal Point Report 2011), the *Choices for Life* online, interactive substance use education programme continues in Scotland and has been further developed in partnership with a number of stakeholders.[72] As part of this, a new website was launched in September 2012, which aims to offer young people credible, factual information and interactive content on substance use (alcohol, tobacco and drugs), including the social consequences, so that they are able to make informed health choices.[73] The website also provides links to other relevant sites in

[70] Around 300 schools across England are due to participate in a trial in which headteachers will be responsible for ensuring that the pupils they permanently exclude are provided with an alternative source of education, as opposed to it being the responsibility of the local authority, as is the case currently. The school will also receive the funding instead of the local authority. The aim is to encourage schools to intervene early with children who are at risk of being excluded. See: http://www.education.gov.uk/inthenews/inthenews/a00199305/schools-to-trial-new-approach-to-exclusions

[71] Choices for Life is an interactive substance use education programme (covering drugs, alcohol and tobacco), project managed by the Scottish Crime and Drugs Enforcement Agency (SCDEA) and funded by the Scottish Government. It was previously delivered as large-scale concert style events for 10 and 11 year old children across Scotland, combining health education with music, drama and quizzes. In order to widen access to the programme to young people aged up to 18 years old, the programme was re-launched online in late 2011 and delivered using GLOW, the schools intranet system in Scotland.

[72] A number of partner agencies are involved in both the planning and delivery stages, including Young Scot (a national youth information and citizenship charity), Education Scotland and the Scottish Government. The partnership with Young Scot allows young people to be engaged throughout the process with the aim that the website is a youth-led, co-designed, interactive hub.

[73] See: www.choicesforlifeonline.org

Scotland.[74] There will also be a series of modular live webcasts throughout the school year. An affiliate programme will offer opportunities for groups and individuals across the country to showcase community initiatives and projects around substance misuse on the website, linking local areas and offering an information sharing hub. In addition to young people, educators will be able to access online resources to help them teach young people about drugs, tobacco and alcohol. The materials will be fully aligned with Scotland's *Curriculum for Excellence (CFE)* with the live webcasts specifically designed to complement the Health and Wellbeing experiences and outcomes in CFE.

Wales

All Wales School Liaison Core Programme (AWSLCP) [75]

A recent operational review of the programme recommended that a more integrated neighbourhood policing model was needed and that consideration should be given to the programme being co-delivered in primary schools by Police Officers and Police Community Safety Officers. A small working group has been established to take the recommendations of the report forward.

3.3.2 Community

England

Positive Futures[76]

A total of 91 projects across the Positive Futures programme continue to deliver prevention and diversionary activities targeted at vulnerable 10 to 19 year olds to prevent and reduce substance misuse. Reducing substance misuse remains one of the seven strategic priorities for the programme, which also includes reducing crime and preventing serious youth violence. This is the last year of central government funding for the programme. Future funding of local prevention activity beyond March 2013 will depend upon the investment case that local areas are able to make to Police and Crime Commissioners (see section 9.3.2) and other local partners and commissioners, and on the outcomes being delivered locally.

Repository of impact studies on youth services

The Government has announced its support for the development of a database of programmes and services for young people by the Centre for Analysis of Youth Transitions (CAYT)[77] (HM Government 2012a). The aim of the database is to house information and evidence regarding the effectiveness and impact of prevention initiatives.

[74] Such as The Lowdown (an online guide to teenage health supported by a free and confidential helpline) see: http://www.getthelowdown.co.uk/home.aspx), Young Scot, Know the Score and NHS Health Scotland.

[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: UK Focal Point Reports 2008 to 2011.

[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.ifs.org.uk/centres/cayt

Scotland

CashBack for Communities[78]

The CashBack for Communities Programme takes the gains of crime, recovered through the *Proceeds of Crime Act 2002*,[79] and invests them into community programmes, facilities and activities largely, but not exclusively, for young people with the aim of benefitting Scottish communities affected by crime and anti-social behaviour. Money is provided to local communities to support a wide range of sporting, cultural, educational and mentoring activities for children and young people aged 10 years. The Programme is delivered through a number of partnerships with key Scottish sporting, arts, business, community and youth associations. Projects range from diversionary work to more long-term intervention projects, which aim to provide individuals with the opportunity of employment, education, or volunteering. Over £46million has been invested and an estimated 600,000 young Scots have participated.

3.3.3 Sources of information on drugs

England

School survey

In 2011, and similar to previous years, 60% of school pupils in England aged 11 to 15 recalled having received drug education in school in the previous year (Fuller 2012; see section 2.4.1). Older pupils were more likely to report receiving these lessons than their younger counterparts (66% of Year 11 pupils compared to 41% of Year 7 pupils).[80]

Pupils were most likely to cite teachers as a source of information on drugs (69%) with parents (66%), television (64%), and the police in schools (53%) as the next most common sources. Half of pupils mentioned the internet (50%) and magazines/newspapers were stated by 45%. Two-fifths (41%) of pupils found other relatives and friends a source of helpful information and over one-third (37%) said other adults at school were a source of useful information.

The FRANK campaign was mentioned by just over one-quarter of all pupils (27%) with older pupils more likely to mention it than younger pupils (39% of 15 year olds compared to 9% of 11 year olds). Pupils who had taken drugs (either ever or in the previous month) were more likely to cite FRANK as a source of useful information that those who had never taken drugs (40% compared to 24%)

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

3.4 Selective prevention in at-risk groups and settings

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

[78] See: http://www.scotland.gov.uk/Topics/Justice/public-safety/17141/cashback
[79] See: http://www.legislation.gov.uk/ukpga/2002/29/contents
[80] Year 7 pupils are aged 11 and 12.Year 11 pupils are aged 15 and 16.

3.4.1 At-risk groups

Local authorities in England have been given the power to make funding decisions at a local level through the introduction of the Early Intervention Grant,[81] which pools together various smaller grants (HM Government 2012a).

Choices programme

The Choices programme was funded by the Home Office in 2011/12 with the aim of building and enhancing the capacity and capability of the voluntary and community sector to deliver proven prevention and early intervention programmes. The programme targeted vulnerable groups aged 10 to 19 and included those in at-risk groups who showed early behavioural problems, poor family functioning, early substance misuse and family members or peers involved in substance misuse or other problem behaviours. The programme involved the development of partnerships of national and local voluntary and community organisations to deliver targeted programmes. Choices was developed using proven approaches but with an emphasis on developing more effective solutions for local communities. The expectation is that the learning generated from the programme will add to the evidence base and demonstrate the benefits of locally developed, innovative approaches in working to reduce substance misuse and related offending by young people. Choices involved 11 national voluntary and community sector organisations working with around 190 local voluntary organisations and engaging over 10,000 young people. A range of interventions were delivered through Choices and these included: mentoring and peer mentoring; intensive support; one-to-one brief interventions; motivational interviewing; the use of arts, media, youth work and sports based activities to enhance protective factors and build resilience; intensive preventative interventions to young people affected by parental substance misuse; and intensive support to young people and their families who were on the edge of statutory intervention in relation to substance misuse and related offending.

NICE guidance on interventions to reduce substance misuse in vulnerable young people

During 2011/12, the National Institute for Clinical Excellence (NICE) and the Department of Health will consider the possibility of a broader review of the prevention of substance misuse (including alcohol) but with a narrower age range and greater focus on vulnerable populations. It is possible that any resulting guidance might supersede the 2007 NICE guidance, *Community-based interventions to reduce substance misuse amongst vulnerable and disadvantaged children and young people* (NICE 2007a; see UK Focal Point Report 2007).

Inspiring Scotland

The Inspiring Scotland 14 to 19 fund has been running since 2008.[82] The Scottish Government has invested £9.4m between 2009 and 2012 and a further £4m will be invested between 2012 and 2013. Government is one of many investors from public and private sectors, alongside high net worth individuals and other trust funding. In 2011, a total of 5,242 vulnerable young people, including those with issues around drug use, were assisted across 22 ventures which helped them into education, training or employment. Since 2008, a total of 12,976 vulnerable young people engaged with the programme, of which 5,845 individuals have achieved 'positive destinations'.

[81] See: http://www.education.gov.uk/childrenandyoungpeople/earlylearningandchildcare/delivery/funding/a0070357/eig-faqs

[82] Inspiring Scotland works with venture organisations to improve performance, build capacity and develop by providing access to support and advice from benefactors and Inspiring Scotland fund managers.

In the first quarter of 2012, Ventures engaged with 2,638 vulnerable young people, against a year-end target of 5,410.

Scottish Government and Department for Work and Pensions (DWP)
The Scottish Government has been working with the DWP in Scotland and local Alcohol and Drug Partnerships (ADPs) to try and ensure that people seeking help with drug or alcohol problems are always able to receive swift referrals that are appropriate to their needs.

3.4.2 At-risk families

Wales
Strengthening Families programme 10-14
The Strengthening Families Programme (SFP)[83] helps parents and children gain a better understanding of the harms of alcohol and substance misuse, and how to reduce health-damaging behaviour. A team of researchers led by Cardiff University's Cardiff Institute of Society, Health and Ethics (CISHE) is evaluating SFP[84] and will monitor the results for two years after families enter the trial. The initial results will be available in August 2013 with the final report published in September 2014.

Scotland
Getting Our Priorities Right
The Scottish Government is currently consulting on an update of the *Getting Our Priorities Right (GOPR),* the good practice framework for all child and adult service practitioners working with children and families affected by problem parental alcohol and/or drug use, which was originally published in 2003 (Scottish Executive 2003). The aim of the guidance is to support the wider recovery agenda for families facing substance use issues, ensuring that child protection, recovery and wider family support concerns are brought together as part of a co-ordinated approach. The guidance is part of a wider programme of actions that the Scottish Government is taking on early intervention, supporting vulnerable children and young people, and tackling alcohol and drug problems and has been developed for practitioners by practitioners. The consultation ran until September 2012 and the refreshed guidance is expected in early 2013.[85]

3.4.3 Research
A systematic review of the evidence on interventions to reduce risk factors in school children reporting both substance use and risky sexual behaviour[86] reported that programmes which targeted multiple risk and protective factors were favourable to those that addressed only one factor (Jackson et al. 2011). The authors found the evidence of effectiveness to be limited but reported that those programmes which did show promise, addressed several areas of influence on risk behaviour (individual and peer, family, school and community). Positive effects in terms of drug use were limited with only three out of ten studies reporting a significant difference in at least one drug outcome.

[83] Project SFP Cymru involves families in Swansea, Carmarthenshire, Flintshire, Caerphilly, Merthyr Tydfil and Wrexham.
[84] This is part of a £2.5m randomised controlled trial (RCT) funded by the Medical Research Council (MRC).
[85] See: http://www.scotland.gov.uk/Publications/2012/07/9484/0.
[86] Defined here as use of alcohol, tobacco and/or illicit drug use. The authors examined 18 studies, largely from North America, reporting on interventions targeting alcohol, illicit drug or tobacco use and sexual risk behaviour outcomes. Fourteen interventions were evaluated via a randomised controlled trial (RCT) and four in a controlled trial. One study was rated as strong, 12 moderate and five weak.

3.5 National and local media campaigns

Talk to FRANK

The FRANK[87] service, which provides information and advice about drugs for young people has been re-launched. A webchat feature is currently being piloted and further, enhanced methods of interaction with FRANK are being explored (HM Government 2012a). The Government has pledged to continue to provide information on drugs and new psychoactive substances (NPS) through partnership working and targeting high risk groups. Information on the health harms associated with NPS will be targeted to users through FRANK, social media, magazines, and partners who work with users.

Know the Score campaign: Scotland

In Scotland, Know the Score[88] continues to offer drugs information and advice, delivered via a website and a free 24 hour helpline. In response to the use of NPS, the Scottish Government funds a third sector organisation 'Crew 2000'[89] to deliver training and resources on NPS and emerging trends to professionals in drug services and the youth sector across Scotland.

The Welsh Drug and Alcohol Helpline DAN 24/7

In 2011/12 the DAN 24/7[90] helpline responded to 3,162 callers, an increase of 18% on the previous year (2,678 in 2009/10). Television advertising was used for the first time and promotion of the service was targeted at drug/alcohol and other services which come into contact with substance users. The accompanying website was enhanced and in 2011/12 it received 22,700 hits, an increase of around 50% compared to the previous year (Welsh Government 2012b).

[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 nine years. See: http://www.talktofrank.com and http://www.homeoffice.gov.uk/media-centre/news/frank-campaign .

[88] See: http://knowthescore.info/

[89] See: http://www.crew2000.org.uk/

[90] Drug and Alcohol Helpline, 'DAN 24/7' is a bilingual (Welsh and English) telephone helpline 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 signpost callers to local relevant services. See: http://www.dan247.org.uk

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.[91] In Scotland, problem drug use refers to the problematic use of opiate[92] and/or the illicit use of benzodiazepines and drug injecting; in Wales it is long duration or regular use of opioids, cocaine powder and/or crack cocaine; and in Northern Ireland problem opiate and/or problem cocaine powder use. For the purpose of this chapter the term problem drug use (PDU) will be used to encompass all of these definitions from across the UK and to allow for comparisons across Europe to be made by the EMCDDA.

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

Latest national and regional estimates for England are for 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, the latest national and regional estimates for problematic opiate and/or benzodiazepine use are also for 2009/10 and were published in 2011. Drug injecting estimates for Scotland are available for 2006. In Wales, local and national estimates for 2009/10 for long duration or regular use of heroin, other opioids, crack cocaine and/or cocaine powder were published in 2011. Estimates for Northern Ireland for 2004 were published in 2006 and cover problem opiate and/or problem cocaine powder use.

Based on these, it is estimated that there are a total of 383,534 problem drug users in the United Kingdom, and 133,112 people who inject drugs (PWID) (primarily opiates or crack cocaine).

4.2 Prevalence estimates of problem drug use

4.2.1 Estimates of problem drug use in England

The most recent estimates of problem drug use in England were published in 2011 (Hay et al. 2011; see UK Focal Point Report 2011) showing that there were an estimated 306,150[93] opiate and/or crack cocaine users in 2009/10. New national and local estimates of the prevalence of opiate and/or crack cocaine use (OCU) are being calculated for 2010/11 with separate estimates for opiate use, crack cocaine use and injecting drug use. It is anticipated that the results will be available in 2013.

4.2.2 Estimates of problem drug use in Scotland

National and local estimates of the prevalence of problem drug use in Scotland for 2009/10 were published in autumn 2011 (ISD Scotland 2011). Estimates are for problematic opiate

[91] Injecting drug use refers to estimates of the numbers injecting out of those that are opiate and / or crack cocaine users. It does not include estimates of injectors of amphetamines, performance and image enhancing drugs (PIED) or other drugs.
[92] Including illicit and prescribed methadone.
[93] Confidence interval (CI) 95% = 299,094 to 319,916.

and/or illicit benzodiazepine use[94] amongst individuals aged between 15 and 64 years old. Previous estimates have been published for the calendar years 2000, 2003 and 2006 (Hay et al. 2001; 2004; 2009).

In 2009/10 there were an estimated 59,600[95] individuals aged between 15 and 64 with problem drug use in Scotland, an increase from the 2006 (n=55,328) and 2003 (n=51,582) estimates.[96] (Hay et al. 2004; 2009). The estimated rate of individuals with problem drug use in 2009/10 was 17.1 per 1,000 population, a non-significant increase from 2006 but lower than the rate in 2003 (Table 4.1).

Table 4.1: *Estimates of problem drug use[97] and rates per 1,000 population aged 15 to 64 in Scotland, 2003, 2006 and 2009/10*

Year	Estimate	95% Confidence Interval	Rate	95% Confidence Interval
2009/10	59,600	58,300-61,000	17.1	16.7-17.5
2006	55,328	54,500 - 57,200	16.2	15.9-16.7
2003	51,582	51,456 - 56,379	18.4	18.4-20.1

Source: ISD Scotland 2011, Hay et al. 2004; 2009

In 2009/10, 71% of individuals with problem drug use were male, of whom 19% were aged between 15 and 24; 38% were between 25 and 34; and 43% were aged between 35 and 64. However, the rate of problem drug use was highest in the 25 to 34 year old age group (50 per 1,000 population compared to 23 per 1,000 population for 15 to 24 year olds and 18 per 1,000 population for 35 to 64 year olds). There are apparent decreases in the estimated prevalence rate in both the 15 to 24 and 25 to 34 year old age groups (from 1.75% in 2006 to 1.63% in 2009/10 for 15 to 24 year olds and from 3.90% in 2006 to 3.60% in 2009/10 for 25 to 34 year olds. However, for the 35 to 64 years old age group, the estimated prevalence rate appears to have increased from 0.89% in 2006 to 1.18% in 2009/10.

Regional differences in problem drug use prevalence rates were found in Scotland with comparatively low rates reported in most rural areas and the highest prevalence rates reported in Glasgow City (34.1 per 1,000 population) and Dundee City (32.9 per 1,000 population)

4.2.3 Estimates of problem drug use in Wales

National PDU estimates for Wales for the period 2009/10 were published by the Welsh Government in October 2011 (Welsh Government 2011a; see UK Focal Point Report 2011). Regional differences were noted in the report across Health Board areas. The rate (per 1,000 population) ranged from 3.5 (95% CI 2.4 to 9.6) in the rural Powys area to 14.3 (95% CI 11.0 to 19.0) in the Abertawe Bro Morgannwg University (ABMU)[98] area.

[94] Problem drug use is defined as the "problematic use of opioids (including illicit and prescribed methadone use) and/or the illicit use of benzodiazepines and implies routine and prolonged use as opposed to recreational and occasional drug use."
[95] Confidence interval (CI) 95% = 58,3000 to 61,000.
[96] It should be noted that these are estimates only and as such there are margins of error and so caution should be taken when comparing trends in prevalence levels and confidence levels should be taken into account.
[97] Opiate and/or benzodiazepine users.
[98] Incorporating Swansea, Neath, Port Talbot and Bridgend.

4.2.4 Estimates of problem drug use in the United Kingdom

Combining the 2009/10 estimates for England, Scotland, Wales (Hay et al. 2011; ISD Scotland 2011; Welsh Government 2011a) and the most recent estimate for Northern Ireland for 2004 (Centre for Drug Misuse Research 2006) it is possible to derive an estimate for the United Kingdom of 383,534 problem drug users, a rate of 9.38 per 1,000 population aged 15 to 64 (Table 4.2).

Table 4.2: *Estimates of problem drug use in the United Kingdom: number and rate[99] per 1,000 population aged 15 to 64*

Country	Estimate	95% Confidence Interval		Rate	95% Confidence Interval	
England	306,150	299,094	319,916	8.93	8.72	9.33
Northern Ireland	1,395	1,316	1,910	1.19	1.12	1.62
Scotland	59,600	58,300	61,000	17.15	16.78	17.55
Wales	16,389	13,850	23,580	8.45	7.14	12.2
United Kingdom	383,534	372,560	406,406	9.38	9.11	9.94

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

As reported in the UK Focal Point Report 2011, the latest available[100] estimate for the number of people who inject drugs (PWID) (predominantly opiates and crack cocaine) in the UK is 133,112 a rate of injecting of 3.27 per 1,000 population aged 15 to 64.

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

Table 4.3 shows estimates provided over time by the UK Focal Point; the dates refer to the year the estimate was produced for the UK Focal Point on Drugs rather than the year the estimate is for. Please see footnotes for the year that the estimates are for. [101]

There has been a non-significant decrease in the number of problem drug users from 398,845 in the 2007 estimate to 383,534 in the 2012 estimate.

[99] Calculated using the following 2009 population estimates for 15 to 64 year olds: England 34,299,600; Northern Ireland 1,177,207; Scotland 3,475,011; Wales 1,938,837; United Kingdom 40,890,655.

[100] 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. 2011; Hay et al. 2009; Welsh Government 2011).

[101] For more information on these estimates see previous UK Focal Point Reports.

Table 4.3: *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% confidence interval		Rate	95% confidence interval	
2007[102]	398,845	397,033	421,012	10.15	10.11	10.72
2008[103]	403,547	395,378	423,907	10.19	9.98	10.70
2009[104]	404,884	396,267	431,120	10.10	9.88	10.75
2010[105]	397,346	387,536	419,949	9.79	9.55	10.35
2011[106]	379,262	368,711	402,640	9.31	9.05	9.88
2012[107]	383,534	372,560	406,406	9.38	9.11	9.94

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

4.3 Data on PDUs from non-treatment sources

Statistics from the Northern Ireland Addicts Index 2011

The Northern Ireland Addicts Index provides information about individuals reported to be addicted to one or more of 14 specific drugs[108] classified under the *Misuse of Drugs Act 1971* (PHIRB 2012). The index showed that as at 31st December 2011:

- 272 individuals were registered on the Addicts Index, a decrease of 14% from 315 in 2010;
- as in 2010, 79% of registered addicts were male;
- similar to previous years around one-quarter (26%) of registered addicts were aged 29 years and under (24% in 2009 and 2010; 25% in 2008);

[102] 2007 estimate is based on estimates of opiates and/or crack cocaine use in England for 2004/05 (Hay et al. 2006), opiate use in Northern Ireland for 2004 (The Centre for Drug Misuse Research 2006), and problem drug use in Scotland, 2003 (Hay et al. 2004). Estimates for Wales are extrapolated from the estimates for England.

[103] 2008 estimate is as 2007 above except for England for 2005/06 (Hay et al. 2007).

[104] 2009 estimate is based on estimates of opiates and/or crack cocaine use in England for 2006/07 (Hay et al. 2008), opiate use in Northern Ireland for 2004 (The Centre for Drug Misuse Research 2006), opiate and/or benzodiazepine use in Scotland for 2006 (Hay et al. 2009) and long duration or regular use of opioids, powder cocaine and/or crack cocaine in Wales for 2006/07 (WAG 2009).

[105] 2010 estimate is based on estimates of opiates and/or crack cocaine use in England for 2008/09 (Hay et al. 2010a;b), opiate use in Northern Ireland for 2004 (The Centre for Drug Misuse Research 2006), opiate and/or benzodiazepine use in Scotland for 2006 (Hay et al. 2009), and long duration or regular use of opiates and/or cocaine in Wales for 2006/07 (WAG 2009).

[106] 2011 estimate is based on estimates of opiate and/or crack cocaine use in England for 2009/10 (Hay et al. 2011a), opiate use in Northern Ireland for 2004 (Centre for Drug Misuse Research 2006); opiate and/or benzodiazepines use in Scotland for 2006 (Hay et al. 2009), and long duration or regular use of opiates and/or crack cocaine/ cocaine powder in Wales for 2009/10 (Welsh Government 2011).

[107] 2012 estimate is based on estimates of opiate and/or crack cocaine use in England for 2009/10 (Hay et al. 2011), opiate use in Northern Ireland for 2004 (Centre for Drug Misuse Research 2006), opiate and/or benzodiazepine misuse in Scotland for 2009/10 (ISD Scotland 2011), and long duration or regular use of opioids and/or crack cocaine/ cocaine powder in Wales for 2009/10 (Welsh Government 2011).

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

- as in previous years, heroin was the most frequently used notifiable drug (reported by 83%) with methadone (18%) and cocaine (7%) the second and third most commonly reported drugs;
- 55% of registered addicts whose injecting behaviour was known reported currently injecting, similar to previous years (54% in 2010; 55% in 2009);
- there were 240 re-notifications in 2011 (compared with 255 in 2010) and 32 new notifications; and
- 12% (n=32) of individuals on the Index were registered within the last year; 51% (n=140) have been registered for between one and five years; and 37% (n=100) have been registered for six years or more.

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

Looked after children

Since 2006, the Department for Education[109] has collected information on the number of looked after children identified as having a substance use problem. Of the 46,090 children looked after for at least 12 months in the year ending 30th March 2011, 1,960 (4.3%) were identified as having a substance use problem.[110] Sixty-one per cent (n=1,200) of these were male (DfE 2011b).

Problematic use amongst schoolchildren

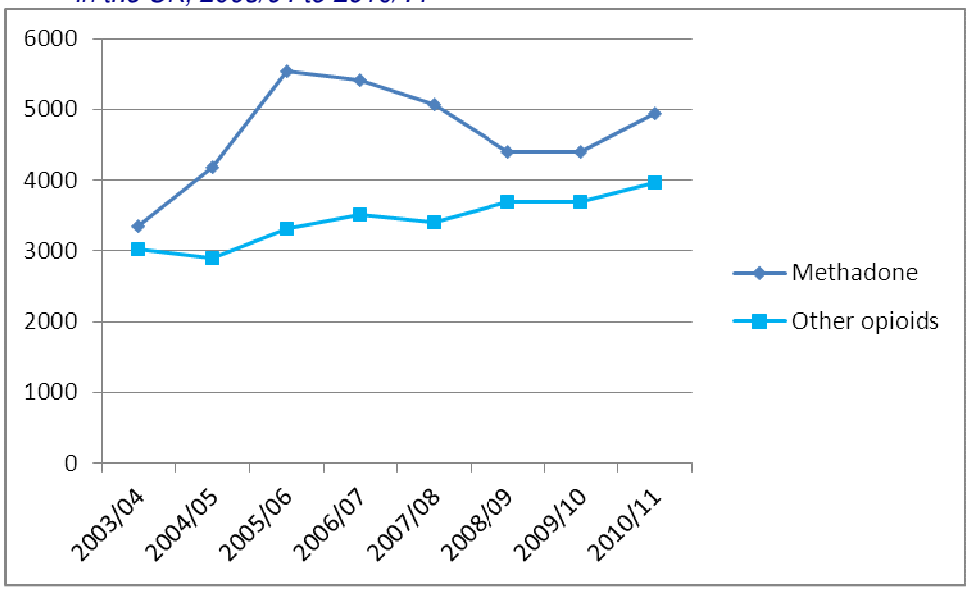
Data from the 2010 Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) (see section 2.4.2) showed that four per cent of 15 year old respondents who had ever used drugs felt that they needed help because of their drug use (7% of 13 year olds). Fourteen per cent of pupils who reported using drugs most days felt they needed help. Amongst drug users, 18% of 13 year olds and 13% of 15 year olds reported being in trouble with the police because of drug use in the last year. Four per cent of 15 year olds who had ever used drugs and eight per cent of 13 year olds reported being admitted to hospital overnight in the last year due to drug use (NHS Scotland 2011).

4.5 Other opioid indicators

While heroin indicators have decreased in the past year (see Trends Analysis section), where data are available, they suggest a recent increase in problems related to other opioid use. Presentations to treatment for 'other opioids' (excluding methadone) in the UK, while accounting for only three per cent of treatment presentations and six per cent of primary opioid presentations, have increased since 2003/04 and between 2009/10 and 2010/11, increased by seven per cent (Figure 4.1). Amongst first ever treatments, the primary use of 'other opioids' (excluding methadone) increased by 40% between 2009/10 and 2010/11 and now account for 10% of first ever opioid presentations. Similarly presentations for primary methadone use have increased since 2003/04 and after declining between 2005/06 and 2009/10, increased by 12% in 2010/11. The number of first ever primary methadone presentations increased by 61% between 2009/10 and 2010/11. UK treatment data suggest a reduced risk of injecting amongst primary users of other opioids compared to primary heroin users; two per cent of those reporting primary methadone use and six per cent of primary users of other opioids reported injecting as their usual route of administration compared to 39% of primary heroin users. An analysis of treatment data from England showed that one-third (34%) of 'other opioid' (excluding methadone) users were primary buprenorphine users, 17% were primary codeine users and 12% were primary dihydrocodeine users (NDTMS – unpublished data).

[109] Previously known as the Department for Children, Schools and Families (DCSF).
[110] See: http://www.education.gov.uk/rsgateway/DB/SFR/s001046/index.shtml

Figure 4.1 *Number of presentations to treatment for primary use of methadone and other opioids in the UK, 2003/04 to 2010/11*

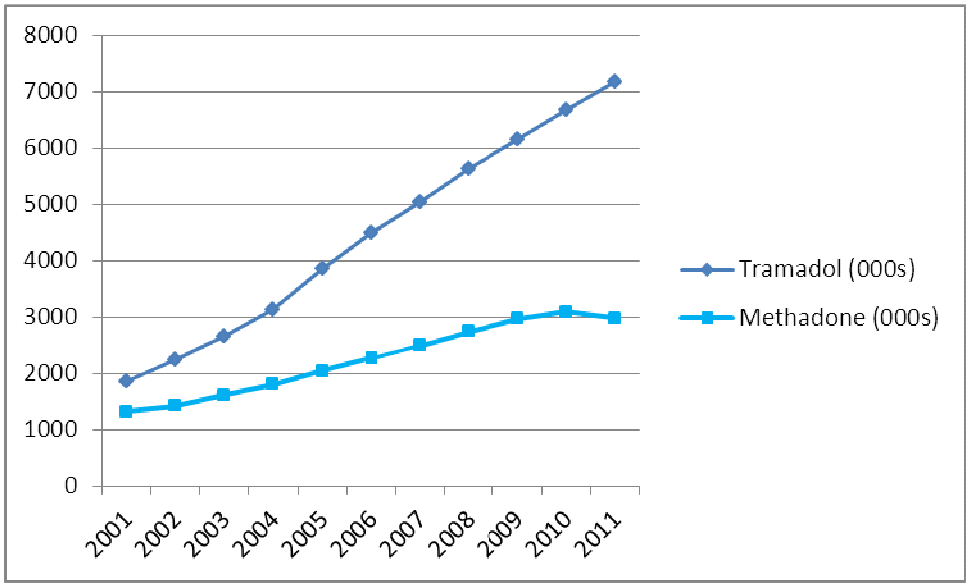


Source: Standard Table 34

Other health indicators show an increase in hospital discharges and deaths for 'other opioids' and methadone. Between 2007/08 and 2010/11 in the UK, there was a 31% increase in hospital discharges for 'other opioid' poisoning and a 43% increase in discharges for methadone poisoning (see section 6.3.2). Over the same period there was a 19% decrease in heroin poisoning discharges with a 21% decrease between 2009/10 and 2010/11. Between 2003 (n=292) and 2011 (n=765) there was a 162% increase in the number of deaths mentioning methadone in the UK with a 52% increase between 2010 (n=503) and 2011 (see section 6.4.1). The annual average number of methadone deaths increased from 448 for 2006-2008 to 617 for 2009-2011. Deaths involving tramadol have also increased substantially; in 2011 (n=205) they were four times the level of 2003 (n=51). Treatment data from England, however, show that only 2.5% (n=148) of 'other opioid' clients in treatment in 2010/11 reported tramadol use. In addition, there were a further 158 clients who reported tramadol as a secondary drug. Figure 4.2 shows that the number of tramadol prescriptions in England has increased substantially since 2001, which may be due, in part, to the withdrawal of co-proxamol in 2005. There have also been increases in the number of methadone prescriptions[111] issued in England although there were decreases between 2010 and 2011.

[111] Includes methadone prescribed for drug dependence (British National Formulary 4.10) and as an opioid analgesic (British National Formulary 4.7.2).

Figure 4.2: *Number of prescription items for tramadol and methadone issued in England, 2001 to 2011*



Source: Prescription Cost Analysis Data, 2001 to 2011

Data from the Scottish National Drug-related Deaths Database for 2010 (Graham et al. 2012; see section 6.4.2) showed that, of the 162 deaths with methadone detected,[112] 53% (n=86) were not receiving substitute medication at the time of their death. A survey of 886 drug users carried out in Merseyside, England (86% of whom were receiving methadone) found that 60% had obtained illicit methadone in the last year and 22% had obtained illicit methadone in the last four weeks (Duffy and Baldwin 2012). Seizures data show that there were 1,333 seizures of methadone by police in the UK.[113]

A report on addiction to medicines including opioid analgesics was published by the National Treatment Agency for Substance Misuse in 2010, exploring prescription and treatment data and the response of the treatment system in England (NTA 2011a). While the report highlighted slight year on year increases in the number of individuals in drug treatment reporting problem use of prescription only and over the counter opioids, it indicated that the rapid increase in the prescribing of opioids was not fully reflected by an increase in demand for treatment.

[112] A total of 365 drug-related deaths were explored, a subset of the 485 drug-related deaths reported in Scotland in 2010.

[113] Data from the UK Border Agency for 2010/11 cannot separately identify methadone from the recording system. Data from previous years show a maximum of eight UKBA seizures of methadone per year.

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

5.1 Introduction

United Kingdom (UK) drug strategies identify treatment as being effective in tackling problem drug use and, therefore, seek to improve its quality and effectiveness. *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (DH and the devolved administrations 2007) continues to provide the clinical framework for drug treatment in the UK. With an increasing focus on recovery oriented treatment, UK countries have developed further guidance to support treatment delivery, effectively updating and replacing (in England) the *Models of Care for Treatment of Adult Drug Misusers: Update 2006* (NTA 2006a) (SQ27, part 2).

There are many types of drug addiction treatment available in the UK including: one to one drug addiction counselling; day programme addiction treatment; quasi-residential drug addiction treatment; fully residential drug addiction treatment; drug addiction detox; inpatient treatment; and home drug addiction detoxification (SQ27, part 1). The National Institute for Health and Clinical Excellence (NICE) also provides guidance on a number of topics.[114] 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. Naltrexone is recommended as a treatment option to prevent relapse in detoxified formerly opioid-dependent people who are highly motivated to remain in an abstinence programme.

Co-ordination and integration between a range of providers is seen as key in helping problem drug users reintegrate into society and all recent drug strategies in the United Kingdom focus on this area. While providing treatment remains a priority, housing, employment, education and training have also been identified as important, 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 UK 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 rebalance treatment services to support this aim.

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

[114] See UK Focal Point Report 2010.

substantially, levelling off in 2006/07 before rising in 2007/08 and 2008/09 and decreasing in 2009/10 and 2010/11. 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 and 2010/11. Cannabis presentations increased between 2003/04 and 2009/10 and now account for one-fifth of all treatment presentations and one-third of first ever presentations.

It is estimated that, in 2010/11, TDI data represented around half of all those receiving drug treatment in the UK during that year.

5.2 Strategy and policy

5.2.1 England

The National Treatment Agency for substance misuse (NTA) in England will cease to exist as a separate organisation from April 2013 and will become part of Public Health England, a new Executive Agency of the Department of Health. Responsibility for public health will be transferred to local authorities and the ring fence around the pooled treatment budget (PTB) will be removed. In the Public Health Outcomes Framework, a set of 65 national indicators published in January 2012 (DH 2012), there is a drug treatment indicator, successful completion of drug treatment, which will be measured by the number of people leaving treatment free from their drug of dependency and not re-presenting in the following six months. Another indicator, people entering prison with a substance dependence issue who are previously not known to community treatment, is also drug-related.

For 2012/13, the PTB was maintained at £406.7 million. While the amount remains the same, the formula for allocating the money has changed to include a recovery element. Previously, one-quarter of the amount received by local areas was based on a measure of deprivation with the other three-quarters allocated according to growth in the numbers of adults in effective treatment compared to the national average. In 2012/13, 20% of the allocation is based on the number leaving treatment free from their drug of dependency and not re-presenting for six months, in line with the public health national outcome with a corresponding decrease in the effective treatment component.[115]

The NTA's 2012-13 Action Plan aims to support the development and delivery of a locally led and owned recovery-orientated system. The plan sets out a number of actions around this theme in addition to on-going preparation for the transition to Public Health England (NTA 2012a).

Eight payment by results (PbR) pilots went live in England in April 2012. The pilots will run for two years and a large-scale evaluation will run alongside the pilots.

Putting full recovery first

The Home Office published an Inter-Ministerial Group on Drugs document, *Putting Full Recovery First* (IMG on Drugs 2012). The document set out in more detail than was possible at the time of the 2010 Drug Strategy's publication, how the new local arrangements in health, criminal justice and beyond could work together to support the aims of the Government to promote recovery. It also provided an update on the actions that government departments and agencies are taking to support local areas through transition. Core commitments contained within the document are to:

- contextualise treatment reforms with the government's wider social reform agenda;
- transfer the functions of the NTA into the new Public Health England in April 2013;

[115] See: http://www.nta.nhs.uk/uploads/overviewofhowtheptb12-13hasbeenallocated.pdf

- support local areas to re-orient and re-balance local commissioning structures towards full recovery;
- support local areas to integrate and expand alcohol treatment;
- equip the treatment sector to achieve full recovery where possible;
- develop a payments by results (PbR) model to incentivise outcome based reform and to deliver value for money;
- establish recovery champions;
- build recovery capital in individuals and communities; and
- reform criminal justice system treatment interventions to tackle re-offending.

5.2.2 Scotland

In Scotland, in line with the *Road to Recovery* drugs strategy (Scottish Government 2008a), people are offered a range of treatments for their problem drug use including substitute prescribing, residential and community rehabilitation, community detoxification and motivational interventions. Between April and June 2012, 90% of people got access to specialist treatment within three weeks. This is nine months ahead of Scotland's HEAT target that states that people will wait a maximum of three week for drug treatment by March 2013.

The Drug Strategy Delivery Commission (DSDC) in Scotland, in its first year report on progress in delivering the drug strategy (see section 1.3.2), states that the Scottish Government has "made impressive progress in specific areas" such as improved performance through the Health improvement, Efficiency, Access Treatment (HEAT) target. However, the report stressed that significant progress is still required, particularly in producing evidence of change towards recovery. Two areas of concern were raised: the ability to deliver recovery outcomes; and quality assurance of medical interventions (DSDC 2011).

The Scottish Government has asked Scotland's Chief Medical Officer, in collaboration with the DSDC, to consider objectively the evidence supporting the role of opiate replacement therapy in the treatment of substance misuse in Scotland. Following this process of evidence gathering, the panel will make recommendations to the Scottish Government by Spring 2013.[116]

5.3 Treatment systems

5.3.1 Guidance

Building recovery in communities (BRiC)

The NTA in England launched a consultation in February 2011 to gather opinion on the update of the service framework for substance misuse (see Focal Point Report 2011). There were 280 responses to the consultation[117] from various individuals and organisations. Responses to the consultation are broken into 17 sections to cover many aspects of a new evidence-based service framework. The key messages are that an integrated recovery system should focus on collaborative working, prompt access to interventions, provide high-quality treatment, encourage successful treatment completion, and link to support networks to sustain recovery and reintegration (NTA 2012b).

[116] See: http://www.scotland.gov.uk/News/Releases/2012/10/treatment05102012
[117] The consultation involved a questionnaire and local focus groups.

Medications in recovery

A report from the expert group on recovery-orientated treatment was published in 2012.[118] It sets out practical steps to meet the 2010 Drug Strategy commitment that all those on substitute prescriptions should engage in recovery activities. It drew upon expert advice, the BRiC consultation responses and a review of the evidence on OST[119] to come to a consensus on providing recovery-orientated treatment for heroin users (NTA 2012c). The report, alongside the development of a suite of recovery resources[120] provide a new national framework for best practice for practitioners and effectively update and replace the *Models of Care* document (NTA 2006a). The group declined to set time limits on OST but advised medical and healthcare professionals to:

- Review all existing patients to ensure that they are working to achieve abstinence from problem drugs;
- Ensure treatment programmes are dynamic and support recovery, with the exit visible to patients from the moment they walk through the door; and
- Integrate treatment services with other recovery support such as mutual aid groups, employment services and housing agencies.

Guidelines on the pharmacological management of substance abuse

Lingford-Hughes et al. (2012) updated their British Association of Psychopharmacology guidelines on the pharmacological management of those being treated for substance abuse, addiction and co-morbid psychiatric disorders. The guidelines are aimed at clinicians who prescribe to such clients and to other practitioners, patients, and family members. The revision is in light of new evidence in areas that previous guidelines do not cover.[121] Guidance covers both methadone maintenance treatment (MMT) and buprenorphine maintenance treatment (BMT). The appropriate dosage for each treatment is provided and the key uncertainties are highlighted. Management of withdrawal from opioid drugs is also addressed in the guidelines, as well as the pharmacological management of polydrug use, opioid use in pregnancy and co-morbidity.

Practice standards for treatment of young people with substance misuse problems

The Royal College of Psychiatrists' *Practice Standards for Young People with Substance Misuse Problems* (RCPsych 2012) aims to support practitioners, professionals and workers who work with young people with substance misuse problems and other co-existing difficulties. The standards were developed in collaboration with professionals in the health, social and voluntary sectors and were informed by a consultation with young advisors. They aim to address the issue of understanding each young person's needs to properly co-ordinate a sustained intervention. The five main practice standards cover: identification of those at risk and brief assessments; comprehensive assessments; integrated care planning; integrated care and interventions; and planned completion and transfer of care.

[118] The expert group was set up in August 2010 to examine how the range of treatments used in drug addiction could have a clearer orientation towards recovery. It was set up in response to the Coalition Government's 2010 Drug Strategy, which said too many people risked remaining on a substitute prescription when it should be the first step on the road to recovery. Chaired by Professor John Strang, the group comprised of a number of experts in the field including GPs, psychiatrists, psychologists, nurses, service users, and providers from both the NHS and voluntary sectors. An interim report was published in 2011 (see UK Focal Point Report 2011).

[119] See: http://www.nta.nhs.uk/uploads/medications-in-recovery-appendixc.pdf

[120] See: http://www.nta.nhs.uk/recovery-resources.aspx

[121] Experts in the field of addiction and co-morbidity reviewed relevant randomised controlled trials (RCTs) and systematic reviews identified through MEDLINE and EMBASE searches, and from the Cochrane Database. Materials for review were also identified from guidelines and by experts.

Support pack for commissioners

The NTA published a support pack to aid commissioners in developing effective commissioning for integrated drug treatment and recovery (NTA 2012d). It provides operational prompts to ensure that the recovery principles contained in the 2010 Drug Strategy are put into practice.

5.3.2 User involvement

Cargill et al. (2012) studied the arrangements made by English Drug Action Teams (DATs) to provide advocacy to problem drug users (PDUs). As advocacy is not a requirement of the DATs, it is at the DAT commissioning teams' discretion to assess and provide services for local advocacy needs.[122] Twenty-nine out of the 43 respondents stated that advocacy was needed in their area. However, findings indicated that only four DATs had formally commissioned professional and independent advocacy services. None of the DATs had any strategic planning for the commissioning of advocacy.

Braden et al. (2011) conducted a preliminary study on the provision of heroin dependency services in Northern Ireland, in order to pilot a method of focus group data collection. Specifically, the pilot research aimed to assess how successful heroin dependency services are at meeting the needs of heroin users, carers and professionals, by exploring their shared and contrasting experiences.[123] All groups agreed that service provision in Northern Ireland had generally improved in recent years although there were inconsistencies between local and national drug treatment provision. The user group felt concerned about what they perceived to be a 'blameful' attitude from professionals, with both carers and users experiencing a sense of powerlessness. Professionals felt that the treatment culture was risk averse, and therefore, the most complex cases were avoided. Many users felt ostracised by the lack of service distinction from alcohol dependency. All commended community support teams and users felt that community prescribing was the only option other than prison-based treatment programmes. However, some viewed taking methadone as another addiction. All participants had aspirations for an increase in service provision and an improvement in drug education.

5.3.3 Substance misuse workforce

An updated *Substance Misuse Workforce Development Action Plan* for 2011-2014 was published by the Welsh Government in 2011 (Welsh Government 2011b). The Action Plan identifies three priority areas for action: partnership working; skills and competence development; and performance management and workforce development.

5.3.4 Alternative types of treatment

Injectable opioid treatment

The Department of Health has launched a pilot which will further explore supervised Injectable Opioid Treatment (IOT). The IOT pilot is intended to explore:

- how to deliver a low-volume service such that it is accessible to a population which is relatively thinly-spread, given that patients need to travel to the clinic twice-daily;
- how referral pathways should operate;
- the case management that is necessary to ensure that people progress as appropriate to less intensive treatment once they are stabilised; and

[122] Fifty DATs (out of 149) were selected randomly using SPSS. The questionnaire used was based on one previously used to explore user involvement approaches implemented by DATs. The most appropriate person from each DAT was identified to complete the questionnaire. Informants from 43 DATs completed the questionnaire (86% response rate).

[123] Three focus groups were carried out in 2007, comprising of seven ex/current heroin users, four family carers and four health/social care professionals, who were selected through purposive sampling to identify culturally experienced individuals. Focus group schedules covered five thematic areas including experiences, support needs, and treatment aspirations.

- the commissioning procedures appropriate to a service with these constraints.

The pilot is taking place in three locations: Brighton; Easington; and London, and will run from 2012 to 2015. The pilot builds upon the results of the Randomised Injectable Opioid Treatment Trial (RIOTT) which looked at the clinical effectiveness of the intervention (Strang et al. 2010; see UK Focal Point Report 2010).

System change pilots

The independent final evaluation report on the Drug Systems Change pilot programme has been published (NatCen 2012). The programme, funded jointly by the Department of Health and the Home Office, ran between 2009 and 2011. The aim was to test whether local drug and alcohol treatment partnerships could tailor services better, in response to local needs, if they were allowed more flexibility in how they used the range of funding streams available to them and were not constrained by central targets.

The seven pilot sites investigated how they could redesign the commissioning and delivery of drug treatment and related social provision, both in prison and in community settings, adopting more user-led, outcome-focused approaches, and so improving the outcomes achieved by their service users. The evaluation report highlights: the challenges of system redesign; the importance of partnership working in affecting change; lessons in enhancing continuity of care, implementing single points of assessment and personalised treatment budgets.

5.3.5 Inpatient and residential treatment

Information on residential treatment is available in the selected issue chapter 11.

5.3.6 Other research and commentary on the drug treatment system

Barriers to treatment amongst problematic drug users out of treatment

Notley et al. (2012) explored barriers to treatment amongst problematic drug users currently not in treatment.[124] They identified a number of barriers and grouped them into three main headings: system barriers; social barriers; and personal and interpersonal barriers. System barriers included the perception of long waiting times, inflexibility around missed appointments, and poor communication between services. The main social barrier was stigma, particularly amongst certain communities. Personal and interpersonal barriers included a perceived lack of choice and personal control over the type of treatment received. Research participants suggested a number of ways to break down these barriers such as drop-in clinics, more out-of-hours crisis support, outreach, more flexible appointment schedules, less rigid urine testing regimens and increased primary care provision.

Interagency working

Baldacchino et al. (2011) looked at the interagency networking involved in dual diagnosis cases. Three sites from the UK: Middlesex, Peterborough, and Dundee, were included in the pan-European Integrated Services Aimed at Dual Diagnosis and Optimal Recovery from Addiction (ISADORA) project.

Uptake of opiate substitution therapy

Roberts et al. (2012) reviewed the literature on successful interventions for increasing the uptake of OST amongst people who inject drugs (PWID), with a specific focus on the interventions' application and development. A search of databases was conducted to gather

[124] A total of 43 drug users not in structured treatment were recruited from low threshold agencies using snowballing techniques in a rural area in East England. Six focus groups and five in-depth interviews were held with problematic drug users over the age of 16 in 2008.

the relevant literature.[125] A total of 14 out of 1,607 studies identified met the inclusion criteria. Seven studies were categorised as motivational interventions, three studies were categorised as case management interventions and a further three studies were not categorised as either as they included aspects of both types of intervention. One study matching the inclusion criteria was a systematic review. The studies showed that both motivational interventions and case management interventions could have the positive effect of increasing OST uptake. Although the interventions investigated in each study varied in their delivery and format, there were low levels of heterogeneity in each intervention effect.

The role of treatment in reducing criminal behaviour

A number of analyses looking at the impact of treatment on reducing criminal behaviour have been published and are described in section 9.3.3.

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.[126] Data presented are from the National Drug Treatment Monitoring System in England, the Scottish Drug Misuse Database, the Welsh National Database for Substance Misuse[127], and the Northern Ireland Drug Misuse Database. Data are presented for the UK as a whole unless otherwise stated.[128] Continuous national data are available from 2003/04.

5.4.1 Treatment centres

In 2010/11, 1,814 treatment centres reported data to the Treatment Demand Indicator. The majority of these were outpatient centres (n=1,501) with 140 inpatient centres and 173 GPs also providing data, the latter from England only. It is estimated that the coverage of outpatient centres is high. There are, however, inpatient centres that do not report to the TDI, primarily private companies that do not rely on government funding. It is unknown what the coverage of GP is. Data were only received from England for 2010/11 and represent just two per cent of the number of GP practices in England during 2010 (n=8,324) (The Information Centre 2011). Not all GPs will treat drug users and it is assumed that those treating a higher number of drug users will report to NDTMS.

Reflecting the profile of treatment centres reporting to the TDI, the majority of clients (94%) presenting to drug treatment are treated in outpatient centres (Table 5.1). This has been the case for a number of years and reflects the prevailing model of community drug treatment. Changes in the number presenting to treatment via GPs should be treated with caution given low coverage of GP services reporting to the TDI and data only being received from certain parts of the UK. Although the number presenting through GP services appears to be relatively low, the role of GPs is more pronounced given that they are likely to be involved with the treatment of drug problems through shared care agreements with local drug agencies, which would be classified as outpatient centres.

[125] Search criteria included RCTs in adult IDUs who were out of treatment. Outcome criterion was treatment entry to OST and any studies with an outcome of treatment retention or adherence were excluded.
[126] For further information about the TDI, please see the TDI Protocol document available at: http://www.emcdda.europa.eu/html.cfm/index65315EN.html
[127] Data from Wales include less structured treatments.
[128] Percentages quoted are valid percentages. Where missing data are substantial, this has been stated in the text.

Table 5.1: *Presentations by centre type in the United Kingdom, 2004/05 to 2010/11*

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

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

Previous treatment

In 2010/11, 58% of those presenting to treatment had been previously treated with 42% first ever treatments. Cannabis users were more likely to be first ever treatments (68%) whilst it was more uncommon for primary opiate users to be accessing treatment for the first time; 28% did so in 2010/11 (see also section 5.4.3).

5.4.2 Characteristics of treated clients (TDI)

Source of referral

Self-referral has traditionally been the most common referral source but in 2010/11 the percentage of clients referred from the criminal justice system (CJS) was at the same level (29%). Amongst males, the CJS was the most common source of referral; one-third (33%) of all males presenting to treatment in the UK were referred from the CJS ranging up to 36% of male outpatient presentations in England. Females were substantially less likely to be referred from the CJS (18%), particularly females presenting to treatment for the first time (13% compared to 30% of males). Conversely, females were more likely than males to be referred from health sources or social services.

Drugs used

Opiates were the most common primary drug, accounting for 59% of treatment presentations in 2010/11 (Table 5.2). Primary opiate users accounted for the vast majority of GP (92%) and inpatient (83%) presentations. Eighty-seven per cent of primary opiate users were heroin users, seven per cent were primary methadone users and six per cent were other opiate users. An analysis of other opiate users in treatment in England in 2010/11 shows that around one-third (34%) were primary buprenorphine users, 17% were codeine[129] users and 12% were dihydrocodeine users.

Primary cannabis users accounted for one in five treatment presentations and one-third of those presenting to treatment for the first time (Table 5.6).

[129] Includes those reporting codeine tablets, codeine unspecified and codeine linctus.

Table 5.2: *Primary drug by centre type in the United Kingdom, 2010/11*

Drug	Outpatients		Inpatients		GP*		Total	
	n	%	n	%	n	%	n	%
Amphetamines	3,364	*3.1*	59	*1.6*	63	*1.7*	3,486	*3.0*
Benzodiazepines	2,329	*2.2*	64	*1.7*	24	*0.6*	2,417	*2.1*
Cannabis	23,160	*21.6*	92	*2.5*	126	*3.3*	23,378	*20.3*
Cocaine powder	8,376	*7.8*	112	*3.0*	27	*0.7*	8,515	*7.4*
Crack cocaine	5,220	*4.9*	275	*7.4*	67	*1.8*	5,562	*4.8*
Opiates	61,544	*57.3*	3,080	*82.6*	3,488	*91.6*	68,112	*59.3*
Other	3,376	*3.1*	45	*1.2*	13	*0.3*	3,434	*3.0*
Sub Total	*107,369*	*100*	*3,727*	*100*	*3,808*	*100*	*114,904*	*100*
Not Known	4,739		7		2		4,748	
Total	112,108		3,734		3,810		119,652	

*data are for England only

Source: Standard Table 34

While in England, Scotland and Wales, primary opiate users accounted for the majority of treatment presentations, in Northern Ireland primary opiate users only accounted for 12% of treatment presentations (Table 5.3). The largest group of treatment presentations in Northern Ireland were cannabis users (40%), while in England, Scotland and Wales, cannabis users were the second largest group presenting to treatment after opiate users (20%, 17% and 18% respectively). Of the four UK countries, Northern Ireland had the highest proportion (21%) of primary benzodiazepine users presenting to treatment, followed by Scotland (10%), Wales (2%) and England (1%). Unlike elsewhere in the UK, Wales had a higher percentage (8%) of primary amphetamine users presenting to treatment than cocaine powder users (5%).

Table 5.3: *Number and percentage of drug treatment presentations by primary drug of use in the United Kingdom, 2010/11*

Drug	England		Northern Ireland		Scotland		Wales*		UK	
	n	%	n	%	n	%	n	%	n	%
Amphetamines	2,506	*2.7*	16	*0.7*	158	*2.1*	806	*7.5*	3,486	*3.0*
Benzodiazepines	931	*1.0*	485	*20.7*	750	*10.1*	251	*2.3*	2,417	*2.1*
Cannabis	19,265	*20.4*	935	*39.9*	1,248	*16.8*	1,930	*17.9*	23,378	*20.3*
Cocaine powder	7,499	*8.0*	133	*5.7*	314	*4.2*	569	*5.3*	8,515	*7.4*
Crack cocaine	5,430	*5.8*	1	**	28	*0.4*	103	*1.0*	5,562	*4.8*
Opiates	56,335	*59.7*	280	*11.9*	4,780	*64.2*	6,717	*62.1*	68,112	*59.3*
Other	2,152	*2.5*	496	*21.1*	167	*2.2*	436	*4.0*	3,434	*3.0*
Sub Total	*94,301*	*100.0*	*2,346*	*100.0*	*7,445*	*100.0*	*10,812*	*100.0*	*114,904*	*100.0*
Not Known	183		0		2,260		2,305		4,748	
Total	*94,484*		*2,346*		*9,705*		*13,117*		*119,652*	

*Data from Wales includes structured and less structured treatment

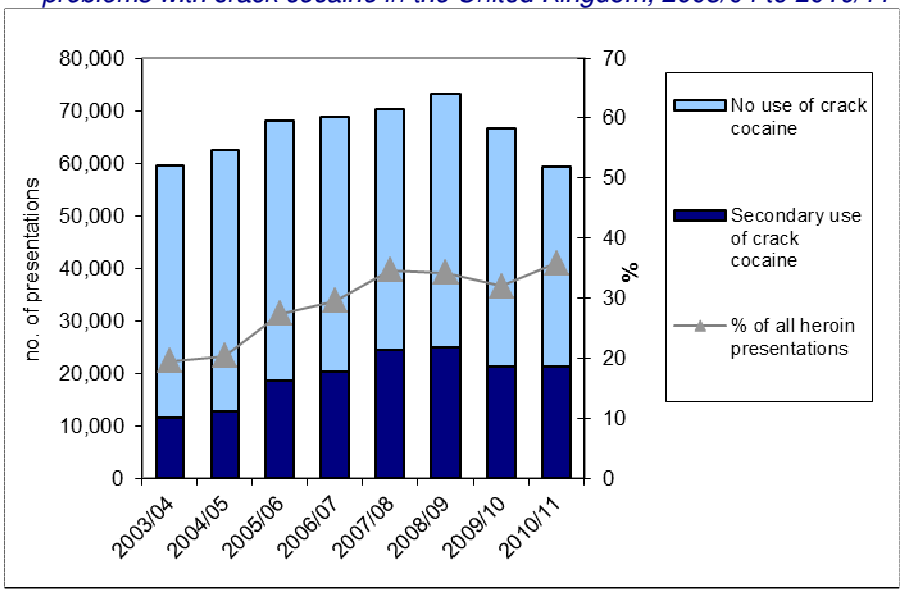
**percentage is less than 0.05

Source: Standard Table 34

Secondary drugs

The number of presentations reporting primary use of heroin decreased in 2010/11. However, the number of primary heroin users reporting secondary problems with crack cocaine remained relatively stable causing an increase in the percentage requesting treatment for secondary crack cocaine use from 32.0% to 35.1% (Figure 5.1). The percentage of primary heroin users reporting secondary problems with alcohol increased again (see UK Focal Point Report 2011) to 15%. Eleven per cent of primary heroin users reported secondary problems with benzodiazepines; the same level as in 2009/10.

Figure 5.1: *Number and percentage of primary heroin presentations reporting secondary problems with crack cocaine in the United Kingdom, 2003/04 to 2010/11*



Source: Standard Table 34

Over one-third of primary cannabis users (37%) reported secondary problems with alcohol in 2010/11 and one in ten reported secondary problems with cocaine powder. Just under one-third (30%) of primary cocaine powder users reported secondary problems with cannabis. The highest number of clients seeking treatment for secondary use of MDMA was 755, amongst primary cannabis users. Nevertheless, this accounts for only three per cent of all primary cannabis users.

Age

The mean age of those seeking outpatient treatment in England was 31.1 years old, with men (31.3 years) slightly older than women (30.3 years). Amongst first ever treatments, the average age was younger at 28.2 years. Those seeking treatment via a GP (34.5 years) were older than those seeking outpatient treatment, which probably reflects the higher proportion of opiate users and lower proportion of cannabis users in the GP data. Indeed primary cannabis users presenting to treatment have a distinctively different age pattern than other drug users. Over half of primary cannabis users were under the age of 20 with 69% under the age of 25. Only 13% of primary cannabis users were over the age of 35 years old. In contrast, 45% of primary heroin users were over the age of 35 years with around one-quarter (24%) over the age of 40. Since 2003/04 the percentage of primary heroin users who are over the age of 40 years has increased from 10%, with an increase from 21% in 2009/10. Primary crack cocaine users were older still with one-half (49%) aged 35 years and over and 31% over the age of 40 years in 2010/11.

Age of first use

The older age of primary crack cocaine clients may reflect the older age at which they first used the drug; one-third (33%) started using the drug aged 25 and over compared to one-quarter of primary heroin users (26%). Primary heroin users were most likely to report first using the drug between the ages of 15 and 19 years (37%) with 11% first using the drug under the age of 15 years old. As expected, given the young age of primary cannabis users, they were more likely to report first use under the age of 15 years old.

Gender

As in previous years, and reflecting the pattern seen in problem drug use estimates (see section 4.2), females account for around one-quarter of those presenting to treatment. They

were less likely to be presenting for primary use of cannabis (22%) and more likely to be presenting for primary use of benzodiazepines (37%).

Injecting status

Fifty-seven per cent of clients had never injected drugs in 2010/11, an increase since the previous year (52%). This may be due to a larger proportion of treatment presentations being primary cannabis users and a corresponding decrease in the proportion of primary heroin users (Table 5.4). In 2010/11 28.6% reported that they had injected but weren't currently and 14.2% reported current injecting. Ninety-three per cent of those reporting current injecting were primary opiate users and three per cent were primary amphetamines users. The percentage of heroin users reporting current injecting decreased from 34.3% in 2007/08 to 25.0% in 2010/11.[130] The reduction in injecting amongst the treatment population is supported by decreases in estimates of injecting drug use between 2004/05 and 2009/10 (Hay et al. 2011; see UK Focal Point Report 2011) and a decrease in the number of people who inject drugs reporting needle and syringe sharing from 28% in 2005 to 17% in 2011 (HPA 2012a; see section 6.2.4). Primary amphetamine users were also less likely to report current injecting in 2010/11; 13.2% compared to 17.2% in 2008/09.

Clients are also asked about their usual route of administration of their primary drug. Primary heroin users (38%) were most likely to report injecting as the usual route of administration followed by primary amphetamines users (22%). Those presenting to treatment for the first time were less likely to report injecting as the usual route of administration (34% of primary heroin users and 16% of primary amphetamines users).

Table 5.4: *Injecting status amongst all clients entering treatment in the United Kingdom, 2010/11 by gender*

Injecting status	Male		Female		Total	
	n	%	n	%	n	%
Ever injected, but not currently	23,640	*28.7*	8,194	*28.4*	31,834	*28.6*
Currently injecting (in last month)	12,062	*14.7*	3,689	*12.8*	15,751	*14.2*
Never injected	46,559	*56.6*	16,976	*58.8*	63,535	*57.2*
Sub Total	*82,261*	*100*	*28,859*	*100*	*111,120*	*100*
Not known/missing	6,132		2,400		8,532	
Total	88,393		31,259		119,652	

Source: Standard Table 34

Living and labour status

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

5.4.3 TDI trends

Although the number of clients presenting to treatment decreased by seven per cent between 2009/10 and 2010/11, the number of those presenting for the first time increased by six per cent.

Data show that the number of primary cannabis presentations more than doubled between 2003/04 and 2010/11 with an increase each year until 2010/11 when there was a three per cent decrease (Table 5.5). This coincides with an increase in young people's treatment services as young people account for the majority of cannabis presentations (see section 5.4.2). The number of primary cocaine powder presentations increased until 2008/09, since when the number has decreased to 2006/07 levels. Between 2003/04 and 2008/09, as the treatment system expanded, the number of primary opiate users increased by 24% although

[130] Changes in injecting status prior to this should be interpreted with care as there was a high proportion of missing data; 46% in 2003/04.

they accounted for a smaller proportion of all treatment presentations. Since then, the number of presentations has decreased and opiate users now account for 59% of all treatment presentations compared to 71% in 2003/04.

Despite relatively small numbers, in 2009/10 and 2010/11 the number reporting primary use of other drugs has increased, perhaps as a result of the emergence of a number of new psychoactive substances. For example, in England and Wales during 2010/11 there were 924 presentations to treatment for primary use of cathinones and 726 for primary use of ketamine.

Table 5.5: *Number and percentage of all drug treatment presentations by primary drug in the United Kingdom, 2003/04 to 2010/11*

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

Source: Standard Table 34

While the total number of primary cannabis presentations decreased in 2010/11, the number of first time cannabis presentations continued to increase, accounting for around one-third of all first drug presentations (Table 5.6). After decreasing since 2005/06, the number of first ever primary opiate presentations increased by four per cent between 2009/10 and 2010/11. Amongst this group, primary heroin presentations decreased but there was a 40% increase in primary use of 'other opioids' from 1,223 clients to 1,716 and an increase in primary methadone clients, by 61% from 746 clients to 1,198.

Although the overall number of primary benzodiazepine presentations remained stable since 2004/05, the number of first ever primary benzodiazepine treatments increased in 2010/11.

Table 5.6: *Number and percentage of first drug treatment presentations by primary drug in the United Kingdom, 2003/04 to 2010/11*

Drug		2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Amphetamines	n	1,455	1,619	1,812	2,045	1,976	1,640	1,415	1,615
	%	5.1	4.1	3.9	4.3	4.4	3.8	3.3	3.6
Benzodiazepines	n	675	1,226	1,153	916	1,285	1,074	1,270	1,406
	%	2.3	3.1	2.5	1.9	2.9	2.5	3.0	3.1
Cannabis	n	5,289	8,653	11,506	11,325	12,251	12,214	13,969	14,559
	%	18.6	22.1	24.8	24	27.2	28	32.5	32.4
Cocaine powder	n	1,683	3,016	4,197	4,951	5,980	6,581	5,345	5,107
	%	5.8	7.7	9.1	10.5	13.3	15.1	12.4	11.4
Crack cocaine	n	1,722	2,589	3,116	2,900	2,822	2,922	1,998	2,078
	%	6.0	6.6	6.7	6.1	6.3	6.7	4.6	4.6
Opiates	n	16,656	20,464	23,021	21,561	19,126	17,892	17,377	18,005
	%	57.8	52.3	50.0	45.7	42.5	41.0	40.4	40.0
Other	n	1,329	1,525	1528	1,468	1,573	1,360	1,617	2,214
	%	4.6	3.9	3.3	3.1	3.5	3.1	3.8	4.9
Sub Total	*n*	*28,809*	*39,092*	*46,333*	*45,166*	*45,013*	*43,683*	*42,991*	*44,984*
	%	100	100	100	100	100	100	100	100
Not Known	n	1,056	3,405	3,292	1,999	1,588	1,365	1,933	2,582
Total	n	29,865	42,497	49,625	47,165	46,601	45,048	44,924	47,566

Source: Standard Table 34

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 from December 2012. In Northern Ireland a census of those in treatment on a certain day is carried out every two years.

It is estimated that, in 2010/11, TDI data represented around half of all those receiving drug treatment in the UK during that year.

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 2011b), 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 (NTA 2011b) 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. Amongst those who started treatment after 2005/06, primary cocaine powder users were most likely to have completed treatment over this period (48%) followed by primary cannabis 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.

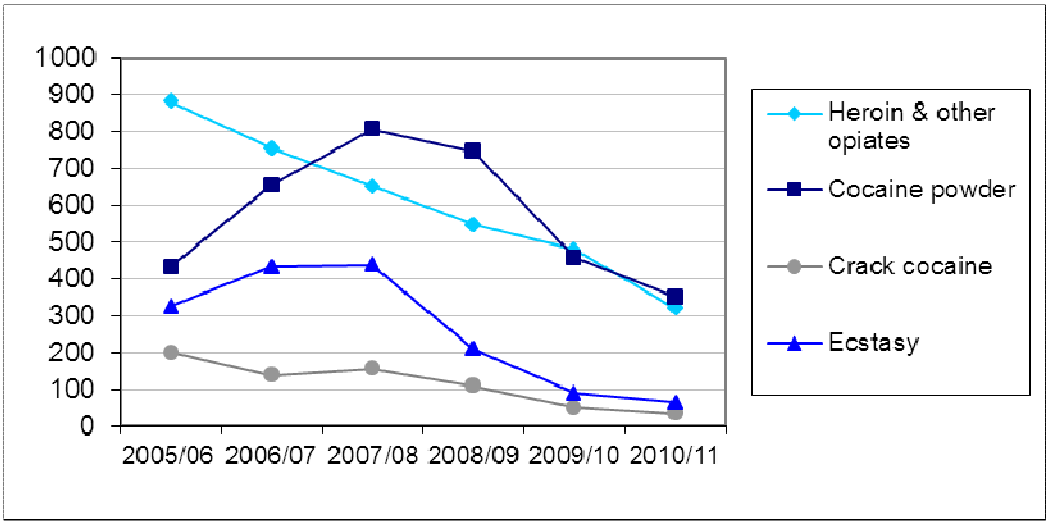
A further analysis of the six years of treatment data showed that clients who first contacted treatment services between 2008/09 and 2010/11 had better outcomes than those who first contacted treatment services between 2005/06 and 2007/08; 33% completed treatment compared to 25% respectively (NTA 2012e). Of the heroin users who started treatment since 2005/06 and were retained in treatment at 31st March 2011 (49%, n=73,640), 41% had been in a continuous journey[131] and 18% had three or more journeys since their first presentation.

Young people in treatment in England

NDTMS data show that 21,955 young people under the age of 18 were in treatment in England during 2010/11 (NTA 2011c), a seven per cent decrease from 2009/10 (n=23,528). Cannabis continues to be the drug for which treatment is most commonly sought, 58% of those in treatment were primary cannabis users in 2010/11; a slight increase from 56% in 2009/10. Despite this, the number in cannabis treatment decreased after continued rises in recent years, decreasing by three per cent since the previous year. The number of under-18s receiving treatment for primary heroin or crack cocaine use has fallen each year for the last six years and, for opiates, the steepest decrease was in the last year (Figure 5.2). After a large increase between 2005/06 and 2007/08, the number of under-18s seeking treatment for cocaine powder use decreased to pre-2005/06 levels.

[131] The concept of the treatment journey is described in: http://www.nta.nhs.uk/publications/documents/nta_modelsofcare_update_2006_moc3.pdf. The operational definition of a journey is that episodes are considered as linked elements of an ongoing treatment journey if they are concurrent, or if 21 days or less elapses between discharge from one episode and starting the next.

Figure 5.2: *Numbers of under-18s in treatment for individual Class A drugs in England, 2005/06 to 2010/11*



Source: NTA 2011c

Data from the Welsh National Database on Substance Misuse

Data show that in 2010/11 there were 9,443 people who received treatment for drug problems in Wales. Of these, 6,775 were problem drug users with 5,508 opioid users. Data cannot be compared to TDI data as TDI data also include individuals receiving less structure treatment.

Census of drug and alcohol treatment service in Northern Ireland

Data from the fourth census of statutory and non-statutory drug and alcohol services in Northern Ireland carried out on 1st March 2012 were published (NISRA 2012a).[132] Out of 5,916 clients in treatment, 1,514 (26%) were in treatment for drug misuse only and 1,291 (22%) were in treatment for both drugs and alcohol. The number of those in treatment for drug misuse only increased by 17% from the previous census carried out in 2010 (n=1,294) while the number in treatment for both drugs and alcohol increased by five per cent (n=1,224). Those in treatment for alcohol only decreased by seven per cent. Of all those in treatment, around two-thirds (65%) were receiving treatment from statutory services such as Community Addiction Teams, 32% were receiving treatment from non-statutory services and three per cent were receiving treatment from prison-based services.

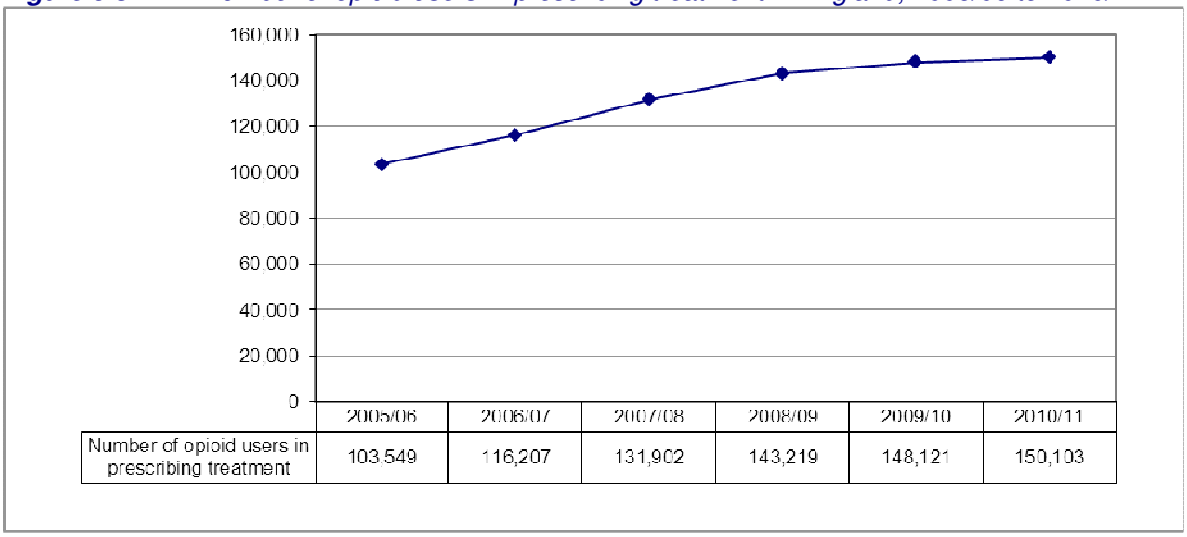
5.5.2 Substitution treatment

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

Data show that the number of opioid users in prescribing treatment increased by one per cent between 2009/10 and 2010/11 and by 45% since 2005/06 (ST24; Figure 5.3).

[132] A comprehensive list of statutory and non-statutory treatment services was developed and a short one page form was provided to all identified organisations (n=84). Seventy organisations responded giving a response rate of 83%.

***Figure 5.3**: Number of opioid users in prescribing treatment in England, 2005/06 to 2010/11*



	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Number of opioid users in prescribing treatment	103,549	116,207	131,902	143,219	148,121	150,103

Source: Standard Table 24

Data from the Welsh National Database for Substance Misuse

In Wales during 2010/11 there were 2,129 clients in opioid substitution treatment (OST), a 16% increase from 2009/10 (n=1,828).[133] However, this is considered to be more reflective of better recording rather than an actual increase. Data show that 80% of those in OST received methadone and 20% received buprenorphine, a similar split to previous years (ST24).

Substitution treatment in Northern Ireland

Data from Northern Ireland show that 607 clients received opiate substitution treatment in 2010/11, a 12% increase from 2009/10 (n=543) and a 155% increase from 2003/04 (n=238) (ST24). Of those receiving OST in 2010/11, 51% received methadone, 47% buprenorphine and two per cent dihydrocodeine. Three-quarters (76%) of clients had been in OST for longer than 12 months and 29% received OST from a GP.

[133] 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.

6. Health correlates and consequences

6.1 Introduction

There is evidence of increased morbidity amongst drug users. HIV prevalence amongst people who inject drugs (PWID) in the United Kingdom was 1.2% in 2011, 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 44% (in England, Wales and Northern Ireland). The figure for Scotland for the 2011 Needle Exchange Surveillance Initiative (NESI) survey was 53%.

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.

Data on drug-related visits to Accident & Emergency (A&E) departments are not available in the UK. However, inpatient data are available based on ICD-10 codes.

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.[134] The UK Drug Misuse Definition (DMD)[135] 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.[136]

The UK Drug Misuse Definition has been adopted by the General Mortality Registers (GMRs) across the UK and is a subset of the ONS definition. Historical information on deaths is also available from a Special Mortality Register (SMR).[137] In the United Kingdom, based on the EMCDDA definition, DRDs rose steadily from 1996, when 1,152 deaths were registered. Following a period of decline between 2001 and 2003, deaths increased again between 2004 and 2008 when they reached their highest level (2,231). There has been a year-on year decrease since 2008 and latest figures for 2011 reported a 7.5% decrease from the previous year (1,785 deaths in 2011 compared to 1,930 in 2010).

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

[135] Formerly known as the Drug Strategy Definition (DSD) and originally adopted to measure progress against an aim in a former UK Drug Strategy (Home Office 2002; UK Focal Point on Drugs Reports 2003-2011)

[136] See: ONS (2012) http://www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/2011/stb-deaths-related-to-drug-poisoning-2011.html

[137] The National Programme on Substance Misuse Deaths (np-SAD) published data until 2010 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.

6.2 Drug-related infectious diseases

Information on infectious disease is based on that presented in *Shooting Up: Infections amongst people who inject drugs in the United Kingdom 2011* (HPA et al. 2012) and provided to the EMCDDA in Standard Table 09.

6.2.1 HIV/AIDS

The overall prevalence of HIV seen amongst people who inject drugs (PWID) in 2011 was similar to that seen in recent years, and remains higher than that found in the late 1990s. The Unlinked Anonymous Monitoring (UAM)[138] survey of current and former PWID in England and Wales indicated an overall HIV prevalence of 1.3% in 2011 (ST09). In 2011, the prevalence was 1.4% amongst men and 0.95% amongst women, with prevalence increasing with age from 0.89% amongst those aged under 25 years to 1.4% amongst those aged 35 years and over (ST09)

The prevalence of HIV amongst the PWID taking part in the 2011 UAM Survey across England, Wales and Northern Ireland was 1.2%.[139] Between 2001 and 2011, prevalence varied between 0.93% and 1.6% (HPA 2012a; HPA 2012b; Figure 6.1).

In 2011 in England, prevalence was 1.3%[140], which is not significantly higher than in 2001 when the prevalence was 1.0%. In Wales in 2011, prevalence was 1.1%[141] and in Northern Ireland prevalence was 0.56%[142] (HPA 2012b).

There is also evidence of on-going HIV transmission amongst PWID within the UK. 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 varied over time ranging from 0.36% in 2001 to 1.3% in 2008. The prevalence amongst the recent initiates participating in the UAM Survey in 2011 was 0.47%[143] which is similar to the level found in 2001 (HPA 2012a; HPA 2012b; Figure 6.1).

[138] Data are taken from a voluntary unlinked anonymous self-completed surveillance questionnaire which is offered by drug agencies to clients who have ever injected drugs. Those clients who agree to participate also provide either an oral fluid 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). This multi-site survey is managed by the Health Protection Agency (HPA), with support from Public Health Wales and the Public Health Agency Northern Ireland. The survey is a collaboration involving over 70 specialist drug agencies across England, Wales and Northern Ireland. Data on viral infections amongst current and former PWID, 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 anonymised.

[139] 95% confidence interval (CI) 0.86%-1.7%.

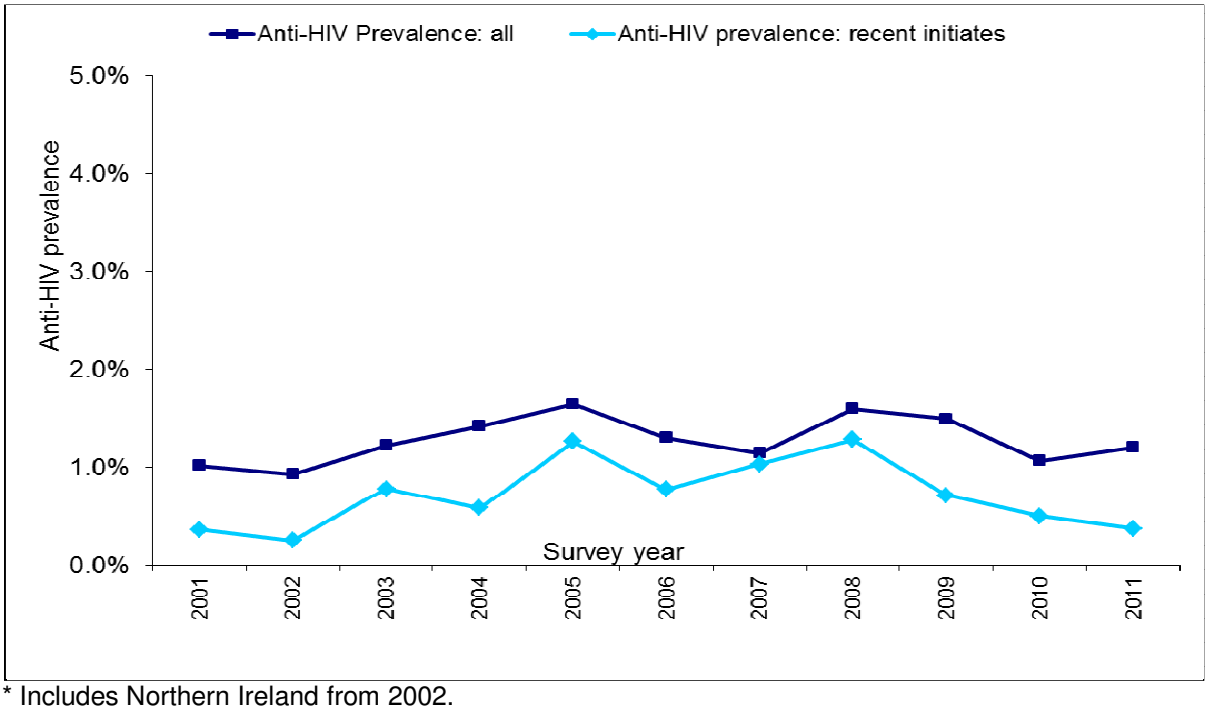
[140] 95% CI: 0.88%-1.8%

[141] 95% CI 0.14%-4.1%

[142] 95% CI 0.01%-3.1%

[143] 95% CI 0.01%-2.6%

Figure 6.1: *Trends in the prevalence of HIV infection amongst participants in the Unlinked Anonymous Monitoring Survey of PWIDS in England, Wales & Northern Ireland*, 2000 to 2011*



* Includes Northern Ireland from 2002.

Source: HPA 2012a

In Scotland, the prevalence of HIV amongst PWID has been monitored through the surveillance of people undergoing voluntary confidential HIV testing. A HIV prevalence of 0.4% was found amongst PWID undergoing testing in Scotland during 2010. This compares with a prevalence of 1.4% to 3.2% in the early to mid-1990s and 0.3% to 0.9% during the period 1998 to 2009 (HPA et al. 2012; ST09).

6.2.2 Viral hepatitis

Hepatitis C

The prevalence of hepatitis C infection amongst PWID remains high overall (HPA et al. 2012). In 2011, 44% of the (current and former) PWID participating in the UAM Survey in England and Wales had antibodies to hepatitis C[144], 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 2011 was 46% amongst men and 41% amongst women, and increased with age from 22% amongst those aged under 25 years to 53% amongst those aged 35 years and over (ST09).

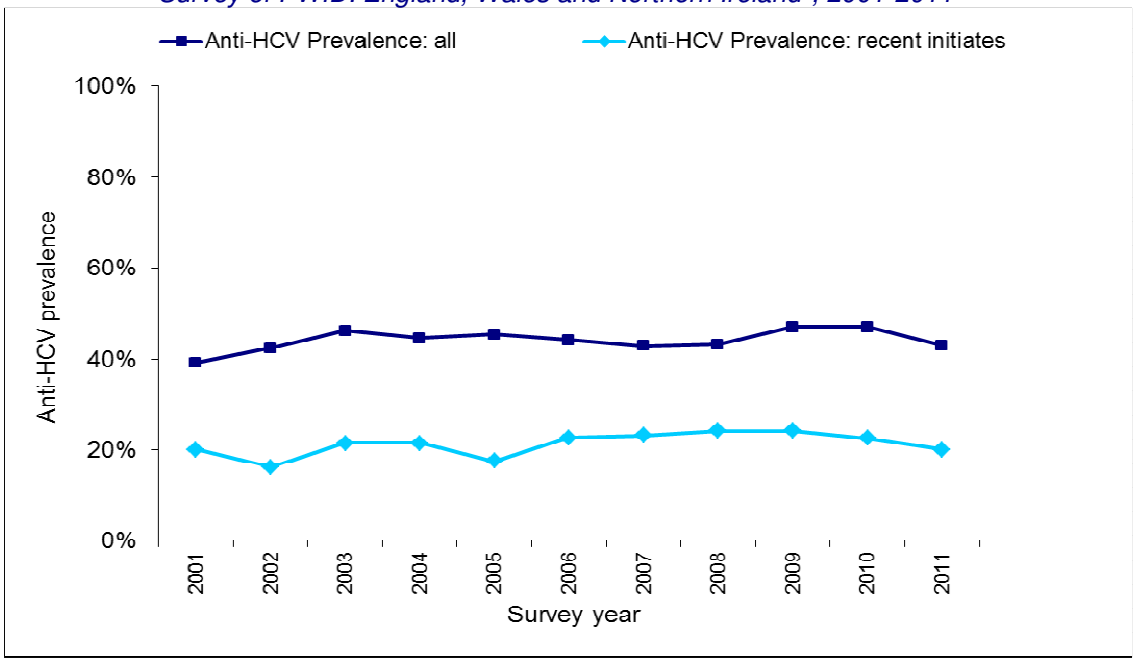
In 2011, the overall prevalence of antibodies to hepatitis C amongst the PWID participating in the UAM Survey across England, Wales and Northern Ireland in 2011 was 43%. This is

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

lower than the 47% recorded in 2010, however, it is not significantly different from the prevalence of 39% seen in 2001 (HPA 2012b; Figure 6.2). In England in 2011, the hepatitis C prevalence amongst participants in the UAM Survey was 45%, however, there were very marked regional variations ranging from 33% in the West Midlands, East Midlands and North East to 60% in the North West (HPA 2012a). The prevalence in Wales (39%) and Northern Ireland (29%) was lower than in many of the English regions (HPA 2012a).

The prevalence of antibodies to hepatitis C amongst recent initiates in England, Wales and Northern Ireland (those injecting for less than three years) is higher than in 2000 (12%) and earlier years. In 2011, amongst those in this group who participated in the UAM Survey from throughout England, Wales and Northern Ireland, the prevalence was 20% and similar to that seen between 2001 and 2010 (Figure 6.2) (HPA 2012b).

Figure 6.2: *Prevalence of anti-HCV amongst participants in the Unlinked Anonymous Monitoring Survey of PWID: England, Wales and Northern Ireland*, 2001-2011*



*Includes Northern Ireland from 2002.

Source: HPA 2012a

In Scotland, the estimated prevalence of antibodies to hepatitis C was 53% amongst current and former PWID surveyed at needle exchanges across the country as part of the Needle Exchange Surveillance Initiative (NESI) in 2011 (ST09 HPA et al. 2012). The prevalence amongst the recent initiates (those who had commenced injecting in the previous three years) was 19% (HPA et al. 2012). These are similar to the levels found in the previous NESI survey in 2008/09 (HPA et al. 2012).

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, however risk factor information is often missing or incomplete. There has been a marked increase in the annual number of new diagnoses throughout the UK reflecting 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 2011, there were 12,642 laboratory diagnoses of hepatitis C infection in the UK: 9,908 in England; 2,147 in Scotland; 474 in Wales; and 113 in Northern Ireland (HPA et al. 2012; ST09).

Incidence of HCV amongst PWID

In England, Wales and Northern Ireland, recent transmission of hepatitis C has been explored amongst participants in the UAM survey of PWID by looking for those who have recently developed antibodies to hepatitis C. This was undertaken by looking at the avidity of antibody to hepatitis C. Antibodies with weak avidity, in the presence of hepatitis C RNA, are probably from individuals who have recently been infected. The length of time that recently infected individuals will have antibodies with weak avidity is unclear, but this state may last from two to ten months. In 2011, 1.7% of the participants in the UAM Survey that could have recently acquired hepatitis C[145] were found to have probably been recently infected (HPA 2012c). These data are consistent with an incidence of hepatitis C infection amongst PWID in England, Wales and Northern Ireland of between two and 10 infections per 100 person years of exposure (HPA 2012c).

In the very early stages of hepatitis C infection, individuals have high levels of viraemia prior to developing antibodies. This is often referred to as the viraemic pre-seroconversion window. During this relatively short period, individuals will test hepatitis C antibody negative but RNA positive. In Scotland, amongst PWID participating in NESI survey at NSPs who were hepatitis C antibody negative, 1.5% were found to be RNA positive; lower than the level amongst PWID surveyed in 2008-2009 (2.1%) (HPA 2012c). Assuming a viraemic pre-seroconversion window period of 51 days, the incidence of hepatitis C infection amongst PWID across Scotland is estimated at 9.5 per 100 person years during 2010; this compares with an estimated incidence of 13.3 per 100 person years during 2008-2009 (HPA 2012c HCV).

Research

BBV amongst male PWID who have sex with men.

An analysis of data from the first participants in the annual UAM Surveys of PWID between 1998 and 2007 found that HIV prevalence amongst male PWID was significantly higher amongst men who have sex with men (MSM) than amongst men who have sex with women only (3.2% compared to 0.8%) (Marongiu et al. 2012). The prevalence of HCV infection was also a third higher amongst this group. The authors suggest that the higher rate of HIV infection in the MSM group was probably due to sexual transmission of the virus. The higher rate of HCV infection in the MSM group, however, was possibly due to the sharing of injecting equipment as participants from this group were significantly more likely to self-report unsafe injecting practices (38% compared to 27%).

Hepatitis B

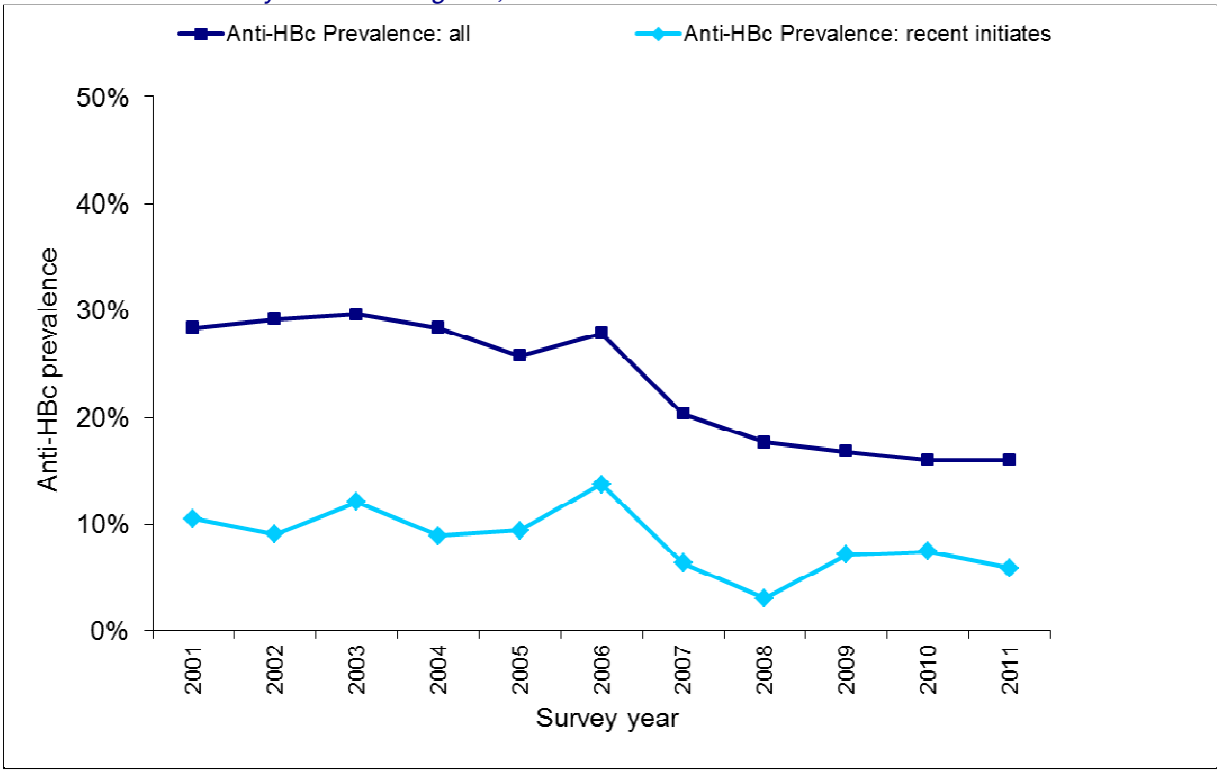
Overall, about one in six IDUs has ever had hepatitis B infection. In 2011, 16% of the current and former PWID who took part in the UAM Survey in England, Wales and Northern Ireland had antibodies to hepatitis B core antigen (anti-HBc, a marker of previous or current hepatitis B infection)[146]; this is lower than in 2001 when prevalence was 28% (HPA 2012a; HPA, 2012b). The prevalence of anti-HBc varied by country in 2011: in England the prevalence was 16% (down from 29% in 2001); in Wales it was 11% (down from 23% in 2000/01); and in Northern Ireland it was 10% (similar to the 13% found in 2004) (HPA 2012a; HPA 2012b).

[145] That is those participants that were either hepatitis C antibody negative or antibody positive with weak avidity and hepatitis C RNA also present.

[146] Prior to 2009, this survey only collected oral fluid samples, however in 2009 and 2010 both oral fluid and dried blood spot (DBS) samples were collected from participants. In 2011, only DBS samples were collected. The sensitivity of the test on DBS samples for antibodies to hepatitis C is almost 100%. However, the sensitivity of the oral fluid sample test for antibodies to hepatitis C is about 75%. Results presented are adjusted to allow for the poorer sensitivity of the tests on the oral fluids samples.

The overall decrease may reflect the impact of increased uptake of the hepatitis B vaccine amongst PWID (HPA 2011b; see section 7.3.2).

Figure 6.3: *Prevalence of anti-HBc amongst participants in the Unlinked Anonymous Monitoring Survey of PWID: England, Wales and Northern Ireland 2001-2011**



*Includes Northern Ireland from 2002.

Source: HPA 2012a

The samples collected by the UAM Survey of PWID during 2011 that had anti-HBc detected were also tested for hepatitis B surface antigen (HBsAg), a marker of current infection. The proportion of samples from the UAM Survey of PWID with HBsAg is an indicator of the prevalence of current hepatitis B infection amongst PWID. In 2011, of samples with anti-HBc, 4.8% had HBsAg detected indicating current infection; this represents 0.74% of all the PWID surveyed in England, Wales and Northern Ireland that year (HPA et al. 2012). In Wales, data are also available from the monitoring of routine diagnostic testing undertaken in specialist drug services using dried blood spot samples. In 2011, of the samples tested 0.60% were positive for both HBsAg and anti-HBc (HPA et al. 2012).

The number of diagnosed hepatitis B infections in the UK are principally monitored through laboratory reports rather than through the use of statutory notifications. In England, a total of 589 acute or probable acute hepatitis B cases were reported from health protection units and laboratories in 2011. Of these cases, 296 (50%) had associated exposure information, and only thirteen (4.4%) of these were associated with injecting drug use (HPA et al. 2012). Overall heterosexual exposure (58%) and homosexual exposure (20%) were the most commonly reported routes of infection (HPA et al. 2012). In 2001, 37% of the acute hepatitis B cases reported in England were associated with injecting drug use, though it should be noted that these data were from a different system (HPA et al. 2012).

In Scotland and Northern Ireland, reported hepatitis B diagnoses encompass both acute and chronic infections. In Scotland, there were 846 reports in 2011, compared to a total of 357 in the 2001. The increase in reports over time probably reflects a rise in chronic cases being clinically recognised. The proportion of reports indicating injecting drug use as the main risk

factor has declined over time from 19% in 2001 to 0.6% in 2011 (HPA et al, 2012); however, as risk factor information is rarely provided, this decline needs to be interpreted cautiously. In Northern Ireland, a total of 123 infections were reported in 2011, of which 15 were known to be acute. Some of these infections will have been related to injecting drug use; however, risk factor information is not available (HPA et al, 2012).

These data indicate that the level of current hepatitis B infection amongst PWID in the UK is low.

6.2.3 Other infectious morbidity

Infections due to spore-forming bacteria

Severe infections in PWID caused by spore forming bacteria have been major problem in the UK over the last decade (Hope et al. 2012).

In December 2009, the first ever confirmed cases of anthrax amongst PWID in the UK were reported. 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.[147] During 2009 and 2010, a total of 124 cases of anthrax amongst heroin users were reported in the UK (119 in Scotland and five in England) (see UK Focal Point Reports 2010 and 2011). No cases of anthrax were reported in heroin users in the UK, in 2011 (HPA et al. 2012). However, cases have occurred in Europe again in 2012 with four cases reported in the UK (HPA et al. 2012). Three deaths were reported amongst PWID in the UK in the summer of 2012. (see section 6.2.3).

In December 2011 Health Protection Scotland, on behalf of Scotland's Outbreak Control Team published a report into the outbreak of anthrax amongst injecting drug users which occurred in Scotland between December 2009 and December 2010 (HPS 2011; see section 6.2.3).

In order to determine the demographical and behavioural correlates of anthrax infection, Palmateer et al. (2012) conducted a case-control analysis of data collected in Scotland during the 2009/10 outbreak. Data were probabilistically linked to the Scottish Drug Misuse Database using limited identifiers.[148] Results indicated that those who had been injecting for 10 years or more and those who were currently receiving opioid substitution treatment, were both more likely to be a case who had contracted anthrax. Those who had only smoked heroin in the last month were also likely to be a case and alcohol consumption was marginally associated with a greater chance of being a case recorded by HPS.

In 2011, there were no reported cases of wound botulism amongst PWID in the UK. This was the first year without a reported case since 1999; between 2000 and 2010 a total of 163 cases were reported (HPA et al. 2012). There were also no reported cases of tetanus amongst PWID in 2011, while between 2000 and 2010 a total of 35 cases were reported (HPA et al. 2012).

Tuberculosis

In total, there were 8,963 cases of tuberculosis reported across the UK in 2011 (HPA 2012d). Amongst cases with information on the four 'social risk factors' monitored, 2.5% (201/8,059) had a history of problem drug use, 3.5% (273/7,894) of alcohol misuse/abuse, 2.5% (202/8101) of homelessness and 2.6% (207/7,858) of imprisonment. Approximately

[147] See: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Anthrax/.
[148] Sixty-five out of 82 (79%) confirmed/probable cases of anthrax were linked to the SDMD. Ten controls per linked case were randomly selected from the SDMD.

8.6% of cases (634/7,372) had at least one of these social risk factors. Around one in five of these cases (127/634) had more than one of these risk factors. (HPA 2012d).

Other bacterial infections

Cases of severe infection related to both meticillin resistant Staphylococcus aureus and Group A streptococci continue to occur amongst PWID (HPA et al. 2012). For example, data from the mandatory enhanced surveillance of MSSA bacteraemia in England indicate that, amongst those reports where risk factor information was provided 6.9%, reported injecting drug use (HPA et al. 2012).

In 2011, over one-quarter (28%) of PWID participating in the UAM Survey in England, Wales and Northern Ireland reported that they had experienced an abscess, sore or open wound during the preceding year, all possible symptoms of an injecting-site infection, (HPA et al. 2012; HPA 2012a). In 2011, more women reported an injection-site symptom than men: 36% of women reported a symptom compared with 26% of men (HPA 2012a: HPA 2012b).

6.2.4 Behavioural data: sharing

The level of needle and syringe (direct) sharing reported by participants in the UAM Survey in England, Wales and Northern Ireland has declined from 33% in 2001 to 17% in 2011 (HPA 2012a; HPA 2012b). Direct sharing was reported by 17% of the participants in England (regional range: 11% to 23%), 11% of those in Wales, and 29% of those in Northern Ireland in 2010 (HPA 2012a; HPA 2012b). Throughout the period 2001 to 2011, direct sharing levels were consistently higher amongst those aged under 25 years than amongst older participants; in 2011, 24% of those aged under 25 years reported direct sharing compared with 17% of those aged 25 to 34 years and 16% of those aged 35 years and over (HPA 2012a; HPA 2012b).

Sharing of any of the injecting equipment asked about the in the UAM Survey (i.e. needles, syringes, mixing containers, water or filters; direct and indirect sharing) was reported by 37% of those participating in the survey in 2011. Sharing of any of this equipment was reported by 38% of the participants in England (regional range: 31% to 49%), by 32% in Wales, and by 37% in Northern Ireland in 2009 (HPA 2012a).

In Scotland, data from the Scottish Drug Misuse Database indicates that 7% of PWID reported current needle and syringe sharing in 2010/11, this is a decline from 12% during 2006/07 (ISD Scotland 2012a).

6.3 Other drug-related health correlates and consequences

6.3.1 Psychiatric co-morbidity

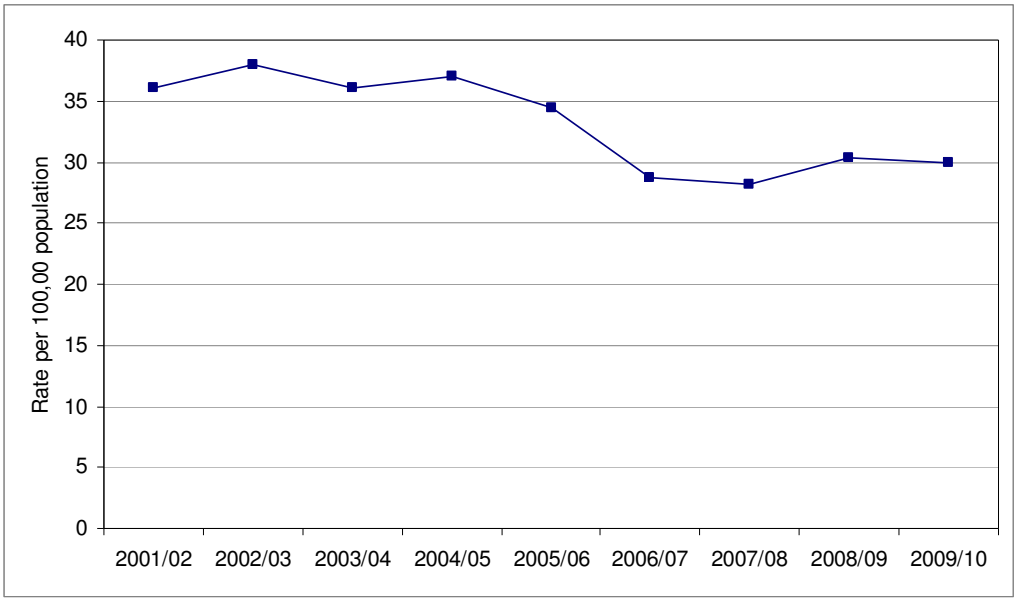
Scotland

Similar to last year, inpatient hospital data from Scotland[149] show that in 2009/10, six per cent (n=1,479) 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 per 100,000 population), the rate fell until 2007/08, when it stood at 28 per 100,000 population. In 2008/09, the rate increased to 30 per 100,000 population and remained stable at this level in 2009/10 (Figure 6.4). The rate increased between 2005/06 and 2009/10 in the older age groups (from 72 to

[149] Note that historical data have been amended since the publication of the UK Focal Point Report 2011 as provisional data for 2008/09 were used. Data for 2009/10 are also provisional and are subject to change in later editions.

76 per 100,000 population amongst 35 to 39 year olds and from 13 to 15 per 100,000 amongst those aged 40 and over), with an overall decrease reported in the younger age groups over the same period (ISD Scotland 2012a).

Figure 6.4: *Psychiatric inpatient discharges with a diagnosis of drug misuse in Scotland, 2001/02 to 2009/10; rate per 100,000 population*



Source: ISD Scotland (2012a)

In 2009/10, 54% (n=798) 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 slight decrease from 58% in 2008/09. As in previous years, the most frequently reported single drugs in psychiatric discharges were opioids, recorded in 33% (n=482) of cases and cannabinoids, recorded in nine per cent (n=128) of cases (ISD Scotland 2012a).

6.3.2 Non-fatal overdoses and drug-related emergencies

Data on drug overdoses and drug-related emergencies are provided using hospital inpatient data and International Classification of Diseases (ICD-10) codes.[150] It is difficult to assess the full extent of non-fatal overdoses and drug-related emergencies due to the use of illegal drugs. This is 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 (NPS). Furthermore, data from hospitals are only available for those who are admitted to hospital and have an inpatient stay. Evidence shows that less than one-third of those presenting to hospital with acute recreational drug toxicity are admitted and, even then, they may not be assigned an appropriate ICD-10 code (Wood et al. 2011a; see UK Focal Point Report 2011).

Hospital inpatient data

Hospital inpatient data for 2010/11 show that, of the 33,889 inpatient discharges recording poisoning by drugs in the UK,[151] over half (64%) were due to 'other opioids' (including morphine and codeine). Almost all drug poisonings were emergencies (94%). There were 2,500 heroin poisonings, almost all of which were emergencies (96%). The next most

[150] See: http://www.who.int/classifications/icd/en/
[151] Using ICD-10 diagnosis codes T40 and T43.6.

common individual drug was cocaine (2,247 discharges) followed by methadone (1,954 discharges).

The number of heroin poisonings were relatively stable until 2010/11 when they decreased by 21% from the previous year. This may be due to a reported reduction in the supply of heroin in late 2010 to early 2011 (see section 10.2.1). In contrast, methadone poisonings increased by 27% and poisonings by other opioids by 12%. Following an increase in cocaine poisonings between 2007/08 and 2008/09, the number decreased in 2009/10. The emergence of mephedrone during the same period of time has been hypothesised as a possible factor in this reduction in cocaine-related harms.[152] However, cocaine poisonings increased by 13% in 2010/11 on the previous year, although they are still at lower levels than in 2007/08 and 2008/09 (Table 6.1).

Table 6.1: *Inpatient discharges recording poisoning by drugs in the UK 2007/08 to 2010/11*

Drug	Year							
	2007/08		2008/09		2009/10		2010/11	
	n	%	n	%	n	%	n	%
Other opioids including morphine and codeine	16,452	50.6	17,902	57.2	19,266	62.9	21,509	63.5
Heroin	3,071	9.4	3,053	9.8	3,155	10.3	2,500	7.4
Cocaine	2,477	7.6	2,627	8.4	1,986	6.5	2,247	6.7
Methadone	1,365	4.2	1,493	4.8	1,533	5.0	1,954	5.8
Total	*32,511*	*100.0*	*31,319*	*100.0*	*30,618*	*100.0*	*33,889*	*100.0*
% Emergencies	*n/a*	*99.0*	*30,991*	*99.0*	*30,311*	*99.0*	*31,794*	*93.7*

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

6.3.3 Pregnancies and children born to drug users

Inpatient hospital data on effects of maternal use of drugs

In the United Kingdom during 2010/11, there were 220 discharges with an ICD-10 code P04.4 related to foetus and new-born affected by maternal use of drugs of addiction and 1,103 discharges with an ICD-10 code P96.1 of neonatal withdrawal symptoms from maternal use of drugs of addiction.

Scotland

Inpatient data from Scotland show that in 2009/10, there were 925 maternities for which drug misuse was recorded,[153] a rate of 16.1 per 1,000 maternities. This is an increase of 53% from 2008/09, when 603[154] (10.4 per 1,000) were recorded. However, it is reported that this is primarily as a result of better recording of data rather than a large increase in drug use during pregnancy.

Seventy-six per cent of births[155] where drug misuse was recorded were full-term normal birth-weight and 15% were pre-term compared to 90% and seven per cent respectively of all

[152] See: http://www.straightstatistics.org/article/banned-drug-may-have-saved-lives-not-cost-them
[153] Defined as ICD-10 codes 035.5, F11, F12, F13, F14, F15, F16, F18 and F19.
[154] The recording of these data became mandatory in April 2011. Previous year's data have been revised since the publication of the UK Focal Point on Drugs Report 2011. It is reported that the recording of drug misuse data has improved in some hospitals over the past five years. Therefore, care should be taken when making comparisons over time.
[155] In 2009/10 there were 930 births where drug use was recorded including multiple births.

births. Of all births[156] recording drug misuse between 2005/06 and 2009/10 (n=282,305), 52% were classed as coming from the most deprived areas, with a further 26% from the next most deprived area. Only four per cent (n=100) were from the least deprived areas[157] (ISD Scotland 2012a).

6.3.4 Drug driving

In 2010, impairment by drugs (illicit and medicinal) was recorded as a contributory factor[158] in 39 fatal road traffic accidents (2% of total) and 158 serious accidents (1% of total). Pedestrians impaired by drugs (illicit or medicinal) were a contributory factor in nine fatal accidents (1% of total) and 57 serious accidents (0.3% of total) (DfT 2011).

6.3.5 New psychoactive substances (NPS)

Further information about new psychoactive substances can be found in the supplementary chapter.

ACMD report on NPS

The ACMD published *Consideration of the Novel Psychoactive Substances (Legal Highs),* which discussed a range of harms associated with these substances (ACMD 2011b; see section 1.2.3). The harms are described as 'multi-faceted' and may present themselves as physical and/or social harms. The authors discuss an increase in the number of hospital admissions with drug toxicity as a result of NPS use, with the majority presenting symptoms akin to those seen with cocaine and amphetamine toxicity. It is reported that the variability of NPS in terms of content and potency can put users at increased risk of acute harm and toxicity. The authors state that, when a new NPS emerges, there is a particular risk of harm as there is often a lack of understanding and knowledge of the drug's effects. As there are currently no data in relation to the pharmacology, chemistry, toxicology or safety of many NPS available in the UK, this presents a particular risk to users. The ACMD recommend that: further research is undertaken on NPS; the UK should pro-actively develop EU and international networks; existing legislation should be fully utilised to prosecute sellers of NPS and new legislation should be considered; and information regarding the harms associated with NPS should be shared with the public through resources such as FRANK.

Review of clinical toxicology of NPS

In a review[159], of the evidence, several new psychoactive substances were considered in terms of their pharmacology, clinical effects and acute toxicity (Hill and Thomas 2011). The authors stated that most of the NPS that have become popular in recent years can be classified into one of four distinct groups according to their chemical structure. These four 'chemical families' are: the piperazines; phenethylamines; tryptamines; or piperidines and related substances. Each of these groups were reviewed and their chemical structure and known clinical effects were summarised.

In a similar review, Gibbons (2012) discussed the chemical structure and effects of a variety of new psychoactive substances and considered their similarities to existing illicit drugs and

[156] Where deprivation category could be assigned.
[157] Using Scottish Index of Multiple Deprivation (SIMD) 2006. See: http://www.isdscotland.org/isd/3207.html
[158] The contributory factor system enables up to six factors to be recorded in injury road accidents where the police have attended the scene. The police use a form that includes 77 contributory factors, which fall into nine categories. One of the nine categories is "impairment or distraction" which includes the factor "impaired by drugs (illicit or medicinal)" this refers to the driver of the vehicle. Another category "pedestrian only (casualty or uninjured)" contains the factor "pedestrian impaired by drugs (illicit or medicinal)".
[159] A mixture of peer-reviewed sources e.g. published literature, and non-peer reviewed sources e.g. books, media reports, government publications, drug user web forums were considered.

endogenous neurotransmitters (such as serotonin, norepinephrine and dopamine). The article was presented in terms of the pharmacology of specific substances within several different classes of novel psychoactive drugs, namely phenethylamine, tryptamine, cocaine and phencyclidine. The author provided an overview of how many NPS have been synthesised to mimic the effects of existing illegal substances and suggested that this has been done with relative ease by chemists as the chemical structures are often so similar and can be developed using compounds that currently fall outside of the legislation.

Emergency department presentations for mephedrone before and after control

It is reported that the number of emergency department presentations[160] in one hospital in London for mephedrone toxicity declined slightly in the year after legal controls were introduced (58 presentations in the year prior to control and 55 in the following year) (Wood et al. 2012a; see section 1.2.5).

Methoxetamine

Shields et al. (2012) examined three cases of methoxetamine toxicity presenting to a hospital in York, England.[161] It was reported that all three cases presented with a lack of co-ordination of muscle movements and reduced conscious levels. The authors suggest that methoxetamine has similar dissociative properties to ketamine and also has the potential to cause dysarthria,[162] nystagmus[163] and acute cerebellar[164] toxicity. All three patients recovered without treatment but recovery times ranged from 24 hours to three to four days.

'Ivory wave' case reviews of toxicity amongst users

Following a spate of poisonings in a short space of time due to reported use of 'Ivory Wave', case reviews of presentations to an A&E department in Edinburgh with toxicity associated with the ingestion of this product were undertaken (Murray et al. 2012). The aim was to investigate the clinical features of poisoning amongst people who had taken 'Ivory Wave' and also to establish the active ingredients commonly used in the manufacturing of this branded product. It was reported that common psychiatric effects lasted for up to several days (due to the long half-life of the drug) and physical symptoms included: tachycardia, tachypnoea, elevated creatinine kinase (CK) concentration,leucocytosis and acute dystonia. Further information on the substance was gained using data collected by the TOXBASE© enquiry database, analysis of a test purchase of 'Ivory Wave' from a local 'head shop' and blood and urine samples collected from five patients who presented to A & E. It was reported that the results of the biological samples from four out of five patients identified desoxpipradrol as the active ingredient and this was also the case in the sample of powder. The authors suggest that desoxpipradrol may have been the likely cause of this spate of poisonings in Edinburgh although they cannot say with any certainty if this is also true of all the cases that were identified across the UK during the same time period as NPS brands often vary in their composition.

[160] A retrospective analysis of all acute mephedrone toxicity presentations between 16th April 2009 to 15th April 2010 (12 months prior to control) n=58 and between 16th April 2010 to 15th April 2011(12 months after control) n=55 was carried out to establish a comparison of trends pre- and post-legislative control.

[161] Three cases were reviewed were individuals reported to a hospital emergency department with acute neurological toxicity associated with confirmed methoxetamine exposure.

[162] Dysarthria is a condition that occurs when problems with the muscles that help you talk make it difficult to pronounce words.

[163] Nystagmus is an involuntary movement of the eyes, usually from side to side, sometimes up and down and in some cases, in a circular motion. In most cases vision is also significantly worse than average.

[164] The cerebellum is the part of the brain which controls movement and co-ordination.

Analysis of recreational drug samples

In an analysis of 21 drug samples[165] obtained from patients who had presented to a hospital emergency department (Wood et al. 2011b), the authors reported that of the samples which were analysed, four did not contain any illicit drugs nor pharmaceutical medications; five contained legal compounds (including paracetamol and codeine); and 11 contained recreational drugs. The incidence of identified recreational drugs included: two MDMA; two methamphetamine; two ketamine; one cocaine/phenacetin; one cocaine/ lidocaine; one chlorophenylpiperazine; one 1-benzylpiperazine; and one heroin. Of the liquids sampled, five contained γ-butyrolactone (GBL) and two contained isopropyl nitrite.

6.3.6 Heroin

Attitudes to food amongst heroin users

Eating patterns and attitudes towards food were considered as part of a qualitative study with current and former heroin users[166] (Neale et al. 2012). It was reported that eating well was often not regarded as a priority when using heroin for a variety of reasons such as: loss of appetite; lack of money; being homeless; and wanting quick and/or sweet foods. Several participants reported that being in residential rehabilitation changed their eating habits as food was usually plentiful, meal times there were often regulated and they were usually required to actively participate either by being involved in the cooking or being present for communal eating. To some this brought positive effects such as learning to enjoy food as a way to interact socially with others, being exposed to healthy foods and learning to cook. However, some participants discussed the negative effects of this such as anxiety about weight gain, a particular problem for (mainly) women and also some participants who had a pre-existing eating disorder, whilst others found communal eating stressful.

Depression amongst heroin users

Experiences of depression amongst heroin users receiving opioid substitution therapy were examined in a small qualitative study[167] (Cornford et al. 2012). Descriptions of depressive symptoms by participants were unclear but included anxiety, stress and phobias and in some cases could not be differentiated from symptoms of drug withdrawal. Several participants referred to their depression as being caused by unfavourable social or personal circumstances which also led them into social situations where drug taking occurred.

[165] Thirty-three samples of drugs left by or obtained from individuals presenting to an emergency department at a London hospital with acute recreational drug toxicity were considered in this analysis. Twelve samples were liquid and 21 were non-liquid. Liquid samples were analysed by infrared spectrophotometry and non-liquid samples were analysed by gas chromatography-mass spectrometry. Only seven of the liquid samples were suitable for analysis, and it is thought the remaining five were alkyl nitrates as they had evaporated in the time between collection and analysis due to their high volatility. The non-liquid samples consisted of seven powder; six crystalline substances and eight tablets.

[166] Forty current or ex-heroin users (21 male) were interviewed about their current and previous eating habits during periods of: active heroin use; detoxing; residential drug treatment and not using heroin. After three months, follow-up interviews on the same topic were conducted with 37 of the original sample. Participants were recruited from community and residential drug services and peer support groups in southern England. Data from the 77 interviews were transcribed and coded according to themes and analysed using the 'framework' approach (Ritchie and Spencer 1994).

[167] Semi-structured interviews were carried out with 17 individuals (11 male) who were in receipt of opioid substitution therapy (either methadone or buprenorphine) and also prescribed antidepressants (including mirtazapine, fluoxetine and citalopram). They were recruited from a GP surgery in the north east of England which specialises in drug treatment. A focus group interview was also carried out with seven (5 male) members of a service user group made up of current and former opioid users, some of whom had also had depression. The group discussed aspects of depression such as the causes, impact, relationship with drug use and use of antidepressants.

6.3.7 Cannabis

The British Lung Foundation (BLF) published a report on the health harms associated with cannabis use (BLF 2012). In the report, the authors discuss prevalence of cannabis use in the UK and the pharmacology of cannabis. They provide a brief review of the current evidence on the potential health effects of cannabis use, including: chronic obstructive pulmonary disease (COPD); lung cancer; collapsed lung; and respiratory infections. The authors conclude that further research is needed to establish the true impact of cannabis smoking on respiratory health.

6.3.8 Other research

Sexual risk behaviour and substance use in adolescents

In Scotland, trends in associations between substance use and sexual behaviour were compared using two cohort studies carried out at different times amongst young people at the same ages[168] (Jackson et al. 2012). The authors examined the influence of several adolescent risk factors[169] (including drug use and sexual behaviour) to establish if associations between these factors changed over time. In both cohorts associations were found between drug use and risky sexual behaviour, in both early and late adolescence. Strong associations were reported between: early substance use and early sexual initiation; and late adolescent drug use and multiple partners. These associations were broadly similar in both genders and between social classes.

Cognition and drug use in middle age

An investigation into the long-term impact of drug use and cognitive functioning reviewed data from the National Child Development Cohort Study[170] which measured drug use amongst participants aged 42 and their memory and executive functioning aged 50. A slight positive association[171] was reported between those who had used illicit drugs (ever or current use) and cognitive functioning. In participants who were classed as drug dependent[172], a non-significant negative association was reported between dependent drug use and cognitive function. The authors reported that participants who had used illicit drugs tended to have higher educational attainments than the non-drug using group and suggested this as a possible factor in their attainment of higher cognition scores than the non-drug user group. They concluded that in this study past or current drug use was not associated with impaired cognitive function in early middle age.

Ketamine use and urinary symptoms

Winstock et al. (2012) aimed to assess the prevalence and patterns of ketamine use and the prevalence and correlates of urinary symptoms amongst a cohort[173] of non-treatment-

[168] The 'Twenty-07 Study' conducted in 1987 and 1990 and the '11-16/16+ Study' conducted in 1999 and 2003 in Glasgow, Scotland. In 1987, 1,009 participants (aged 15) were recruited to the 'Twenty-07 Study' and 90% (n=908) took part in a follow-up study in 1990. In the '11-16/16+ Study' participants were initially recruited aged 11 (n=2,584) and were followed up in 1999 aged 15 (n=2,196) and at ages 18 to 19 in 2002-2004 (n=1,258). Data were collected in both studies at ages 15 and 18 to 19 and were used in this analysis.

[169] Smoking, drinking, illicit drug use, early sexual initiation and multiple partners.

[170] The National Child Development Study has followed 17,415 individuals born in the UK between 3rd and 9th March 1958. Eight surveys have been carried out at ages seven, 11, 16, 23, 42, 46 and 50. Testing of cognitive functioning was conducted in three areas: memory index; executive functioning; and overall cognitive index, using a combination of verbal fluency and immediate and delayed recall tests.

[171] $p<0.001$.

[172] Dependent use was classified using data from earlier surveys at ages 16, 23 and 33 in addition to data at 42 years when participants had self-reported that they had ever had a drug dependency.

[173] A total of 3,806 surveys were completed with 1,947 (51.1%) of these reporting 'ever use' of ketamine and 1,285 (33.8%) reporting use in the last 12 months. Those 1,285 who had used in the

seeking ketamine users. Data were collected from a wider online survey in collaboration with *MixMag* dance music magazine. Ketamine users were divided into three groups based on the typical dose taken per session: low-use (31%), medium-use (35%) and high-use (34%). The mean number of maximum consecutive days of use was 3.5 days and 11.6% of respondents reported ever using on seven consecutive days or more. Those who had used in the last month had used ketamine on a mean of 4.2 days in that month. Using the seven Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) criteria for dependence, 17 per cent of the sample could be considered as dependent on ketamine. Dependence was strongly associated with higher doses of ketamine used per session and higher frequency of use. Three-hundred and forty (26.6%) respondents reported experiencing at least one urinary symptom, 224 (17.4%) reported experiencing the need to pass urine frequently. Other symptoms include pain in the lower abdomen, burning or stinging when passing urine, incontinence and blood in their urine. Higher typical doses were associated with all the reported symptoms. More frequent use was associated with significantly higher rates of lower abdominal pain, frequency of urination and experiencing burning or stinging when passing urine. Around half of the 251 respondents (51%, n=128) who reported on their experiences of symptoms related to their ketamine use, reported an improvement following cessation of use while 3.8% reported a deterioration upon cessation of use. Of those experiencing symptoms, 10% (n=35) had sought help for their urinary problems, 2.9% (n=10) had been referred to a specialist and 1.8% (n=6) had attended A&E. The authors suggest that the results exhibit a link between ketamine use and urinary symptoms.

6.4 Drug-related deaths and mortality of drug users

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

The latest data on drug-related deaths (DRD) across the United Kingdom are for 2011. Using the EMCDDA definition, there were 1,785 deaths in 2011, a decrease of 7.5% since 2010 (n=1,930) (Figure 6.5). Drug-related deaths have decreased year on year since 2008 (from 2,231). However, they are still 55% higher than in 1996 (n=1,152).

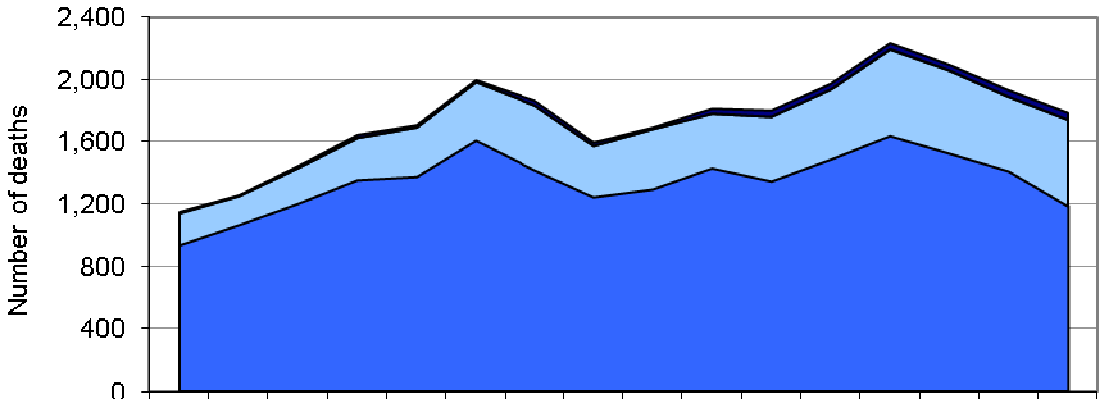
Figure 6.4 shows that the trends are different across the UK with deaths in England and Wales at their lowest level since 1997 whilst the number of drug-related deaths in Scotland and Northern Ireland are at their highest levels. Between 2010 and 2011[174], deaths in England and Wales decreased by 16% while the number of deaths in Scotland increased by 16% back to 2008 levels after decreases in 2009 and 2010. In 2011 the rate of deaths per 100,000 population (all ages)[175] using the EMCDDA definition was 10.58 in Scotland, 2.43 in Northern Ireland and 2.11 in England and Wales. The UK average was 2.83 (this figure was 1.98 in 1996).

last 12 months comprised the final sample and were directed to further questions on their ketamine use.

[174] Year on year fluctuations can affect interpretation. For long-term trends the use of rolling averages may be more appropriate.

[175] Four per cent of drug-related deaths in 2011 (n=71) were aged 65 years and over. The rate of drug-related deaths per 100,000 population (for ages 15-64) in the UK was 4.11 in 2011. However, rates across constituent countries varied: England and Wales had a rate of 3.05 drug-related deaths per 100,000 population (15-64), Northern Ireland had a similar rate of 3.64, while Scotland had a much higher rate of 15.45.

Figure 6.5: *Drug-related deaths in the United Kingdom, 1996 to 2011: EMCDDA definition*

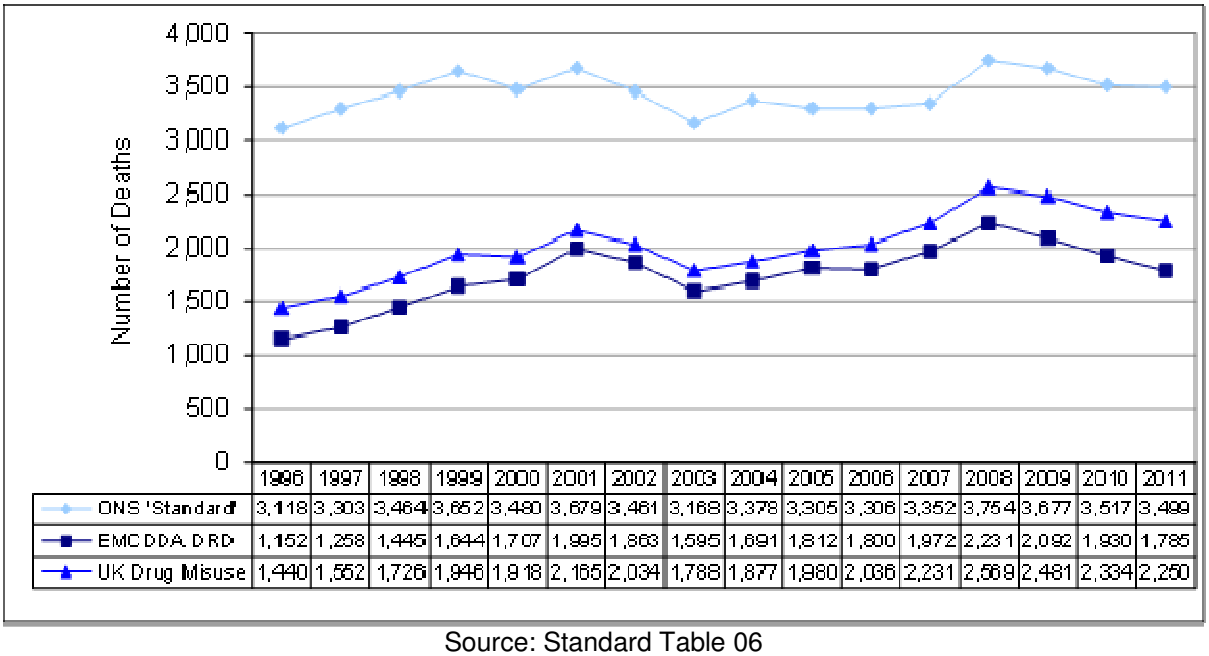


	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Northern Ireland	9	6	13	19	15	11	29	21	10	31	39	36	38	35	42	44
Scotland	208	188	230	272	318	376	417	331	387	352	416	450	556	532	479	556
England & Wales	935	1,064	1,202	1,353	1,374	1,608	1,417	1,243	1,294	1,429	1,345	1,486	1,637	1,525	1,409	1,185

Source: Standard Table 06

The slightly different drug misuse 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 2011 was 2,250 a decrease of 3.6% since 2010 (n=2,334). Using the much wider ONS definition, the total number of deaths in 2011 was 3,499 a decrease of 0.5% from the previous year (n=3,517) (Figure 6.6).

Figure 6.6: *Comparison of total number of deaths using three definitions in the United Kingdom, 1996 to 2011*



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
ONS 'Standard'	3,118	3,303	3,464	3,652	3,480	3,679	3,461	3,168	3,378	3,305	3,306	3,352	3,754	3,677	3,517	3,499
EMCDDA DRD	1,152	1,258	1,445	1,644	1,707	1,995	1,863	1,595	1,691	1,812	1,800	1,972	2,231	2,092	1,930	1,785
UK Drug Misuse	1,440	1,552	1,726	1,946	1,918	2,165	2,034	1,788	1,877	1,980	2,036	2,231	2,569	2,481	2,334	2,250

Source: Standard Table 06

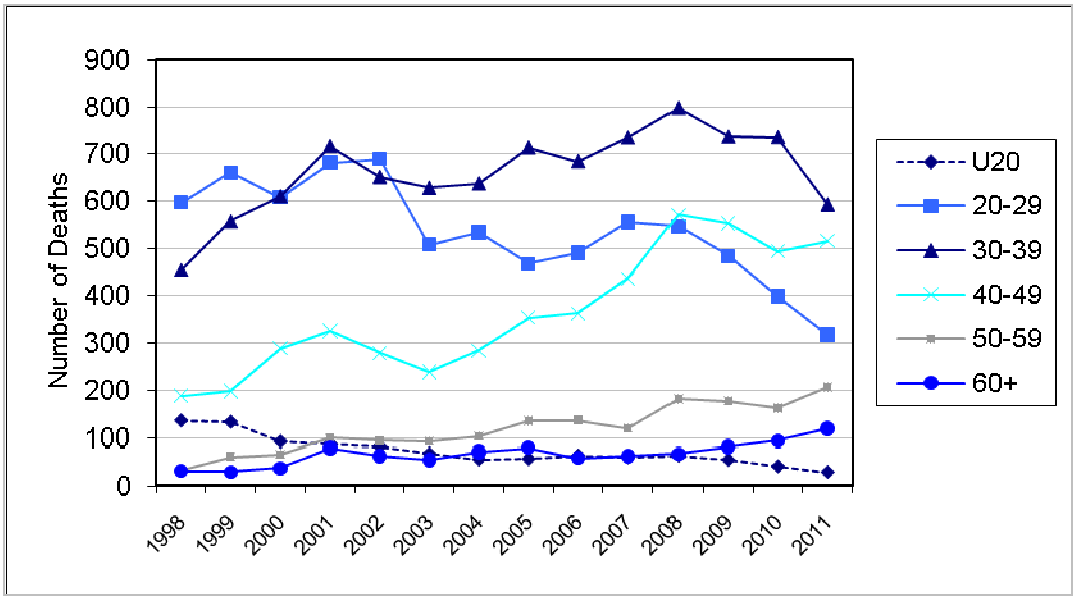
Age and gender

In the UK in 2011, using the EMCDDA definition, males accounted for 1,323 deaths (74.1%) and females for 462 (25.9%) (male to female ratio=2.9:1).

The lowest percentage of males was 66.7% in Northern Ireland[176], then 72.7% in Scotland and the highest was England and Wales (75.0%). The number of deaths amongst males in the UK decreased by 13.6% between 2010 and 2011 while the number of deaths amongst females increased by 16.1%. Drug-related deaths amongst females increased in each of the UK jurisdictions between 2010 and 2011; by 10.4% in England and Wales (n=296), by 23.6% in Scotland (n=152), and by 100% in Northern Ireland (n=14). Across the UK, the biggest increase was amongst women aged over 50 years old; by 54% amongst those aged 50 to 54 years old (n=43), by 150% amongst those aged 54 to 59 years old (n=40), and by 40% amongst those aged 60 to 64 years old (n=21).

The average age of death was 40.8 years with males (39.4 years) tending to be around five years younger than females (44.8 years). The average age of death has increased from 31.5 in 1996. Deaths of males tended to occur in younger age groups in Northern Ireland. Overall, most deaths in the UK in 2011 occurred in the 35 to 39 years age-group, although deaths amongst this age group decreased by 13.9% from the previous year. Figure 6.7 shows that, since 2008 when drug-related deaths were at their peak, deaths decreased for all age groups apart from the older age groups aged 50 to 59 years old and over 60 years old.

Figure 6.7: *Number of deaths by age group in the United Kingdom,1998 to 2011: 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=820) and methadone (n=765) (Table 6.2). However, between 2010 and 2011 there was a 23% decrease in the number of heroin/morphine mentions on death certificates and a 52% increase in methadone mentions in the UK. In Scotland the number of deaths involving methadone was higher than the number mentioning heroin for the first time since 1997. This may be a result of the reduced supply of heroin reported in late 2010 and early 2011. (see section 10.2.1).

Ecstasy mentions fell sharply (by 72%) between 2009 and 2010 in the UK but increased between 2010 and 2011, although they are still lower than in previous years. Cocaine mentions continued a downward trend since 2008, decreasing by 16% between 2010 and

[176] Note there was a comparatively low number of deaths in Northern Ireland (n=44).

2011, although they are still much higher than levels seen in 2000 (n=88). Deaths involving tramadol increased by 11% between 2010 and 2011 and are mentioned in four times the number of deaths as in 2003. Alcohol was mentioned with one or more drugs in 29% of deaths.

Table 6.2: *Drug mentions on death certificates in the United Kingdom, 2002 to 2011*

Drug	Year									
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Heroin/ Morphine	1,118	883	977	1,043	985	1,130	1,243	1,210	1,061	820
Methadone	300	292	300	292	339	441	565	582	503	765
Cocaine	161	161	192	221	224	246	325	238	180	152
Amphetamine	55	41	47	57	55	62	68	46	50	66
Ecstasy-type	79	66	61	73	62	64	55	32	9	24
Diazepam[177]	356	282	217	205	186	223	489	300	315	336
Temazepam	89	114	87	55	55	56	55	48	38	46
Tramadol	45	51	56	75	109	116	128	135	185	205

Source: NRS 2012; NISRA 2012b; ONS 2012

6.4.2 Drug-related deaths database in Scotland

The second report from the National Drug-related Deaths Database (NDRDD)[178] in Scotland was published in early 2012. The drug-related deaths in the report are a sub-set of the 485 drug-related deaths recorded in Scotland for 2010 (GROS 2011) and examine the personal circumstances behind the deaths of 365 individuals (Graham et al. 2012) (see section 7.2.1). The report showed that:

- the majority of cases were male (79%);
- 83% of deaths occurred in the under 45 age group;
- where known, 62% (n=214) of individuals who died of a drug-related death had previously been in contact with drug treatment services;
- of these, 143 cases[179] had been in contact with services in the six months before death and 90 individuals in the four weeks before death;
- over half (n=124) had been in contact with either a GP or drugs service at least 12 weeks before their death;
- over half were known to have had injected drugs (n=199);
- one-third (38%) had children under 16 years of age and eight per cent (n=29) lived with a child at the time of death;
- over half lived alone;
- over half died in their own home (53%) or someone else's (27%) and another person was present in nearly two thirds of cases (62%); and
- a total of 238 children either lost a parent or parental figure to a drug-related death in Scotland in 2010 and 45 children were living with the individual that died at the time of death.

[177] A revised data collection form was introduced in Scotland in 2008 which has resulted in more specific drugs being identified than in previous years. This is thought to account for the large increase in diazepam deaths between 2007 and 2008.

[178] 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.

[179] Unknown seven cases, 143 cases 26 weeks or less, 64 cases over 26 weeks.

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 found in over three-quarters of cases (78%) and heroin in nearly two-thirds of cases (64%).

The report concludes that, although these results are broadly similar to those reported in the previous year (Graham et al. 2011), these data confirm that individuals at risk of a drug-related death do not form part of a homogenous group. They suggest that there is an ageing cohort of drug users who may be at increased risk due to co-existing health problems, recurrent overdoses and social isolation in some cases.

6.4.3 Systematic review of drug-related deaths in Wales

Since the last report was published in 2011 (see UK Focal Point on Drugs Report 2011) a further 56 drug-related deaths from across Wales have been reviewed by four regional panels. It is reported that the majority of cases were not in contact with treatment services at the time of their death (Welsh Government 2011c) (see section 7.2.1). The key findings from these cases are that:

- 84% of deaths involved males;
- 70% died in a home setting;
- cardiopulmonary resuscitation (CPR) was attempted by family and friends in 32% of deaths; and
- 26% were accessing substance misuse services at the time of death;

The main substances recorded as the medical cause of death included:

- heroin/morphine (alone or combination) in 40% of cases;
- alcohol (in combination) in 29% of cases;
- benzodiazepines (alone or combination) in 34% of cases; and
- methadone (alone or in combination) in 38% of cases.

6.4.4 Deaths associated with new psychoactive substances

Suspected and confirmed fatalities associated with mephedrone use in the United Kingdom were examined using data from np-SAD (Schifano et al 2012). By the end of the summer 2011, 128 alleged mephedrone-associated fatalities had been reported. Mephedrone was identified at post mortem in 90 cases; inquests had been concluded in 69 cases, 62 of which are analysed in the paper. Individuals were typically young (mean age, 28.8 years), male, and with a previous history of drug misuse. There was a notable number of deaths involving self-harm. Mephedrone alone was identified at post mortem on eight occasions (13% of the inquests' sample).

Corkery et al, (2012a) reviewed what is known about the pharmacological, physiological, psychopharmacological, toxicological and epidemiological characteristics of 5-MeO-DALT. They also report the first death involving the use of this substance.

Other reviews of NPS have also covered aspects of toxicity and deaths, for example MDAI (5,6-Methylenedioxy-2-aminoindane) (Gallagher et al. 2012), 2-DPMP (Corkery 2012b) and methoxetamine (Corazza et al. 2012).

See also the supplementary chapter on new psychoactive substances.

6.4.5 Deaths associated with volatile substance abuse

A review of all VSA deaths in the UK between 1983 and 2007[180] found that there was a substantial rise in the number of VSA deaths between 1983-1987 and 1988-92 from 449 to 609. This was followed by a large decrease to 378 in 1993-1997 before a more gradual decline to 258 in 2003-2007 (Butland et al. 2012). The pattern, however, was different across age and sex groups resulting in a change in the age-sex distribution. The mean age at death in males and females increased over time with 59% of deaths in 1983-1987 amongst children (aged under 18 years old) and 82% in 2003-2007 amongst adults. The authors suggest that this coincided with a Department of Health advertising campaign aimed at reducing volatile substance abuse amongst children; in 1992 VSA deaths amongst young people under 18 year old fell by an estimated 56% for boys and 64% for girls.

There were reported increases observed in the number of VSA deaths amongst women from six in 1983-87 to 45 in 2003-2007 and in the proportion of VSA deaths that occurred indoors. The authors reported that there was no evidence of a change in VSA deaths amongst under 18 year olds following legislation which was introduced in 1999 to prohibit the sale of cigarette lighter refills containing butane to under 18 year olds. Between 1983-1987 and 2003-2007, the ratio of aerosol to gas fuel deaths fell by an estimated 80% in adults while the ratio of glue to gas fuel deaths fell by an estimated 95% in adults and an estimated 87% in those under 18 years old. The authors conclude that volatile substance abuse in adults should be considered when formulating prevention strategies.

6.4.6 Deaths from HIV/AIDS and HCV

Deaths of people who inject drugs (PWID) with AIDS accounted for 7.9% (1,464) of the total number of AIDS deaths in England and Wales up to the end of December 2011 (n=18,469). In Northern Ireland the percentage was 7.6% (8 deaths, n=105), but in Scotland it was 47.6% (829 deaths, n=1,740). The levelling off in the number of deaths of PWID AIDS deaths seen in recent years gave way to a slight increase in 2009 followed by a decline in 2010. By the end of December 2011, 48 deaths had been reported for that year: the number is likely to increase. The UK figure of 48 for 2011 (51 in 2010) is about 23% of the peak level in 1995 (n=212) (Health Protection Agency – unpublished data).

6.4.7 Mortality and causes of deaths amongst drug users (mortality cohort studies)

The Nationally Integrated Quantitative Understanding of Addiction Harms (NIQUAD) Medical Research Council (MRC) Addiction Research Cluster[181] is undertaking a cohort study of mortality related to opiate and crack cocaine use in England.[182] This study considers the largest cohort of its type, to date, examining all-cause mortality amongst a group of more than 200,000 opiate and/or crack cocaine users identified via multiple treatment and non-treatment sources, with more than 575,000 person-years of observation. Treatment effects on mortality are examined for a subset of 165,000 treated users, with 474,000 person years of follow-up. The study aims to:

- Quantify, and compare to the general population, the extent of mortality that could be defined as avoidable;
- Consider whether specific demographic and drug-use factors are associated with heightened risk and, importantly, possible interactions between these;
- Clarify the specific causes of death that area elevated amongst an opiate and /or crack using cohort; and

[180] Data on VSA deaths across the UK and Islands have been recorded on a database at St George's, University of London since 1983 using stable and systematic methods of data collection.
[181] See: http://www.niquad.net/
[182] Incidence, prevalence, harms and intervention effects for problem and injecting drug use: crime, morbidity & mortality, Medical Research Council, 2011-2014. Investigators: Millar, Bird, Buchan, Davies, Donmall, Dunn, Lloyd, Marsden, Seddon, King, Hutchinson, Ades, DeAngelis Hickman, & Welton

- Clarify the association of treatment periods with changes in mortality risk, particularly temporal changes in risk and the persistence of these in relation to treatment status.

The study cohort has been drawn from the Drug Data Warehouse (Millar et al. 2012; see section 9.3.3), a case-linked data resource that combines event data about more than 1,000,000 substance misusers known to treatment and criminal justice agencies in England, including records of some 17,000,000 health and criminal justice events that they have experienced.

A study in Scotland by Copeland et al. (2012) aimed to present a description of the life histories of a group of PWID who had recently died.[183] For many of those who died, early life adversity was apparent with a steady progression into early criminal behaviour and drug misuse. Poor adult life outcomes were also reported and death occurred significantly earlier than in the general population or those living in deprived communities who did not use drugs.

[183] As part of the Edinburgh Addiction Cohort study (see UK Focal Point Report 2010), 432 follow-up interviews were carried out with PWID between 2005 and 2007 The interviews used the life grid approach and detailed early life, education, employment, drug use, opiate substitution treatment, criminal history, mental health problems and overdose. Thirty-three individuals who had taken part in these interviews subsequently died Information about the cohort was also compiled from full primary care records and General Register Office death certificates.

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 Wales, guidance on developing local confidential reviews into drug-related deaths in Wales was published in 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 people who inject drugs (PWID). Measures include: the provision of free needles and syringes; promoting the safe disposal of used equipment; information campaigns on safer sex and safer injecting; and HIV/AIDS counselling, support and testing. Treatment for infectious diseases is provided as part of the National Health Service (NHS), including the provision of anti-retroviral treatment for HIV, hepatitis B (HBV) and hepatitis C virus (HCV).

A *Hepatitis C Action Plan for England* was published in 2004 (DH 2004), prioritising prevention of infection and disease progression. In Scotland the *Sexual Health and Blood-borne Virus Framework 2011-2015* (Scottish Government 2011a) brings together hepatitis C, HIV, sexual health and hepatitis B into a single integrated strategy, adopting a multi-agency, cross-policy approach. Quality standards applicable to all HIV services (HIS 2011a) and quality indicators applicable to all hepatitis C services (HIS 2011b) were also published in Scotland in 2011. An *Action Plan for the Prevention, Management and Control of Hepatitis C* was launched in Northern Ireland in 2007 (DHSSPSNI 2007). The *Blood-borne Viral Hepatitis Action Plan for Wales 2010-2015* was published in 2010 (WAG 2010a).

The Health Protection Agency and Health Protection Scotland undertake surveillance on infectious disease and provide health warnings and advice to the public when necessary via their network of experts, for example, during a recent anthrax outbreak amongst injectors of contaminated heroin. The Public Health Agency (Northern Ireland) and Public Health Wales also provide similar functions.

Standards of care for problem drug users with mental health problems were agreed in 2001 (HAS 2001). Guidance on good practice (DH 2002) and the provision of services were developed in England.

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.

There is guidance on identifying pregnant drug users and ensuring that their needs, and those of their babies, are met (DH and the devolved administrations 2007).

7.2 Prevention of drug-related emergencies and reduction of drug-related deaths

7.2.1 Data collection and information provision

Drug-related deaths

Scotland

A report on 2010 data from the National Drug-related Deaths Database (NDRDD)[184] has been published detailing the personal situations and background behind the drug-related deaths of 365 individuals (Graham et al. 2012, see section 6.4.2) in order to build a picture of the circumstances behind drug-related deaths and learn lessons for the future. This is a sub-set of the 485 drug-related deaths recorded in Scotland for 2010 (GROS 2011).

In its *Annual Report 2010/11*, the National Forum on Drug-Related Deaths[185] in Scotland recommended that the investigation and reporting of drug-related deaths should be standardised across the country with the final cause of death recorded "within a reasonable time-frame" (Scottish Government 2011b).

In its *Annual Report 2010/11*, the Scottish Drugs Forum (SDF)[186] detailed a range of presentations, training sessions and harm reduction materials that the Forum had delivered in the preceding 12 months (SDF 2012).

Wales

Systematic review of drug-related deaths[187]

The last report into drug-related deaths in Wales was published in 2011 (see UK Focal Point Report 2011). Since then, a further 64 drug-related deaths from across Wales have been reviewed by four regional panels (Welsh Government 2011c). The panels have reported details of the treatment status and personal circumstances of the individuals who died alongside the main substances which were attributed as the cause of death (see section 6.4.3). The Welsh Government is currently working with Public Health Wales to review the process for confidential drug-related death enquiries in Wales.

Overdose awareness day

In December 2011, the Welsh Government held the first annual 'overdose awareness day' to raise awareness of prevention techniques and to acknowledge the deceased. A leaflet and

[184] 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. The data do not include every death recorded as drug-related by the GROS (n=485) as some of those cases did not meet the criteria of a drug-related death set out by the NDRDD, for example suicides, or the required data for inclusion on the database were missing. A full explanation of the methodology used is given here: http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2012-02-28/2012-02-28-NationalDrugRelatedDeathsDatabase2010-Report.pdf?14175051451 in Appendix A4.

[185] The National Forum on Drug-Related Deaths was set up in response to one of the main actions of the *Scottish DRD strategy* (SACDM 2005). The forum is independent and has representation from experts in a range of professional fields. It provides advice and recommendations to the Scottish Government and partners on measures to reduce drug-related deaths in Scotland.

[186] Scottish Drugs Forum is a national, voluntary sector and membership-based drugs policy and information agency. See: http://www.sdf.org.uk/

[187] A National Monitoring Group into drug-related deaths (chaired by the Welsh Government) oversees the work of four Regional Confidential Review Panels that periodically analyse a sample of deaths where illicit and prescribed drugs were involved.

poster accompanied the day.[188] The day comprised memorial events, overdose workshops and naloxone training for service users and carers.

Harm reduction groups

The number of harm reduction groups in Wales continues to increase. Most areas have a local forum to develop plans to reduce drug-related deaths and other drug-related harms. The forums have also been involved in initiatives such as hepatitis services, pharmacy interface, naloxone and needle and syringe programmes (Welsh Government 2011a).

Information sharing protocols within emergency care settings

The Welsh Government has developed an information sharing protocol between Accident and Emergency (A&E) departments and local substance misuse services. This is to enable the introduction of interventions to reduce unnecessary deaths to those most at risk and to encourage entry to services. The protocol establishes a treatment pathway which aims to be timely, effective and appropriate. The intended outcome is cohesion in harm reduction approaches in A&E departments to ensure that basic harm reduction advice is available (both verbal and written). The protocol is being piloted in the Hywel Dda Health Board area and, if successful, other areas will be encouraged to implement the protocol to allow onward referral to substance misuse services.

7.2.2 Naloxone

England

ACMD review of naloxone

The Advisory Council on the Misuse of Drugs (ACMD) published a review of naloxone (ACMD 2012c). It provided a background of its current legal status (a prescription-only medicine), its effects and methods of administration and a summary of its provision throughout the UK. The report contained three main recommendations:

- the availability of naloxone should be increased across the UK;
- restrictions on who can be supplied with naloxone should be relaxed by the Government; and
- effective training for individuals supplied with naloxone, in how to administer it and how to deal with overdose situations, should be investigated by the Government.

The ACMD concluded that naloxone is safe and efficacious and any potential risks of using it are outweighed by its benefits. They suggest that provision of naloxone on its own is not enough to reduce drug-related deaths and that it should also be backed up by training of service users, peers and carers in other aspects of overdose response such as basic life support training. The report also states that naloxone's prescription-only status is limiting the opportunities for a range of people to intervene in a potential overdose situation, such as hostel staff.

Naloxone Investigation (N-ALIVE) randomised controlled trial

Recruitment to the N-ALIVE randomised controlled trial (RCT)[189] commenced in 2011 with the aim of reducing DRDs amongst newly released prisoners in England. The trial will be initiated early in 2012.

[188] This annual event takes place on 13th December each year. See: http://cymru.gov.uk/topics/housingandcommunity/safety/substancemisuse/publications/odawarenessday/?lang=en.

[189] 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 participants who give consent. See:

Scotland

National Take-Home Naloxone (THN) programme

Scotland is now in the second year of the roll out of the national take-home naloxone programme. In 2011/12 local take-home naloxone programmes were developed in 29 out of 30 Alcohol and Drug Partnerships in Scotland. In 2012/13 the Scottish Government allocated a further £400,000 for the delivery of the naloxone programme which includes: continued reimbursement to health boards for naloxone kits; the continued development and implementation of a national training, information and advice resource; continued support to prisons; and a comprehensive monitoring and evaluation programme. The Scottish Government is working closely with the National Naloxone Co-ordinator and Training Development Officer based at the Scottish Drugs Forum (SDF) to increase awareness of the programme and ensure that it is embedded as a key critical intervention for those at risk. The National Naloxone Co-ordinator and Training Development officer are funded by the Scottish Government as part of the national programme, and have taken forward a number of strands of work in 2012/13. This includes: delivering training and awareness raising sessions to police officers and ambulance staff on overdose awareness and the national naloxone programme; and the development of multimedia training resources suitable for trainers, clinicians, drug users and their families, including a mobile phone app to use as a training resource and as a guide in emergency situations. A new website[190] has been launched to provide a focus for Scotland's naloxone programme. It hosts a range of information and resources on the naloxone programme such as: training resources; research; legal information; policy and discussion forums; and a directory of services providing take-home naloxone kits. Other priorities this year include supporting drug services to develop peer trainer networks to widen the reach of the training and also a focus on general practitioner (GP) engagement in the scheme; examining the needs of GPs and developing a suitable training package.

The National Naloxone Monitoring Programme is managed by ISD Scotland and monitoring began on 1st April 2011. Services collect a minimum dataset[191] each time a supply of naloxone is provided (Scottish Government 2011b). The first annual release of the monitoring data and the baseline measure[192] for Scotland's national naloxone programme was published in July 2012 (ISD Scotland 2012b). The data show that:

- a total of 3,445 take-home naloxone kits were distributed in 2011/12;
- 2,730 kits were distributed in the community;
- 87% were distributed to those at risk of opiate overdose (n=2,370), 11% to service workers (n= 295), two per cent to family members and friends of those at risk (n=60) and five (<1%) 'unknown' who they were supplied to;
- 84% of kits were a first supply (n=2,287), 13% were a repeat supply (n=348) and 95 (3%) 'unknown' if first or repeat supply;

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124595.pdf and http://www.kcl.ac.uk/iop/depts/addictions/research/drugs/N-ALIVE.aspx

[190] See: http://naloxone.org.uk/

[191] Including: who the naloxone is provided to (person at risk, family/friends or service/prison worker); first or repeat supply; what the previous supply was used for; gender; age; postcode.

[192] It should be noted that the programme was rolled out incrementally between April 2011 and January 2012 and this may impact on the first year of monitoring statistics and should be taken into account when making comparisons over time. It is also anticipated that, in future years, data quality and completeness will improve. The National Naloxone Advisory Group agreed that measurement of the number of (opioid) drug-related deaths before and after the implementation of the programme would be used to assess the impact of the naloxone programme. It was also agreed that data on the number and proportion of those (opioid) drug-related deaths that occurred within the crucial first four weeks after prisoner release would be used to assess the impact of the programme.

- in 132 cases, repeat supply was due to use of a previous kit on a person at risk of overdose; and
- a further 715 kits were issued by prisons to at risk prisoners on release from prison.

On average it is estimated that, in the community, 46 kits were issued per 1,000 people with drug use problems in Scotland. For prisons, this figure was estimated as 100 kits issued per 1,000 liberations of at risk prisoners.[193] Information on naloxone programmes and harm reduction in prison settings can be found in section 9.6.5.

Wales

Take-Home Naloxone (THN) scheme[194]

Following the results of an evaluation and as part of the *Drug strategy implementation plan for 2011-12* (Welsh Government 2012a), the THN scheme is now available across Wales both in the community and prison settings. Revised naloxone guidance to reflect good practice and recommendations identified in the evaluation (Bennett and Holloway 2011, see UK Focal Point Report 2011) has been written and will shortly be published on the Welsh Government website

A national harm reduction database for THN was implemented in March 2012 and enables the recording of naloxone training and supply/ resupply to all individuals across Wales, as well as recording demographics and circumstances surrounding overdoses. Since the start of the naloxone scheme in 2009, a total of 1,894 kits have been provided to those at risk of opiate overdose. Of those supplied, there have been 229 replenishments with 129 reported uses to reverse the effects of overdose (7% of all kits given out).

A full national report will be published in late 2012. A paramedic study will be launched in one area of Wales in 2012. This study will be a randomised controlled trial (RCT) involving assessing the feasibility of paramedics providing overdose training and take-home naloxone at the scene of an overdose. In addition, a pilot scheme of take-home naloxone in emergency care settings is to commence by November 2012 within the University Hospital of Wales in Cardiff, where individuals attending A&E following an opiate overdose, or those identified as being at risk of opiate overdose, will be supplied with take-home naloxone on discharge.

As well as the THN scheme, various harm reduction initiatives have also been delivered in conjunction with the scheme including: dissemination of a harm reduction wallet providing information on BBV, overdose risk and available services; and a naloxone training DVD for service users and carers (Welsh Government 2011d).

Northern Ireland

Naloxone Pilot

A take-home naloxone scheme is being piloted in Northern Ireland during 2012. Following evaluation of the scheme consideration will be given to rolling it out across Northern Ireland.

Stakeholder views on take-home naloxone

In an exploratory study, the views of drug service users, service staff and family/ friends of drug users in Scotland were compared regarding the provision of take-home naloxone (THN)

[193] Calculated by combining the results of the total number of liberations from prisons in Scotland in 2011/12 (n=19,792) with the number of prisoners testing positive for opioids on reception to prison (n=7,125).

[194] See previous UK Focal Point Reports and EDDRA. http://www.emcdda.europa.eu/themes/best-practice/examples

and associated training (Hill and McAuley 2011).[195] The authors found that of the three groups, the drug users themselves were the least enthusiastic about THN and also the least aware of services providing it. There was an inverse relationship between having witnessed an overdose and awareness of naloxone amongst the three groups, with significantly more drug users having witnessed an overdose (76% compared to 67% of family/ friends and 47% of staff) but being significantly less likely to be aware of naloxone (56%, compared to 94% of family/ friends and 98% of staff) and its uses (53% compared to 94% of family/ friends and 95% of staff). Drug users were also significantly less likely than the other groups to be willing to use naloxone (79%, compared to 100% of family/ friends and 96% of staff), although agreement levels were generally high across all groups. It was reported that, in the main, there was a strong agreement that training, including resuscitation techniques, should be given prior to the provision of THN. The authors note limitations in the study in terms of small sample size and an under-representation of male, younger and older drug users. They conclude that there is a need for increased awareness of THN particularly amongst drug users.

7.3 Prevention and treatment of drug-related infectious diseases

7.3.1 Needle and syringe programmes (NSPs)

The vast majority of participants in the UAM Survey of people who inject drugs (PWID) from across England, Wales and Northern Ireland (see section 6.2.1) reported that they had used NSP services: with 92% reporting having ever done so in 2011 (HPA 2012a).

England

Needle and syringe programmes (NSP): results from the UAM survey of PWID

NSPs are provided throughout England principally through pharmacies and specialist services. NSP coverage in England is estimated using data collected through the UAM survey of PWID. Participants in the UAM Survey are asked about their use of NSPs, and in 2011 the vast majority (87%) of the participants who had injected during the preceding year, reported that they had used an NSP during that time (only 4% of these participants had never used an NSP) (HPA 2012c).

Participants in the UAM Survey in England who had injected in the preceding four weeks were also asked about both the number of times they had injected and the number of needles that they had received from NSPs during that time. In 2011, just over half (57%) indicated that the number of needles they had received was greater than the number of times they had injected (HPA 2012c).These data should to be interpreted very cautiously. Firstly, some people get more needles than they need from NSPs, and then pass them on to their partner or to friends (secondary distribution). Secondly, on average, more than one needle is likely to be needed per injection, as needles may also be used during drug preparation and an injection may require several attempts (and therefore needles) to access a vein. In England almost a third (32%) of UAM Survey participants in 2011 who had injected during the preceding four weeks had injected with a needle that had been previously used and which they had attempted to clean (HPA 2012c). The authors suggest that together these data indicate that the amount of equipment provided in England needs to be increased.

[195] The research for the study was carried out in 2009. The THN service in Glasgow was introduced in 2007. Clients, their family and friends and staff at drug services in Scotland were recruited using convenience sampling. The sample was divided into three groups: drug (service) users n= 37; family/ friends n=18; and service staff n=103. The cross-sectional study utilised a quantitative questionnaire which was administered online to staff. The same questions were answered by drugs users and their family/friends using a paper-based survey. Participants were asked to discuss their views on THN supply and training provision.

Scotland Injecting Equipment Provision (IEP) Survey 2010/11

Results from the 2010/11 IEP survey in Scotland have been published (ISD Scotland 2012c).[196] Following a steady increase in reported attendances at IEP services between 2007/08 and 2009/10 there was an 11% decrease in attendances in 2010/11 compared to the previous year (from approximately 263,000 to 234,000).[197] There are however, a number of factors that are likely to have contributed to this decrease. Amongst these are a reduction in the percentage of IEP outlets reporting that their service limits the number of needles/syringes distributed in a single transaction and an increased provision of supplies for the purposes of secondary distribution, both in line with national guidelines. NHS Boards have also commented on the reduction in the supply of heroin that occurred during 2010/11 as another likely contributor to the drop in numbers of contacts at IEP services in 2010/11. As in previous years, the majority of clients were male (78%). Survey results show that:

- 4.5 million needles/syringes were distributed, a 3.7% decrease from 4.7 million in 2009/10 but higher than in 2007/08 and 2008/09;
- there have been increases in the number of filters and spoons distributed since 2008/09;
- after needles and syringes, wipes/swabs and citric acid were the next most commonly provided injecting paraphernalia;
- the majority of services provided sharp bins (n=242/269), wipes/swabs (n=225/269), and citric acid/vitamin c (n=243); and
- sterile water was only provided in 10% of outlets (n=27).

Northern Ireland Needle and Syringe Exchange Scheme

Northern Ireland has operated a Needle and Syringe Exchange Scheme since 2001, and activity monitoring information is collected from 14 pharmacies and one Community Addiction Team that offer the service. In 2011/12, a total of 196,780 syringes were issued, an increase of 9.5% from the previous year. The number of visits to a needle and syringe exchange also increased from the previous year (by 15%) (Table 7.1).

Table 7.1: *Syringe provision: number of visits and syringes issued in Northern Ireland, 2001/02 to 2011/12*

Year	Number of visits	Number of syringes issued
2001/02	5,213	67,989
2002/03	6,043	67,516
2003/04	7,508	82,731
2004/05	7,440	86,056
2005/06	8,797	85,801
2006/07	9,997	97,684
2007/08	11,387	116,935
2008/09	13,389	135,700
2009/10	15,828	153,625
2010/11	17,712	179,700
2011/12	20,407	196,780

Source: DHSSPS and Standard Time 10

[196] Responses were received from 269 IEP outlets across Scotland's 14 NHS Board areas (IEP services were available in 12 of these areas). The majority of these outlets (76%) are situated in pharmacies.

[197] It is advised that caution should be used when looking at trends as there are likely to be inconsistencies across local reporting areas (as some areas have improved the accuracy of reporting mechanisms over time) and some missing data. Also, the proportion of IEPs using estimated figures has increased over the past year.

Welsh NSP data collection project

In September 2010, a comprehensive data collection system for NSP services, the Harm Reduction Database (HRD) was implemented in all statutory, voluntary and mobile services across Wales. In 2011/12, there were 244 sites providing NSP services, a total of 5,140,314 syringes/needles were distributed and there were 45,328 visits to NSPs. It is expected that the HRD will be extended to include all pharmacy based NSP services by April 2013.

7.3.2 Viral hepatitis prevention and treatment

Hepatitis C: uptake of testing

Amongst PWID taking part in the UAM Survey throughout England, Wales and Northern Ireland the proportion of survey participants ever tested for HCV has risen from 54% in 2001 to 83% in 2011 (HPA 2012a; HPA 2012b). Fifty-one per cent of those infected with hepatitis C were aware of their status in 2011, compared to 41% in 2001 (HPA 2012a; HPA 2012b).

In 2011, 50% of HCV infected PWID in England participating in the UAM Survey reported being aware of their HCV positive status, an increase from 42% in 2001. In the same survey, 83% of PWID reported ever having had a voluntary confidential test for HCV in 2011, an increase from 55% in 2001 (HPA 2012a; HPA 2012b). In Wales, 56% of HCV infected PWID participating in the UAM Survey in 2011 reported being aware of their HCV positive status, similar to levels reported in previous years; 86% reported ever having had a voluntary confidential test for HCV in 2011, an increase from 60% in 2006 (HPA 2012a; HPA 2012b). In Northern Ireland, 61% of HCV infected PWID participating UAM Survey in 2011 reported being aware of their HCV positive status, similar to levels reported in previous years; 90% reported ever having had a voluntary confidential test for HCV in 2011 (HPA 2012a; HPA 2012b).

In Scotland, amongst 3,100 PWID interviewed at NSP during 2010 as part of the Needle Exchange Surveillance Initiative (NESI) study, 77% reported having been tested for hepatitis C in the past, while 38% reported a test in the last year. Amongst 1,747 PWID who were hepatitis C antibody positive, and were interviewed, 44% reported that they had been diagnosed hepatitis C positive and a further 12% reported having cleared the hepatitis C virus (HPA 2012c).

NICE Guidance

The National Institute for Health and Clinical Excellence (NICE) are in the final stages of developing guidance which aims to increase the uptake of hepatitis B and C testing for high-risk groups, including drug users who have previously injected drugs and/or have shared other drug paraphernalia such as straws for snorting. *Hepatitis B and C - ways to promote and offer testing to people at risk of infection*[198] (NICE 2012) is due for publication in December 2012.

Scotland: *Sexual health and blood-borne virus framework*

During the first year of implementation of the *Sexual health and blood-borne virus framework* (Scottish Government 2011a), the Scottish Government report that the majority of NHS Boards have been working towards closer integration of planning and management structures for sexual health and blood borne viruses. Most NHS Boards have planned, and begun, to utilise new protease inhibitors for the treatment of those with the hepatitis C virus Genotype 1 and the number of people initiated into antiviral treatments for hepatitis C continues to rise with further capacity being progressed to support future treatment targets. NHS Boards also have Managed Care Networks encompassing viral hepatitis or BBVs and delivery plans and clinical leads for viral hepatitis and HIV are also in place.

[198] See: http://guidance.nice.org.uk/PHG/Wave22/3

Work has been taken forward to standardise algorithms for neo-natal hepatitis B vaccination across Scotland. This had included work to develop the functionality with the national immunisation call and recall IT system to support follow-up for second and third doses of vaccination.

Injecting equipment is provided in line with the Scottish Government Guidelines for Services providing Injecting Equipment (2010) and is supported by the delivery of local safer injecting education, peer to peer education, staff training initiatives and the national procurement of equipment. The majority of services providing injecting equipment now have policies that follow the national guidelines in respect of secondary distribution and the return of used needles/syringes. It is also reported that the use of dried blood spot testing is enabling staff to test and engage with new populations, particularly harder to reach populations.

Wales: *Blood-borne viral hepatitis action plan for Wales 2010-2015*[199]

Reporting on the first year actions in response to the *Blood-borne viral hepatitis action plan for Wales 2010-2015* (WAG 2010a; Welsh Government 2011a), the Welsh Government has noted the following:

- over 100 individuals have participated in a 'Training the Trainer' course on blood-borne viruses and are now delivering sessions within their own organisations;
- selected substance misuse services are now using dried blood spot testing (DBS);
- the five prisons in Wales are all now linked with their local blood-borne virus prison nurse specialist to provide treatment within the prison environment;
- the Harm Reduction Database, which collects data on needle/syringe use and other harm reduction interventions, has been introduced in all statutory and voluntary NSPs across Wales;
- Health Boards and treatment centres have local BBV delivery/action plans and clinical leads;
- there are an increased number of BBV specialist nurses in the community; and
- treatment centres are increasing their capacity.

Hepatitis B vaccination

The percentage of PWID participating in the UAM Survey in England, Wales and Northern Ireland who reported having taken up an offer of the hepatitis B vaccination has increased markedly over time from 37% in 2001 to 76% in 2011[200] (HPA 2012a; HPA 2012b). Self-reported vaccination uptake varied by region and country in 2011: in Wales uptake was 79% (up from 17% in 2000/01); in England it was 77% (up from 39% in 2001); and in Northern Ireland it was 68% (up from 49% in 2003/04) (HPA 2012a). Of those who reported vaccination in England, Wales and Northern Ireland 62% self-reported receiving three or more doses in 2011, compared to 49% in 2001 (HPA 2012a).

In Scotland during 2011, 73% of individuals participating in a voluntary anonymous survey of PWID attending needle and syringe programmes (NSP) reported receiving at least one dose of hepatitis B vaccine. This compares to 68% in both 2008/09 and 2010 (HPA 2012a).

[199] In April 2010 the Welsh Government and Public Health Wales published the *Blood-Borne Viral Hepatitis Action Plan for Wales*, which sets out a number of actions to be implemented between 2010 and 2015. The plan aims to reduce the transmission of hepatitis infection in Wales, increase the diagnosis of current infection and improve treatment and support for infected individuals (see UK Focal Point Reports 2010 and 2011).

[200] Vaccination uptake data should be interpreted with caution as it is based on self-reported data.

Hepatitis C infection amongst recent injecting initiates

Following publication of the Department of Health's *Hepatitis C Strategy for England* in 2002, a HCV Action Plan was published in 2004 setting out a number of targets. Hope et al. (2012) explored the impact of the HCV Action Plan on the targets for reducing infection and increasing voluntary confidential testing (VCT) uptake amongst recent initiates to injecting. Data from the annual UAM Survey between 2000 to 2008 were included in the analyses. The overall prevalence of anti-HCV amongst recent initiates was 18% over the nine years (n=619). Uptake of VCT for HCV totalled 1,460 (42%), with greater uptake amongst women, those ever imprisoned, those having used needle exchange services, those currently or previously prescribed a detoxification or substitute drug and those providing an anti-HCV-positive sample. Test uptake increased from 26% in 2000 to 45% in 2004, and then to 62% in 2008, however, the authors state that it cannot be ascertained whether this is due to the Action Plan. HCV prevalence has remained stable since the Action Plan was published in 2004, suggesting that it has had no detectable effect on transmission rates.

Effect of scaling-up OST and NSP on reducing HCV prevalence

Vickerman et al (2012) modelled the effect of scaling-up opiate substitution therapy (OST) and needle and syringe programmes (NSP) on HCV prevalence. Recent intervention effect estimates were used to assess the probable impact of 100% NSP[201] and OST on HCV prevalence, and the impact of scaling-up both interventions in the UK. For chronic HCV prevalence baselines of 20%, 40% and 60%, modelling suggests that OST and 100% NSP coverage can reduce HCV prevalence by one-third, but requires the coverage of each intervention to be more than 60% for 15 years, or more than 40% for 20 years. The UK impact analysis suggests that chronic HCV prevalence in the UK could be up to 65% without OST and 100% NSP. Based on the model, the authors suggest that chronic HCV prevalence is unlikely to reduce to less than 30% over 10 years, or to less than 25% over 20 years, unless coverage of both OST and NSP is increased to 80% or more. The model also demonstrates the difficulty in extending the coverage of OST and 100% NSP if the average duration that individuals remain on OST and 100% NSP is not extended.

Venous access and avoidance of HCV

A sample of drug users in the south east of England participated in qualitative interviews[202] to investigate the types of strategies that they had used to avoid contracting HCV (Harris and Rhodes 2011). It was reported that those who employed safer injecting practices, and thus remained HCV-negative in the longer term, primarily tended to do so for reasons of venous access and to reduce the discomfort associated with injecting with shared needles (which are often blunted after the first use) rather than to avoid hepatitis. The authors suggest that approaching safer injecting interventions from this angle, specifically by addressing the immediate priorities of people who inject drugs in terms of venous care, may be a novel and effective way of engaging with drug users who may not be influenced by typical hepatitis prevention messages, which focus on long term health outcomes.

[201] Defined as obtaining one or more sterile syringes for each injection reported.

[202] A sample of 35 (9 female) current injectors (last 30 days), who had been injecting for at least the past six years were recruited from a mixture of low threshold OST prescribing services in London and the south east of England, drug user networks and snowball sampling. The average age was 39 years old and the average length of time injecting was 19 years. Twenty participants were HCV antibody-negative and 15 were HCV antibody-positive. Two in-depth qualitative interviews were carried out with participants (in all but one case who was lost to follow up at the second interview) one to three months apart. The first interview asked participants for an in-depth life history. The second interview explored the connections between participants' significant life events, social conditions, networks and strategies to reduce the risk of HCV transmission. The data were analysed thematically using grounded theory techniques.

7.3.3 HIV prevention and treatment

HIV testing

Amongst PWID, there has been an increase in the uptake of HIV testing in recent years. In 2011, 77% of PWID who took part in the UAM Survey reported ever having had a voluntary confidential test for HIV (HPA 2012a; HPA 2012b). This is the highest level ever recorded in this survey, and compares with 55% having ever been tested in 2001 (HPA 2012a). Of the participants in the UAM survey who had antibodies to HIV, 88% reported being aware of their infection in 2011 (HPA 2012a).

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 1,636 seen in 2011 (HPA et al. 2012). In 2011, 531 people who had acquired their HIV-infection through injecting drug use, and who were seen for care, had CD4 counts of 350cells/mm^3 or less (the level at which it is recommended to start anti-retroviral therapy; Gazzard et al. 2008). Of these, 87% were on anti-retroviral treatment; this level is comparable to that for other groups (HPA et al. 2012).

House of Lords Select Committee report

The House of Lords Select Committee on HIV and AIDS (2011) reported that the provision of needle and syringe programmes has been effective at maintaining HIV at relatively low levels in the UK amongst PWID in comparison to other countries. The committee recommends the continued provision of these services and that the UK Government should promote the benefits of needle exchange programmes to other countries where HIV epidemics are driven by drug injecting.

Condom use

Participants in the UAM Survey of PWID are asked about the number of sexual partners they had and condom use with these partners during the preceding year. Data from the survey for England, Wales and Northern Ireland indicate that, amongst those reporting more than one sexual partner during the past year, only 19% had always used a condom for vaginal or anal intercourse (HPA 2012a).

7.3.4 Anthrax

In response to a confirmed case of anthrax in Scotland in July 2012 (see section 6.2.3), the Scottish Drug Forum published a range of information materials including a poster and leaflet aimed at heroin users and a guide for drug workers.[203] In England, the Health Protection Agency (HPA) and NTA also issued similar guidance, leaflets and posters.[204] These materials have been cascaded to service working with drug users.[205]

Following the 2009/10 outbreak of anthrax amongst heroin users (see UK Focal Point Reports 2010 and 2011) the National Anthrax Outbreak Control Team (NAOCT) in Scotland published a report in December 2011 (HPS 2011). The report summarises the background to the outbreak, the actions taken and makes a series of good practice points and recommendations in the following areas: planning and preparedness for anthrax outbreaks; outbreak investigation and management; risk assessment; risk management (control measures) and risk communication. The Scottish Government has responded to the report's

[203] See: http://www.sdf.org.uk/index.php/news-and-media/general-news/new-anthrax-information-materials-available/

[204] See: www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1265637197663

[205] See: http://www.hpa.org.uk/hpr/archives/2012/news3312.htm#nthrx

recommendations[206] and has asked Health Protection Scotland (HPS) to lead on the development of a formal National Emergency Plan to deal with any future outbreaks of infection amongst drug users. The aim of the plan is to make sure that any future outbreaks are responded to effectively and to identify key roles, responsibilities and actions for partner organisations to ensure this happens. The Scottish Government has also pledged to explore future research possibilities; support measures to remind clinicians about the signs and symptoms of anthrax infection; and utilise the information that has been learned from this outbreak to improve diagnosis, treatment, prevention and to identify new research opportunities.

7.3.5 Research

A HCV screening intervention, targeted at individuals with a history of injecting drug use, was introduced in a sample of GP surgeries in Scotland (for a maximum of six months) between February and October 2007 (Cullen et al. 2012).[207] It was reported that of the 105 patients tested, 70% were HCV antibody positive and of these, 58% (n=43) were chronically infected (PCR positive). When the results for uptake of testing were compared to control practices[208], it was reported that the targeted intervention yielded higher test uptake (around 3 times higher) and diagnosis rates (around 10 times higher). The authors conclude that this intervention is an effective example of how to identify HCV-infected former IDUs. However, they report that the treatment uptake rate was low and should be considered in future studies. They also recommend that alternative means of testing, such as dried blood spot testing, should be looked at in future to reduce some of the potential problems experienced with this group of participants such as having to keep multiple medical appointments and poor venous access.

7.4 Responses to other health correlates amongst drug users

7.4.1 Mental health

The Scottish Government's *Mental Health Strategy for Scotland: 2011-2015* was published in August 2012 (Scottish Government 2012b). The new Strategy sets out a plan to work with partners to respond to the on-going challenge of improving mental health and wellbeing and ensuring improved services and outcomes for individuals and communities over the period to 2015.[209] The Strategy sets out the work that has already started and focusses on areas of key changes improvements for the future within a clear performance and accountability framework.

[206] See: http://www.sdf.org.uk/index.php/download_file/view/217/243/ and http://www.sdf.org.uk/index.php/news-and-media/general-news/national-emergency-plan-to-be-drawn-up-for-drug-infection-outbreaks/

[207] In eight surgeries in areas of high deprivation with high HCV prevalence and injecting drug use. Potential participants at eight GP surgeries taking part in the intervention were identified by interrogation of the General Practice Administration System Scotland (GPASS) to identify patients aged between 30 and 54 years old who had indicators of past injecting drug use. A total of 13,037 patients aged 30 to 54 were registered at intervention practices, of whom 6.4% (n=838) were identified as having indicators of past injecting drug use. Following review, the target population was 485 (3.7% of total practice population). Of these, 422 attended the practice during the six months of the intervention for a non-urgent consultation, 218 were offered testing and 121 patients accepted. A total of 105 patients were tested as some individuals could not be tested due to poor venous access or because they did not return for the test.

[208] Where HCV screening was not targeted to injecting drug use. During the intervention 36 people aged 30 to 54 (0.25% of the practice population) were tested across eight control practices. Twenty-two per cent were HCV positive (n=8) and 14% (n=5) were PCR positive.

[209] See: http://www.scotland.gov.uk/Topics/Health/health/mental-health

The Welsh Government is currently consulting on *Together for Mental Health – A Cross-Government Strategy for Mental Health and Wellbeing in Wales* (Welsh Government 2012b). Consultation events were held across Wales in June 2012 and the consultation closed at the end of July 2012.[210] Consultation results will be published in October 2012.

7.4.2 Substance use amongst pregnant women

In its *Substance Misuse Annual Report*, the Welsh Government stated the importance of effective screening for substance misuse amongst pregnant women to ensure that advice can be offered as soon as possible (Welsh Government 2011a). In several areas of Wales[211], specialist support services are being developed to enable partnership working with specialists during the planning, implementation and evaluation of care.

7.4.3 New psychoactive substances

Winstock and Mitcheson (2012) conducted a review[212] of the features of some common new psychoactive substances (NPS) and discussed their characteristics including: methods of administration; neurobiological mode of action; and clinical and desired effects. They developed a framework for use in a primary care setting for conducting interviews with users who may be experiencing problems as a result of using an NPS. It included a brief screening procedure and an assessment protocol designed to capture key information from users. The authors recommend using a 'staged approach' which begins in a primary care setting using a brief motivational intervention with users of these substances who are experiencing harms.

7.4.4 Other research

Groin injectors

In England, ultrasound scanning was used during a health check with groin injecting drug users to investigate levels of femoral vein damage at the injecting site (Senbanjo et al. 2012). [213] The authors reported on the level of damage for 84 participants using a four-point scale of severity[214] and also sought to evaluate the potential of utilising portable scanning devices in drug treatment services in the future. A total of 160 groin scans were carried out and the results showed significant femoral vein damage in nearly three-quarters of scans (73%). Damage to the veins was classed as severe or very severe in 42% of scans. It was concluded that future use of portable ultrasound devices in services could be useful in uncovering hidden damage amongst drug injectors and raising awareness amongst them of the risks of groin injecting. It is recommended that further evaluation of this initiative is undertaken.

Evaluation of a nurse-led BBV programme

An evaluation of a nurse-led screening programme for drug service users reported high levels of service user satisfaction and was found to meet the needs of its clients well[215]

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[210] See: http://wales.gov.uk/consultations/healthsocialcare/mhealth/;jsessionid=RfNYPpQSGfV1yL0GjV3v6pG2fqJGxzvQpsZZ51w2XLsJnwGnpJvN!639923638?lang=en

[211] Specifically the Hywel Dda Health Board which covers the Carmarthenshire and Pembrokeshire regions.

[212] Based on case series; observational studies; personal clinical experiences of the authors and of their colleagues; and consensus guidelines.

[213] Service users from a network of community treatment services in the south east of England were invited to attend a health check clinic following a referral from their drug treatment service and their femoral vein(s) were scanned using a portable ultrasound device. Sixty-nine per cent of the sample were male and the mean age was 37 years.

[214] Grade 1 (minimal or no change); grade 2 (moderate damage); grade 3 (severe damage); and grade 4 (very severe damage).

[215] The programme was provided at nine services in east London with three to nine half day sessions offered to clients. An analysis of the clinical activities of the service during one year was conducted using a prospective audit. Service user and professional stakeholder experiences of the service were

(Callaghan et al. 2012). The service was developed to identify and address the health needs of service users and, in the 12 months covered by this analysis, staff carried out 4,450 consultations with 1,940 service users providing general health advice, test results, vaccinations and HBV antibody testing. It is noted that the services user satisfaction questionnaire was administered by staff at the service and this may have had an influence on the results.

Provision of help for substance use amongst health workers

A postal survey was carried out amongst Occupational Health Providers (OHP) employed by the NHS in the UK to establish the levels of substance use training received by OHPs and the type of services and advice they provided to their clients when they presented to them with substance use issues (Gross et al. 2012). [216] It was reported that three-quarters of OHPs (74%, n=108) had received training in substance misuse and, of them, both drugs and alcohol were covered in two-thirds of cases (n=96). Three OHPs had received training in drugs only. The average duration for drug misuse training was 2.8 days and just under one-quarter had received the training in the last five years. However, the majority of OHPs did not feel that they had been sufficiently trained in the detection, assessment and treatment of substance misuse and less than half (44%) stated that they felt confident assessing someone who presented to them. Standardised screening tools to identify drug use with their clients were not used by any respondent. The authors suggest that there is a need for improved provision in this area but note that the fieldwork for this survey was conducted in 2006 and it is possible that improvements have occurred since then.

collected via semi-structured interviews (n=20). Service user satisfaction was measured using a quantitative survey. A convenience sample of 132 service users were asked 16 closed and two open questions regarding their satisfaction with the service. Staff at the service administered the questionnaires.

[216] Participants were recruited from a database of members of the professional body for OHPs, the Association of National Health Occupational Physicians. A total of 145 responses were received (65% response rate), 55% were male, the average age was 49 years and they had worked for the NHS for an average of 9.6 years.

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; and high proportions live in inappropriate housing (Seddon 2006). Research in 2008 suggested that around 80% (266,798) of problem drug users in England in 2006/07 were in receipt of state benefits, representing seven per cent of all those receiving such benefits (Hay and Bauld 2008). There are also further concerns about the effect of parental drug use on children, leading to problems of social deprivation for them.

Social reintegration is a key element within recent drug strategies in England, Scotland and Wales. The strategy for Northern Ireland also recognises the need to provide support with housing and employment, and wider support with social reintegration. There are various programmes to help drug users including The Supporting People Programme, introduced in 2003, which 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. Attention is also focused on the impact of parental drug use on children. Work in Scotland includes a 2010-12 strategy for children affected by parental substance misuse (CAPSM). There are a number of responses aimed at addressing neighbourhood problems associated with problem drug use, including drug dealing. For example, the *Anti-social Behaviour Act 2003* seeks to stop the use of premises for drug dealing. There is also guidance to tackle the inappropriate disposal of drug paraphernalia.

8.2 Social exclusion and drug use

8.2.1 Housing

Data from the National Drug Treatment Monitoring System (NDTMS) in England show that in 2011/12, of the clients who reported their housing situation when presenting to treatment, nine per cent reported having no fixed abode and a further 15% reported housing problems such as staying with family, friends or in a hostel on a short-term basis (NTA 2012f).

Of those clients taken onto the Drug Interventions Programme (DIP) caseload in Wales during 2010/11 (see section 9.3.1), approximately 25% were in temporary accommodation with eight per cent reporting no fixed abode (Welsh Government 2012c).

Data from the Scottish Drug Misuse Database (SDMD)[217] on new clients accessing drug treatment services in Scotland showed that in 2010/11, 72% of individuals (who provided information) reported that they lived in owned or rented accommodation at the time of presentation; a decrease from 80% in 2009/10. Twelve per cent reported that they were homeless in 2010/11; previous data have recorded 16% homelessness from 2007/08 to 2009/10[218] This decrease in the percentage of those who are in owned or rented accommodation and those who are homeless can be accounted for by an increase in the

[217] 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.

[218] This includes those reporting living in temporary or unstable accommodation, or a hostel.

percentage (from 3% in 2009/10 to 15% in 2010/11) of those reporting their accommodation as 'other', which includes prison accommodation (ISD Scotland 2012a).

8.2.2 Employment and education

Treatment Demand Indicator (TDI) data (see section 5.4) show that in 2010/2011, 59% of clients presenting to treatment in England, Scotland and Northern Ireland were unemployed. This is a decrease from 66% in 2009/10. Fifteen per cent reported being in regular employment, similar to previous years. Males (16%) were more likely to be employed than females (11%). A higher percentage of clients reporting to treatment for the first time were in regular employment (18%).

Sixty-seven per cent of clients entering drug treatment in Scotland in 2010/11 were unemployed (compared to 73% in 2009/10) and 12% were in employment.[219] Seventy per cent reported that their drug use was funded by welfare benefits; a slight decrease from 72% in 2009/10 (ISD Scotland 2012a).

Data from the Department for Work and Pensions (DWP 2012) show that in the UK in February 2011 there were a total of 34,940 individuals claiming Incapacity Benefit or Severe Disablement Allowance (IBSDA)[220] with 'drug abuse' as their primary disabling condition and 10,140 individuals claiming Employment and Support Allowance (ESA). By May 2011, the number of individuals claiming Incapacity Benefit or Severe Disablement Allowance as a result of a main disabling condition of 'drug abuse' decreased to 34,080. The number of individuals claiming ESA due to drug abuse remained the same.

8.2.3 Families

In Scotland in 2010/11, 41% of new clients reporting to the SDMD stated that they had dependent children under the age of 16 years old; this figure has remained largely stable since 2006/07 (ISD Scotland 2012a).

According to the National Drug-related Deaths Database (NDRDD)[221] in Scotland in 2010, 238 children either lost a parent or parental figure to a drug-related death in Scotland in 2010 and 45 children were living with the individual that died at the time of death (Graham et al. 2012) (see section 6.4.2).

In Northern Ireland in 2010/11, Treatment Demand Indicator (TDI) data show that 14% of clients presenting to outpatient treatment lived with a child, a decrease from 20% in 2009/10. Just over one-third of those living with a child (35%) live alone with a child.

Parental socio-economic status

Sutherland (2012) looked at the relationship between parental socio-economic status (SES) and adolescent substance use including cannabis use. Data were gathered from the longitudinal Peterborough Adolescent and Young Adult Development Study (PADS+) which involved interviews with 628 parents of children entering secondary school in 2003, followed by group interviews with their children a few months later. This was repeated in six annual

[219] Employed includes: paid and unpaid employment, support into employment and full time education/ training.

[220] Severe Disablement Allowance (SDA) was replaced by Incapacity Benefit (IB) in April 2001. In January 2011 Incapacity Benefit was replaced by Employment and Support Allowance (ESA). Those who were already receiving either SDA or IB will continue to do so until a review of all cases is completed in 2014, by which time all claimants will receive ESA if they are still eligible.

[221] The National Drug-Related Death Database (Scotland) is commissioned by the Scottish Government to draw from a wide range of local data sources including each individual's toxicology reports and their previous contact with health and criminal justice services.

data sweeps.[222] Data from the first four data sweeps were used in the current study (from ages 11 and 12 up to ages 14 and 15). The pupils were asked whether they had used a substance (including cannabis) in the last year and if so, how often. Parents' occupations, education level and household income were recorded.[223] Using a risk model, which excluded any participants who had used substances prior to the study and recorded new initiates in each data sweep, the author found that pupils who had parents of a higher occupational class were at a lower risk of initiation to cannabis use than those who were from lower working class households.

Grandparents

Templeton (2012) explored the dilemmas experienced by grandparents caring for grandchildren who are affected by parental substance misuse.[224] Findings showed that grandparents often felt like they had dual identities as parents and grandparents. Grandparents also faced problems attempting to help maintain bonds between children and their parents, regardless of how the grandparents felt about the parents. Another dilemma was communicating with their grandchildren about their parents' substance misuse. They often did not know how much their grandchildren knew or how much they should tell them. Many of the grandparents reported having never received or been offered support apart from those who were receiving support through their child's engagement with substance misuse treatment services.

8.2.4 Barriers to accessing health and social care

The *Annual Review of the Drug Strategy* highlights the stigma that is associated with drug dependence as a barrier to successful recovery. The drug strategy aims to support the treatment sector and local commissioners to challenge such stigmas (HM Government 2012).

8.2.5 Sex workers

Data from Scotland for new clients reported to the SDMD showed that two per cent of those entering drug treatment in 2010/11 funded their drug use through sex work (ISD Scotland 2012a).

8.2.6 Perceptions of anti-social behaviour

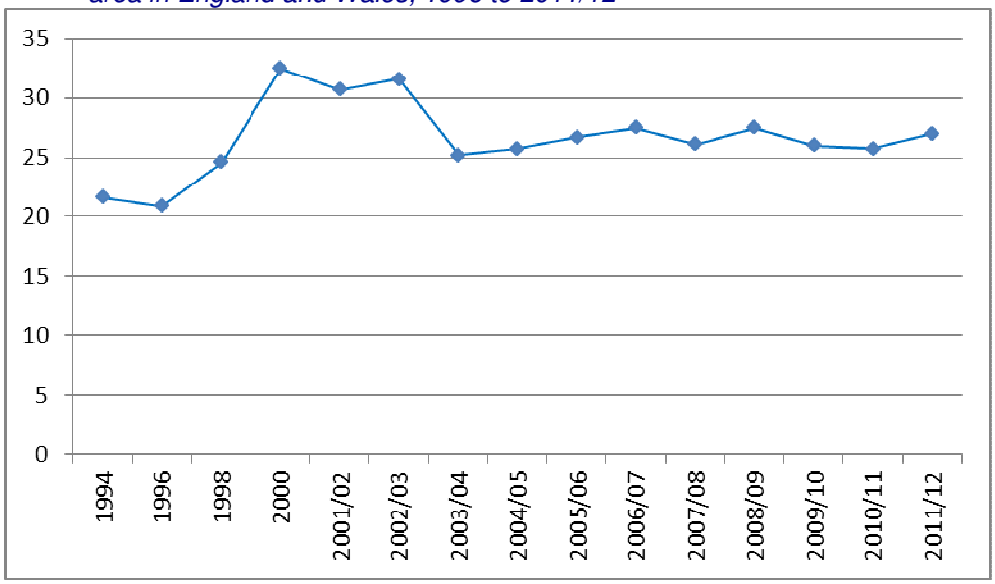
Analysis of the 2011/12 Crime Survey for England and Wales (CSEW) (Home Office 2012b) looking at measures of anti-social behaviour shows that 15% of respondents perceive there to be a high level of anti-social behaviour in their area, an increase from 13.7% in 2010/11. One of the seven indicators used to compile this measure is people dealing or using drugs. In 2011/12, 27% of respondents reported that this was a problem in their areas, a statistically significant increase from 25.7% in 2010/11. The long term trend shows that levels are now higher than those reported from 1994 to 1998, but lower than the levels reported in the early 2000s, with rates relatively stable since 2003/04 (Figure 8.1).

[222] PADS+ is a random sample of one-third of all families in Peterborough with children who began secondary school in 2003 at the age of 11 and 12 years old (originally recruited n=716). Data were taken from school and local government sources in order to construct the sampling frame.

[223] Classification of occupations was adapted from the Swedish longitudinal study *Project Metropolitan* as either 'lower working', 'working', 'lower middle', 'upper middle' and 'upper classes'. Four possible outcomes of parental education levels were 'not completed compulsory schooling', 'completed compulsory schooling' (GCSE), 'completed A Levels', 'completed a university degree'.

[224] Qualitative data were collected through interviews with grandparents and professionals from relevant organisations. in Birmingham, England. The first phase involved semi-structured interviews with grandparents (n=12) either face-to-face (n=6) or via telephone (n=6). The second phase involved four focus groups (two with professionals from local organisations and two with grandparents). Twelve grandparents took part in the focus groups (5 grandparents had also taken part in phase one). The data were analysed using a realist approach informed by interpretative phenomenology.

Figure 8.1: *Percentage of adults reporting people using or dealing drugs to be a problem in their area in England and Wales, 1996 to 2011/12*



Source: ONS 2012

The Scottish Household Survey 2011[225] (Scottish Government 2012c) found that 11.7% of respondents perceived drug misuse or dealing drugs to be 'very' or 'fairly common' in their neighbourhood. This is a slight increase from 11.0% in 2010 and may suggest a return to similar findings between 2005 and 2009 where the percentage of respondents who reported drug misuse or drug dealing as 'very' or 'fairly common' in their neighbourhoods remained stable at around 12%.

In *Perceptions of Crime: findings from the Northern Ireland Crime Survey* (NICS) 2010/11[226] (Freel and Campbell 2012) 71% of respondents believed that drugs were one of the major causes of crime in Northern Ireland and 23% cited drugs as the main cause of crime. The survey also measured aspects of anti-social behaviour, with 13% (the same figure as 2009/10) of respondents feeling that levels are high in their local area. Similar to the Crime Survey for England and Wales (CSEW)[227], one of seven measures of anti-social behaviour in Northern Ireland is people dealing or using drugs. Twenty-two per cent of respondents stated that this was a problem in their area compared to 27% in England and Wales.

[225] The Scottish Household Survey is a continuous cross-sectional survey of the general population in private residences in Scotland, the Highlands and the Islands, which started in 1999. Each complete sample is covered in the course of two years and data are provided annually. Multi-stage stratified design with a mix of clustered and unclustered sampling is used to select a sample from the small user Postcode Address File (PAF). Interviews were conducted in respondents' homes using Computer Assisted Personal Interviewing (CAPI). The overall response rate was 68.7%. See: http://www.scotland.gov.uk/Topics/Statistics/16002/PublicationAnnual

[226] NICS is a representative, continuous, personal interview survey of the experiences and perceptions of crime of adults aged 16 years and over, living in private households at randomly selected addresses throughout Northern Ireland. The survey was conducted on an ad hoc basis in 1994/95, 1998, 2001 and 2003/04 and has operated on a continuous basis since January 2005. The core questions and format of the 2010/11 NICS closely mirror those of the 2010/11 British Crime Survey (now known as the Crime Survey for England and Wales (CSEW), allowing for comparisons with data from England and Wales, with some additional questions and modifications to reflect local issues and the smaller sample size of the NICS. In 2010/11 4081 individuals were interviewed.

[227] Known as the British Crime Survey (BCS) until 2011/12.

Illegal drugs are cited as one of the drivers of anti-social behaviour in the UK Government White Paper on measuring and tackling antisocial behaviour (Home Office 2012c). The White Paper highlights that the *Community Protection Order (public space)* allows for public access to any public highway to be restricted if, for example, the area is being used for drug taking. In addition, *the Community Protection Order (closure)* allows for landlords to use a mandatory route to possession if a tenant, member of their household, or a visitor to the property, have been convicted of supplying drugs or production with intention to supply drugs, in that location in the last 12 months.

8.3 Social reintegration

8.3.1 Housing

In 2010/11 local authorities spent £33.1 million on housing-related support services for drug users funded through the Supporting People programme.[228]

The Department for Communities and Local Government (DCLG) are supporting the production of guidance, led by the housing sector and the drug sector, to improve understanding of how they can work together to support people to achieve full recovery (HC Debate, 20 March 2012, c651W).

In 2010/11, 87 individuals taken onto the Drug Interventions Programme (DIP) in Wales engaged with wrap-around support services (Welsh Government 2012c).

Hostel accommodation

Stevenson and Neale (2011) explored the intimate relationships of homeless drug users who stayed in either emergency hostels or night shelters.[229] Participants reported a desire to be together, particularly in a private space away from the communal hostel areas. This desire, for some participants, resulted in 'sleeping rough' if they were unable to secure accommodation together. Separation or the threat of separation was upsetting for those who wished to be housed together as some reported feeling safe with their partner in an unfamiliar environment. Couples reported helping each other to decrease or co-regulate the amount of drugs they used. Participants felt that this was often ignored by hostel staff. Although some participants detailed relationships that could be violent and volatile, the research highlights that homeless drug users can and do engage in positive relationships and suggests that services that do not recognise this may be exacerbating the social exclusion felt by homeless drug users.

In a further analysis of the same study[230] (Nettleton, Neale and Stevenson 2012), the authors hypothesised that, as sleep is shaped by socio-economic position, homeless drug users may struggle to secure enough sleep. Even in recovery participants reported disrupted sleep because of disturbing memories, which resulted in continuing feelings of danger in new and safe environments. A theme amongst all participants was the diversity of sleeping localities. Often it was preferable to sleep on the streets as hostels were perceived as hostile

[228] 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/2015800.xls

[229] Data collection took place in South Central England. The sample comprised of 40 participants, some of whom were in a relationship at the time, while the remainder had past experiences of a relationship whilst homeless Thirty-six participants reported either heroin or crack cocaine as their primary drug. Cocaine powder, amphetamines, mephedrone, ketamine and cannabis were also mentioned as either primary drug or other commonly used drugs.

[230] The authors used qualitative data that had been collected to examine the support needs of homeless drug users (HDUs) in emergency hostels. Interviews were conducted with 40 HDUs in 2010-2011 with an age range of 21 to 54 years old. Maximum variation sampling was used to recruit participants from towns and cities in southern England.

environments as some residents were violent, there was constant noise and participants reported being abused and intimidated. The authors argue that for homeless drug users sleep is a risky action. Therefore, emergency hostels must be able to provide a safe and secure environment with minimal noise and disruption so that homeless drug users can benefit from them. Additionally, homeless drug users should be able to access other services through staying at emergency hostels and shelters.

8.3.2 Education and training

As part of changes to the welfare benefits system, the Work Capability Assessment (WCA)[231] was introduced in October 2008 to assess a claimants' entitlement to the Employment and Support Allowance (ESA) on the grounds of illness or incapacity.[232] The WCA is reviewed independently each year to look at the experiences of drug users. As of 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.

Wales: peer mentoring scheme[233]

The European Social Fund (ESF) 'Peer mentoring' scheme in Wales began in October 2009 and will be funded until September 2013 (see UK Focal Point Report 2011). The ultimate aim of the service is to support people who have alcohol or substance misuse issues achieve economic independence through paid work. Participants receive support from Peer Mentors, many of whom have suffered from substance misuse issues themselves, in identifying employment, training and volunteering opportunities. Six substance misuse service providers have been contracted to deliver the service across all regions in Wales and there is currently a protocol in place between the providers and the Job Centre Plus regarding referrals into the service.

It was announced in May 2012 that the scheme is due to be expanded to raise awareness of substance misuse issues in the workplace. A final evaluation report is to be provided by the University of Glamorgan and related partners in December 2013.

8.3.3 Employment

Legislation

As part of the *Welfare Reform Act 2012 Universal Credit Regulations 2012,* a new out-of-work benefit will be introduced in place of six existing benefits. In order for claimants, who are unable to work due to their drug addiction, to claim Universal Credit, they must be 'receiving or participating in a structured recovery orientated course of drug addiction treatment, for a period of up to six months'.

[231] See: http://www.dwp.gov.uk/policy/welfare-reform/employment-and-support/wca-independent-review/

[232] Employment and Support Allowance (ESA) was introduced on 27th 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.

[233] The Peer Mentoring scheme is a European Social Fund Initiative with the Welsh Government which aims to provide additional wrap around support for adult substance misusers who have or who are completing treatment.
See: http://wales.gov.uk/topics/housingandcommunity/safety/substancemisuse/peerment/?lang=en

The Work Programme

Data from DWP show that, between 1st June 2011 and 31st January 2012, 1,150 people who have been identified as having drug problems were referred to the Work Programme[234] (HC Deb 17 July 2012 c772W).

In 2009, the Department for Work and Pensions (DWP) introduced a system of voluntary referrals to discuss treatment options for Jobcentre Plus (JCP)[235] customers who were opiate or crack cocaine users. A low number of referrals led to the implementation of the Intensive Activity (IA) trial,[236] which aimed to explore whether JCP could work more closely with treatment providers to improve the service offered. The trial extended access for referral to customers misusing any drug. DWP's evaluation of the trial (Fisher 2011) aimed to explore views of JCP and treatment professionals to assess whether IA has the potential to increase identification and referrals of clients with drug misuse issues. Qualitative findings from focus groups and interviews[237] indicated that treatment provider presence in JCPs was viewed by both staff groups as: positive; reassuring; improving customer reactions; being central to increasing referrals; and providing an environment which enabled closer working relationships. In addition, staff felt more comfortable raising the issue of treatment with substance misusing customers when treatment providers were present. Additional positive reactions from customers were experienced when a 'Drug Champion' from the JCP conducted outreach in the treatment provider's premises. Barriers to referrals included: restrictions on treatment providers' activities within the JCPs due to health and safety risk assessments; and difficulty in achieving existing JCP targets with an increased workload. Quantitative findings indicated increases in the number of referrals in all three JCPs during the trial. However, there were smaller increases than had been hoped for by the JCPs. The author suggests that JCPs might find it hard to justify adopting IA after such limited increases in referrals. However, the trial did highlight some lessons for best practice, including having effective 'Drug Champions' in each JCP and a closer working relationship between JCPs and treatment providers.

8.3.4 Families

Scotland's national drugs strategy, the *Road to Recovery* (Scottish Government 2008a) included 17 actions on *Children Affected by Substance Misusing Families.* In their first annual report, the Drugs Strategy Delivery Commission (DSDC 2012; see section 1.3.2) suggested three areas where further work needs to be done: better quality and reliability of national data on Children Affected by Parental Substance Misuse; better evaluation of the effectiveness of cross-cutting work at national and local level; and the governance and accountability of local delivery. In July 2012, the consultation on updated *Getting our Priorities Right* practice guidance was published. This is aimed at all service providers and practitioners who work with children, young people and families where problematic alcohol and/or drug use is a factor.

The Scottish Families Affected by Drugs (SFAD) is a charitable organisation and works with families at a local and national level across Scotland advocating and promoting the essential role of families and communities in supporting sustained recovery from problem drug use. SFAD raises awareness of the issues associated with drug misuse; provides information

[234] The Work Programme provides tailored support for claimants who need more help to undertake active and effective job-seeking.
[235] As part of the Department for Work and Pensions, Jobcentre Plus aims to support those of working age from welfare into work.
[236] Three Jobcentres were selected for the trial as they had a number of drug misusing clients who were not in treatment and were therefore, viable for referral. They also had a low record of previous referrals. The trial took place for eight weeks in two centres and four weeks in one centre with treatment providers present for several sessions per week.
[237] Interviews were conducted after the IA trials with stakeholders in each JCP.

through seminars and training events for families and family support groups; and provides constant access to support through their national helpline, email service and website.

Troubled Families Programme

The Department for Communities and Local Government (DCLG) have published a financial framework for the Troubled Families programme in England (DCLG 2012). The programme aims to incentivise and encourage local authorities, through Payment-by-Results (PbR), to work with 'troubled families' by providing intensive support. The framework provides information on the criteria that should be used when deciding which families to include in the programme. Families will have to meet five out of seven criteria to be classified as 'troubled' including: involvement in crime or anti-social behaviour; parents with addiction; and households affected by truancy and/or exclusion from school. The next criteria for families for further consideration are those who have an adult who is receiving out of work benefits. Although some households that are affected by drug misuse may qualify under the above criteria, drug and alcohol misuse is also cited as a particular priority health need, which should be considered when planning which families to include in the programme. The Annual Review of the Drug Strategy 2010 states that the Government will make £448 million available over the next three years (2012-2015) to support the programme (HM Government 2012a).

Wales

Integrated Family Support Services (IFSS)

In Wales, IFSS[238] 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 2010b). An evaluation of the project in four pilot areas is underway and is due to be completed in 2012/13.

Adult Family Members (AFMs) affected by drug misuse

The UK Drug Policy Commission (UKDPC) carried out a two-phase programme of work on adult family members affected by drug misuse, the first of which is reported in the UK Focal Point Report 2010 (Copello et al. 2009). The second phase comprised three elements: an on-line survey of current provision of UK services for adult family members of drug users: a qualitative study of services in England and Scotland, and a review of the policy and guidance of services in the UK. These were then synthesised in a policy overview *The Forgotten Carers: Support for adult family members affected by a relative's drug problems* (UKDPC 2012e).

Quantitative survey of current service provision for AFMs

The aim of the survey (Copello and Templeton 2012) was to provide an overview of the services available to adult family members (AFMs) of drug misusers in the UK.[239] All respondents worked with AFMs of drug misusers in some capacity and nearly one-quarter (n=61) worked solely with them, and these were mainly in non-statutory services (91%). Most of the remaining respondents (58% of respondents) provided support to AFMs as part of a wider service for drug misusers. Overall, 70% of responses were from non-statutory

[238] See: http://wales.gov.uk/topics/childrenyoungpeople/parenting/help/ifst/?lang=en.

[239] An online questionnaire about services provided for AFMs and the nature of these services was distributed across the UK through a wide range of networks to try and obtain as complete coverage as possible. A total of 352 responses were received, of which 253 were valid and included for analysis. Responses from England accounted for 57% (n=145) of the total responses, Scotland accounted for 28% (n=72), Northern Ireland for 8% (n=19), and Wales for 7% (n=17). There was no relationship between the number of responses and the total adult population of a region, or the number of adults receiving treatment for drug misuse.

service providers. Services that worked solely with family members tended to be smaller with nearly three-quarters reporting nine or fewer members of staff compared to 56% of services overall. There was a wide variation in the amount of time devoted to supporting AFMs in each service and the main services offered were basic information and signposting, structured therapeutic interventions were offered by less than a third of all services. Respondents were optimistic about the future of AFM support services with 60% of them believing that service provision would increase in the next 12 months. There was a general consensus that more needs to be done to cover the full range of AFM needs.

Qualitative study of AFM service provision in England and Scotland

Interviews were carried out with commissioners and service providers in England and Scotland to complement the quantitative survey data and to provide a more in-depth view of the characteristics of services available to AFMs (Copello et al 2012).[240] A review of local treatment plans found that the majority of plans were committed, in broad terms, to developing services for families and carers. However, the focus was more on children of substance misusing parents than on AFMs. Generally, there was a lack of detail on how specific needs would be met. A number of recurring themes were identified in interviews with commissioners in England and ADP co-ordinators in Scotland. Themes were categorised as: knowledge and understanding of the problem; commissioning processes; challenges/barriers to involving families; and service delivery. The results of the interviews indicated that, in both countries to varying degrees in each area, there is room for improvement in terms of understanding the issues around AFMs. It is reported that service provision varies across areas and the treatment system is underdeveloped when providing further services for AFMs. Finally, a comparison of the service provision in each area was made against a template of comprehensive provision produced in phase 1 of the UKDPC study (see UK Focal Point Report 2010). This indicated that, as a whole, service provision was underdeveloped, there was a lack of robust prevalence assessments, implementation of evidence based interventions was low and service responses were varied.

Review of policy and guidance

The aim of the review (Templeton and Copello 2012) was to explore the extent to which AFMs of drug misusers were mentioned in UK policy and guidance. The review looked mainly at illegal drugs policy and five overlapping areas: families and carers; children and safeguarding; domestic abuse; mental health and criminal justice.[241] Thematic analysis considered three main issues: acknowledgement of the issue and its impact; involvement and planning of family services alongside the drug misusers' treatment; and treatment and support for AFMs. The authors highlighted that the issue and its impact had been acknowledged in UK policy and guidance but there was less, or underdeveloped, detail on how to actually support and involve AFMs. Policies on carers, children and families were more likely to contain details of good practice on the subject of supporting AFMs. Any progress that had been made was through the Hidden Harm and Every Child Matters agendas. The authors also argued that some of the support that was provided to AFMs was

[240] Four Drug Action Teams (DATS) were selected from each of five English regions: East Midlands; West Midlands; London; South West and North East and the main drug service commissioner was identified for each area. For all parts of the analyses, all 20 areas in England were included and a total of 43 interviews were completed. In Scotland, three cities, two semi-rural and three rural areas were selected through a consultation with key informants. Commissioners and service providers were from eight areas in England and from eight ADPs in Scotland.

[241] Documents from England and the devolved administrations were included (and one from the Isle of Wight). A total of 50 documents were reviewed including policies, consultation documents and guidance. In England, documents were from the previous Labour Government and the current Coalition Government. In Scotland, documents from the former Scottish Executive and current Scottish Government are included.

focused more around the drug misusing client rather than the AFMs in their own right such as helping AFMs to support the client while they are in treatment.

Parents under Pressure

The Parents under Pressure (PuP) scheme in Scotland aims to address the danger faced by young children in families where one or both parents abuse drugs or alcohol, through an intensive home-based programme. Staff help parents to build parenting skills and develop strong caring relationships with their babies and young infants. Staff can report signs of abuse and are also available to parents if emergency support is needed. The Scheme is currently being rolled out in the Central Belt of Scotland and is supported by NSPCC Scotland.

Parental Substance Misuse

The Institute for Research and Innovation in Social Sciences has developed a *Leading for Outcomes: parental substance misuse* guide intended for anyone working with Scottish families for whom parental substance misuse is an issue (IRISS 2012). This also includes families where there are children living or visiting the family home or where reunification of the family is a goal. The publication is part of a 'Leading for Outcomes' series which aims to support team leaders, managers and trainers to lead teams in the adoption and implementation of an outcomes-focused approach. The document includes ten exercises with sets of training materials for team leaders to direct their team through. The exercises focus on: defining the approach and promoting the benefits of outcomes in parental substance misuse; challenges and concerns around the outcomes approach; tackling secrecy and denial through the therapeutic relationship; family strengths and values; setting outcomes; negotiating outcomes; brainstorming for solutions; parents' social and community networks; different agencies working together; and motivating families through positive progress feedback.

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

9.1 Introduction

Drug use is not a crime in the United Kingdom, but possession, production and dealing, as well as trafficking (including importation and exportation) are specific offences under the *Misuse of Drugs Act 1971*. Recorded drug crimes, after increasing following the introduction of the cannabis warning in England and Wales in 2004, have decreased in the past three years, which coincides with the removal of the police target regime. The number of persons dealt with by the courts or cautioned for drug offences has risen since 2005; mainly for cannabis and cocaine powder related offences, although the latter decreased in 2010. 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. Despite the complexity of the drugs-crime relationship, there is research evidence of the link between drug use, particularly use of heroin and crack cocaine, and acquisitive crime (Boreham et al. 2007). Around two-thirds of those in custody are reported to be recent drug users with an estimated 40% of prisoners received into custody being problematic drug users, 40% of whom identify themselves as people who inject drugs (Stewart 2008).

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 88,000[242] into drug treatment in 2011/12. 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.

In Scotland, there are a number of interventions at different levels of the criminal justice system, including diversion from prosecution to drug treatment/education, community payback orders with a drug treatment requirement, Drug Treatment and Testing Orders (DTTOs) for particularly high tariff offenders who are entrenched in their drug use, as well as services for prisoners post-release, including Throughcare Addiction Services. DTTOs provide offenders with access to treatment services which they are required to comply with, combined with regular progress reviews from the Court. A less intensive version (DTTO II) has been developed for lower tariff offenders and rolled out on a pilot basis in Edinburgh and Lothians from June 2008.

There is a range of measures to prevent drugs entering prison including clearly-defined searching procedures covering all possible routes; passive and active drug dogs, with passive dogs available to all prisons; CCTV surveillance of all social visit areas and low-level fixed furniture; and comprehensive measures to tackle visitors attempting to smuggle drugs, including closed visits, visit bans and police arrest. Recently introduced initiatives include drug free wings and further developments of mobile phone signal denial equipment, including the *Prisons (Interference with Wireless Telegraphy) Bill*.

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

[242] 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.

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 both clinical and non-clinical drug and alcohol treatment in all prisons and the community in England with responsibility for commissioning substance misuse services devolved to local partnerships in line with the key Patel Review recommendation that integrated and needs led treatment services are best commissioned at a local level. In Wales health services are the responsibility of the Welsh Government. As such, NOMS retains responsibility for its non-clinical substance misuse services in Wales, with clinical services being delivered by the NHS in Wales as part of the Welsh Government's devolved responsibilities. In Scotland, responsibility for health care in prisons was transferred to the National Health Service in November 2011.

Those in prison have access to HIV and hepatitis testing, and vaccination against hepatitis B. Naloxone is increasingly available for prisoners at risk of drug overdose on release from prison.

9.2 Drug law offences

Data on drug law offences are available at various points in the criminal justice system. Recorded crime data count the number of drug offences brought to the attention of police and represent the widest measure of drug offences available in the UK. However, at present the individual drug involved is not recorded (except for cannabis possession offences). Arrests data record the number of persons who are arrested for a drug offence and represent a smaller proportion of drug offences since some penalties such as formal warnings for cannabis do not constitute an arrest. These data are not available by drug or by offence type. Finally, convictions data record the number of offences where an individual is found guilty at court or cautioned for a drug offence. Data from each level of the criminal justice system cannot be compared for a number of reasons including: time lag between offence and conviction; the basis on which the data are provided (offender or offence); counting rules[243]; and year of data (calendar or financial year). Further information on the recording of drug offence data are contained in a selected issue chapter on sentencing statistics in the UK Focal Point Report 2008.

The recording of drug offences is dependent on police activities and priorities and is not a reliable indicator of the level of drug offending.

9.2.1 Recorded drug crime

The number of recorded drug crimes in the UK decreased by one per cent in 2011/12 (Table 9.1). There were variations across the UK with increases in Northern Ireland (8%) and Scotland (2%) and a decrease in England and Wales (-2%). In Scotland the increase was for possession offences with a decrease in trafficking offences while in Northern Ireland there were increases for both possession and trafficking offences. In England and Wales the decrease in possession offences was mainly for drugs other than cannabis while in Northern Ireland the increase in possession offences was mainly accounted for by an increase in cannabis offences. In England and Wales the number of possession offences for both cannabis and other drugs peaked in 2008/09. The decrease in recorded drug offences in England and Wales since 2008/09 coincides with the end of the national target regime for police (Chaplin et al. 2011). This demonstrates the impact of police priorities on recorded drug offences.

[243] See: http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/counting-rules/count-drug?view=Binary

Table 9.1: *Recorded crime: Drug offences in the United Kingdom by offence type and country, 2004/05 to 2011/12*[244]

	Year							
	2004/05	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**2011/12**
England and Wales								
Trafficking*	24,190	25,276	26,550	28,323	29,885	33,234	32,336	31,339
Possession	120,866	152,602	167,003	200,773	212,528	201,240	199,444	196,638
Other drug offences**	781	601	680	816	1,123	1,122	1,142	1,126
Total offences	*145,837*	*178,479*	*194,233*	*229,913*	*243,536*	*235,596*	*232,922*	*229,103*
Northern Ireland								
Trafficking	375	349	475	530	607	668	762	846
Possession	2,246	2,594	1,934	2,186	2,364	2,472	2,708	2,924
Other drug offences	1	1	4	5	3	6	15	10
Total offences	*2,622*	*2,944*	*2,413*	*2,721*	*2,974*	*3,146*	*3,485*	*3,780*
Scotland								
Trafficking	9,333	9,613	10,890	9,827	10,315	9,901	7,138	6,684
Possession	32,268	34,440	31,329	30,559	31,805	29,179	26,960	28,326
Other drug offences ***	222	194	203	360	389	328	249	147
Total offences	*41,823*	*44,247*	*42,422*	*40,746*	*42,509*	*39,408*	*34,347*	*35,157*
United Kingdom								
Trafficking	33,898	35,238	37,915	38,680	40,807	43,803	40,236	38,869
Possession	155,380	189,636	200,266	233,518	246,697	232,891	229,112	227,888
Other drug offences	1,004	796	887	1,181	1,515	1,446	1,406	1,283
Total offences	*190,282*	*225,670*	*239,068*	*273,379*	*289,019*	*278,140*	*270,754*	*268,040*

* Trafficking usually includes production, supply, possession with intent to supply, possession on a ship, carrying on ship and unlawful import and export.
** For England and Wales, and Northern Ireland 'other drug offences' mainly concern permitting premises to be used for the production, supply and use of drugs.
*** For Scotland 'other drug offences' include production and manufacture of drugs (not illegal cultivation), offences related to money laundering, and other drug offences not designated as trafficking or possession.
Source : Taylor et al. 2012; Chaplin et al. 2011 PSNI 2012; Scottish Government 2012a

Cultivation offences

Data from Scotland show that there has been a large increase in recorded cultivation offences since 2006/07 from 437 to 1,242 in 2011/12 (Scottish Government 2012a). This corresponds to an increase in the number of cannabis plant seizures from 304 in 2006/07 to 970 in 2010/11, the last available year of data (Scottish Government 2008e; 2012d; see section 10.3.1). Analysis carried out by the Association for Chief Police Officers (ACPO) suggest that there were 14,982 cannabis production offences in the UK in 2010/11 (ACPO 2012; see section 10.3.3).

9.2.2 Arrests for drug offences

The number of arrests for drug offences in England and Wales continued to increase in 2010/11 with a three per cent increase on the previous year (Table 9.2).[245] There were around 125,000 arrests for drug offences in 2010/11, constituting nine per cent of all arrests and up to 14% in some regions. Drug offences accounted for six per cent of all arrests in 2006/07, since when arrests for drug offences have increased by 40%. Although recorded drug crime has also risen during this time (Table 9.1), the increase has been smaller at around 20% for both possession and trafficking offences. This may suggest the greater use of arrest when dealing with drug offenders. Of those arrested for drug offences, 12% were under the age of 18 with 28% under the age of 21 years old.

[244] 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.
[245] See: http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/police-research/immigration-tabs-q4-2011/stops-searches-1011-tabs

In Northern Ireland, arrests for drug offences have also increased, by eight per cent since 2009/10. The increase in Northern Ireland has been more gradual than in England and Wales where there was a large increase between 2006/07 and 2007/08.

Table 9.2: *Number of persons arrested for drug offences in England and Wales, and Northern Ireland, 2003/04 to 2010/11*

	Year							
	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
England and Wales	113,100	84,800	88,600	89,200	104,500	115,300	121,000	124,900
Northern Ireland	1,754	1,356	1,440	1,726	1,896	2,014	2,250	2,435
Total	*114,854*	*86,156*	*90,040*	*90,926*	*106,396*	*117,314*	*123,250*	*127,335*

Source: Home Office Arrests Table A.02 ; PSNI 2004; 2006; 2008 ; 2010 ; 2011

Stop and searches for drug offences

In 2010/11 there were almost 600,000 stop and searches for drugs carried out by the police in England and Wales accounting for almost half of all police stop and searches for any reason (Home Office 2012d). This is a five per cent increase on the previous year and continues a trend of increased use of this power. Almost half of the drug searches recorded were carried out in London. Overall, a stop and search for drugs resulted in an arrest in seven per cent of cases across England and Wales with the British Transport Police, South-East England, London, and East Midlands below the national average. This compares to a 12% arrest rate for searches for non-drug reasons. The number of arrests as a result of drugs stop and search was 41,961.

9.2.3 Convictions and cautions for drug offences

There were 152,451 drug offences where the person was found guilty at court or cautioned in the United Kingdom during 2010 (Table 9.3; ST11). This represents a four per cent increase on the previous year (n=147,013) and resumes the upward trend that was evident between 2005 and 2008. Convictions for almost all drugs apart from cannabis decreased or remained stable with cocaine powder offences decreasing by 11% and ecstasy offences decreasing by 50%. The number of heroin offences remained stable.

Cannabis offences continued to increase by 13% since the previous year with cannabis offences now accounting for half of all drug cautions and court convictions and wholly responsible for the increase in total drug offences. Cannabis trafficking offences increased by 41% from 11,054 in 2009 to 15,534 in 2010. This is likely to be due to the continued increase in the number of cannabis farm discoveries and related production offences (ACPO 2012; see section 9.2.1 and 10.3.3).

Table 9.3: *Drug offences where the offender was found guilty or issued a caution in the United Kingdom, 2002 to 2010 by individual drug*

	Year								
	2002	2003	2004	2005*	2006*	2007*	2008*	2009*	2010*
Amphetamines	5,820	6,163	6,249	6,864	7,422	7,478	7,822	7,096	7,487
Cannabis	83,152	85,768	82,845	54,813	55,984	55,563	63,103	66,598	75,284
Cocaine powder	6,990	7,905	9,382	12,028	15,470	19,216	22,874	22,529	20,034
Crack cocaine	1,830	2,270	2,450	3,734	4,076	4,613	5.895	4,241	3,679
Ecstasy	6,590	5,940	6,209	6,337	6,233	7,189	5,107	3,608	1,812
Heroin	11,860	11,277	12,412	15,629	15,741	16,557	17,926	16,354	16,648
LSD	90	150	90	183	172	165	156	106	69
Total	*113,465*	*117,532*	*122,459*	*118,706*	*124,344*	*135,655*	*146,909*	*147,013*	*152,451*

* Data since 2005 are on an all offence basis; data for 2000 to 2004 are based on principal drug offence.

Source: Standard Table 11

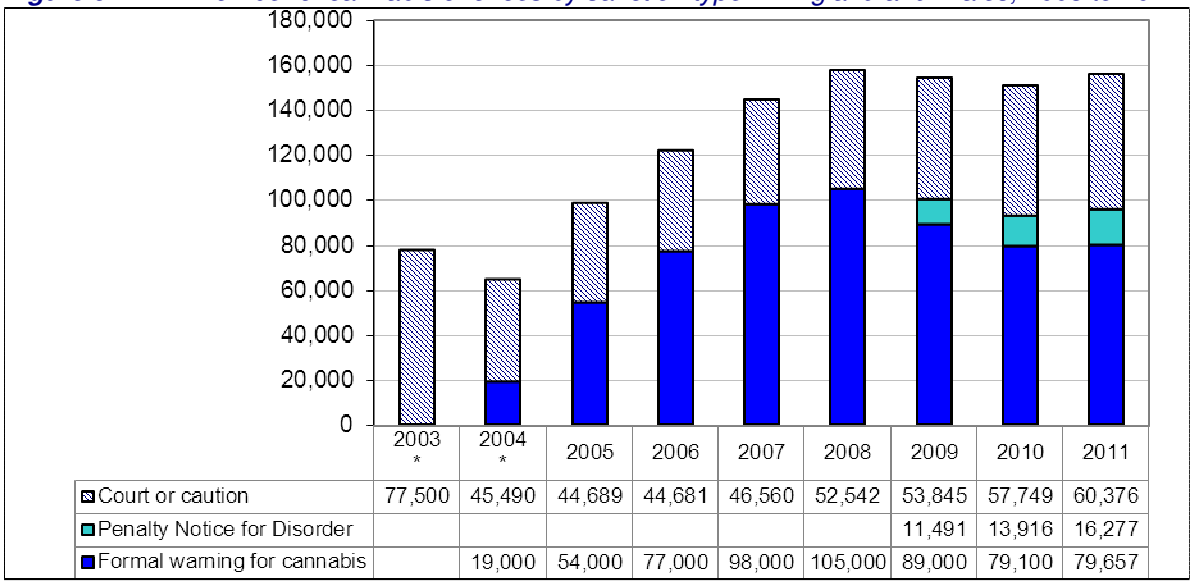
9.2.4 Convictions, cautions and administrative penalties for cannabis possession in England and Wales

While the number of convictions (at court or cautions) for cannabis possession in 2010 (n=59,750) is 26% lower than in 2003 (n=80,656) before the introduction of the formal warning for cannabis[246] in England and Wales, the number has increased by 24% since 2007 (n=48,299) (ST11). This suggests that more punitive sanctions are being used to deal with cannabis possession offences. Data from England and Wales show that there was a seven per cent increase in cannabis possession offences dealt with by a caution or in court between 2009 and 2010 with a corresponding seven per cent decrease in the use of non-criminal sanctions such as the formal warning for cannabis and the penalty notice for disorder[247] (Figure 9.1). Although the total number of cannabis possession offences dealt with by law enforcement (either through criminal or administrative measures) decreased between 2009 and 2010 (from 154,336 to 150,765), the number remains almost twice as high as before the introduction of the formal warning for cannabis (n=77,500). This is despite a decrease in reported cannabis use over the period (see section 2.2 and Trends Analysis section).

[246] The formal warning for cannabis possession was introduced in January 2004

[247] Penalty notices for disorder were introduced for cannabis possession offences in January 2009.

Figure 9.1: *Number of cannabis offences by sanction type in England and Wales, 2003 to 2011*



	2003 *	2004 *	2005	2006	2007	2008	2009	2010	2011
Court or caution	77,500	45,490	44,689	44,681	46,560	52,542	53,845	57,749	60,376
Penalty Notice for Disorder							11,491	13,916	16,277
Formal warning for cannabis		19,000	54,000	77,000	98,000	105,000	89,000	79,100	79,657

*Data since 2005 are on an all offence basis while previously they were based on principal drug offence

Source: Standard Table 11; MOJ 2011a

9.2.5 Other drug-related crime

Supply of cutting agents

The Serious Organised Crime Agency (SOCA) has been tackling the supply of cutting agents used in the illicit drug trade. In 2011/12, three men were sentenced for a total of 44 years for importing 26 tonnes of cutting agents. The men were found guilty of conspiring to supply cocaine, diamorphine and amphetamine, the first time such a charge has been applied to those supplying large quantities of cutting agents (SOCA 2012a). Other successful prosecutions for the supply of cutting agents have been reported in 2012 using the offence of 'committing an act capable of assisting the commission of an indictable offence (i.e. supplying controlled drugs), believing that an offence would be committed and that the act would assist in the commission of it, contrary to section 65 (sub-section 45) of the *Serious Crime Act 2007'.*[248]

Drug driving

The Government announced its intention to create a specific offence of driving above specified limits of specified drugs in a person's body (see section 1.2.4).

The Association of Chief Police Officers (ACPO) reported that during the month of December, 540 Field Impairment Tests (FIT)[249] were conducted, 17% of which resulted in an arrest for drink or drug driving.[250]

Homicides

Data from Scotland show that, in 2010/11, five per cent of the 138 people accused of homicide reported that they were 'on drugs' at the time of their offence with a further 14% 'drunk and on drugs' (Scottish Government 2011c). Combining both of these, almost one in

[248] See:http://content.met.police.uk/News/Brothers-jailed-for-role-in-drugs-supply/1400008956232/1257246741786

[249] Field impairment tests are tests of sobriety, which can be undertaken at the roadside or police station. They consist of five tests. See: http://drugdrive.direct.gov.uk/testfordrugs.shtml

[250] See: http://www.acpo.presscentre.com/Press-Releases/More-than-7-000-arrested-during-ACPO-Christmas-drink-and-drug-driving-campaign-14a.aspx

five of accused persons were 'on drugs' compared to half of the accused who reported being drunk. The role of alcohol and drugs in homicide cases may be higher since the alcohol/drug status was unknown in 30% of cases. If the unknowns are excluded, 72% of those accused of homicide were drunk and 27% were 'on drugs'.

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. The government allocated £97 million[251] to local areas for the operation of DIP in 2012/13, a 17% decrease since 2009/10.[252] From April 1st 2013, central funding for DIP will cease and it will be for individual Police and Crime Commissioners (PCCs) to decide which (if any) measures to address drug-related offending will be funded.

DIP data show that, in 2011/12, around 88,000 individuals were helped into drug treatment and recovery services, including non-structured treatment in England. Treatment data show that, in 2010/11, there were 9,926 adults entering structured treatment from arrest referral/DIP in England,[253] accounting for 14% of all those entering treatment. This is slightly lower than in 2009/10 (n=10,626) but accounting for a similar proportion of all new treatment entrants (13%) (NTA 2011b).

Data from Wales show that in 2010/11 there were 2,937 referrals to DIP, 98% of which were added to the DIP caseload. As part of the 'Tough Choices' programme, police in five areas in Wales[254] are able to drug test offenders if they are arrested for certain trigger offences. Data from 2010/11 show that 29% of tests were positive for opiates or cocaine, 16.5% for opiates alone, 9.0% for cocaine alone and 4.5% for both (Welsh Government 2012c).

Research on policing and the Drug Interventions Programme (DIP)

Hancock et al. (2012) carried out an exploratory study looking at police experiences with DIP in three basic command units within the Southern policing region in England.[255] They found a different approach to policing and DIP interventions across the three areas with one area having a comprehensive approach incorporating enforcement, arrest, and treatment referral while another area had little involvement with DIP or treatment agencies preferring to focus on the disruption of retail drug supply and the targeting of dealers. In the third area, the authors state that process issues hampered the use of conditional cautions and the lack of referral workers in custody suites also prevented use of the full range of actions available through DIP. The authors conclude that further research is required looking at the consistency of the application of DIP and related initiatives across the UK in order to provide best practice examples and to assess impact and value for money.

[251] See: http://www.homeoffice.gov.uk/publications/about-us/non-personal-data/drugs/dip-grants/?view=Standard&pubID=908020

[252] Information on the calculation of the DIP main grant can be found in Appendix D here: http://www.nta.nhs.uk/uploads/dip_operational_handbook.pdf . The funding model is complex and takes into account, amongst other factors, the level of acquisitive crime. Decreases in crime levels may, therefore, lead to decreases in funding.

[253] Structured treatment only. This cannot be compared to the DIP figure, which includes non-structured treatment.

[254] Cardiff, Swansea, Newport, Carmarthenshire and Wrexham.

[255] Using a case study approach, qualitative semi-structured interviews were held with a purposive sample of informants including police custody support managers, drug treatment service outreach workers, and police officers in three Basic Command Units (BCUs).

9.3.2 Police and Crime Commissioners in England and Wales

On 15th November 2012, Police and Crime Commissioners (PCCs) will be elected in England and Wales.[256] They will determine local policing priorities, set the budgets for their local police force and will have powers to commission community safety activities. In 2013-14 PCCs will receive some funding from the un-ringfenced temporary Community Safety Fund, which they can use to commission community safety services which meet their local priorities. A briefing for the drug and alcohol sector on the role and potential impact of PCCs has been published by DrugScope (DrugScope 2012).

9.3.3 Re-offending and re-conviction

Although sometimes used interchangeably, there is a difference between re-offending and re-conviction. It is difficult to measure the level of re-offending without self-report data. Data provided here generally refer to re-conviction.

Drug Data Warehouse

The Drug Data Warehouse (DDW) is a project that linked together data from a number of criminal justice and drug treatment datasets to create a single anonymised database.[257] A report describing the construction of the DDW and containing descriptive analysis has been published (Millar et al. 2012). The findings show large overlaps of individuals between drug treatment and the criminal justice system (CJS). While treatment data show the key role the CJS has in referring drug users to treatment, results from the DDW show that 43% of individuals identified as an opiate and/or crack cocaine user in the database had contact with the CJS only and did not appear in treatment databases over the period covered. Other analyses showed that around one-third of those who tested positive in a DIP test[258] during this period had another positive test within 12 months and a similar proportion of those finishing a treatment episode re-presented to treatment within 12 months.

Using data from the Drug Data Warehouse, the National Treatment Agency on Substance Misuse (NTA) carried out an analysis looking at the differences between conviction rates of adult offenders during the two years before their initial assessment for drug treatment and the two years after (NTA 2012g).[259] Of the 19,570 individuals included in the study who had been convicted of a 'trigger' offence[260] or solicitation in the two years prior to initial assessment, 41% had no re-convictions in the two years following assessment. Amongst those retained in treatment for the full two years there was an average reduction of 47% in convictions and those successfully completing treatment after being retained in treatment for six months or more showed a similar reduction in convictions (48%). CJS referrals showed similar reductions in re-conviction as those who were self-referred, or referred from other sources. The authors conclude that, while reductions in convictions cannot be solely attributed to drug treatment due to the inability to control for confounding factors, the results nevertheless reinforce findings from previous studies showing a reduction in offending following treatment engagement.

[256] Police and Crime Commissioners will be elected for four years in each police force area. See: http://www.homeoffice.gov.uk/police/police-crime-commissioners/

[257] Records included all individuals identified through drug treatment programmes in England or the Criminal Justice System between 1st April 2005 and 31st March 2009 as being drug users of any illicit substance. Information on data sources is provided in the published report (Millar et al. 2012).

[258] Testing on arrest. Tests were for heroin or cocaine use.

[259] The analysis used an extract from the DDW consisting of NDTMS records and conviction records from the Police National Computer (PNC). Changes in patterns of conviction were explored for those starting treatment between 1st April 2006 and 31st March 2007.

[260] As defined in Schedule 6 of the *Criminal Justice and Courts Services Act 2000*. See: http://www.legislation.gov.uk/ukpga/2000/43/schedule/6

Costing the crime reduction benefits of drug treatment

As part of an assessment on value for money of drug treatment and recovery, the NTA assessed the crime reduction benefits of drug treatment (NTA 2012h). Data from the National Drug Treatment Monitoring System (NDTMS) were linked to the Police National Computer (PNC) and supplemented with data on self-reported offences from the Drug Treatment Outcomes Research Study (DTORS). DTORS asked a cohort of individuals starting treatment in 2006/07 about the volume and type of offence they had committed in the previous 28 days and asked the same question at follow-up (Jones et al. 2009). Assuming that: the pattern of offending in the last 28 days was the same as for the previous 12 months; all offending was drug-related; and scaling the volume of offences up to the whole population in effective treatment in 2010/11, it was estimated that drug treatment and recovery systems may have prevented around 4.9 million crimes in 2010/11. The estimated saving to society from the reduction in crime was £960 million. The model also suggested that a further 4.1 million offences may be prevented over a nine year period (from 2011/12 to 2019/20) at a cost saving to society of £700 million due to those leaving treatment in 2010/11 sustaining long-term recovery. For every £1 million taken out of the drug treatment system, the report estimates a £1.8 million cost to society from drug-related crimes. A presentation on how treatment and recovery systems reduce drug-related offending was also published.[261]

Re-offending in England and Wales

Data on re-offending is published quarterly in England and Wales.[262] The most recent data show that 57% of drug misusing offenders[263] identified between October 2009 and September 2010 re-offended within 12 months. This compares to 55% amongst those identified between October 2008 and September 2009. The average number of offences per re-offender was four. Despite an increase in the re-offending rate, the total number of offences committed by drug misusing offenders decreased due to a reduction in the number of drug misusing offenders identified. The number of offenders identified between October 2008 and September 2009 was 55,680 compared to 45,544 between October 2009 and September 2010.

9.3.4 Other commentary and research on prevention of drug-related crime

Drug enforcement in an age of austerity

The United Kingdom Drug Policy Commission (UKDPC) carried out a survey of police forces[264] to find out how police action to tackle drug-related problems may be impacted by financial austerity (Beck 2011). Participants reported that they expected drug-related policing expenditure and activity to decrease particularly proactive policing work.

Rehabilitating drug policy

A report aiming to address the question of what can be done better to reduce offending by drug addicts was published by a charity, Civitas[265] (Cowen 2012). Interviews were carried out with practitioners and advocates in the field of drug addiction and the author also consulted the evidence base. The report concluded that there are historic divisions between those advocating harm reduction strategies and those advocating abstinence based approaches and that both of these perspectives have strengths. The author admits, however, that the findings of the report may be limited by the partial examination of the

[261] See: http://www.nta.nhs.uk/uploads/vfm-crimepresentationvfinal.pdf
[262] See: http://www.justice.gov.uk/statistics/reoffending/proven-re-offending
[263] Drug misusing offenders are classed as those who have been given drug orders as part of their sentence or test positive for opiates on arrest.
[264] A survey was hosted on the Association for Chief Police Officers (ACPO)'s intranet. In total 29 police forces (74% response rate) responded and 52 other responses, mainly from Basic Command Units, were received. A workshop was also held with five officers from four police forces.
[265] See: http://www.civitas.org.uk/

evidence base and the fact that it represents the opinions and experiences of only a few practitioners in the drug treatment field.

9.4 Interventions in the criminal justice system

Drug offences: definitive guidance

In January 2012, the Sentencing Council published a definitive guideline on sentencing for drug offences (Sentencing Council 2012). The guideline covers both Crown and Magistrate's courts in England and Wales. As set out in the 2011 consultation document and in previous recommendations from the now defunct Sentencing Advisory Panel (Sentencing Council 2011; SAP 2010; see UK Focal Point Reports 2010 and 2011), the guide uses a matrix that assesses both the role of the offender (culpability) and the quantity of drug involved (category of harm) in setting an appropriate sentence. It is envisaged that the guideline will mean increased sentences for those found guilty of large-scale production and less harsh sentences for drug mules. Other changes include the addition of an aggravating factor of dealing to a person aged under 18 years of age.

Scotland

A review of interventions in the criminal justice system for drug misusing offenders and the effectiveness and cost-effectiveness of such interventions[266] was carried out on behalf of the Scottish Government (Malloch 2011). The review found that there has been an increasing number of CJS referrals to treatment and that engagement with treatment can reduce re-offending. In terms of the interventions available in Scotland, the author states that there is some evidence to suggest that Drug Courts and Drug Treatment and Testing Orders (DTTOs) are effective in reducing drug use and re-offending. However, there was insufficient evidence of the effectiveness of diversion from prosecution, arrest referral, prison throughcare, and low tariff DTTOs. The author concludes that there are problems measuring costs and outcomes and of attributing changes in behaviour to the intervention.

It should be noted that, in general, reconviction rates for DTTOs are relatively high due to the type of offenders who are subject to such orders. This has been falling over the past seven years: in 2002-03 the one year reconviction frequency rate was 241 reconvictions per 100 offenders, compared to 150 for the 2009-10 cohort (Scottish Government 2012f).

9.4.1 Sentencing for drug offenders

England and Wales, 2011

Of the 60,075 individuals sentenced for drug offences in England and Wales during 2011, 16% were given immediate custody (Table 9.4), a similar proportion to previous years. The vast majority of those convicted of import/export offences received immediate custody (93%) with an average sentence length of 90.5 months for Class A importation offences (Table 9.5). Half (52%) of those convicted at Court of a drug possession offence received a fine with one-fifth (19%) receiving a community sentence and three per cent receiving immediate custody.

[266] The review was carried out between August and November 2010. It aimed to map evidence related to CJS interventions for drug-misusing offenders and used all types of evaluation studies with some measure of effectiveness.

Table 9.4: *Number and percentage of offenders receiving each disposal for drug offence type in England and Wales, 2011.*

	Immediate custody		Suspended sentence		Community sentences		Fine		Other		Total sentenced	
	n	%	n	%	n	%	n	%	n	%	n	%
Import/export	618	92.9	29	4.4	6	0.9	7	1.1	5	0.8	*665*	*100*
Trafficking*	7,740	46.3	3,376	20.2	4,156	24.8	974	5.8	489	2.9	*16,735*	*100*
Possession	1,247	3.0	655	1.6	8,136	19.3	21,862	52.0	10,167	24.2	*42,067*	*100*
Other	76	12.5	125	20.6	194	31.9	108	17.8	105	17.3	*608*	*100*
Total	9,681	16.1	4,185	7.0	12,492	20.8	22,951	38.2	10,766	17.9	*60,075*	*100*

*Includes production, supply, and possession with intent to supply

Source: MOJ 2012a

The average sentence length for offenders given immediate custody increased with the seriousness of the offence with the shortest sentences for those convicted of possession offences and the longest for those convicted of importation offences (Table 9.5).

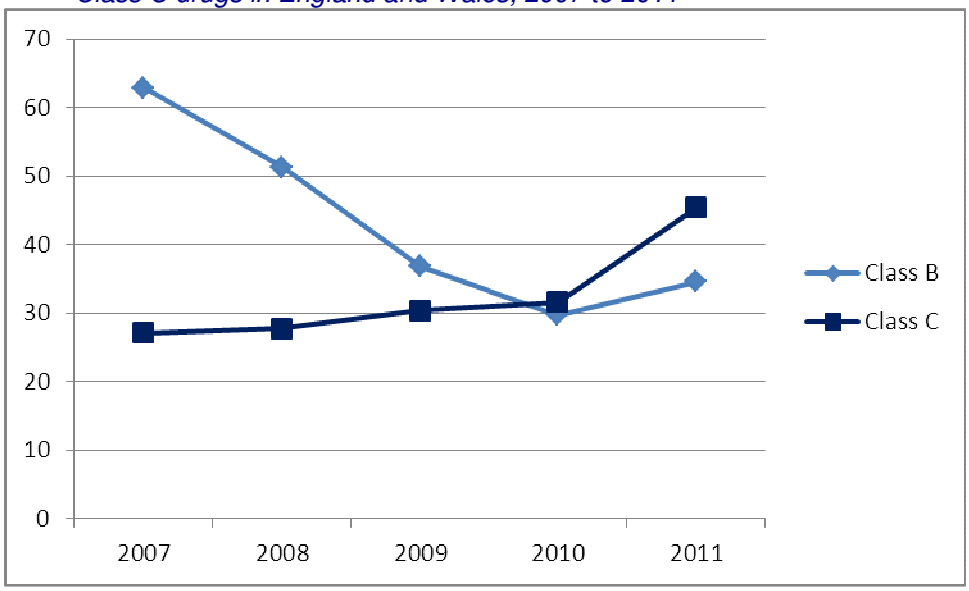
Table 9.5: *Average sentence length (months) for offenders given immediate custody in England and Wales, 2011 by offence type and drug class*

Drug class	Importation	Trafficking	Possession
Class A	90.5	40.6	5.2
Class B	34.6	17.6	2.3
Class C	45.4	19.4	2.1

Source: MOJ 2012a

Since the re-classification of cannabis from Class C to Class B in January 2009, the average sentence length no longer reduces with the class of drug. Figure 9.2 shows that the average sentence length for importation of Class B and Class C drugs converged around the time of the re-classification of cannabis and is now shorter for Class B offences than for Class C offences. This is similar for trafficking offences. While the circumstances surrounding individual cases cannot be determined by national statistics, this may suggest that cannabis offences are dealt with in a similar manner by the law courts regardless of classification. The new drug offence guidelines may have an impact on this trend.

Figure 9.2: *Average sentence length for those sentenced for the importation of Class B and Class C drugs in England and Wales, 2007 to 2011*



Source: MOJ Criminal Statistics 2007-2011

Scotland

In Scotland during 2010/11 there were 7,500 persons found guilty of drug offences at court, a two per cent decrease from the previous year (n=7,683).[267] This represents 86% of those proceeded against for drug offences and six per cent of all those found guilty of criminal offences (Scottish Government 2011d). Of those found guilty, 19% were sentenced to custody, 16% to a community sentence and 50% to a monetary penalty. The average sentence length of those given custody was 567 days, similar to previous years. Sixteen per cent of custodial sentences were three months or less with a further 16% between three and six months. The *Criminal Justice and Licensing (Scotland) Act 2010* introduced a presumption against short prison sentences of three months or less, which came into force on 1st February 2011.

9.4.2 Alternatives to prison

Drug Rehabilitation Requirement in England

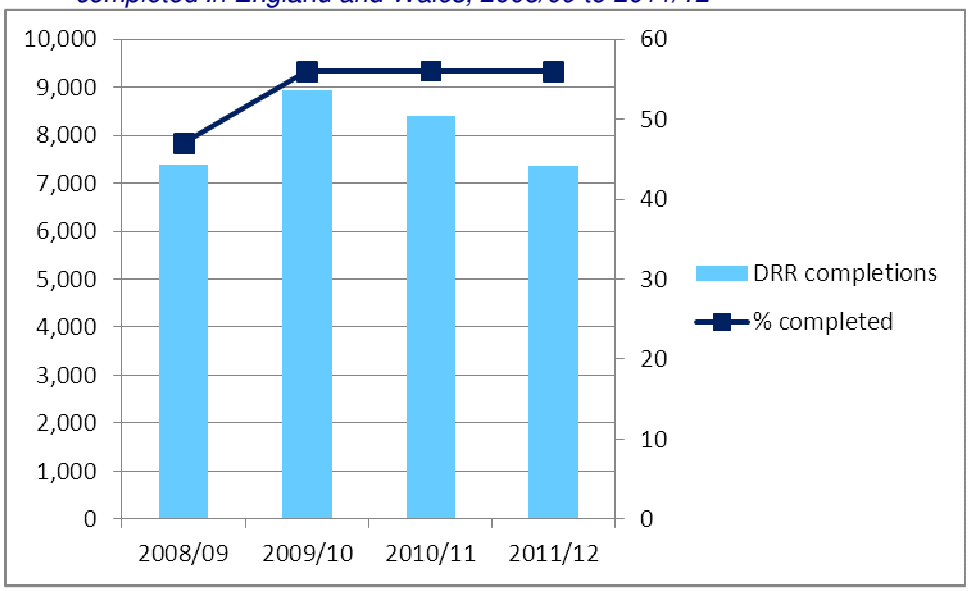
The Drug Rehabilitation Requirement (DRR) within a community order or suspended sentence of imprisonment is an intensive vehicle for tackling the drug misuse and offending of many of the most serious and persistent drug misusing offenders in England and Wales (SQ31). DRRs involve treatment, regular testing and court reviews of progress.

Data show that 13,602 DRRs were commenced in 2011, 9,857 as part of a community order and 3,745 as part of a suspended sentence order (MOJ 2012b). This represents a 15% decrease from 16,071 starts in 2010 and a 22% decrease from 17,457 starts in 2008. The decrease since 2008 is partly due to police initiatives, which divert offenders from charge and a change in focus from commencements to maximising completion rates. The fall in the last year partly reflected a reduction in court activity generally (the number of offenders starting community orders in 2011 was down 5 per cent from the previous year) but the most significant issue was the reduction in the numbers coming via arrest referral and testing on arrest, with significantly fewer positives for opiates/cocaine.

[267] From 2009/10, data 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.

Fifty-six per cent of DRRs were successfully completed in 2011/12 There were 7,360 successful DRR completions in 2011/12, a 12% decrease from the previous year (n=8,392) reflecting the decrease in DRR commencements (MOJ 2012c). There was no completion rate target in 2011/12 but the rate has remained stable for the past three years at 56% after increasing between 2008/09 and 2009/10 (Figure 9.3).

Figure 9.3: *The number of Drug Rehabilitation Requirement (DRR) completions and percentage completed in England and Wales, 2008/09 to 2011/12*



Source: National Offender Management Service (NOMS)

Intensive alternatives to custody in England and Wales

A process evaluation of intensive alternatives to custody (IAC) in five pilot areas in England and Wales found that many of the persistent offenders were positive about the use of the order (Wong et al. 2012). Those with drug and alcohol misuse problems suggested that the interventions they received had enabled them to regain some control and stabilise their substance misusing. Needs assessments across the five sites identified drug misuse in 48% of IAC offenders, a similar percentage as those not on an IAC suggesting that drug misuse was not a factor in an offender deciding to accept the order or not.

Alternatives to custody pilot

In England the Department of Health, the Ministry of Justice, HM Court Services, the National Offender Management Service and the Home Office are working together to take forward government proposals to invest in liaison and diversion services at police stations and courts to ensure that an individual's health needs or vulnerabilities are identified and assessed early and that they are linked to appropriate treatment services. Within this wider programme, an "Alternatives" pilot has been set up to test alternatives to custody at the point of sentencing, i.e. court based activity. The project is restricted to those offenders who have mental health problems, including personality disorder, and/or a substance misuse problem and whose index offence and risk of reoffending is of sufficient seriousness to attract a short prison sentence.

Four substance misuse pilots commenced in October 2011, focusing on offenders receiving DRRs as part of a community sentence. A further twelve pilots focusing on offenders receiving Mental Health Treatment Requirements began work in April 2012. The pilot sites bring together treatment (residential and community based provision), rehabilitation and restorative justice. The schemes seek to offer a balance between punitive elements and rehabilitation and include life skills training, gaining qualifications, peer support, and

wraparound support services. The Department of Health is conducting an evaluation of the health and criminal justice benefits of these schemes.

Scotland

There are a number of interventions at different levels of the criminal justice system in Scotland (SQ31). Malloch and McIvor (2012) reviewed the range of criminal justice interventions available in Scotland and assessed evidence of their effectiveness. They echoed previous concerns of net widening and concluded that, despite the advantages of dealing with drug-misusing offenders in the community rather than prison, there is still limited evidence related to outcomes. Malloch (2011) states that small sample sizes and the inability to identify control groups due to the nature of the interventions makes it difficult to evaluate the effectiveness of criminal justice drug interventions. However, evaluations of criminal justice interventions often find reductions in re-offending or the rate of re-offending.

Following the process evaluation of the DTTO II pilots in Scotland (Scottish Government 2010; see UK Focal Point Report 2010), the pilots were extended until the end of March 2013 to allow longer term monitoring of a larger sample for assessing effectiveness.

In 2010/11, there were 31 diversion from prosecution cases referred to drug treatment or education in Scotland, up from 17 in 2009/10 but lower than the number in 2008/09 (n=43) and 2007/08 (n=51) (Scottish Government 2011e). The number of probation orders commenced with a condition of drug treatment/education remained stable at around 500 in 2010/11. The community payback order (CPO) was implemented in February 2011 and replaces the probation order, community service order and supervised attendance order for offences committed on or after 1 February 2011. In the first 14 months after the introduction of the CPO, 193 drug treatment requirements where imposed. Full data for the period 2011/12 are due to be published in December 2012.

During 2010/11, a total of 661 Drug Treatment and Testing Orders were made, an 11% decrease from 2009/10 (n=739) (Scottish Government 2011e). Numbers for DTTOs can fluctuate on an annual basis due to the small numbers involved, and therefore it is difficult to assess to what extent the most recent drop reflects a longer term trend. Of those given a DTTO, 72% were unemployed and a further 22% were not seeking employment. Only three per cent were employed. The average length of a DTTO was around 18.5 months.

In 2010/11 a total of 1,273 DTTO assessments were carried out, a decrease of 13% (n=1,466) on the previous year, which continues the trend since 2008/09 when the number of assessments peaked at 1,680. Data show that there was a slight increase in the proportion successfully completing DTTOs from 44% in 2009/10 to 45% in 2010/11 following a larger increase from 40% in 2008/09. Despite this, there was a small increase in the proportion of individuals who had their order revoked due to a breach from 26% in 2009/10 to 29% in 2010/11 but this follows a large decrease in the previous year (Table 9.6).

Table 9.6: *Reasons for termination of DTTOs in Scotland, 2004/05 to 2010/11*

	2004/05		2005/06		2006/07		2007/08		2008/09		2009/10		2010/11	
	n	%	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	266	45.0
Revoked due to review	32	10.2	81	17.4	76	14.2	68	13.8	83	15.3	112	20.3	103	17.4
Revoked due to breach	133	42.2	154	33.1	197	36.8	173	35.2	193	35.6	144	26.1	174	29.4
Transfer out of area	-	-	4	0.9	2	0.4	7	1.4	8	1.5	4	0.7	6	1.0
Death	1	0.3	4	0.9	1	0.2	2	0.4	3	0.6	4	0.7	6	1.0
Other	29	9.2	36	7.7	51	9.5	58	11.8	40	7.4	44	8.0	36	6.1
Total	*315*	*100*	*465*	*100*	*535*	*100*	*491*	*100*	*542*	*100*	*551*	*100*	*591*	*100*

Source: Scottish Government 2011e

9.4.3 Drug Courts

The Scottish Government funds two bespoke Drug Courts, one in Glasgow and one in Fife, targeted at offenders over 21 with complex and deeply entrenched drug problems that relate to their offending behaviour. The aims of the Drug Courts are to reduce the level of drug-related offending behaviour and to reduce or eliminate offenders' dependence on, or propensity to use, drugs through: the fast-tracking of offenders; a pre-review system allowing for in depth discussion between multi-disciplinary professional; and dialogue between the specialised Sheriff and the offender. The most common sentence imposed by a Drug Court is a DTTO; in 2010/11 the Glasgow Drug Court imposed 79 DTTOs and the Fife Drug Court imposed a further 46.

9.4.4 Interventions for substance misusing offenders with mental health

The Department of Health is currently setting up an audit of the mental health needs of offenders, both in prison and, where possible, in community settings. A feasibility study for this work is due to start later this year with a larger research study expected to be commissioned in 2013.

9.4.5 Other interventions in the criminal justice system

Substance misuse detainees in police custody

The Royal College of Psychiatrists published the fourth edition of guidelines for the clinical management of substance misuse detainees in police custody (RCP 2011). The guidelines cover the whole process from taking a history and examining an individual to the principles of medical management including arrest referral schemes, liaison with other agencies, health risks and prescribing. Other sections include fitness for interview, the effect of withdrawal or intoxication on the validity of confession and managing specific drug problems.

Ethics and effectiveness of coerced treatment

Stevens (2012), in an article discussing the ethics of coerced treatment of people who use drugs, suggests that compulsory treatment is not ethical for any group but that in certain circumstances, quasi-compulsory treatment may be ethical. The author believes that quasi-compulsory treatment (QCT) for drug possession offences is only justified if it is minimally restrictive of an individual's liberty since the offence only provides harm to the individual. In the case of other drug-related crimes, QCT is more likely to be ethical since these crimes involve harm to others. Given that evidence suggests that QCT is as effective as wholly voluntary treatment, the author concludes that it may help individuals reduce their drug use and offending. However, Stevens argues that this is unlikely to have a large impact on population levels of drug use and crime.

9.5 Drug use and problem drug use in prisons

9.5.1 Drug use before entering prison

Scotland

Data from the Scottish Prison Service (SPS) Prisoner Survey 2011 show that just under two-thirds of respondents (64%) had taken an illegal drug in the 12 months prior to imprisonment with 39% reporting that drug taking was a problem for them outside of prison (SPS 2011a). Forty-four per cent reported being under the influence of drugs at the time of their offence with 18% reporting that they committed their offence in order to get money for drugs. A separate analysis looking at female offenders found that 71% reported using drugs in the last 12 months compared to 61% of male offenders (SPS 2011b). Female offenders were also more likely than male offenders to report that their drug use was a problem for them on the outside (58% compared to 36%), that they were under the influence of drugs at the time of their offence (60% compared to 42%) and that they committed their offence in order to get money for drugs (35% compared to 16%). This backs up findings from the Ministry of Justice led Surveying Prisoners Crime Reduction (SPCR) cohort study in England and Wales (Stewart 2008).

Data show that, of the 1,343 addiction prevalence tests carried out on reception to prisons in Scotland during 2010-11, 73% were positive for illegal drugs, an increase from 56% the previous year but similar to the proportion testing positive in 2008/09 (71%). Benzodiazepines were the most frequently detected drug; 53% tested positive for benzodiazepines with 40% testing positive for cannabis and 36% testing positive for opiates. Apart from opiates, the proportion testing positive for all other drugs increased (Table 9.7).

***Table 9.7**: Results of drug testing on reception to Scottish prisons, 2008-09 to 2010-11*

Drug	% positive tests on reception		
	2008-09	2009-10	2010-11
Amphetamines	2	1	2
Barbiturates	-	0	1
Benzodiazepines	49	38	53
Buprenorphine	3	0	2
Cannabis	42	28	40
Cocaine	6	6	8
Methadone	4	6	11
Opiates	36	36	36
All illegal drugs	71	56	73

Source: ISD Scotland 2010; 2012a

9.5.2 Drug use in prison

Scotland

Data from the SPS Prisoner Survey 2011 show that 20% of prisoners reported using drugs in the last month while in prison compared to 22% in 2009, 26% in 2008 and 30% in 2007 (SPS 2011a; ST12). Women (26%) were more likely to report using drugs in prison than men (19%) (SPS 2011b). However, there was no difference in the percentage reporting a decrease in drug use since coming to prison (76%). Fourteen per cent of prisoners reported an increase in drug use since being in prison while 10% reported a similar level of use but with different drugs.

Seven per cent of respondents reported ever having injected drugs in prison with one per cent reporting injecting in the last month. This is a decrease from 2009 (8% and 3% respectively). Of those who had injected, 69% said they had shared equipment. This compares to 71% in 2009 and 80% in 2007 and 2008.

Of the 735 prisoners subject to addiction prevalence testing on prison exit, 17% tested positive for illegal drugs with benzodiazepines (8%), buprenorphine (5%), cannabis and opiates (both 4%) the most commonly detected drugs (ISD Scotland 2012a).

England and Wales

The target for Mandatory Drug Testing (MDT) was removed in 2011/12 although the information was still collected for management purposes. In England and Wales during 2011/12, 7.0% of prisoners tested positive for drugs through random MDT, similar to the previous year (7.1%) (NOMS 2012).

9.6 Responses to drug-related health issues in prison

9.6.1 Drug treatment in prisons

From 1st April 2012, substance misuse treatment in prisons in England is to be reported to the National Drug Treatment Monitoring System (NDTMS) (see section 5.4). NDTMS is also being introduced into the young people's secure estate.

In 2010/11, a total of 61,109 prisoners received a clinical drug intervention in England and Wales. Of these 30,650 (50%) received a maintenance prescription for opioid dependency of either methadone or buprenorphine. The other half received a detoxification treatment (Table 9.8). The proportion receiving a maintenance prescription has increased year-on-year in line with an increase in prison drug funding and the introduction of the Integrated Drug Treatment System (IDTS) in prisons (see selected issue in UK Focal Point Report 2011).

Table 9.8: *Number of prisoners receiving detoxification and extended prescribing programmes in prisons in England and Wales, 2004/05 to 2010/11*

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
2010/11	30,459	49.8	30,650	50.2	61,109

Source: Offender Health

In addition to clinical drug interventions, former substance misuse services known as Counselling, Assessment, Referral, Aftercare and Throughcare (CARATs) provided low to medium intensity, non-clinical drug treatment including: assessment of need; advice and information; care planning; harm reduction advice; and release planning. CARATs may also have provided one-to-one sessions and group work to address a client's substance misuse. Following the devolution of responsibility for deciding which drug and alcohol prevention, treatment and recovery services to commission and fund to local partnerships, establishments are no longer required to deliver the 'CARAT' service however local generic substance misuse services should broadly meet the same purpose.

A range of accredited substance misuse interventions, structured psychosocial interventions and other evidence based approaches designed to address the needs of offenders with substance misuse problems are available in prisons including a number of programmes developed by NOMS and other providers of service. The variety of interventions allows the provision to meet the wide ranging needs of offenders.

The substance misuse programmes available for use in prisons under the NOMS suite of accredited interventions can broadly be categorised as: behavioural based life skills interventions; 12-Step programmes; and therapeutic communities. Data show that in 2011/12, 8,120 prisoners started an accredited psychosocial substance misuse (including alcohol) treatment programme, a 14% decrease since the previous year (n=9,401) and a 25% decrease since 2008/09 (n=10,881). There was a smaller decrease (9%) in the number completing a substance misuse treatment programme[268] between 2010/11 and 2011/12 (Table 9.9).

Table 9.9: *Number of individuals starting and completing an accredited substance misuse treatment programme in England, 2008/09 to 2011/12*

	2008/09	2009/10	2010/11	2011/12
Treatment starts	10,881	10,206	9,401	8,120
Treatment completions	8,054	7,629	7,319	6,671

Source: MOJ 2012c

Scotland

Due to legislative change, the responsibility for the provision of health care, including the delivery of Substance Misuse Services and the Enhanced Addiction Casework Service, was transferred from the Scottish Prison Service (SPS) to NHS Scotland in November 2011.

In 2010/11, 4,222 prisoners undertook an integrated case management substance misuse assessment, accounting for 93% of those offered an assessment. In the 2011 Prisoner Survey, 56% of respondents reported being assessed for drug use upon admission to prison (SPS 2011a) During 2010/11, 13,375 one-to-one motivational support sessions were delivered, an increase of 14% on the previous year (n=11,722) (ISD Scotland 2012a).[269]

Data show that on 17th December 2010, 1,639 prisoners were being prescribed opioid substitution drugs representing 22% of the prison population (ISD Scotland 2012a). This is a similar percentage to those reporting being prescribed methadone in the 2011 Prisoner Survey (23%). In the survey, 80% reported being on a maintenance dose and 20% on a reducing dose (SPS 2011a). The proportion receiving methadone is 94% higher than in 2004 and three per cent higher than in the previous year (Table 9.10).

Table 9.10: *Number and percentage of all prisoners prescribed opioid substitution drugs on a given day in Scottish prisons, 2004 to 2010*

Date	Number	%
17th December 2004	845	14
30th December 2005	984	16
8th December 2006	1,228	17
14th December 2007	1,354	19
12th December 2008	1,487	19
11th December 2009	1,586	21
17th December 2010	1,639	22

Source: ISD Scotland 2012a

[268] Data on treatment starts and completions cannot be used to determine the percentage of successful completions since a treatment programme could span two financial years.
[269] Other interventions delivered by Enhanced Addiction Casework Service (EACS) are monitored internally for contract management purposes but data are not published.

Northern Ireland

In Northern Ireland in 2010/11, 247 individuals entered drug treatment in prisons, 46% of whom were primary cannabis users, 31% were primary opiate users and seven per cent were primary cocaine users.

Guidance

A document setting out the guiding principles for transferring commissioning responsibility for substance misuse interventions in the young people's secure estate from the Youth Justice Board to local partnership areas was published (YJB and NTA 2012). The key principles underpinning the delivery of substance misuse services and the governance arrangements of such services are set out in the document. In addition, guidance was provided about how to carry out a needs assessment, the topics and themes to be covered and how to record performance management information.

Prison addiction therapeutic communities

NOMS has carried out research exploring the current delivery of four prison addiction therapeutic communities (TCs) in England to assess whether they are functioning as intended (Powis et al. 2012).[270] The study found that the sites were functioning well and generally adhering to the addiction TC model. Feedback from interviews and participants was positive and a number of key strengths were identified such as the open and supportive relationships between staff and residents. Using psychometric questionnaires, the authors observed positive change between programme start and graduation for participants. This finding was supported by a large majority of current residents (83%) and graduates (92%) reporting that they had changed in a positive direction as a result of their involvement in a TC. One of the main weaknesses identified during the study was the low rate of referrals, which pressured staff into selecting participants who may not meet the selection criteria in order to maintain numbers. An analysis of data showed that nearly one-quarter of participants did not meet all the selection criteria. Overall, 51% of those starting on a TC programme graduated. Recommendations from the study included promoting TCs as a national resource in order to increase referrals, recruiting officers for evening and weekend work to minimise regime slippage and exploring the feasibility of dedicating space on the TC exclusively to TC residents.

Measuring service quality

Sondhi and Day (2012) assessed whether a survey instrument, SERVQUAL[271] can be used to measure service users' satisfaction levels in English prisons.[272] The study found that there

[270] Data collection took place between January and May 2010 in the four establishments delivering accredited TCs for drug users in the prison estate in England and Wales: Channings Wood; Garth; Holme House; and Wymott. Structured observation was carried out at each TC site and supported by semi-structured interviews with residents and staff. Face-to-face interviews were carried out with 71 current residents, 43 graduates and 29 non-completers. Telephone interviews were carried out with 20 TC staff and 20 non-TC staff. A questionnaire was completed by all 171 staff and residents of the TCs and routine TC data sources were interrogated.

[271] SERVQUAL is a validated scale, that was originally developed for the financial services sector, that measures gaps in perceived customer expectations of a service and the actual standard of service delivery that they have experienced. Using a 5-point likert scale customers are asked how far they agree with a series of statements relating to their expectations of the service. Customers are then the same questions but asked to answer in terms of their perceptions of the actual standard of service delivery that they have received. The differences between the scores for the expectation and perceived standards questions are calculated to identify areas where there are gaps between what the customer expects of the service and the actual standard of service delivery.

[272] A sample of 96 male prisoners across eight prisons in one English region were interviewed using the SERVQUAL instrument. The use of SERVQUAL was supplemented by additional questions to gauge overall satisfaction levels.

was a gap between perceptions of the treatment service received by prisoners and the expectations they had of that service. Despite relatively high scores for perception of the treatment service, the authors conclude that the gap between perception and expectation may demonstrate a greater level of dissatisfaction than the high perception score suggests.

9.6.2 Prevention and reduction of drug-related harm

Data from Scotland show that, in 2010/11, 10,943 prisoners attended a national harm reduction awareness session on admission to prison, representing 62% of all admissions. Further data show that 4,794 prisoners attended a pre-release harm reduction group work session (ISD Scotland 2012a).

Guidance

A report commissioned by the Department of Health looked at potential problems with the management and use of controlled drugs in the prison healthcare setting in England (National Prescribing Centre 2012). A number of recommendations were provided including appointing a nominated controlled drug governance lead in the prison healthcare setting. The report referred to the Royal College of General Practitioners' (RCGP) recently published guidance on safer prescribing in prisons, which includes a section on prescribing for substance use (RCGP 2011).

9.6.3 Prevention, treatment and care of infectious disease

Viral hepatitis testing and treatment

Hepatitis C

Data show that in 2011, 9,970 new receptions to prison in England received a hepatitis C test representing 6.2% of all new receptions to prison during that year (HPA 2012c). Kirwan et al. (2011), using data from sentinel laboratories in England,[273] found that between 2005 and 2008 hepatitis C testing increased by 47% while the percentage testing positive decreased significantly from 26% to 23%. They estimate that 2.4% of the prison population was tested for anti-HCV between 2005 and 2008 and conclude that, although hepatitis testing has increased, only a small proportion of the prison population are tested and this should be increased.

A survey of hepatitis C services in prisons in England[274] found that almost all prisons (99%) use venous blood sampling for testing although 10% also use dried blood spot testing (DH and HPA 2012). Only 40% of blood samples were routinely tested for polymerase chain reaction (PCR)[275] following a positive antibody test result. Three-quarters of prisons surveyed reported having a written pathway for those with a positive hepatitis C test, which is a requirement of the Prison Health Performance Quality Indicator (PHPQI). The treatment service model, however, varied with 54% of prisons having an in-reach service provided by local hospitals, 41% referring prisoners to outpatient hospital appointments and 20% providing treatment in-house, which is overseen by a prison doctor. The majority of prisons (86%) reported follow-up for those being discharged from prison although this may just be a letter to a prisoner's GP.

Around half (48%) of those taking part in the *2011 Scottish Prisoner Survey* reported being tested for hepatitis C in prison, a large increase from around one-third in the previous three surveys carried out between 2007 and 2009 (SPS 2011a). Fifty-eight per cent of

[273] Data were available from 16 laboratories performing testing for 39 prisons in England (30% of the prison estate).
[274] A short survey questionnaire was sent to all Prison Governors and Heads of Healthcare in England in September 2011. Of the 128 prisons, 110 responded giving a response rate of 86%.
[275] A polymerase chain reaction (PCR) test identifies current circulating virus. More sophisticated PCR tests can then identify the amount (viral load) and the genotype of the virus.

respondents reported being given information about hepatitis C and 85% said they would take a test in prison if offered one.

To support delivery of the Welsh Government's *Blood-Borne Viral Hepatitis Action Plan* for Wales 2010-2015, a liver health programme was launched across Welsh prisons in 2012 (Public Health Wales 2012). The promotion of diagnostic testing amongst those with risk factors for hepatitis infection is one aim of the programme in addition to hepatitis B vaccination for every prisoner and treatment for every diagnosed individual.

In Scotland there is no current evidence available of the prevalence and incidence of HCV (hepatitis C) amongst Scottish prisoners; however in line with Action 23 of the hepatitis C Action Plan for Scotland (Phase II) (Scottish Government, 2008e), research was conducted between June 2010 and March 2011 that measured HCV risk behaviours in all fourteen closed prisons in Scotland.

The resulting report, *Hepatitis C Prevalence and Incidence amongst Scottish Prisoners and staff Views of its Management* will be published on the 31st October 2012.[276]

Hepatitis B

Kirwan et al. (2011) found that between 2005 and 2008 testing for hepatitis B increased by 35% with no significant change in the proportion testing positive. Over the same period vaccine coverage increased from 24.8% to 49.4%.

9.6.4 Drug recovery wings

There are currently eleven prisons involved in a pilot study for Drug Recovery Wings (DRWs) focused on abstinence, being drug-free and connecting offenders with community drug treatment and recovery services on release. In June 2011 DRWs were launched in five prisons: Manchester, Holme House, High Down, Bristol and Brixton. These pilots are focussed primarily on drug and alcohol misusing offenders sentenced to between 3 and 12 months in custody where there is limited time available in prison to complete treatment interventions. NOMS launched a second tranche of six DRWs in April 2012 - three women's prisons (New Hall, Styal and Askham Grange) and a Young Offenders Institution (Brinsford), as well as Chelmsford and Swansea. The focus will continue to be on those serving short sentences but the scope has been extended to include those on remand, those serving 12 to 24 months, and those serving longer sentences but in the last year of their sentence.

The initial pilots will run for at least 18 months (until December 2012). The Department of Health has launched an open competition for a rigorous independent evaluation which is expected to start in September/October 2012. An initial scoping and feasibility phase to help inform a detailed evaluation approach is expected to report in Summer 2013. There has been significant interest in the development of DRWs and other prisons have introduced their own models, although their efficacy has yet to be evaluated.

Drug free wings

In addition to DRWs, NOMS is committed to increasing the number of Drug Free Wings (DFWs) in prisons and is similarly piloting them. There are currently five prisons involved in a pilot study for DFWs, which have less emphasis on substance misuse treatment than DRWs and are aimed at prisoners abstinent from drugs and substitute prescribing. This includes those in recovery but also prisoners who have never had a substance misuse problem and want to avoid the temptation to use. Three of the five pilot drug free wing (DFW) sites

[276] For a copy of the Executive Summary see: http://www.sps.gov.uk/Publications/Publication-4189.aspx

(Bristol, New Hall and Swansea) will be linked to DRWs to explore the relationships between the two approaches.

In addition, a number of prisons have developed their own framework for drug free wings. There are a reported 16 prisons with drug free wings, but these are locally delivered with local standards.

9.6.5 Prevention of overdose risk upon prison release

Naloxone is issued to prisoners on release. Of the total 715 kits issued in prisons in 2011/12, 679 (95%) were reported to be a ‘first’ supply and 36 (5%) a ‘repeat’ supply (ISD Scotland 2012a). Where the supply was noted as a 'repeat’ supply this could be following initial supply in the community, or it could be that the previous supply was made on release from a previous stay in prison. Using data on prison liberations and the percentage of opioid positive tests amongst those tested on reception to prison, it is estimated that there were 100 kits issued per 1,000 liberations of prisoners who were using opioids prior to imprisonment.

Take home naloxone is available in all prisons in Wales through NHS Wales. All prisoners at risk of opiate overdose are encouraged to attend training in overdose awareness and the use of take home naloxone. Prisoners in Wales are then supplied a kit of take home naloxone on release from prison.

9.7 Reintegration of drug users after release from prison

Data from Scotland show that in 2010/11 there were 1,515 cases commenced as part of the throughcare addiction service (TAS), a similar number to recent years (Scottish Government 2011d). TAS forms part of the voluntary aftercare service. It is delivered by local authority criminal justice social work staff, who work with the offender in the 6 week period prior to their release from custody and the 6 week period after release, to help them address their addiction. 2011b).

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 significant increase in domestic cannabis cultivation over the past five years. Throughout the UK, large numbers of commercial cannabis cultivation operations have been discovered and there is an increasing recent trend towards smaller operations in multiple locations.

The overall picture of United Kingdom drugs distribution 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. Organised crime groups in Merseyside impact on the drug supplies into Wales.

The numbers of seizures increased in the United Kingdom until 2008/09 but there were decreases in 2009/10 and 2010/11. Cannabis is the most seized drug and the number of herbal cannabis seizures has increased since the introduction of cannabis warnings in England and Wales in 2004, although quantities have fallen. There have been increasing seizures of cannabis plants. Cocaine powder seizures increased substantially until 2008/09 but have decreased since. 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. Following a reported reduction in the supply of heroin in late 2010 and early 2011 heroin purity has decreased and purity-adjusted price has increased.

The most recent estimate of the size of the illicit drug market in the United Kingdom is (£5.3 billion) in 2003/04, with a wide margin of error of (£4 billion) to (£6.6 billion). The Home Office is currently updating its estimate of the size of the UK drugs market. In Scotland the size of the illicit drug market has been estimated at (£1.4 billion) for 2006.

10.2 Availability and supply

10.2.1 Availability in the general population

Reduced availability of heroin

Most areas of the UK reported a reduced availability of heroin between April 2010 and mid-2011. Section 10.4.3 has further information about this. The Home Office is undertaking research looking at the impact of the reduced availability of heroin.

England and Wales

In 2011/12, three-quarters of those aged 16 to 59 years old in England and Wales reported that it was easy to obtain drugs with little difference between those who had used drugs in the last year and those who had not (Home Office 2012b).

Scotland

In Scotland the percentage of individuals reporting being offered drugs in the last year continued to decrease; in 2010/11, 11.6% of adults aged over 16 reported being offered drugs in the last year compared to 12.9% in 2009/10 and 13.7% in 2008/09 (Scottish Government 2012a). The drugs most commonly offered were cannabis (9.3%), cocaine powder (5.1%) and ecstasy (4.6%), all of which saw a decrease since the previous year's survey. Males (15.9%) were twice as likely as females (7.6%) to report being offered drugs in the last year with the difference most pronounced for stimulants (10.7% and 4.6% respectively). Younger adults were also more likely to have been offered drugs with just over one-third (35%) of 16 to 24 year olds being offered drugs in the last year. Analysis showed that 43% of those offered an illicit drug in the last year had taken a drug in the last year, with 28% of those being offered drugs in the last year never having taken an illicit drug.

10.2.2 Availability amongst school children and young people

England

In 2011, 29% of pupils in England reported having being offered drugs, similar to the level in 2010 (28%) but a decrease from 2009 (33%) and the levels seen in the early 2000s (40 to 42%) (Fuller 2012). Half of 15 year olds had ever been offered drugs compared to one in ten of 11 year olds. Cannabis remained the most commonly offered drug (19%) with cocaine the next most common (6%). Girls were less likely to have been offered cannabis or opiates than boys but were as likely to report being offered stimulants.

Twenty-eight per cent of pupils stated that it was easy to get hold of drugs while 25% reported it was difficult and the remainder didn't know. This is similar to previous years. Half of 15 year olds thought it was easy to obtain drugs.

Scotland

As amongst the general population, data from Scotland show that there has been a decrease in the number of school pupils who reported that they had been offered drugs (NHS Scotland 2011). In 2010, 16% of school pupils aged 13 and 42% of pupils aged 15 reported that they had been offered drugs at some point in their lives compared to 22% and 51% respectively in 2008.

Cannabis was the most commonly offered drug, reported by nine per cent of 13 year olds and 36% of 15 year olds. Since 2008, the number of young people being offered cannabis has decreased. Six per cent of 13 year olds had been offered stimulants compared to 19% of 15 year olds. Of the new psychoactive substances asked about, six per cent of 15 year old pupils reported being offered mephedrone, two per cent Spice and one per cent BZP (see supplementary chapter). This compares to 11% of 15 year old pupils reporting being offered ecstasy and 10% reporting being offered cocaine.

Fifteen per cent of 13 year olds said they thought it was easy to get hold of drugs with 41% of 15 year olds reporting that obtaining drugs was easy. Boys were more likely to report that obtaining drugs was easy than girls, both amongst 13 year olds (16% compared to 13%) and 15 year olds (44% compared to 38%). The percentage reporting that it is easy to obtain drugs has decreased substantially since the previous two surveys.

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. During 2011, a significant amount of the heroin seized at UK borders had been trafficked directly from Pakistan. By comparison, it was a period of continued reduction in the supply of heroin supplied via Turkey-based organised crime groups. However, in 2012, there have been a number of large heroin seizures in Turkey suggesting that some Turkish trafficking groups are no longer having difficulties sourcing and supplying sizeable quantities. Heroin trafficked via Pakistan to the UK is most likely to have either; passed west through Pakistani Baluchistan into Iran, to Turkey and then onward through Europe; been sent directly from Pakistan by parcel, air freight, air courier or maritime container; or been trafficked by sea onto eastern and southern Africa where a proportion moves on to western Europe.

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. Cocaine is smuggled into Europe by a variety of methods and enters key transit hubs, such as the Netherlands/Belgium and the Iberian Peninsula. The majority of cocaine destined for the European market is judged to have crossed the Atlantic by sea in quantities up to multi tonne loads, primarily in maritime containers from Latin America, but also concealed in general cargo, yachts and fishing vessels. Air transportation remains important for smuggling smaller amounts on a regular basis, through use of air couriers and air freight.

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). The UK drugs market has seen diversification through the emergence of a variety of new psychoactive substances (NPS). The majority of these substances are being produced overseas, in particular China and India. Mislabelling of these substances, by overseas suppliers, suggests they are complicit in circumventing European and UK border controls. The marketing and sale continues to take place on the internet presenting challenges for law enforcement to control their sale and distribution.

Following the classification of mephedrone to Class B in April 2010 in the UK, 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 estimated to be worth around £842 million in 2011. 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 'sinsemilla' (or skunk) throughout the UK. Organised criminals involved in the supply of cannabis often 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.

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. Project CLAUDIA is a SOCA initiative, which aims to increase knowledge of the current drugs market in Scotland using effective collaborative working arrangements between SOCA, SCDEA, UKBA and other relevant partners to facilitate and assure the delivery of local, regional and national reporting (SOCA 2012b).

Sources of supply

Findings from the 2011/12 British Crime Survey show that almost two-thirds of respondents aged 16 to 59 years old (63%) obtained drugs from someone well known to them[277] such as a friend, neighbour or work colleague (Home Office 2012b). Five per cent reported obtaining drugs from a dealer not known to them personally, the same percentage as those reporting obtaining drugs from a family member or from a shop. Only one per cent reported obtaining drugs from the internet. The majority of individuals (58%) bought or were given drugs at their own or someone else's home, with those buying cannabis most likely to report obtaining drugs in this location (65%). Those buying cocaine and ecstasy were most likely to report obtaining it in a bar, club or a rave (48% and 55% respectively).

School pupils

In 2011, 71 per cent of pupils in England reported getting drugs from a friend the last time they used drugs with four per cent saying they got them from a stranger (Fuller 2012). Older pupils were more likely to report getting drugs from a friend (89% of 15 year olds compared to 61% of 11 year olds). Those who reported taking Class A drugs on the last occasion they used drugs were more likely to say they got them from a stranger (16%) than those who had only used cannabis on the last occasion (3%). The source of supply of drugs was similar when asked about the first occasion they took drugs.

The majority of pupils in Scotland who reported using drugs in 2010 said they got their drugs from a friend, with seven per cent reporting that they obtained drugs from a stranger and two per cent reporting that they obtained drugs from the internet (NHS Scotland 2011).

Nature of methadone diversion

A study looking at the nature of methadone diversion in Merseyside, England[278] found that 60% of participants reported obtaining illicit methadone in the past year with 22% reporting obtaining illicit methadone in the past four weeks (Duffy and Baldwin 2012). Fourteen per cent of participants reported providing methadone to others in the last year. The majority of participants (86%) were prescribed methadone at the time of their interview. Most diversion of methadone took place between friends or acquaintances with few obtaining methadone from a dealer. There was an equal split between those buying methadone and those given it for free. Supervised clients were more likely to have obtained illicit methadone and less likely to have provided methadone than non-supervised clients.

10.3 Seizures

10.3.1 Drug seizures in the United Kingdom in 2010/11

Data for the United Kingdom show that there were 243,667 drug seizures in the United Kingdom in 2010/11, of which 77% involved cannabis (n=186,979). Overall, seizures from England and Wales accounted for 87% of the total seizures, Scotland for 11% and Northern Ireland for one per cent (Table 10.1). However, this differed depending on the drug. One-third (34%) of cannabis resin seizures were from Scotland with a corresponding lower

[277] The question asks where an individual obtained their drugs from the last time they took drugs.

[278] A total of 886 participants took part recruited from 28 sites in Merseyside between November 2008 and September 2010. Sites included: prescribing services; agencies providing treatment for offenders; service user forums; and accommodation services. A 28-item questionnaire was developed and used covering prescribing and use of illicit methadone.

proportion of UK herbal cannabis seizures (5%). Scotland also accounted for one-quarter (24%) of heroin seizures and half of all benzodiazepine seizures, which may reflect the higher rate of opiate use in Scotland compared to elsewhere in the UK and the problematic use of benzodiazepines (see section 4.2.2). Crack cocaine seizures were almost exclusively in England and Wales (97% of all seizures) while Northern Ireland accounted for a higher than average proportion of mephedrone seizures (17%).

The number of mephedrone seizures is not available from Scotland but Table 10.1 shows that the number of seizures is around the same level as the number of ecstasy seizures and at a much lower level than cocaine powder or amphetamines seizures.

Table 10.1: *Number of seizures of individual drugs in the United Kingdom by country in 2010/11*

Drug	England and Wales	Scotland	Northern Ireland	UK
Amphetamines	7,177	1,151	128	8,456
Cannabis – herbal	139,209	6,777	1,644	147,630
Cannabis – resin	18,293	10,046	1,072	29,411
Cannabis plants	14,411	970	231	15,612
Total cannabis	167,381	16,871	2,727	186,979
Cocaine powder	17,689	2,086	304	20,079
Crack cocaine	5,380	189	0	5,569
Ecstasy type substances	2,535	269	150	2,954
Heroin	10,812	3,484	47	14,343
LSD	95	5	3	103
Benzodiazepines*	3,354	3,670	212	7,236
Mephedrone	1,946	-	391	2,337
Total	212,784	27,319	3,564	243,667

*includes diazepam and other benzodiazepines but excludes temazepam

Source: Standard Table 13

Data in Table 10.2 show the quantity of drugs seized in the United Kingdom during 2010/11. It is not possible to comment on the quantity seized by individual countries within the United Kingdom since data from England and Wales include seizures made by the United Kingdom Border Agency (UKBA),[279] which accounts for a large percentage of the quantity seized while data from Scotland and Northern Ireland are police seizures only.

Data on the quantity of mephedrone seized are not available from England and Wales or Scotland. In Northern Ireland 21kg of mephedrone was seized in 2010/11, with an average quantity of 73g per seizure (PSNI 2011). Data from 2011/12 (not shown), however, show

[279] In March 2012 the UK Border Agency was split in two with responsibility for operational border control being the responsibility of the new UK Border Force (UKBF).

that the average quantity of mephedrone per seizure decreased to 11g, with the number of seizures decreasing from 286 to 205 (PSNI 2012).

Table 10.2: *Quantity of individual drugs seized in the United Kingdom by country in 2010/11*

Drug	Unit	England and Wales	Scotland	Northern Ireland	UK
Amphetamines	Kg	710	261	11	982
Cannabis – herbal	Kg	20,693	867	176	21,736
Cannabis – resin	Kg	27,866	1,068	87	29,021
Cannabis plants	Plant	729,502	34,799	10,330	774,631
Cocaine powder	Kg	2,387	145	8	2,540
Crack cocaine	Kg	50	9	0	59
Ecstasy type substances	Tablet (000s)	357	10	15	382
Heroin	Kg	732	96	5	833
LSD	Dose (000s)	4	0.1	0.1	4.2
Benzodiazepines*	Tablets	664,000	679,000	82,128	1,425,228

*includes diazepam and other benzodiazepines but excludes temazapam

Source: Standard Table 13

Assuming a yield of 40g per cannabis plant (Sentencing Council 2012) and using the most recent estimate of the size of the UK cannabis market[280] (EMCDDA 2012), it is estimated that cannabis seizures accounted for 28% of the size of the cannabis market in 2010/11. That equates to 33g of cannabis per last year cannabis user (see Table A.1 for UK prevalence data).

10.3.2 Trends in drug seizures in England and Wales

As seizures data for the whole of the United Kingdom have not been available since 2006/07, data from England and Wales (which make up 87% of the number of UK seizures in 2010/11) have been used to comment on trends.

Number of drug seizures

In 2010/11, there were a total of 212,784 drug seizures in England and Wales, a five per cent decrease from the previous year (224,401 seizures). Since 2009/10 the number of seizures recorded by the UKBA has remained stable while the number of seizures by police forces has decreased. This may be connected to the end of the police target regime, which has coincided with a decrease in the number of recorded drug offences (Chaplin 2011; see section 9.2.1).

While the decrease continues the pattern from the previous year, the number of seizures is still around twice as high as in 2004 (112,923) when the cannabis warning was first introduced (Coleman 2011; Table 10.3). Since then the proportion of all seizures that involve cannabis has increased from 72% to 79%. The number of seizures of cannabis plants continued to increase, by 12% from the previous year, while seizures of herbal cannabis (-4%) and cannabis resin (-25%) decreased.

[280] Estimated to be 290 tonnes in 2007/08.

Cocaine powder seizures, after increasing substantially between 2004 and 2008/09 continued to decrease, by 17% on the previous year. Seizures of ecstasy also continued to decrease while seizures of ketamine (n=1,792) increased by 11% on the previous year. The largest increase was for 'other Class B drugs,' from 377 in 2009/10 to 2,722 in 2010/11. This is primarily the result of the classification of mephedrone and other cathinones, with 1,946 seizures of mephedrone and a total of 2,268 seizures of Class B cathinones in 2010/11 (Home Office – unpublished data).

Table 10.3: *Number of seizures of drugs by law enforcement agencies in England and Wales, 2004 to 2010/11*

Drug	2004	2005	2006/07*	2007/08	2008/09	2009/10	2010/11
Amphetamines	6,504	7,837	8,477	8,863	7,760	7,302	7,177
Cannabis – herbal	43,072	76,157	109,649	137,526	145,353	144,456	139,209
Cannabis – resin	35,219	41,454	32,590	30,870	35,795	24,339	18,293
Cannabis plants	2,930	4,327	5,805	8,539	9,380	12,920	14,411
Cocaine powder	8,279	12,512	16,917	21,346	24,659	21,377	17,689
Crack cocaine	5,164	6,705	6,955	7,578	6,623	5,081	5,380
Ecstasy type substances	6,256	6,688	8,184	7,173	5,218	3,724	2,535
Heroin	11,668	14,072	13,942	14,186	13,302	12,836	10,812
Benzodiazepines**	830	1,747	2,261	2,815	4,038	2,957	2,488
Ketamine	-	-	-	-	1,269	1,612	1,792
LSD	144	204	169	145	132	101	95
Total	112,923	169,802	196,099	228,131	241,473	224,401	212,784

*in 2006/07 data moved to a financial year basis
** includes diazepam and other benzodiazepines but not temazepam
Source: Coleman 2011

Quantity of drugs seized

The number of seizures of steroids decreased by 23% from the previous year after large increases in 2008/09, although the number of police seizures remained stable. Similarly the quantity of steroids seized decreased overall and for the UKBA but increased by 292% amongst police forces from 85,000 doses to 333,000 (Coleman 2011).

In addition to the number of seizures decreasing, the quantity of cocaine seized also decreased, by 10% on the previous year. However, this continues the trend seen since 2003, which is largely attributed to police seizing smaller amounts of cocaine. In 2010/11 two-thirds (65%) of all police seizures were under one gram.

The quantity of heroin seized in 2010/11 decreased substantially to half the amount of the previous year. This may be due to reduced availability of heroin in late 2010/early 2011 (see section 10.2.1 and 10.4.3). Analysis of the breakdown of seizure amounts show both that the UKBA did not make any seizures in the largest category of over 100kg (compared to three the previous year) and that the police made less seizures of heroin in the lower size categories.

Table 10.4: *Quantity of seizures of drugs by law enforcement agencies in England and Wales, 2004 to 2010/11*

Drug	Unit	2004	2005	2006/07*	2007/08	2008/09	2009/10	2010/11
Amphetamines	Kg	1,257	2,091	1,390	1,811	2,939	1,326	710
Cannabis – herbal	Kg	21,535	20,583	25,832	20,093	33,363	17,951	20,693
Cannabis – resin	Kg	63,234	50,591	19,851	16,710	31,799	12,563	27,866
Cannabis plants	Plant	93,469	220,019	363,679	535,888	643,510	758,943	729,502
Cocaine powder	Kg	4,640	3,821	3,244	3,453	2,916	2,643	2,387
Crack cocaine	Kg	140	51	60	37	33	59	50
Ecstasy	Tablet (000s)	4,740	3,019	6,685	965	547	171	357
Heroin	Kg	2,170	1,907	1,030	1,059	1,552	1,516	732
Ketamine	Kg					27	293	802
LSD	Dose (000s)	37	1,137	6	3	20	3	4

*in 2006/07 seizures data moved to a financial year basis

Source: Coleman 2011

Cannabis seizures

While the quantity of herbal cannabis seized increased by 15%, this is wholly attributable to a 50% increase in the quantity seized by police with UKBA seizures at the same level as the previous year. The quantity of herbal cannabis seized by UKBA is lower than at any point since 1999 but not significantly lower than in 2003. The number of herbal cannabis seizures in 2009/10 and 2010/11, however, was lower than at any point since 1998. This may suggest that cannabis grown within the UK has a larger market share than imported cannabis. Nevertheless, criminals are still importing significant amounts of cannabis into the UK. The quantity of cannabis resin seized in 2010/11 more than doubled from the previous year with increases by both the police and the UKBA. There were seven police cannabis resin seizures in the largest category (over 100kg) compared to none the previous year and double the number of UKBA seizures in the largest category (31 compared to 16 the previous year). However, the number of police seizures in the lowest size categories decreased as did the overall number of cannabis resin seizures.

The number of cannabis plants seized decreased slightly in 2010/11 after large increases in the past seven years.

10.3.3 Cannabis farm discoveries in the UK

The number of cannabis farms discovered continued to increase in 2010/11, by 12% from the previous year to 7,660 (Table 10.5). However, the increase was not as pronounced as in previous years and projected numbers for 2011/12 suggest that this will slow further to a three per cent increase (ACPO 2012). The Association of Chief Police Officers (ACPO) contend that the steep rise in the number of farms discovered between 2007/08 and 2009/10 may be due to an enhanced investigative focus by law enforcement and ensuing public awareness of the issue (see UK Focal Point Report 2009). It notes that numerous police forces reported that the cultivation of cannabis no longer features in their control strategies. This demonstrates the fact that seizures data are just as likely to reflect policing activity as they are to reflect actual trends in drug use and supply.

Table 10.5: *Total number of cannabis farms discovered and the number of plants seized in the United Kingdom, 2007/08 to 2010/11*

	2007/08	2008/09	2009/10	2010/11	Total
Total number of commercial cannabis factories	3,032	4,951	6,866	7,660	22,509
Number of plants recovered	501,905	576,790	749,927	551,930	2,380,552

Source: ACPO 2012

Interestingly, despite the number of cannabis farm discoveries increasing by 12% between 2009/10 and 2010/11, the number of plants decreased by 26% bringing down the average number of plants per farm from 109 to 72 (Table 10.6). This supports ACPO's assertion that the size and scale of commercial cultivation sites are reducing with the emergence of a 'multiple site' model, whereby gardeners manage smaller scale factories across multiple areas (ACPO 2012). Furthermore, there has been an increase in personal cultivation offences, with the economic downturn and the reduction in deal weights suggested as a reason for this. ACPO also report an increase in the purchase of seeds and equipment.

10.3.4 Other seizures data

Data from police seizures submitted for forensic examination show that a number of new psychoactive substances were seized during 2011 (SOCA - unpublished data). The most commonly analysed drugs were cathinones with around 3,000 records and mephedrone accounting for the majority of the cathinone powders and tablets. The amount of naphyrone seized decreased from 2010 while the amount of fluoromethcathinones trebled and the amount of MDPV doubled.

Other significant seizures of NPS were piperazines with around 1,500 records. TFMPP was the most frequently encountered individual piperazine followed by BZP. A large number of records were for a combination of piperazines.

Other new psychoactive substances were encountered in smaller numbers, including 4-fluroamphetamine, methoxetamine, 2-CB and MDAI. There were less than 10 seizure records of D2PM and cannabinoid agonists submitted for analysis.

Police seizures from music festivals

Data obtained through a number of freedom of information requests were published showing the amount of drugs seized at several music festivals[281] in the UK between 2008 and 2011.[282] The amount of cocaine seized decreased significantly between 2009 and 2011 from 2kg to 0.5 kg with the amount of MDMA also decreasing substantially, both in tablet and powder form. The amount of ketamine seized increased in 2011 to 518g from 320g the previous year, 394g in 2009 and 172g in 2008. This is the only commonly encountered drug that increased in terms of quantity seized in 2011.

In 2011, the amount of herbal cannabis seized decreased to 3kg from a high of 11kg in 2009. Of the new psychoactive substances, piperazine tablets were the most commonly seized drug, peaking in 2010 at 1,761 tablets and dropping to 1,304 in 2011. The number of 2-CB tablets seized also peaked in 2010 (n=373) before decreasing in 2011 (n=49). The amount of mephedrone seized was minimal across the four years with eight grams in 2010 and five grams in 2011. Methedrone was seized in higher quantities (149g in 2010 and 114g

[281] Festivals were Bestival, Download, Glastonbury, Isle of Wight, Leeds, Reading, Sonisphere, V Festival, Wireless and Womad. In 2011 the total attendance at these festivals was 833,000.

[282] See: https://docs.google.com/spreadsheet/pub?key=0AuZLaKQQs5xpdFhkSVEwT1NGbXpMNEVlcmdLa3VXTXc&output=html

in 2011). Less than 10 grams of MDPV, Methylone, MRAI and NRG were seized over the four years.

10.4 Price/purity

Wholesale and street drug price data are provided by law enforcement agencies. Figures are supplied by UK Police Forces who use information that 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). Fluctuations in price are subject to a range of factors and artefacts, including how prices are calculated and the sample size.

10.4.1 Wholesale price data

The wholesale price of cocaine powder was more stable in 2011 than in previous years. The typical price for a kilogram of cocaine was £50,000, the same as in 2010, although more adulterated cocaine can sell for less. The wholesale price for heroin continued to increase in 2011 with a typical price of around £25,000 up from £21,000 in 2010 and £16,000 in 2009.The typical wholesale price of skunk cannabis increased from £4,000 per kg to £5,000 and the price of cannabis resin also increased from £1,000 per kg to £1,200.

Other price increases were seen for ecstasy tablets (up from £2,500) per 10,000 to £4,000) while the lowest reported price for mephedrone was £2,500 compared to £2,000 the previous year. The wholesale price of ketamine and amphetamines dropped slightly.

10.4.2 Street-level price data from law enforcement sources

Data on drug prices suggest that the price for almost all drugs has remained stable since the previous year apart from for cannabis (Table 10.6). However, the price of cannabis has been provided using a one gram deal rather than the 1/8 oz. (3.54g) deal as previously provided. The suggestion from law enforcement sources is that the one gram deal is now the most common deal. A cannabis user survey carried out in 2009 suggested that half of users bought cannabis in either 1/8 oz. or 1/4 oz. deals (see UK Focal Point Report 2009) and this is the size used by DrugScope to calculate its drug prices (Table 10.7). Unlike with many other drugs, cannabis cannot be easily adulterated so it may be that a reduction in the size of a standard deal is the method most commonly employed to increase profit. However, it is more difficult to monitor this as it relies on test purchasing, which predominantly takes place using street markets and therefore is unlikely to reflect the purchasing pattern of the majority of users. Furthermore, street markets are known to offer the least value for money.

Table 10.6: *Law enforcement agencies: Mean price of illegal drugs in the United Kingdom, 2005 to 2011*

Drug	Price per gram except where otherwise stated						
	2005	2006	2007	2008	2009	2010	2011
	Exch. rate: £1=€1.4629	Exch. rate: £1=€1.467	Exch. rate: £1=€1.4619	Exch. rate: £1=€1.2588	Exch. rate: £1=€1.1233	Exch. rate: £1=€1.1752	Exch. rate: £1=€1.1462
Amphetamines	£10.00	£9.00	£9.00	£10.00	£10.00	£10.00	£10.00
	€14.63	€13.20	€13.16	€12.59	€11.23	€11.75	€11.46
Cannabis herb*	£2.64	£2.68	£3.95	£2.85	£2.85	£2.82	£5.00
	€3.86	€3.93	€5.77	€3.59	€3.20	€3.31	€5.73
Cannabis resin*	£1.94	£2.12	£2.82	£2.85	£2.85	£2.82	£5.00
	€2.84	€3.11	€4.12	€3.59	€3.20	€3.31	€5.73
Cannabis (sinsemilla)			£6.21	£5.63	£7.15	£7.15	£10.00
			€9.08	€7.09	€8.03	€8.40	€11.46
Cocaine powder	£49.00	£49.00	£46.00	£40.00	£40.00	£40.00	£40.00
	€71.68	€71.88	€67.24	€50.35	€44.93	€47.01	€45.85
Crack cocaine**	£19.00	£18.00	£65.00	£65.00	£60.00	£50.00	£50.00
	€27.80	€26.41	€95.02	€81.82	€67.40	€58.76	€57.31
Ecstasy (per tablet)	£4.00	£3.00	£3.00	£3.00	£2.50	£2.50	£5.00
	€5.85	€4.40	€4.39	€3.78	€2.81	€2.94	€5.73
Heroin	£54.00	£52.00	£48.00	£45.00	£45.00	£45.00	£40.00
	€79.00	€76.28	€70.17	€56.65	€50.55	€52.88	€45.85
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 and the price was converted to gram equivalent. In 2011 prices were provided on a gram basis.
**Crack cocaine prices before 2007 were provided per rock (0.2g) not per gram. Prices after 2007 cannot be compared to earlier prices.

Source: Standard Table 16

10.4.3 Street-level price data from non-law enforcement sources

DrugScope[283] carry out an annual survey of drug prices by contacting drug agencies across the UK. Data from 2011 suggest that the price of cocaine powder has increased and, similar to law enforcement data, the cost of an ecstasy tablet has increased. Unlike law enforcement data, DrugScope suggest that the price of high quality cannabis has decreased slightly, although the difference is likely to be an artefact of the change in the size of the typical deal used by law enforcement agencies. DrugScope's heroin price data suggest an increase in price during 2011.

[283] See: http://www.drugscope.org.uk/

Table 10.7: *DrugScope: Mean price of drugs at street level in the United Kingdom, 2007 to 2011*

Drug	Price per gram except where otherwise stated				
	2007	2008	2009	2010	2011
	Exch. rate: £1=€1.4619	Exch. rate: £1=€1.2588	Exch. rate: £1=€1.1233	Exch. rate: £1=€1.1664	Exch. Rate: £1=€1.1462
Amphetamines	£9.80	£9.00	£9.00	£9.00	£10.00
	€14.33	€11.33	€10.11	€10.50	€11.46
Cannabis herb* (standard quality)	£3.07	£3.14	£4.43	£4.29	£4.29
	€4.49	€3.95	€4.98	€5.00	€4.92
Cannabis resin*	£1.94	£1.80	£3.00	£3.71	£3.71
	€2.84	€2.27	€3.37	€4.33	€4.25
Cannabis (high quality)*	£4.73	£4.63	£5.71	£7.14	£6.57
	€6.91	€5.83	€6.41	€8.33	€7.53
Cocaine powder	£43.00	£42.00	£39.00	£42.00	£50.00
	€62.86	€52.87	€43.81	€48.99	€57.31
Ketamine	£25.00	£20.00	£22.00	£20.00	£21.00
	€36.55	€25.18	€24.71	€23.33	€24.07
Ecstasy (per tablet)	£2.40	£2.30	£2.00	£2.65	£4.58
	€3.51	€2.90	€2.25	€3.09	€4.61
Heroin	£43.00	£49.00	-	£50.00	£66.67
	€62.86	€61.68	-	€58.32	€76.42
MDMA powder	£38.00	£39.00	£36.00	£32.00	
	€55.55	€49.09	€40.44	€37.32	
Mephedrone	-	-	-	£19.00	£17.00
	-	-	-		€19.49

*Until 2008, cannabis prices were converted from ounce prices but in 2009 they were converted from quarter ounce prices.

Source**:** DrugScope 2011

10.4.4 Purity of drugs at street level and composition of drugs/tablets

Until 2007 drug purity data were provided by the Forensic Science Service (FSS). Following the growth of private forensic services, in 2008 and 2009 data were combined with data from the second largest provider, LGC Forensics. In December 2010 it was announced that the FSS was to be closed down by the end of March 2012 with SOCA taking custodianship of the national drugs intelligence function. Data for 2010 onwards has been provided by SOCA from an expanded number of forensic agencies.

Data on cannabis potency are not provided due to concerns about the representativeness of samples submitted for forensic analysis. A cannabis potency study was carried out in 2008 (Hardwick and King 2008). No further study has been carried out. Purity data are shown in Table 10.8 and commentary is provided by individual drug.

Table 10.8: *Street-level 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**	2011
Amphetamines	10.8	9.0	10.1	10.6	10.9	7.8	8.0	8.0	10.4
Cocaine powder	51.2	42.4	42.7	34.5	33.2	28.8	20.3	23.8	26.2
Crack cocaine	69.6	63.7	64.8	49.5	52.3	43.1	27.1	31.0	26.3
Ecstasy***	64.5	66.7	66.3	48	51.8	33.1	43.5	49.0	71.0
Heroin (brown)	32.7	39.9	46.5	43.5	49.8	42.7	44.4	34.9	17.6

*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

Heroin

Data show that there was a large decrease in the average purity of heroin in 2011 (Table 10.8). This follows reports of a reduction in the availability of heroin from late 2010 both within the international supply chain and within the UK. Indeed, the number of seizures the purity data in Table 10.8 is based on decreased by almost one-third in 2011 and seizures data also show a decrease in the quantity of heroin seized in 2010/11 (see section 10.3.2). Despite reports of a reduction in the supply of heroin and an increase in the wholesale price, the street-level price of heroin, as reported by law enforcement agencies, decreased from £45 per gram to £40 per gram. However, when adjusting for purity, the price of heroin increased significantly from £42.16 to £74.32 (Table 10.9). This suggests that dealers are more likely to adulterate their product in times of shortages than increase the price as indicated in research studies (Matrix Knowledge Group 2007). Street-level heroin is commonly adulterated with both caffeine and paracetamol.

An analysis of the potential mark-up of heroin from wholesale to street level has been undertaken using the following calculation:

$$\textit{Bulking} = \frac{wholesale\ purity}{street-level\ purity} \times 1000$$

$$\text{Mark-up} = (Bulking\ x\ street\ price) - wholesale\ price$$

This suggests that the potential profit in 2011 was £32,000 higher than in 2010 (£87,000 compared to £55,000). While this is a crude measure of profitability, it demonstrates how reductions in the supply of heroin are unlikely to have a large impact on criminal profits and, in fact, could provide an opportunity to increase profits.

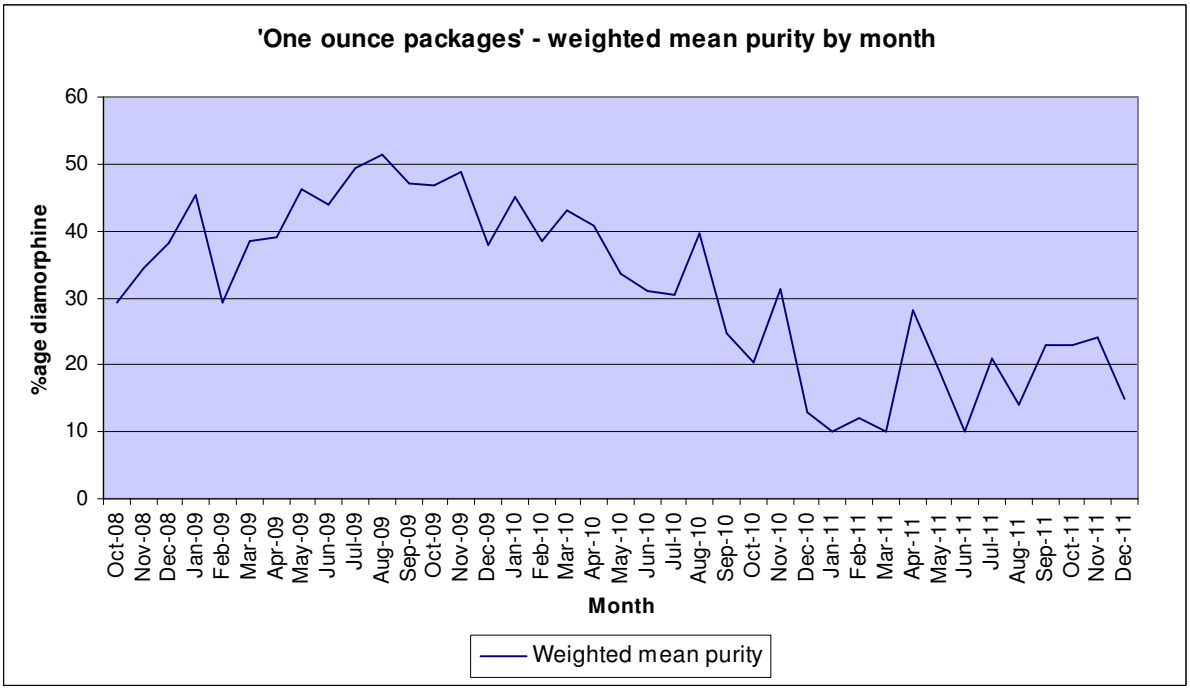
Table 10.9: *Purity-adjusted price of heroin per gram in the UK, 2003 to 2011: indexed to 2003*

Drug	2003	2004	2005	2006	2007	2008*	2009	2010	2011
Heroin	£62.00	£45.08	£37.97	£39.09	£31.52	£34.46	£33.11	£42.16	£74.32
	€89.63	€66.44	€55.55	€57.35	€46.08	€43.38	€37.19	€49.55	€85.19

Source: Standard Tables 14 and 16

Data from SOCA ENDORSE[284] show that the weighted mean purity decreased substantially in the second half of 2010 and, while purity increased slightly near the end of 2011, it is still well below the levels in 2009 and the first half of 2010 (Figure 10.1).

Figure 10.1: *Weighted mean purity of one ounce packages of heroin in the UK by month, October 2008 to December 2011*



Source: SOCA ENDORSE

Cocaine

The mean purity of cocaine powder increased for the second year in a row after decreasing since 2005 (Table 10.8). The purity remains far below the levels seen in 2005 and almost half the level of 2003. Cocaine powder is commonly adulterated with benzocaine and levamisole.

Given that the price of cocaine powder remained stable and purity increased slightly, there was a decrease in the purity-adjusted price of cocaine powder from £86.05 to £78.17 following a peak in 2009 (Table 10.10). Nevertheless, the price remains 42% higher than in 2003.

Table 10.10*: Purity-adjusted price of cocaine powder per gram in the United Kingdom, 2003 to 2011: indexed to 2003*

Drug	2003	2004	2005	2006	2007	2008*	2009	2010	2011
Cocaine powder	£55	£61.58	£58.75	£72.70	£70.94	£71.11	£100.89	£86.05	£78.17
	€79.51	€90.76	€85.95	€106.63	€103.71	€89.51	€113.33	€101.13	€89.60

Source: Standard Tables 14 and 16

MDMA content

Purity data show a large increase in the mean MDMA content of an ecstasy tablet from 49mg to 71mg (Table 10.8). This supports the assertion of a return of high MDMA content ecstasy, which can reportedly cost up to £15 (DrugScope 2011). However, as in previous

[284] SOCA Endorse is a nation-wide forensic initiative to collect and analyse information from Class A and amphetamine seizures made in the UK.

years, the purity data are based on an extremely small number of samples with only 10 records in 2011.[285] Despite this, there was a 50% increase in the number of illicit drug tablet records and an increase in the proportion of those tablets that contained MDMA from 11% to 43% (ST15). This suggests that ecstasy is becoming increasingly available after sharp declines in seizures in previous years (see UK Focal Point Report 2011).

New psychoactive substances

Despite an increase in the proportion of analysed tablets that contain MDMA, there remain a large proportion of miscellaneous tablets seized and analysed (ST15). The largest number of other tablets seized in 2011 contained diazepam (n=569,000) and piperazines (n=411,000). In addition there were over 30,000 records of phenazepam and 2-CB.

No data on the purity of new psychoactive substance are available. However, cutting agents such as benzocaine and caffeine have been found during forensic analysis of cathinone and piperazine powders. In addition, ephedrine has been found in a significant proportion of analysed piperazine tablets.

Cutting agents

Project Kitley is a SOCA project focusing on the disruption and investigation of the supply of cutting agents. It is reported that 9.1 tonnes of cutting agents were seized in 2011/12 worth a potential £410 million to organised criminals (SOCA 2012a). The cutting agents most commonly submitted for forensic analysis in 2011 were benzocaine, paracetamol and caffeine. Law enforcement agencies have been successful in destroying large consignments of cutting agents where no evidence of legitimate use had been demonstrated and have successfully prosecuted a number of criminals involved in the cutting agent trade (see section 9.2.5).

[285] The small numbers may be due to the fact that not all samples are sent for forensic analysis and, even when they are forensically analysed it is not necessary for evidential purposes to know the purity of a substance.

PART B

Selected Issues

11. Residential treatment for drug users

Drug treatment is provided using a range of different methods and settings. In the UK, residential rehabilitation services are provided by voluntary and private sector organisations. They offer structured programmes that may include psychosocial interventions, individual and group therapy, education and training, and social and domestic skills. These programmes and services may differ in their philosophy, inclusion criteria and delivery, but most share the common factors that residents have to stay overnight at the facility to receive treatment and that they are expected to be drug free before they start the programme.

Historically residential treatment services were located in large residences away from inner city areas of drug use, taking many users out of the environment in which they became dependent. Some providers in the UK are now implementing more innovative responses by offering "quasi–residential" drug treatment within urban centres by combining local accommodation and housing support with an off-site treatment programme. Other providers also offer detoxification as a first stage of treatment meaning that patients can be referred to these residential services prior to becoming drug free in community based drug treatment services.

11.1 History and policy frameworks

11.1.1 History of residential treatment

The Advisory Council on the Misuse of Drugs (ACMD)'s report, *Treatment and Rehabilitation*, published in 1982 (ACMD 1982) reported that there were 14 drug free rehabilitation houses in the UK with a total of 229 places, which could be divided into three categories: Christian-based houses; concept-based therapeutic communities (TCs); and community-based hostels (see section 11.2.2). The concept-based TCs were the most common type of residential establishment, accounting for half of the available beds at the end of the 1970s (Yates 2003). However, the report's analysis of referrals and admissions to eight rehabilitation houses showed that demand appeared to outstrip supply with four out of five applicants not gaining admission. The main reasons provided in the report were: no vacancies; applicant being imprisoned; or delays in obtaining funding.

The dominant model of drug treatment at this time was hospital-based Drug Dependency Units (DDU), which offered mainly outpatient treatment. Findings from a survey of outpatient DDUs carried out in 1982 showed that around three-quarters of DDUs made referrals to concept-based TCs and around one-third to Christian-based houses (Smart 1985). However, the majority made referrals infrequently and evidence from the ACMD's 1980 survey showed that only 17% of referrals to the eight rehabilitation houses came from drug treatment clinics or GPs (ACMD 1982).

Following advice from the ACMD to increase funding, the Government made £17.5m available for treatment services between 1983 and 1989 under the Central Funding Initiative (CFI). Sixteen per cent of these monies went to residential rehabilitation services with the majority going to community services (Mold and Berridge 2007) many of which were new establishments. Yates (2003) contends that it is this proliferation of community services, partly as a result of the HIV/AIDS scare, that was responsible for the decline of the TCs influence in drug treatment. Indeed, the ACMD's 1988 report on AIDS and drug misuse (ACMD 1988) called for community services to be "substantially developed and expanded" in order to attract clients who hitherto would not have been in contact with services and to have harm minimisation as its main focus. The ACMD estimated that there were 36 residential rehabilitation services in England and two in Wales at this time.

By the late 1980s it was estimated that there were around 50 units providing residential rehabilitation for drug users, many voluntary organisations with modified concept houses dominating and around 20% Christian based houses with some facilities offering the Minnesota Model[286] (Franey et al. 1993). At this time, a small number of private residential clinics existed with fee-paying clients using largely 12-step approaches. Previously, residential rehabilitation services, like the DDUs, were predominantly located around London and the South-East of England but services had been opened in other areas of the UK. In 1992, the ACMD estimated that there were 72 residential rehabilitation services, with the Minnesota Model becoming increasingly popular. These facilities had changed in that many now accepted those on bail or parole and they were now likely to use community services to assess clients on their behalf. Cook (1988) contends that, while the Minnesota Model has no historical links to the therapeutic community movement it, nevertheless, was a continuation of the change in approach to psychological treatment. He also highlighted the fact that no two programmes are the same and while labelled MM, the emphasis may be different.

In 1993, community care reforms enacted through the *NHS and Community Care Act 1990* saw local authorities become responsible for allocating funds for residential care and therefore controlling access to residential rehabilitation (see section 11.2.1). This meant that drug treatment became part of community care budgets, which were under intense pressure from spiralling demands for elderly residential care and funding cuts. Furthermore, there were some doubts about the effectiveness of residential treatment, particularly the cost-effectiveness (Curson 1991). This has continued into the 21st Century with the Effective Interventions Unit (EIU) in Scotland finding in 2002 that there was inadequate evidence of the effectiveness of residential rehabilitation (EIU 2002).

Throughout the 1990s most treatment services were aimed at opiate users with the preferred method of treatment being community prescribing services. This limited the use of residential rehabilitation services, although there is some evidence that they were used more commonly in the treatment of the growing, albeit relatively small, number of cocaine users (Seivewright et al. 2000). Mold and Berridge (2010) claim that the advent of HIV and the *NHS and Community Care Act* created financial difficulty for residential rehabilitation services.

During the 2000s, reviews of residential services were undertaken in England (NTA 2005), Scotland (Scottish Government 2007) and Wales (Wilkinson and Mistral 2008) and there have been calls for an increase in the number of beds in use in residential treatment (Best et al. 2005) and improved accessibility (WAG 2008a). The National Treatment Agency for Substance Misuse (NTA) state that the lack of effective commissioning processes for inpatient and residential services impeded their growth in the late 1990s and early 2000s with spot purchasing rather than strategic commissioning the norm (NTA 2008). Residential treatment and rehabilitation services are recognised as an integral part of the treatment system. In England, the Department of Health made £54.9 million available for capital investment in Tier 4 services[287] (see section 11.1.2) in 2007/08 and 2008/09.[288]

[286] The Minnesota Model is a holistic grass roots model that aims to address the needs of the individual seeking help for addiction, and their caregiver. It originally focussed on alcohol addiction.
[287] The NTA's *Models of Care* guidelines (NTA 2006a) set out a four-tiered framework for providing drug treatment. The tiers refer to the level of interventions provided. The degree of individual need and support usually increased with each tier. Tier 4 services typically included specialised residential substance misuse units/wards (NTA 2006b; see UK Focal Point Report 2010).
[288] See: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4137601.pdf

11.1.2 Strategy and policy frameworks

Drug strategies

Across the United Kingdom, residential rehabilitation is seen as an important component of an integrated care pathway (NTA 2006a; Scottish Government 2008a). As such, all local teams responsible for drug services are expected to provide access to residential services. Residential services are explicitly mentioned in the drug strategies of Scotland (Scottish Government 2008a) and Wales (WAG 2008a) but not in the Home Office strategy (HM Government 2010) or the Northern Ireland strategy (DHSSPSNI 2011). The Welsh strategy document, *Working together to reduce harm* is the only strategy with an objective explicitly related to promoting access to residential rehabilitation services (WAG 2008a). Nevertheless, all recent drug strategies place an emphasis on recovery (see section 1.1; SQ32) and value the potential of residential services to support recovery as part of an integrated drug treatment system.

In England, the 2010 *Drug Strategy* (HM Government 2010) set out to bring together all aspects of substance misuse treatment and to tackle drug treatment in all settings, whether community, in-patient, residential or prison. It led to a consultation on a national framework for recovery to replace the previous tiered model set out in *Models of care for treatment of adult drug misusers,* which was published in 2002 and updated in 2006 (NTA 2002; 2006a). The response to consultation put aside the concept of separate tiers for community and residential drug treatment services placing residential treatment alongside other treatment interventions as an integrated part of local treatment systems. The Home Office's document, *Putting Full Recovery First* looks to develop patient placement criteria to provide commissioners with clear cost-effective rationale for referring to residential services (Home Office 2012e).

Financing of residential treatment

The *NHS and Community Care Act 1990* shifted responsibility for funding residential rehabilitation to local authority social care services (see section 11.1.1). Social services departments continue to play a major role in funding residential services for drug users. In 2010/11, of the £42 million estimated by local area expenditure reports[289] as being spent on residential rehabilitation in England, £20.2 million was reported to come from social services budgets with a further £1.8 million reported to come from other local government funds. The pooled treatment budget (PTB) contributed £12.8 million for residential rehabilitation, which accounts for less than five per cent of PTB expenditure.

Similarly, a review in Scotland found that social services department contributed two-thirds of the funding made available for residential rehabilitation in 2005/06 with the remainder coming from NHS Boards (Scottish Government 2007).

The Welsh Government ring-fences £1m of its £22m Substance Misuse Action Fund budget for Tier 4 Inpatient Detoxification and Residential Rehabilitation services. This budget is allocated to the 22 Community Safety Partnerships across Wales and is required to be signed off by the Substance Misuse Area Planning Boards, which are co-terminous with the seven health Boards in Wales. In addition, Local Authorities may utilise their ring-fenced social care budgets to fund additional residential rehabilitation places.

Other sources of funding for residential rehabilitation include the Supporting People grant and Drug Interventions Programme (DIP), which are more likely to be used for homeless clients or those clients engaged with the criminal justice system respectively.

[289] Self-reported funding and expenditure profiles were provided by each local Drug Action Team as part of their local treatment plans. The data were of varying quality and the requirement to provide a breakdown no longer exists.

Funding is consistently mentioned as a barrier to accessing residential rehabilitation (Best et al. 2005). In the NTA's *Models of residential rehabilitation* document (NTA 2006b), it states that a mixed economy of care is necessary to secure the provision of residential rehabilitation and that over-reliance on finance from community care funding leads to financial difficulties. It also suggests a mixture of spot purchasing and block contracts to provide services with some degree of security and to maintain flexibility for commissioning.

Unit costs of residential rehabilitation

The unit cost of residential rehabilitation in England in 2010/11 is estimated to be £647 per resident per week or a cost of £92.43 per day (Curtis 2011).[290] This compares to a unit cost of £7.33 per person per day for specialist prescribing and £5.84 per person per day for structured psychosocial treatments: two possible components of community drug treatment (see UK Focal Point Report 2010).[291]

Role and performance of residential rehabilitation

The NTA (2012i) looked at the role and performance of residential rehabilitations as part of the wider treatment system in order to identify the groups of service users for whom they are likely to be able to offer added value over cheaper community options. In light of the high cost of each residential rehabilitation place[292], the NTA aimed to better inform commissioners as England moves towards outcomes based payments. Data from the National Drug Treatment Monitoring System (NDTMS) show that 4,166 individuals in treatment in 2010-11 had attended residential rehabilitation as part of their latest treatment pathway. Out of 3,972 individuals (194 were recorded as still in treatment), 1,110 (28%) left the treatment system directly after residential rehabilitation having overcome their dependency, 898 (23%) continued treatment with a community-based provider (of these 457 then left the treatment system following continued support from a community provider), 144 dropped out and 279 were still in treatment in the community as of March 2012. Just over one-third (1,441, 36%) of the original cohort were recorded as dropping out of residential rehabilitation. The findings indicate that residential rehabilitation is an integrated part of the whole treatment system and is not always an 'exit door' from treatment. A total of 428 clients (11%) were lost to the treatment system following unplanned discharges from treatment. Drop-outs could be due to drug users being put forward for residential rehabilitation before they are ready, or the complexity of those who are referred to residential rehabilitation. They are often using both crack cocaine and heroin, injecting, more likely to be offenders and more likely to have had a higher number of previous unplanned episodes of treatment than other users. Therefore, it is important that clients are adequately prepared by community services before going into residential services and for residential services to ensure they can meet the needs of clients to minimise early drop outs. The data also highlight differences between individual providers as some achieve nearly 80% success rate (measured by numbers of successful completion) and some achieving below 10% success rate. The authors argue that residential rehab is a vital component of the drug treatment system that it can add value to the treatment system by concentrating on the most complex cases and that providers will have to demonstrate their cost effectiveness to ensure their services continue to be commissioned.

[290] Estimated from a sample of 34 residential rehabilitation services. Costs have been uprated from 2007/08 using the Gross Domestic Product (GDP) index.
[291] Prices have been uprated 2007/08 data reported in UK Focal Point Report 2010. The GDP index has been used.
[292] Residential rehabilitation accounts for 10% of central funding for two per cent of people in adult drug treatment.

11.2 Availability and characteristics of residential treatment

This section includes directories, registers and any ad-hoc assessments that provide details of residential rehabilitation availability in the UK, or parts of the UK. The numbers drawn from these sources will only be relevant for the time at which they were collated and may not reflect the current situation. This is due to the fluidity of the residential rehabilitation sector.

11.2.1 National (overall) availability and accessibility of residential treatment

Treatment directories

There is no central register of residential treatment services for drug users in the United Kingdom. However, there are a number of directories produced by government agencies, charities and independent organisations, which aim to list all the services available.

Drink and Drugs News (DDN)[293] have compiled and published a directory of residential treatment services for drug and alcohol users throughout the UK and the Channel Islands. DDN also provides information on programmes and additional services available in each unit. As DDN offers advertising space within the directory, non-statutory providers are more likely to include their details in this directory and pay for additional advertising space. Compilation of the directory is carried out by DDN staff who source information and rely on organisations approaching DDN to request a listing and, possibly, advertisement space (personal correspondence – DDN). DDN's (2011) autumn publication reports a total of 164 drug and alcohol, residential rehabilitation services in the UK. However, the directory also includes detoxification only and supported accommodation services in its listings.

In 2010, the NTA established 'Rehab Online'[294], an online directory of residential drug and alcohol treatment providers in England and Wales. This superseded the NTA's 'BEDVACS': an online listing of residential treatment vacancies and a residential treatment directory. All residential treatment providers can register on the website and submit details regarding their services, facilities and number of beds on a voluntary basis. The NTA had envisaged that the information would be updated weekly to keep records of vacancies up-to-date; however, they are reliant on the service providers to update their own information. In February 2012 *Rehab Online* listed 112 residential rehabilitation services for adult drug users, although this includes some detoxification-only units and some quasi-residential (support housing) services where accommodation is contractually linked to a programme of treatment provided elsewhere.

The Scottish Drugs Service Directory, hosted by the Scottish Drugs Forum, maintains an online directory of drug services in Scotland, including residential rehabilitation units. Information about the specific programmes and additional services they offer is also included. Services can add their own information and continue to update it through an online form, which is submitted for approval to the Scottish Drugs Forum before being updated online. This website also relies on service providers to update their information voluntarily. In February 2012, the directory listed 17 residential rehabilitation units, although it also lists supported housing units and units offering inpatient detoxification only.

All four Northern Ireland Drug and Alcohol Co-ordination Teams (DACTs) have produced a directory of drug and alcohol treatment services available in their respective areas. These directories suggest that there is only one residential rehabilitation unit for drug users in Northern Ireland. However, an additional unit was identified through personal correspondence with the Department of Health, Social Services and Public Safety (DHSSPS), Northern Ireland.

[293] See: http://www.drinkanddrugsnews.com/
[294] See: http://www.rehab-online.org.uk

The directories described above and information gathered through personal correspondence with the NTA, devolved administrations and treatment services, have been used to estimate the availability of residential rehabilitation units in the UK (Tables 11.1 and 11.2; Figure 11.1).[295]

Residential units

Across the UK it is estimated that there are 120 residential rehabilitation services with a further 18 private hospitals providing residential rehabilitative treatment. The majority of residential treatment programmes have a minimum length of less than six months (70.2%, n=85) with just over half of these (n=48, 56.5%) offering programmes[296] with a minimum length of between three and six months (Table 11.1). Those offering treatment programmes of more than 12 months accounted for six per cent of the services (n=7). Data taken from the National Drug Treatment Monitoring System (NDTMS) and the Welsh National Database for Substance Misuse (WNDSM) estimate that during 2010/11 there were 2,938 clients in residential treatment and 2,118 clients entering treatment. Of the 2,938 clients in residential treatment in England and Wales, approximately three-quarters (75.6% n=2,222) were male and approximately one quarter (24.4% n=716) were female, a similar pattern to outpatient treatment centres. Three residential rehabilitation units in Wales reported to the WNDSM in 2010/11 while 93 units reported to the NDTMS in 2010/11. According to the *Census of Drug and Alcohol Treatment Services in Northern Ireland* carried out on the 1st March 2012, there were 14 individuals in residential treatment services for drug misuse and a further 33 who were in residential treatment services for drug and alcohol misuse. Together, the two groups accounted for 2% of all those in treatment for either drug, or drug and alcohol use on 1st March 2012 (NISRA 2012a).

Table 11.1: *Availability and uptake of residential rehabilitation services in the UK and minimum duration of programmes.*

Generic term: Residential treatment		**Programmes included and specific national terminology**		
Number of units in the country	120	12-Step, Cognitive Behavioural Therapy (CBT), social learning, Therapeutic Community (TC), Eclectic/Integrated programmes, Christian philosophy.		
Number of clients in 2010/11	2,938[297]			
Minimum duration	< 3 months	3 < 6 months	6 < 12 months	> 12 months
Number of units	21	66	27	6

Source**:** Rehab Online (NTA), DDN (2011), Scottish Drugs Services, personal correspondence – DHSSPS, Northern Ireland, NDTMS and WNDSM

[295] Directories and information were cross-referenced to ensure that information was not duplicated, or omitted. Service websites were checked to ensure that services had not closed down since directories had been published.

[296] For an explanation of these programmes see 11.2.2

[297] Includes data for 93 residential rehabilitation units reporting to the NDTMS in England during 2010/11 and three units reporting to the WNDSM in Wales during 2010/11. Most cases from residential rehabilitation units in Northern Ireland relate primarily to alcohol and therefore are not added to the Northern Ireland Drug Misuse Database.

Most of the 18 independent hospitals offering residential treatment for drug users in the UK run programmes with a minimum length of three months or less (16). A small number (2) offer programmes with a minimum length of three to six months (Table 11.2). None of the independent hospitals offer programmes of more than six months.

Table 11.2: *Availability of hospital rehabilitation services in the UK, number of clients and minimum duration of programmes.*

Generic term: Hospital (private) treatment		Programmes included and specific national terminology		
Number of units in the country	18	Independent hospitals that offer residential treatment for drug users provide greater access to medical staff, including consultant psychiatrists and access to doctors and nurses 24-hours a day. Hospital based residential treatment units also incorporate psychosocial interventions such as CBT.		
Number of clients in 2010/11	*			
Minimum duration	< 3 months	3 < 6 months	6 < 12 months	> 12 months
Number of units	16	2	0	0

*Treatment data are not broken down for private units.

Source: Rehab Online (NTA), DDN (2011), Scottish Drugs Services, personal correspondence – DHSSPS, Northern Ireland.

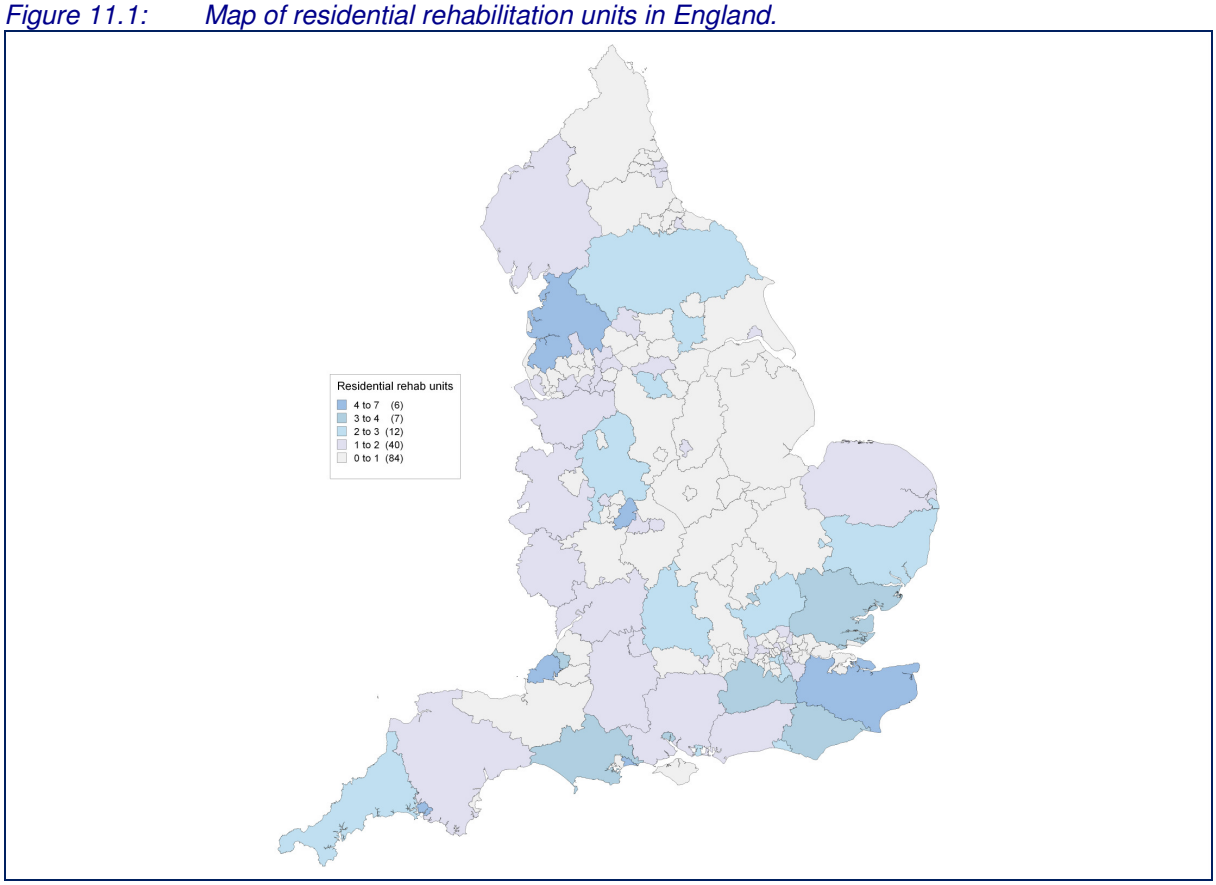
Residential rehabilitation units are either non-profit organisations or commercial organisations. In the UK, 56% (77) of the estimated number of residential rehabilitation units are run by not-for-profit, charitable organisations (including registered charities). Commercial organisations account for 44% (61) of the estimated number of residential rehabilitation units in the UK. Almost all the commercial organisations are situated in England. In England, half (58) of the identified residential units are commercial organisations and half (58) are charitable organisations. However, in both Wales and Northern Ireland, all of the identified residential rehabilitation units are charitable organisations. In Scotland, 12 of the identified units are charitable organisations and three are commercial organisations.[298]

Geographical availability

Figure 11.1 shows the geographical availability of residential rehabilitation services in England. The South East and North West have the highest concentration of residential rehabilitation services with lower numbers in the Midlands. Nevertheless, residential rehabilitation is often a national resource with clients accessing residential rehabilitation outside of their local area and Community Safety Partnerships in Wales also referring clients to English services.

[298] Estimates are based on information from DDN (2011), Scottish Drugs Service, NDACT Directories, personal correspondence with the devolved administrations and services. They have been cross-referenced with service websites.

Figure 11.1: Map of residential rehabilitation units in England.



Source: Rehab Online (NTA), DDN (2011)

Ad hoc studies

Other sources of information on availability of residential drug rehabilitation services are ad-hoc needs assessments and service reviews.

Needs assessment for Tier 4 services in England

The NTA (2005) carried out a needs assessment for Tier 4 drug treatment services in England and sent questionnaires to 105 residential rehabilitation services identified through the NTA's residential directory 'BEDVACS'. Sixty-five of these services responded to the survey. The authors estimated that 6,090 residential rehabilitation spaces were available in 2003/04.[299] However, NDTMS returns were lower, at 4,531 for the same period, giving a mean occupancy rate of 74%. Despite this, services reported that one of the key needs was an increase in the number of beds.

The NTA's latest audit of residential rehabilitation services found that 4,166 individuals in drug treatment in 2010-11 had received residential rehabilitation as part of their latest treatment pathway. Three-quarters of them (76%) had treatment in community services before accessing residential rehabilitation.

[299] Estimate based on 58 drug patients being treated by the 48 agencies, who returned the questionnaire, extrapolated up to the 105 residential rehabilitation services identified.

Review of residential rehabilitation in Scotland

A review by the Scottish Government found that there were 22 residential treatment services for drug and alcohol misuse in Scotland in 2005/06, with an estimated total of 352 beds, ranging from two beds to 104 beds per service (Scottish Government 2007). The estimated capacity per year in Scotland was 1,670 clients. This number includes alcohol only services, so the number providing services for illicit drug users will be lower.

Tier 4 treatment in Wales

The Welsh Government is currently conducting a survey of providers and commissioners to assess the availability of Tier 4 treatment units/beds, to improve the referral process and to ensure that clear referral pathways are in place. A report summarising the outcome of the questionnaires will be taken to Ministers in late 2012.

Referral pathways

In England, each local area is expected to have clear referral pathways and protocols in place for people wishing to access residential treatment. Eligibility for funding is determined by a community care assessment. An initial assessment will also be carried out by the service to establish whether residential rehabilitation is the most appropriate treatment for a client (NTA 2006b). Clients who wish to self-fund their treatment will undergo an assessment by the residential facility to determine their needs.

In additional analyses requested by the UK Focal Point, data on referral source for those in treatment were taken from the NDTMS and the WNDSM. In 2010/11, just under half (45.9%) of all clients in residential rehabilitation in England and Wales were referred to a unit by a hospital or another medical source. Self-referrals or referrals from family and friends accounted for 14.7%, while social services and court/probation/police accounted for 11.9% and 12.4% of referrals, respectively. Other drug treatment centres accounted for 10.8% of the referrals and the least common referral source were GPs at 0.8% (Table 11.3).

Table 11.3: *Source of referral for clients in residential rehabilitation in England and Wales in 2010/11*

Source of referral	2010/11	
	n	%
Self-referred/family friends	431	14.7
Other drug treatment centre	317	10.8
GP	23	0.8
Hospital/other medical source	1343	45.9
Social services	350	11.9
Court/probation/police	362	12.4
Other	103	3.5
Sub total	*2929*	*100*
Not known/missing	9	
Total	**2938**	

Source: NDTMS and WNDSM

The financing of residential rehabilitation plays an important role in determining access (see section 11.1.1). In view of the increased cost and comparable outcomes of residential treatment with community based treatment, NICE recommend that community services should be the frontline treatment option and that residential rehabilitation should be considered particularly for people with co-morbid physical, mental health or social problems. The NICE guidelines on psychosocial interventions also state that all community treatment options should have been exhausted before residential rehabilitation is considered (NICE 2007b).

Waiting Times

ISD Scotland waiting times data for drug and alcohol treatment (ISD Scotland 2012d) show that in the first quarter of 2012 (January to March), 92% of all those seeking residential rehabilitation or residential detoxification started treatment within one week of being ready for treatment and 4.2% were placed two weeks after being ready for treatment. The remainder were placed between three weeks and 16 weeks. During the second quarter of 2012 (April to June), 87.6% of clients seeking residential rehabilitation or residential detoxification started treatment within one week and a further 7% started treatment in two weeks.

11.2.2 Types and characteristics of residential treatment units

Common approaches

The NTA's *Models of residential rehabilitation for drug and alcohol misusers* identifies two sub-sets of rehabilitative programmes: long stay (six-months or more for long-term and entrenched addiction) and short stay (less than 12 weeks) (NTA 2006b). It also lists approaches used in residential rehabilitation services in England and the number of services adopting each approach. Although the list is not exhaustive, it does include commonly used approaches:

- 12-Step views addiction as a disease and originates from the 12-Step Alcoholics Anonymous model. Clients will often complete the programme in the community after exiting a residential service;
- Cognitive Behavioural Therapy (CBT) is a psychosocial treatment and is based on the idea that a person's thoughts cause their behaviour. CBT aims to teach the patient to recognise when they are likely to take drugs and to avoid these situations;
- Therapeutic Communities (TC) - In a TC, both staff and clients participate in a social and learning community and tend to be approximately six months long; and
- faith-based (i.e. Christian Philosophy) services employ staff with religious beliefs and may require residents to share that particular faith.

Many services do not use one approach exclusively, but use a mixture of approaches tailored to a client's needs. The NTA's Rehab Online Directory lists 37 services that use, what they describe to be, an eclectic/integrated approach by combining some of the above listed approaches.

In their treatment framework guidance, the WAG[300] identified three main approaches to residential rehabilitation: Social Learning Theory[301] based programmes; 12-step programmes; and faith-based Therapeutic Communities (TCs) (WAG 2004b). In contrast to the NTA, the Welsh Assembly Government identified TCs as faith-based, whereas the NTA separated the two approaches.

Powis et al (2012) explored the treatment integrity of custodial addiction therapeutic communities by exploring current delivery in four prisons (see section 9.6.1). TCs were seen to be functioning well and adhering to the model of an addiction TC.

Age of first drug use and access to residential rehabilitation

In 2010/11, the average age of those in treatment for heroin use in Wales was 33 years old while the average age in England was 35 years old. The average age of first use of heroin amongst this group was 19 in Wales and 20 in England resulting in an average time lag of 14 years and 15 years respectively. In England, those in residential rehabilitation for primary

[300] Now the Welsh Government.
[301] Social Learning Theory asserts that people learn within a social context

cocaine use also had an average age of 35 and an initiation age of 20. However, those in treatment for primary cocaine powder use were younger (32 years old) than those in treatment for primary crack cocaine use (36 years old) and had a shorter time lag between initiation and being in residential rehabilitation (13 years for cocaine powder users and 16 years for crack cocaine users). The average age of primary stimulant users was the same as cocaine and heroin users; however, their average initiation age was much younger at 17, resulting in an increase of three years in the time lag from initiation to being in residential treatment. Primary cannabis users had a much younger initiation age of 14 and an average age of 32 while in treatment in 2010/11.

Typical mix/integration of services

OST and detoxification

Residential rehabilitation services in the UK are based predominantly on an abstinence model, where residents are required to be drug free and the end goal is that of continued abstinence. Some residential rehabilitation services are just one of a few services offered by an agency. NICE guidelines on psychosocial interventions for drug misuse state that anyone entering residential treatment should already have completed a residential or inpatient detoxification programme (NICE 2007b). A number of residential rehabilitation services offer detoxification for those who are still taking drugs, as the first step within the residential unit. The NTA's (2005) needs assessment found that 22 out of 65 services (34%) offered an additional detoxification service. According to the Drink and Drugs News directory (DDN 2011), there are 72 residential rehabilitation units offering detoxification in England. The DDN directory does not provide details of whether this is community-based, in-house or by referral. The Scottish Drugs Service lists the type of detoxification available with: two units offering in-house detox only; one offering in-patient detox only; five units offering both in-house and inpatient detox; two units offering both inpatient and in-house detox as well as detox by referral: two offering detox by referral only; and one offering support for home-based detox only. Two units in Wales offer in-house detox to residents. Neither of the units in Northern Ireland offer detoxification programmes.

Infectious diseases

The Scottish Drugs Service provides space for residential rehabilitation services to include information on any infectious disease screening services that they offer. Four of the services listed offer counselling for infectious diseases, one service offers a testing service and three offer testing and vaccinations (hepatitis A and B).

Aftercare

In a joint review carried out by the NTA and the Healthcare Commission (now the CQC) (2007), it was found that 88 per cent of inpatient and residential services had policies to enable service users to effectively integrate into the community and to provide appropriate aftercare following the service user's exit. Out of the 164 drug or drug and alcohol residential rehabilitation services listed by DDN (2011), 85 units offer aftercare and 69 units offer resettlement. The NTA's report on the role of residential rehabilitation in an integrated drug treatment system found that residential rehabilitation is not an automatic door from the treatment system, but an integral part of a network of services and the majority of residential rehabilitation clients return to community-based treatment services for further structured support afterwards.

Mental Health

The DDN directory states whether a service deals with dual diagnosis clients or not. A total of 79 of the listed residential rehabilitation units are able to accommodate dual diagnosis clients.

The Scottish Drug Service website provides details of which mental health issues each service is capable of assessing and the mental health interventions available in each service

to deal with such issues. According to the NTA's (2006b) *Models of residential rehabilitation* publication, most residential rehabilitation services are able to work with those who have co-existing mental illness as long as they are not severe and enduring. A needs and risk assessment will determine if the mental illness is too severe for the client to participate fully in the rehabilitative programme.

Specific subgroups

A number of services listed by the residential treatment directories are gender specific. For example, DDN (2011) lists 16 services that are for men only and four services that are for women only. One unit in Wales provides services specifically for women and accepts pregnant women and women who wish to have their young children stay with them at the unit. In these units, additional services are provided and a greater number of service standards and regulations need to be met in order to safeguard residents' children.

Families

DDN (2011) lists 71 residential rehabilitation units in the UK offering family services. One particular service in England is specifically for single mothers, fathers or couples who wish to have their children living with them while they address their substance misuse issues. They cater for children up to the age of 10 and pregnant women are considered for admission. The NTA (2006b) states that, for services in England, specific standards need to be met for units offering family services.

Young People

The last remaining residential rehabilitation service specifically for young people (aged between 11 and 18) closed in 2010 due to a reported lack of funding as commissioners responded to evidence that, for most teenagers with drug problems, residential rehabilitation is not the only solution for their drug problems and often they can receive more appropriate care closer to home. The service, in England, offered a 12-week programme of rehabilitation and offered additional education, therapy, family medication services and activities. The service could house five residents at a time and treated over 400 young people from 1995 to 2010. It was registered as a children's home and was also inspected by Ofsted: the official body for inspecting schools.

Outcomes of residential rehabilitation

Keen et al. (2001) explored the short-term outcomes of residential rehabilitation in a therapeutic community setting using a records-based retrospective cohort study.[302] Retention in treatment for 90 days or more was used as the predictor of long-term success and therefore, the main outcome measure. Reason for departure, categorised as either completed treatment, planned or unplanned departure or expulsion from the programme, was chosen as a secondary outcome measure. Completed treatment and planned departure suggested a favourable outcome and constituted a 'success'. The number of days for which patients stayed in treatment ranged from one to 394 with a mean of 80.2 with 34 individuals (25%) completing 90 days or more. One hundred and thirty-eight entrants were categorised as failures and 18 were categorised as successes. Those who were drug free on admission were more likely to succeed than those who required detoxification. No other patient characteristics were found to be predictive of outcome.

11.2.3 Client characteristics

The majority (75.6%) of clients in residential rehabilitation in 2010/11 in England and Wales were primary opiate users and 17.9% were primary cocaine users. Two per cent were primary stimulant users and 2.5% were primary cannabis users.

[302] One hundred and thirty-eight drug users, who attended therapeutic communities in Sheffield, England over 12 months, were sampled.

Table 11.4: *Number and percentage of clients in residential rehabilitation by primary drug in 2010/11 in England and Wales*

Primary drug	n	%
a) Opiates (total)*	***2,201***	***75.6***
heroin	*2,010*	*69.0*
methadone	*126*	*4.3*
b) Cocaine (total)**	***521***	***17.9***
cocaine powder	*144*	*4.9*
crack	*376*	*12.9*
c) Stimulants (total)***	***63***	***2.2***
amphetamines	*57*	*2.0*
d) Hypnotics & sedatives	***33***	***1.1***
e) Hallucinogens	***17***	***0.6***
f) Volatile inhalants	***3***	***0.1***
g) Cannabis	***72***	***2.5***
h) Other substances	***2***	***0.1***
Sub Total	***2,912***	***100.0***
Not known/missing	*26*	
Total	***2,938***	

*breakdown does not add up to total as 'other opiates' are not included
**breakdown not provided for Wales
***breakdown does not add up to total stimulants as 'other stimulants' are not included
Source: NDTMS and WNDSM

11.3 Quality management in residential treatment

11.3.1 Availability of guidelines and service standards for residential treatment

National and/or local guidelines

There are a large number of guidelines in the UK covering a wide range of topics, settings and client groups. The devolved administrations, the National Institute for Health and Clinical Excellence (NICE) and the NTA are the main sources for guidelines relevant to residential rehabilitation.

NICE is a Special Health Authority funded by Department of Health. It is responsible for producing national guidance documents to promote good health and to treat and prevent ill health. All NICE guidelines[303] are based on an assessment of the available evidence on clinical and cost-effectiveness and are developed through extensive consultation with external organisations. NICE was originally established in 1999 to provide guidance to the NHS in England and Wales. However, Scotland and Northern Ireland have both implemented NICE guidance where relevant and/or appropriate. Consequently, the status of NICE guidance differs throughout the UK (see Table 11.2 in UK Focal Point Report 2010).

National clinical guidelines on psychosocial interventions produced by NICE (2007b), state that psychosocial interventions including contingency management, behavioural couples therapy and CBT, should be available in residential settings just as they are in community settings. The guidance also states that clients should have already completed a

[303] The *Health and Social Care Bill 2011* sets out plans for NICE to become a Non Departmental Public Body and for its remit to expand so that it produces quality standards for the social care sector.

detoxification programme and have exhausted other community-based treatment options before being considered for residential rehabilitation. In the case of relapse to opioid dependence, the residential unit should offer an urgent assessment with prompt access to further treatment.

Commissioning guidelines

Residential treatment is classified within the Models of Care document (NTA 2006a) as a Tier 4 treatment service and therefore, wider guidelines on Tier 4 provision apply to residential rehabilitation services. Guidelines on how to improve quality and provision of Tier 4 interventions for adult drug users in England, provided by the NTA, aim to help Drug Action Team (DAT) partnerships to improve the commissioning and delivery of Tier 4 services by addressing specific problems with accessing and facilitating access to services (NTA 2008).

The NTA's (2006b) framework *Models of residential rehabilitation for drug and alcohol misusers* also aims to support the commissioning of residential rehabilitation services, primarily, at a local level. It lists the types of residential rehabilitation services available in England, sets out the standards that providers should adhere to, and describes funding mechanisms and monitoring arrangements.

Residential Drug Treatment Services: good practice in the field (NTA 2009a) provides evidence of good practice in both commissioning and provision of residential drug treatment. The report's focus is on eligibility criteria for Tier 4 treatment, developing and reviewing contracts, using data to inform commissioning decisions and funding sources for residential rehabilitation. The report is based on evidence from interviews with local drug partnerships that had performed well in the NTA's 2007-2008 service review (NTA 2009b).

Northern Ireland

The Department of Health, Social Services and Public Safety (DHSSPS) has tasked the Public Health Agency and the Health and Social Care Board with developing a Regional Commissioning Framework for Addiction Services in Northern Ireland. The purpose of this work is to create a greater consistency of approach and access to services across Northern Ireland and to ensure that agreed care pathways and protocols are in place.

Clinical Governance

England

The NTA (2009c) has published guidelines on clinical governance for drug treatment services. All providers are expected to designate a clinical governance lead in their service and to adhere to the clinical governance activities of their parent or commissioning body. Similarly, clinical staff have a duty to participate in clinical governance as outlined by the professional body with which they are registered.

Although all providers of residential services and other regulated activities are required to register with and are assessed by the Care Quality Commission (CQC)[304], some providers will have more specific criteria to meet. Mental health and foundation trust substance misuse services are required to operate in accordance with, and actively participate in, their Trusts' clinical governance processes. The requirements for non-statutory service providers can be complex. Services commissioned by Primary Care Trusts (PCTs) are likely to be accountable to the commissioner for clinical governance, and assured against the *Standards for Better Health* (or future standards). Non-statutory services may additionally become answerable to commissioners outside healthcare organisations, funding bodies and, in the case of seconded NHS staff, NHS trusts.

[304] The CQC is responsible for checking all hospitals, care homes and care services to ensure they meet government standards.

Wales

The Welsh Government has an agreement in place with NICE covering technology appraisals, clinical guidelines and interventional procedure guidance, which all continue to apply to Wales. Although clinical guidelines issued by NICE are not subject to the Welsh Government's three months funding direction, NHS bodies in Wales are generally expected to take full account of the recommendations made by NICE when commissioning and delivering services to patients. The health standards in Wales, set out by the Welsh Government, ensures that, across the health care setting, services are provided in line with the clinical guidelines and technology appraisals produced by NICE.

11.3.2 Service standards and regulations for residential treatment provision

As health and social care are devolved responsibilities in the UK, there are different regulatory bodies for residential treatment provision in each of the four countries, as shown in Table 11.5.

Table 11.5: *Regulations and regulating bodies*

Country	Regulating Body	Regulation
England	The Care Quality Commission (CQC)[305]	*Health and Social Care Act 2008 (Regulated Activities) 2010*. For clients under the age of 18, *Supplementary Standards for Care Homes Accommodating Young People Aged 16 and 17*
Scotland	The Care Inspectorate[306]	*Regulation of Care (Scotland) Act 2001*
Wales	Care and Social Services Inspectorate Wales (CSSIW)[307]	*Registered Care Homes Act (1984) now the Care Standards Act (2000)*
Northern Ireland	Regulation and Quality Improvement Authority (RQIA)[308]	*The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003*

England

The CQC published guidance for residential substance misuse treatment/rehabilitation services (RSM) to follow, in order to comply with the *Health and Social Care Act 2008 (Regulated Activities) 2010* (CQC 2010) and to achieve registration with the CQC. The guidance provides details of the regulation in set outcomes. They include: respecting and involving people who use RSM services; consent to care and treatment; fees; care and welfare of clients; meeting nutritional needs; co-operating with other providers; safeguarding clients from abuse; cleanliness and infection control; management of medicines; safety and suitability of premises and equipment; and the suitability and requirements of workers. Staff must have experience and the necessary qualifications; they must also be registered with the relevant professional body for their role, have a full and satisfactory Criminal Records Bureau (CRB) check, be of good character and mentally fit for work. Residential rehabilitation services that provide any other healthcare, such as detoxification, may be required to meet PCT standards if they are commissioned for the purpose of detoxification (NTA 2009c).

[305] See: www.cqc.org.uk
[306] See: www.scswis.com/
[307] See: www.wales.gov.uk/cssiwsubsite/newcssiw/?lang=en
[308] See: www.rqia.org.uk/home/index.cfm

Service standards and staffing levels

Northern Ireland

The Regulation and Quality Improvement Authority (RQIA) assesses health and social care providers against essential service standards set out in the *Quality Standards for Health and Social Care* (DHSSPSNI 2006b). The five key quality themes are corporate leadership and accountability of the organisation; safe and effective care; accessible, flexible and responsive services; promoting, protecting and improving health; and social well-being and effective communication and information.

Wales

In 2004, the Welsh Assembly Government produced a *Service Framework for Residential Rehabilitation* within a wider *Substance Misuse Framework* (WAG 2004b). The document states that residential rehabilitation services in Wales should prioritise relapse prevention and details the stages of residential rehabilitation programmes, from the preparatory stage, to the longer-term residential rehabilitation and through to low intensity and move-on rehabilitation. In 2011, the Welsh Government produced a *Substance Misuse Treatment Framework (SMTF) Guidance for the Provision of Evidence Based Tier 4 Services in the Treatment of Substance Misuse* to replace the frameworks published in 2004 (Welsh Government 2011e). The new framework was developed to outline the best evidence on which interventions work for whom and in what circumstances, to inform decisions about Tier 4 services. The framework also aims to develop the Tier 4 workforce by highlighting their education and training needs.

A seminar was held in Llandrindod Wells in February 2011 to review Community Safety Partnerships' progress against implementing the Tier 4 guidance issued by the Welsh Government in July 2008 and to provide an overview of the changes made to the revised SMTF (Welsh Government 2011e). Following the seminar, a letter was issued in March 2011, tasking Substance Misuse Area Planning Boards with responsibility for implementing the revised SMTF and any remaining actions within the guidance yet to be implemented.

Scotland

The Scottish Government set up the National Care Standards Committee (NCSC) to develop national standards, which are relevant to residential rehabilitation for drug and alcohol users (Scottish Government 2011f). The standards were developed over 10 years when a national care regulator, the then Care Commission, was first set up in Scotland. Some of the regulatory functions of the Care Commission were taken over by the Care Inspectorate, which was established on 1st April 2011 under the *Public Services Reform (Scotland) Act 2010*. There are 16 standards; the first five concern the period before a client uses a service, standards six to 15 concern the period while a client is using the service and standard 16 is concerned with 'moving on'. The aim of the standards is to set out the minimum expectations of service providers and to guide the owner/manager on building requirements, staffing requirements and on how to manage the service. These are taken into account, amongst other criteria, by the Care Inspectorate when visiting and assessing a service. The standards are based on a number of principles: dignity; privacy; choice; safety; realising potential; and equality and diversity. Scottish Ministers recently announced a review of the standards to ensure that the needs of service users continue to be met. The Scottish Government are therefore currently undertaking initial development work on the scope and process of the review.

11.4 Discussion and outlook

Residential rehabilitation for drug users has been recognised across the UK as an important element of the whole treatment system and an individual's treatment journey. It can add value by concentrating on the most complex clients who require more intensive help and its potential to lead to recovery has been recognised in drug strategies across the UK. All frameworks and guidelines recognise that commissioners and service providers need to consider a multiagency approach in order to address the needs of the client. As suggested in the NTA in England's *Role and performance of residential rehabilitation* report, a multiagency approach can help improve residential rehabilitation success rates by ensuring clients are prepared before entering residential services by community services and that their transition out of such services is supported. The challenge for service providers will be to demonstrate the cost-effectiveness of residential rehabilitation as the commissioning of drug treatment in England moves towards a payment by results framework.

12. Recent trends of drug-related public expenditure

12.1 Introduction

Estimations of public expenditure on drugs were provided to the EMCDDA in 2007 (see UK Focal Point Report 2007) and a selected issue on the topic was published by the EMCDDA in 2008 (EMCDDA 2008). This chapter seeks to update the estimates for drug-related public expenditure using an improved methodology.

There is no standard methodology for estimating public expenditures on drugs and therefore it is important that the conceptual framework used is explicit (Reuter et al. 2004). In the 2007 selected issue, the terms labelled and unlabelled were used to categorise different types of public expenditure. Labelled was defined as any drug-related expenditure with a departmental budget line that is drug specific while unlabelled expenditure was defined as non-drug specific expenditure where a proportion may be attributable to drug use (see UK Focal Point Report 2007). This classification will be maintained with an additional distinction between proactive and reactive expenditure.

In studies on the *economic and social costs of Class A drug use in England and Wales* the authors use a conceptual framework that distinguishes between proactive and reactive expenditure (Godfrey et al. 2002; Gordon et al. 2006). The definition provided in Godfrey et al. (2002) is:

"Proactive government expenditure is defined as that spending which has the clearly stated objective of reducing drug use or problems. Reactive government expenditure is expenditure incurred which does not directly reduce either the prevalence of drug use or drug-related consequences but is the result of some consequence related to drug use." (p.1)

Another public expenditure study on drugs carried out in Australia uses this distinction, also referring to it as direct or indirect expenditure (Moore 2005). However, in studies carried out in Europe, the majority aim to identify direct public expenditure only. The rationale used by De Ruyver et al. (2007) to focus on direct expenditure only is that expenditure on the consequences of drug use is not drug policy specific and consequences could have other causes rather than drug use. Therefore, expenditure on consequences are classified as 'external' expenditures, which should be excluded from a public expenditure study.

However, in the UK, part of the argument for increased direct expenditure on the drugs problem, e.g.: through providing drug treatment, is to reduce the cost to society and the public purse of the consequences of drug use such as health and criminal justice costs. Indeed the majority of the evidence for the cost effectiveness of drug treatment in the UK that came out of the National Drug Treatment Outcomes Research Study (NTORS) (Godfrey et al. 2004) was the result of a reduction in crime costs. The study did not even measure health benefits and, although the subsequent Drug Treatment Outcomes Research Study (DTORS) did (Davies et al. 2009), the assessment of QALYs gained was secondary to an assessment of the reduction in cost consequences (see UK Focal Point Report 2011). Furthermore, the centrality of crime costs to economic studies of drug services is not unique to the UK and features strongly in similar studies undertaken on the other side of the Atlantic (Cartwright 2000).

Looking at both the proactive, direct drug policy costs and the reactive, indirect costs will help identify the financial flows and assess the impact of government action and expenditure on drug-related consequences. If the ultimate goal of public expenditure studies is to evaluate the cost-effectiveness of drug policies, this approach is imperative.

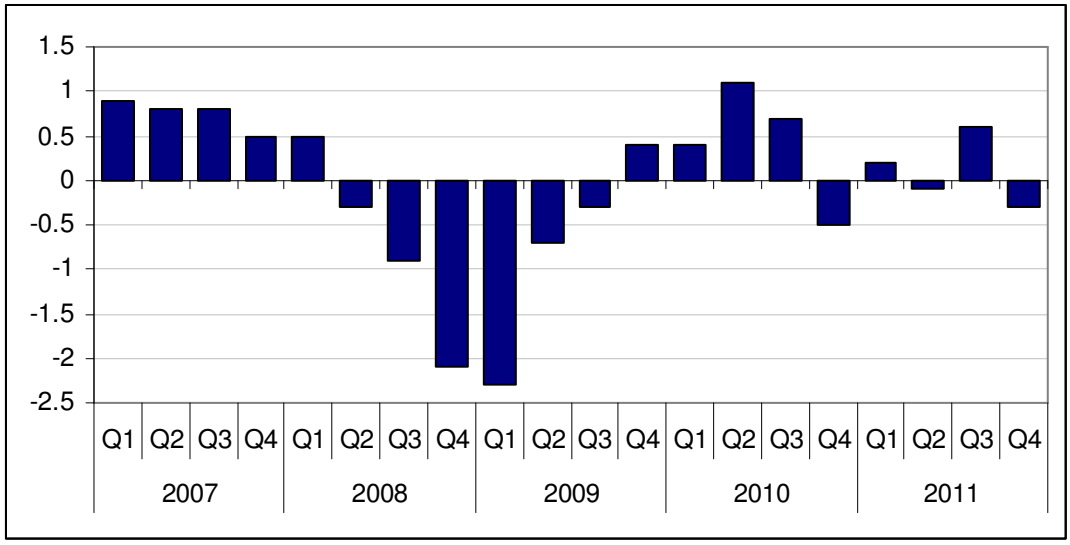
12.2 Economic situation

Over the period covered by this selected issue, a global economic crisis occurred, which was unprecedented in its size and synchronisation (Costa Storti et al. 2011). The World Health Organisation (2011) warned of the impact of economic crisis on mental health while the World Bank highlighted the tendency for health and social protection spending to reduce during budget austerity and urged governments to protect health expenditures in real terms, particularly for the most vulnerable groups in society (Gottret et al. 2009). It is pertinent, therefore not only to explore drug-related public expenditure over this period but also to put this in the context of overall changes in public expenditure.

12.2.1 GDP and inflation in the UK

Data from the Office for National Statistics (ONS) on gross domestic product (GDP) show that the UK economy shrank in the second quarter of 2008 with negative growth continuing for a further five quarters until the fourth quarter of 2009 (see Figure 12.1). Positive growth over the next three quarters was reversed with negative growth in the final quarter of 2010, although a slight positive growth in GDP during the first quarter of 2011 avoided the UK economy officially slipping back into recession. In 2011, each quarter of growth was followed by a quarter where the economy contracted.

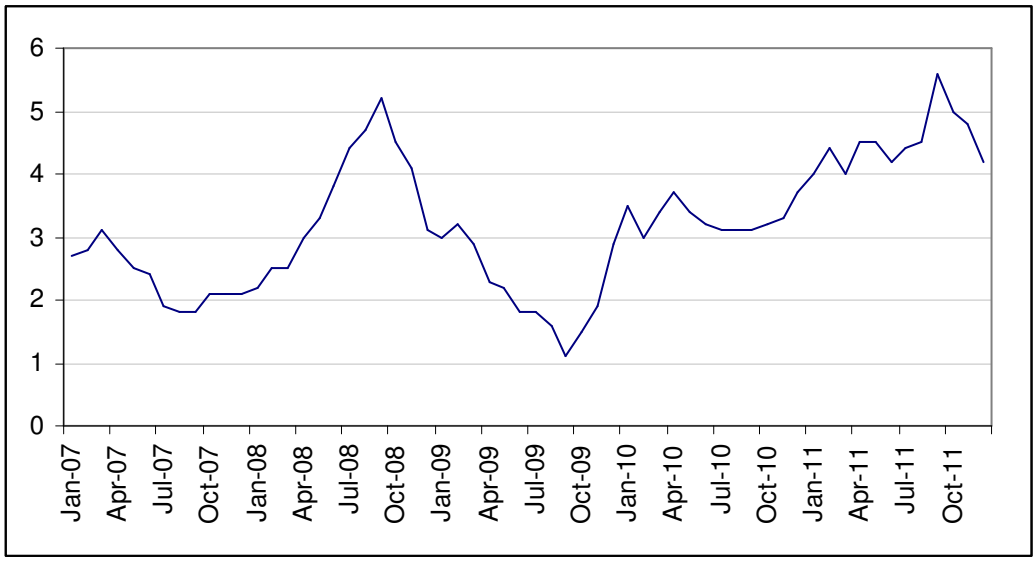
Figure 12.1: *Quarterly Gross Domestic Product (GDP) in the United Kingdom, 2007-2011*



Source: Office for National Statistics

In addition, inflation (as measured by the consumer price index) increased peaking at 5.2% at the height of the recession and remaining above pre-recession levels from 2010, with inflation reaching 5.6% in September 2011 (Figure 12.2).

Figure 12.2: *Inflation: Consumer price index in the UK (% change over 12 months), 2007 to 2011*

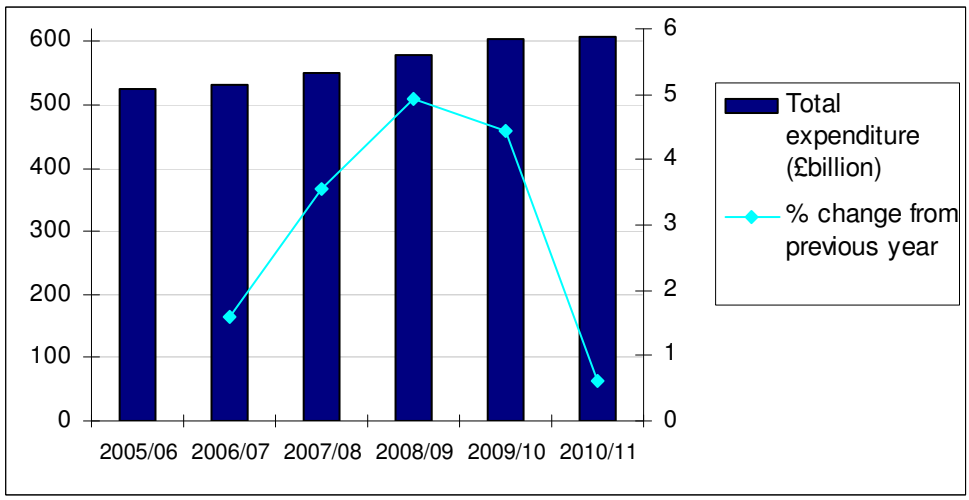


Source: https://docs.google.com/spreadsheet/ccc?key=0Asiju4DoCDhScFhNRlEzZTRhRlkxMW9Ra1RfN0ZoWmc#gid=0

12.2.2 Public expenditure

Over the period covered in this selected issue, overall public expenditure[309] has increased in nominal terms from £524 billion in 2005/06 to £692 billion in 2010/11, an increase of 32% (HM Treasury 2011). In real terms, expenditure over the period increased by 16% from £524 billion to £608 billion although between 2009/10 and 2010/11 public expenditure increased by only 0.6% (Figure 12.3).

Figure 12.3: *Total public expenditure and percentage change from the previous year in the United Kingdom, 2005/06 to 2010/11; adjusted to 2005/06 prices*



Source: HM Treasury 2012

[309] Excluding the temporary effect of banks being classified to the public sector

After remaining at 41% of gross domestic product in the years 2005/06 to 2007/08, public spending increased to 44% of GDP in 2008/09 and 48% in 2009/10 before decreasing slightly to 47% of GDP in 2010/11.

The data presented above demonstrates that, despite the economic downturn and recession, the level of public spending was maintained and actually increased in the period covered by this selected issue. Furthermore, expenditure across many individual sectors also increased over this period, although there were reductions in expenditure on public order and safety (Table 12.1).

Table 12.1: *Public sector expenditure on services by certain functions in the UK, 2005/06 to 2010/11; adjusted to 2005/06 prices*

COFOG category	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
01 – General public services	45.7	46.2	47.8	48.1	47.3	58.5
03 – Public order and safety	29.3	29.4	30.0	31.0	30.9	28.9
07 – Health	89.8	91.7	96.8	101.0	106.7	106.6
09 – Education	69.8	70.7	74.5	76.2	79.8	80.6
10 – Social protection	171.0	171.3	178.4	188.3	202.7	203.9

Source: HM Treasury 2012

12.3 Labelled drug-related public expenditure

In the United Kingdom, responsibility for the drug strategy lies with a number of departments with the Home Office providing the overall lead. Devolution of powers to Scotland, Wales and Northern Ireland means it is increasingly difficult to produce a United Kingdom estimate of drug-related expenditure. This is compounded by devolution of spending to the local level across the United Kingdom. Increased focus on localism since a change of UK Government in 2010 means that specific drug-related expenditure will be more difficult to identify in future, particularly with the removal of ring-fenced drug treatment monies in England from April 2013 (see section 5.2.1).

Data on labelled drug-related expenditure is drawn mostly from government administrative systems. The Scottish Government, Welsh Government and Northern Ireland Office all provide a breakdown of expenditure annually to the UK Focal Point. Data for England are provided by individual government departments using a template created in 2009.

All expenditure data reported here are adjusted to 2005/06 prices using the Office for National Statistics' (ONS) GDP deflator unless otherwise stated.[310]

Data for 2005/06 differ from the data published in the UK Focal Point Report 2007 and cannot be completely compared. This is due to improvements in estimating drug-related public expenditure such as the identification of areas of double-counting and a stricter interpretation of labelled and unlabelled expenditure.

[310] See: http://www.hm-treasury.gov.uk/data_gdp_fig.htm

12.3.1 Drug-related labelled expenditure in the United Kingdom

In nominal terms, labelled drug-related expenditure in the United Kingdom increased by 13% between 2005/06 and 2010/11 from £976.6 million to £1.106 billion, peaking at £1.144 billion in 2009/10. However, in real terms, labelled drug-related expenditure decreased by 0.5% between 2005/06 and 2010/11 from £976.6 million to £971.5 million (Table 12.2). The expenditure category with the largest reduction in labelled spend was social protection. The majority of this reduction was, however, due to the mainstreaming of the young persons' substance misuse grant in England into a wider unlabelled general grant known as the Area Based Grant. Although data are available showing the Home Office's contribution to this grant of £15.4m for the young persons' substance misuse allocation[311], there is no requirement for local authorities to spend the money specifically for this purpose.

Table 12.2: *Labelled public expenditure on drugs by COFOG category in the UK, 2005/06 to 2010/11(£ million): adjusted to 2005/06 prices*

COFOG category	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
01 – General public services	52.7	90.5	80.5	82.6	69.0	58.5
03 – Public order and safety	262.1	306.4	279.6	284.2	297.0	275.7
07 – Health	591.4	630.5	630.2	647.4	652.1	626.4
09 – Education	7.6	5.4	4.3	4.1	4.0	0.9
10 – Social protection	62.8	48.2	29.4	7.0	10.3	10.0
Total	*976.6*	*1,081.0*	*1,024.0*	*1,025.3*	*1,032.3*	*971.5*

Source: Government Departments

Drug-related labelled expenditure accounted for 0.19% of public sector expenditure on services in 2005/06 and 0.17% in 2010/11 and 0.07% of GDP.

Changes in labelled expenditure, however, must be set in context as they are unlikely to reflect absolute changes in expenditure. While some expenditure items such as capital expenditure on Tier 4 services[312] may be discontinued due to the short term nature of the funding, others may be subsumed into larger funding streams. In addition to the young persons' substance misuse grant in England, from April 2013, the pooled treatment budget in England will be subsumed into a wider public health grant allocation to local areas. Whilst the allocation of local public health grants is designed to incentivise continued investment in drug treatment (see section 5.2.1), there are no central requirements to report a detailed breakdown of expenditure.

A study by a charity[313], exploring the impact of the removal of the ring-fence for HIV social care services in England (NAT 2012) found that in 2010/11, after the removal of the ring-fence, 35% of local councils did not spend all of their allocation on providing social care for those with HIV. This compares to 14% before the removal of the ring-fence. With no requirement on local areas to report a detailed breakdown of their expenditure, it is unlikely that the actual level of expenditure on drug treatment will be available in future years.

[311] See: http://webarchive.nationalarchives.gov.uk/20100104175701/http://www.communities.gov.uk/documents/localgovernment/xls/13949921.xls

[312] Tier 4 refers to inpatient and residential treatment

[313] The National AIDS Trust is an independent charity aiming to change society's response to HIV. See: http://www.nat.org.uk/

Whether the budget allocation is sufficient information depends on the purpose of the public expenditure estimates. Whether the allocations should be included in the labelled section is another salient question. If the Pooled Treatment Budget (PTB) allocation in England were removed, it would result in a 37% reduction in labelled drug-related expenditure.

A report exploring drug policy in a time of financial austerity (UKDPC 2012c) highlights the risk that the mainstreaming of drug treatment monies could result in the money being used to meet efficiency savings and, furthermore, that it may expose public health budgets to political influence. It also suggests that funding cuts for wider support services impact on the ability to deliver drug treatment services. This demonstrates that drug-specific public expenditure studies may not be able to capture all the elements of public expenditure that can impact on drug services.

The mainstreaming of drug monies, however, appears to reflect the prevailing theories around health promotion emphasising the wider determinants of health and the need for upstream interventions. The more practice and attitudes around drugs moves away from an individual behaviour paradigm and becomes preventative rather than reactive/curative, the harder, or in fact less relevant, it becomes to isolate drug-specific expenditure.

12.4 Unlabelled drug-related public expenditure

The estimates provided here are different to the estimates provided in 2007 and therefore cannot be compared. This is due both to an improved methodology and changes to the definition of drug-related expenditure, to try and establish causality rather than just association. This section uses micro-costing and gross-costing methods depending on the availability of data and the relevance of each method. Where possible, estimates using both approaches have been provided.

The detailed methodology and assumptions underlying the data are set out in a separate document.

12.4.1 Attributable proportions of non-labelled drug-related expenditure – Public order and safety

Introduction

While the relationship between drugs and crime has increasingly been the focus of government drug policy in the UK (Reuter and Stevens 2008), there is recognition that the relationship is not one of simple causality and is complex in nature (Hough 1996). Simple causation models fail to take into account the social and environmental context of drug use and the interplay between social exclusion, poverty, drug use, alcohol use and crime.

Attempts to quantify the impact of drugs on crime in the UK have often relied on data showing the proportion of offenders intoxicated when committing an offence. Thus results from the New-ADAM survey where offenders were tested on arrest for opiates and cocaine (Holloway and Bennett 2004) have been used to estimate the proportion of crime attributable to drugs (MacDonald et al. 2005). Other methods used in the UK include a unit cost approach where self-reported data on the number of offences committed, taken from NTORS, a cohort study of treatment clients (Gossop et al. 2001) is applied to all problem drug users (Godfrey et al. 2002; Gordon et al., 2006). Recently the National Treatment Agency for Substance Misuse (NTA) has used self-reported offences data from another cohort study, the Drug Treatment Outcomes Research Study (DTORS) and applied it to all individuals in effective treatment to assess the crime component of a value for money model (NTA 2012g; see section 9.3.3).

It has been argued that these methods blur the distinction between association and causality as there is no clear indication that users committed an offence due to drug use (Single et al. 1996; Stevens, 2007). Indeed research has shown that many drug users committed offences before using drugs (Pudney 2002) and that both characterological and situational factors play a part in the drugs-crime relationship (Nurco 1998).

Goldstein (1985) attempted to delineate the simple causal relationship through a tripartite conceptual framework incorporating the psychopharmacological violence model; economic compulsive model; and systemic violence model. In the psychopharmacological model, intoxication causes irrational and sometimes violent behaviour which results in a criminal offence. The economic compulsive model suggests that drug users commit crime in order to support an expensive drug habit. The systemic violence model describes crime and violence intrinsic to the workings of the drugs market. Using Goldstein's conceptual framework as a basis, Pernanen et al. (2002) estimated the drugs attributable fractions for crime in Canada. They added a fourth strand, the substance-defined crimes, for example the crime of drug possession. This fourfold explanation has been adopted by the EMCDDA (2007) although the difficulty in estimating drug-related crime is recognised.

Drug law offences

Estimating the costs of substance-defined crimes, that is drug law offences, should be more straightforward than the estimation of crimes that are drug-related. By definition the attributable fraction for drug offences is 1.0. However, difficulties still exist in estimating the law enforcement costs due to the nature of the relevant cost data.

Policing

In 2007 police costs for England and Wales were estimated using annual Activity Based Costing (ABC) data provided to the Home Office. This used the police financial outturn data and set it against activity data and management information. It was estimated that the cost of policing drugs was £368.9m (UK Focal Point Report 2007). However, police forces are no longer required to submit ABC data to the Home Office and there are concerns about the calculability and interpretation of the data (Collier 2006).

England and Wales

Four methods were identified to estimate police expenditure in England and Wales; using the overall proportion of police expenditure from the 2007 estimate and applying it to 2010/11 expenditure data; using the proportion of arrests that were for drug offences and applying it to expenditure data; using the proportion of recorded crime that was for drug offences and applying it to expenditure data; and using a micro-costing method that uses data on method of detection for drug offences and a unit cost for each.

Table 12.3 shows the large disparity between estimates using different methodologies and highlights the difficulty in estimating police expenditure even for drug-defined crimes. These differences are of a similar magnitude to a Danish study looking at policing cannabis and suggest the need for further research into policing practices, procedures and costs (Moeller 2012).

***Table 12.3**: Estimated costs of policing drug offences in England and Wales 2010/11 by estimation method*

Estimation method	Estimated cost
Activity data	£423m
Macro-costing (arrests)	£1,377m
Macro-costing (recorded crime)	£795m
Micro-costing	£41m

Given the lack of recent activity data, the fact that arrests data are unlikely to reflect reality in respect to drug offences[314] and that the micro-costing method appears to be a substantial underestimate, the gross-costing method using recorded crime data seems the most appropriate method. It is also the method that is closest to the mid-point of the four estimation methods and the only method that it would be possible to apply to Scottish data. Nevertheless, the inclusion of so many cannabis possession offences may overestimate expenditure since they are dealt with relatively cheaply although this may be balanced out by costly drug trafficking investigations.

United Kingdom

For the UK as a whole, the estimated expenditure in 2010/11 on policing drug law offences was **£966.0m** or 5.3% of total police expenditure.

Court and prosecution costs

Data suggest that budgets for courts have reduced since the economic crisis began (CEPEJ 2010). Court and prosecution costs are made up of a number of elements: prosecution costs, court costs; and legal aid costs. It is difficult to estimate a unit cost for each offence given the wide variation in costs, which are determined by the complexity of the case and the defendant's plea.

In 2007 court costs were estimated using a unit cost from 1999 uprated for 2005/06 (see UK Focal Point Report 2007). No comparable recent estimates of costs for England and Wales are available. However, estimated costs per court case for England and Wales (NAO 2011) and Scotland (Audit Scotland 2011) are available, although these are not provided for all court types. Nevertheless, these are the only published costs so will be used in creating the estimate. Using a micro-costing method and applying court data for England and Wales (MOJ 2011a) and Scotland (Scottish Government 2011c) would give an estimated expenditure of £180.1m for the UK, excluding Northern Ireland. Using a gross-costing method, which takes the proportion of all court prosecutions that were for drug offences in 2010 and multiplies it by the overall COFOG court expenditure (HM Treasury 2012), gives an estimated expenditure of £266.5m.

No court data have been available for Northern Ireland since 2007. Given the lower rate of drug offences it is not appropriate to extrapolate from the rest of the UK.

Prison costs

It is also possible to use both micro-costing and gross-costing methods to estimate public expenditure on imprisoning drug offenders (Table 12.4). In the UK, data are published annually on the number of adults in prison on a given day broken down by offence type. These data are used to find the number and proportion of prisoners who are incarcerated for drug offences. The assumption is that the cross-sectional data on the prison population on a given day is representative of the prison population the remainder of the year.

[314] Since the most common drug offence is cannabis possession which is primarily dealt with using an administrative penalty that does not constitute an offence. Also the nature of drug offences where they are often recorded at the point of detection means that they have a higher arrest to recorded crime ratio than other crimes.

***Table 12.4**: Methodology for estimating drug-related unlabelled expenditure on prisons*

Micro-costing method Number of drug offenders x Average cost of a prison place per prisoner
Gross-costing method Proportion of prisoners who are drug offenders x overall COFOG expenditure on prisons

Using data for 2010/11 on the number of prisoners who were drug offenders (MOJ 2011a; Scottish Government 2011d) and the average cost of a prison place (MOJ2011b; SPS 2011c), estimated expenditure on imprisoning drug law offenders using the micro-costing method in the UK is £511.8m. Using COFOG expenditure (HM Treasury 2012), estimated expenditure using the gross-costing method is £637.7m.

Data on the prison population for Northern Ireland for 2010 were not available at the time of writing due to problems with the recording system. Therefore no estimate has been calculated.

Total costs of enforcing drug laws

Overall law enforcement expenditure in the UK for dealing with drug offences ranges from £1.66 billion to £1.87 billion.

Drug-related crime

In 2007 estimates of the proportion of each crime that was drug-related from various sources were used in conjunction with ABC data to provide expenditure estimates. Data from the Arrestee Survey for 2003/04 provided the main source of data using self-reported weekly heroin or crack use by offence type. This assumed that all crime committed by weekly heroin and crack cocaine users was related to their drug use. Using Goldstein's framework, these are primarily economic-compulsive crimes, most commonly acquisitive crime and to a lesser extent psycho-pharmacological crimes. Systematic violence offences are less common and also more difficult to estimate. Therefore analysis in this section will focus on economic-compulsive and psycho-pharmacological offences.

The Home Office used weekly heroin or crack cocaine use as a proxy for estimating drug-related crime in the three years of the Arrestee Survey (Boreham et al. 2007). Pernanen et al. (2002) suggest that this type of analysis merely demonstrates association rather than causality. They propose a method that uses surveys of arrestees and prisoners to ask the reasons for committing crimes in an attempt to determine causality and adjust the proportions accordingly. In an attempt to try and establish a degree of causality in offending behaviour, an analysis of data from the Arrestee Survey was carried out using variables on whether the offender had committed crime in the past 12 months to get drugs or whether they had committed crime while under the influence of drugs.[315] The definition includes only those who reported that most or all of their crimes were committed for the two reasons[316],

[315] Questions on drug-related motivation for crime were only added in the second quarter of the 2005/06 survey so analysis has been carried out on a subset of the Arrestee Survey participants. Analysis was carried out using weighted cases (arrest frequency, study design and interview non-response). Number of weighted cases = 5,962. Analysis was carried out using data from the Economic and Social Data Service (ESDS) and in SPSS v.20.

[316] A new variable was created for all participants who had reported committing crime in the past 12 months to get drugs and that most or all of this crime was to get drugs. This was combined with participants who reported committing crime while high on drugs, that all or most of their crime had been committed whilst high on drugs and that they wouldn't have committed any of their crimes if they hadn't been high on drugs.

which may underestimate crime, particularly as the number of self-reported offences were not taken into account and there is evidence that drug users commit a higher number of offences than non-drug users (REF). The attributable fractions used for each crime type are presented in the technical paper.

The offence categories from the Arrestee Survey do not necessarily match the offence categories used in crime statistics publications. Therefore subjective judgement is required to map the attributable fractions to some offences. Due to a lack of comparative Arrestee Survey in Scotland and Northern Ireland, the estimates from England and Wales have been used. Given the different rates of problematic drug use in these countries, this may either overestimate or underestimate the costs.

Police expenditure

Using recorded crime data and excluding drug offences to control for double counting, it is estimated that police expenditure on drug-related crime in the United Kingdom was £1,664.6m.

Court expenditure

Estimated expenditure on court cases for drug-related offences in the UK during 2010/11 range from £258.7m using the micro-costing method to £459.0m using the gross-costing method.

No court data have been available for Northern Ireland since 2007.

Prison expenditure

Estimated expenditure on prison for drug-related offenders in the UK during 2010/11 ranged from £272.3m using the micro-costing method to £430.7m using a gross-costing method.

Data on the prison population for Northern Ireland for 2010 were not available at the time of writing due to problems with the recording system. No estimate has been calculated.

Total expenditure on drug-related crime

Total estimated expenditure on drug-related crime in 2010/11 ranged between £2.20 billion and £2.55 billion.

Sensitivity analysis

A sensitivity analysis was undertaken using a wider definition[317] of drug-related crime to create attributable fractions. For the UK, estimated expenditure on police was £2.84 billion. For Court expenditure, estimations range from £398.4m to £708.6m**.** For prisons estimated expenditure ranged from £447.2m to £708.7m. This would give an overall expenditure on drug-related crime ranging from £3.7 billion to £4.3 billion.

Overall unlabelled drug-related public order and safety expenditure

Total estimated drug-related expenditure is highly influenced by the choice of both methodology and definition and it is therefore difficult to determine a best estimate without consensus. Therefore, in many cases it is better to provide a range of expenditure estimates. Using micro-costing methods for court and prison expenditure, it is estimated that the total cost of drug-related unlabelled expenditure was £3.9 billion in 2010/11 and using gross-costing methods it is estimated that drug-related unlabelled expenditure was £4.4 billion.

[317] Respondents who indicated that they had committed some, most or all of crimes to get drugs or that they had committed some, most or all of their crimes while high and that they would have committed some most or all of their crime

Using both the method and the definition that give the highest estimated expenditure as per the sensitivity analysis would give an estimated expenditure of £6.2 billion.

12.4.2 Attributable proportions of non-labelled drug-related expenditure – Health

Unlabelled expenditure on drug services from mainstream health budgets

In England and in Wales, the labelled costs for drug treatment include the allocation by local NHS Boards for drug services from wider mainstream health budgets in addition to drug treatment allocations from central government. The local NHS Board expenditure is identified through local treatment plans in England and a ring-fenced allocation in Wales. However, in Scotland, as identified in an Audit Scotland (2009) report, local Health Boards also provide additional unlabelled funding for drug services that is not included in the labelled central government allocation of £28.6m[318] in 2010/11. Therefore, an estimation of the value of the additional Health Board expenditure from unified health budgets has been made based on the findings from the Audit Scotland (2009) report.[319] Using the identified expenditure coming through NHS Boards and adjusting for the labelled funding streams suggests that in 2007/08, the proportion of the unified NHS budget that was spent on drug and alcohol services was 0.009. Applying this proportion to the 2010/11 NHS budget[320] gives an estimated £76.2m expenditure on drug and alcohol services. Using the proportion of expenditure that was drug specific from this study (0.748) gives an estimated expenditure on drug services of **£57.0m**.

Unlabelled substitution treatment prescription costs

While expenditure on methadone prescriptions are included within the labelled drug treatment costs in England, in Scotland they are not. It is estimated that expenditure on methadone prescriptions in Scotland was **£28.0m** in 2010/11 including ingredient costs, dispensing costs, costs of supervision and controlled drug fees. Data from 2010/11 cannot be compared to previous years due to a change in methodology (ISD Scotland 2012a).

Estimated drug-related hospital expenditure

In 2007 health costs were estimated using hospital data and ICD-10 codes related to drug misuse (F11 to F19 excluding F17 and those ending .2), maternal use of drugs (P04.4 and P96.1) and poisoning by narcotics or psychodysleptics (T40). Other costs included those for hepatitis C and HIV. Cost data were obtained from the unit costs work carried out by PSSRU on behalf of the Department of Health. The current estimates seek to improve on the methodology by reviewing the literature and expanding the list of drug-related conditions.

Many studies have shown an association between drug use and health harms and these have recently been summarised in a report published by the Department of Health (The Centre for Public Health 2011). Estimating attributable fractions is complicated by the need to determine causality. The World Health Organisation's (WHO) guidelines for estimating the costs of substance abuse (Single et al. 2003) caution against using studies that only demonstrate association when calculating attributable fractions. This implies that temporality should be established in a study. Rehm et al. (2006a) use a more stringent set of criteria for inclusion in their Canadian cost of substance abuse study specifying four conditions for inclusion: consistency across several studies; established experimental, biological evidence of biological mechanisms; strength of the association; and temporality. Given the

[318] This £28.6m is included under the labelled expenditure in section 12.3.

[319] Since the Audit Scotland report was published, there has been a change in delivery mechanisms in Scotland from Alcohol and Drug Action Teams (ADATs) to Alcohol and Drug Partnerships (ADPs) and a new funding formula has been introduced. This may affect the validity of the assumptions based on the Audit Scotland (2009) report. An updated analysis will be published by Audit Scotland shortly but, at present, the 2009 report is the most up-to-date data available.

[320] See: See: http://www.scotland.gov.uk/News/Releases/2010/03/11093526

complexities of determining causality the estimates will use the conditions identified by Rehm et al. (2006b) based on the WHO's 2000 *Global Burden of Disease Study* (Mathers et al. 2000). A list of these conditions and their associated ICD-10 codes are in Table 12.5.

***Table 12.5**: Illicit drug-related health conditions and ICD-10 codes*

Health condition	Wholly attributable to drug use	ICD-10 code
Infectious disease		
HIV	No	B20-B24
Viral hepatitis B	No	B16, B18.0-B18.1
Viral hepatitis C	No	B17.1, B18.2
Neuropsychiatric conditions		
Mental and behavioural disorders due to use of psychoactive substances	Yes	F10-F12, F14-F17, F19
Cardiovascular diseases		
Acute and subacute endocarditis	No	I33
Maternal drug use		
Low birth weight and short gestation; neonatal conditions	No	P02.0-P02.2, P04.8, P05-P07
Foetus and new-born affected by maternal use of drugs	Yes	P04.4, P96.1
Pregnancy complications	No apart from O35.5	035.5, 036.5, 044-046, 067
Unintentional injuries		
Motor vehicle accidents	No	Various V codes[321] excluding non-traffic accidents; Y85
Accidental poisoning and exposure to illegal drugs	Yes	T40.0-T40.5, T40.7 T43.6
Intentional injuries		
Suicide	No	X60-X84
Assault	No	X85-Y09

Infectious disease

Estimates for treating drug-related HIV/AIDS are constructed using data from the Health Protection Agency on attributable fractions (HPA 2011a; b) and hospital programme budgets in England[322] and Wales (Welsh Government 2011f; 2012d). No data on programme budgets for HIV are publicly available in Scotland and Northern Ireland.

This gives an estimated expenditure of £16.9m on drug-related HIV services.

Published data on hospital inpatient stays related to drug-related viral hepatitis are again only available from England and Wales showing an estimated expenditure of £1.3m (Table 12.6)

[321] V01.1-01.9, V02.1-02.9, V03.1-03.9, V04.1-04.9, V06.1-06.9, V09.2-09.3, V10.4-10.9, V11.4-11.9, V12.4-12.9, V13.4-13.9, V14.4-14.9, V15.4-15.9, V16.4-16.9, V17.4-17.9, V18.4-18.9, V19.4-19.9, V20.4-20.9, V21.4-21.9, V22.4-22.9, V23.4-23.9, V24.4-24.9, V25.4-25.9, V26.4-26.9, V27.4-27.9, V28.4-28.9, V29.4-29.9, V30.5-30.9, V31.5-31.9, V32.5-32.9, V33.5-33.9, V34.5-34.9, V35.5-35.9, V36.5-36.9 ,V37.5-37.9, V38.5-38.9, V39.4-39.9, V40.5-40.9, V41.5-41.9, V42.5-42.9, V43.5-43.9, V44.5-44.9, V45.5-45.9, V46.5-46.9, V47.5-47.9, V48.5-48.9, V49.4-49.9, V50.5-50.9, V51.5-51.9, V52.5-52.9, V53.5-53.9, V54.5-54.9, V55.5-55.9, V56.5-56.9, V57.5-57.9, V58.5-58.9, V59.4-59.9, V60.5-60.9, V61.5-61.9, V62.5-62.9, V63.5-63.9, V64.5-64.9, V65.5-65.9, V66.5-66.9, V67.5-67.9, V68.5-68.9, V69.4-69.9, V70.5-70.9, V71.5-71.9, V72.5-72.9, V73.5-73.9, V74.5-74.9, V75.5-75.9, V76.5-76.9, V77.5-77.9, V78.5-78.9, V79.4-79.9, V80.3-80.5, V80.9, V81.1, V82.1-82.9, V83.0-83.3, V84.0-84.3, V85.0-85.3, V86.0-86.4, V87.0-87.8, V89.2, V89.9,

[322] See: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_131856.xls

***Table 12.6**: Calculations of estimated expenditure on drug-related viral hepatitis in England and Wales in 2010/11*

	Bed days	Cost per bed day	Cost	Emergencies	Cost per emergency	Cost	Total cost
Hepatitis B							
England	404	£365.15	£147,521	45	£147	£6,615	£154,136
Wales	12	£365.15	£4,382	4	£147	£588	£4,970
Hepatitis C							
England	2,922	£365.15	£1,066,968	211	£147	£31,017	£1,097,985
Wales	75	£365.15	£27,386	16	£147	£2,352	£29,738

In addition, estimated expenditure on providing prescription drugs for the treatment of drug-related HBV in 2010 was £3.6m and for HCV it was £25.5m in 2010. [323]

Total estimated drug-related expenditure on drug-related infectious disease was **£47.3 million** in 2010/11.

Neuropsychiatric conditions

Using hospital inpatient data on mental behavioural disorders due to drug misuse[324] and the appropriate bed day cost (Curtis 2011) an overall expenditure of **£44.4m** in the UK is estimated for 2010/11.

Cardiovascular disease – acute and sub-acute endocarditis

Using hospital inpatient data, which are only available for England and Wales, an attributable fraction from English et al. (1995) and the appropriate reference cost from England (DH 2011) gives an estimated expenditure of **£2.3m**.

Maternal drug use

Using hospital inpatient data and, for non-drug specific birth outcomes, an attributable fraction from English et al. (1995) gives an estimated expenditure of **£0.9m**.

Unintentional injuries – motor vehicle accidents

An attributable fraction was derived using the adjusted odds ratio from a cross-Europe case-control study (Hels et al. 2011) and last month drug use in the UK (see UK Focal Point Report 2011). This was applied to the inpatient hospital data on road traffic accidents giving an estimated drug-related expenditure of **£5.0m** for England and Wales.

Inpatient poisonings

Using inpatient data for the UK and the appropriate reference cost, data for England (DH 2011) gives an estimated drug-related expenditure of **£10.4m**.

Intentional injuries – suicides

An attributable fraction for suicides related to opioid use was taken from Degenhardt et al. (2004) and English et al. (1995) and applied to hospital inpatient stays related to suicide attempts. The estimated expenditure for the treatment of drug-related suicide attempts in England and Wales was **£10.3m**.

[323] See: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/prescriptions/hospital-prescribing-england-2010 and

[324] ICD-10 F codes excluding ICD-10 code F11.2 to try and minimise double counting with opioid inpatient detoxification treatments that may be covered under labelled drug treatment expenditure.

Assault

The same attributable fraction used for the calculation of drug-related assault in the crime calculations in section 12.4.1 was used. Using inpatient hospital data for England and Wales gives an estimated drug-related expenditure of **£0.8m**. A sensitivity analysis exploring the impact of a wider definition of drug-related crime would give an estimated drug-related expenditure of £2.4m.

Infection site wounds

A survey amongst people who inject drugs looked at the use of healthcare services for treating infection site wounds (Hope et al. 2008). Using the prevalence of infection site wounds amongst people who inject drugs in 2010 (35%) and applying the proportions using healthcare from Hope et al. (2008) to the most current estimates of injecting drug use (see section 4.2.4) allows an estimation of expenditure to be made. In 2010, it is estimated that **£15.6m** was spent treating infection site wounds in the UK. This includes at GP surgeries, A&E departments and as inpatients.

Overall unlabelled healthcare expenditure

Combining unlabelled expenditure on drug services from mainstream health budgets, unlabelled substitution treatment prescribing costs and the individual health condition expenditure for the UK, as set out above, suggests a total drug-related health expenditure of **£222.0m**. The total estimated expenditure on individual health conditions is summarised in Table 12.7 and amounted to **£137.0** with infectious diseases (34.5%) and neuropsychiatric conditions (32.4%) accounting for the highest percentages.

***Table 12.7**: Estimated unlabelled drug-related health expenditure by health condition and percentage of total*

Health condition	Estimated expenditure (£m)	% of total
Infectious disease	£47.3	34.5
Neuropsychiatric conditions	£44.4	32.4
Cardiovascular disease	£2.3	1.7
Maternal drug use	£0.9	0.7
Unintentional injuries – motor vehicle	£5.0	3.7
Inpatient poisonings	£10.4	7.6
Intentional injuries - suicides	£10.3	7.5
Assault	£0.8	0.6
Infection site wounds	£15.6	11.4
Total	£137.0	100

Estimations of drug-related unlabelled health expenditure will always be an underestimate since data from GP surgeries and from Accident & Emergency departments are not available. The latter would allow a more comprehensive estimate of the health impact of drug use but is not routinely collected in the UK or as an indicator by the EMCDDA. Furthermore, hospital inpatient data by individual ICD-10 codes, while collected in Scotland and Northern Ireland are not routinely published at a non-aggregated level.

12.4.3 Attributable proportions of non-labelled drug-related expenditure – Education

It is difficult to estimate the expenditure on drugs education for a number of reasons. As an unlabelled cost, assumptions need to be made about the proportion of teachers' time that is spent on drug education. In most curricula, drugs are covered together with other forms of substance use; tobacco, alcohol, medicines. It is often difficult to disaggregate this and identify time spent exclusively on drugs issues. Furthermore, guidance on drugs education in schools suggest that drugs education should be taught holistically, across a number of

different strands of the curriculum including science, sport, personal and social health education (PSHE) and general health and well-being (DFES 2004).
In 2007, expenditure on providing drug education in schools was calculated. However, there has been no further research looking at the amount of time spent on drug education and given the difficulties in disaggregating time and the fact that costs are purely opportunity costs rather than a potential saving of public money, it has been decided not to provide estimates this time.

12.4.4 Attributable proportions of non-labelled drug-related expenditure – Social protection costs

Child and family services

It is difficult to quantify the impact of parental drug use on child and family social services. As was the case in 2007 (see UK Focal Point Report 2007), research looking at the relationship between substance misuse and child and family social work often does not distinguish between drugs and alcohol. Furthermore, there is evidence that substance misuse concerns feature more prominently the more serious a case gets (Cleaver et al. 2011). A review of the literature found no further research studies that had taken place since 2007 although some data are available from monitoring sources. Given the large differences between the estimates from monitoring sources and the lack of any new national evidence quantifying the impact, the same attributable risk is used as in 2007, which was 0.20 for England and Wales taken from Forrester and Harwin (2006) and 0.30 for Scotland taken from Scottish Executive (2000).[325] This has not been revised to take into account any changes in problem drug use over this period and demonstrates the need for national research into the impact of parental drug use on children and family social care services. In Northern Ireland, there is a higher rate of referrals to the child protection register than in other UK countries (Northern Ireland Assembly 2012) but the rate of problematic drug use is much lower. Also the health and social care budgets in Northern Ireland are integrated so it is difficult to compare the social care budget with the rest of the UK (Northern Ireland Assembly 2010). Given these issues and the lack of country-specific research on the contribution of drug problems to social work caseloads, no estimate for Northern Ireland has been provided.

Using the percentage of child and family social work expenditure allocated to the relevant headings (83%) in both England (Department for Education 2012) and Wales (StatsWales, Table 001984) and applying this to total COFOG expenditure on children and family personal social services for 2010/11 in England, Wales and Scotland (HM Treasury 2012) gives an estimated expenditure of **£1.42 billion**.

Personal social services for people with mental health problems

Despite studies showing a high rate of co-morbid substance use and psychosis amongst those in contact with services (Carra and Johnson 2009) and high levels of mental health issues amongst drug users accessing treatment (Donmall et al. 2012) the nature of the relationship remains unclear. Given the exclusion of mental health problems from the attributable health costs (see section 12.4.2) and the need to ensure a consistent approach, no estimate of drug-related social services mental health expenditure is provided. This differs from the approach in 2007 when estimates were provided.

Personal social services for substance misuse

Since the 2007 estimate of drug-related public expenditure it has become apparent that providing an estimate of unlabelled expenditure on drug-related personal social services may introduce an element of double counting. This is due to the fact that local mainstream

[325] See UK Focal Point 2007 for a summary of evidence and the rationale behind the use of these percentages.

funding expenditure provided in the labelled data contains an element of social services funding. Consequently, a decision to exclude these data for England has been taken. For Scotland, using the proportion of health and local authority funding that was drug specific in the Audit Scotland (2009) study and applying it to the expenditure on substance misuse services (SPICe 2011) gives an estimated expenditure of **£27.5m**.

Personal social services for adults with HIV/AIDS

Using expenditure data for 2010/11 from England[326], Wales[327] and Scotland (SPICe 2011) and the proportion of HIV infected individuals who were thought to have acquired their infection through injecting drug use (HPA 2011a;b;c) gives a total estimated expenditure of **£0.6m** for the UK, although no estimate from Northern Ireland is available.

A report on HIV social care in England demonstrates the impact of removing ring-fenced monies for the provision of care (National AIDS Trust 2012). The ring-fence for HIV social care was removed in 2010 and, although a specific allocation for HIV social care was maintained within the budget, there is no requirement to spend this on such services. Accordingly, only 30% of those surveyed reported spending all the allocation with 28% spending less than half. Responding to budget cuts across social care, the eligibility criteria for access to HIV care services has been set at substantial or critical in 85% of areas and some types of care such as respite are less likely to be funded as they were in 2008.

Welfare benefits

Similar to other non-labelled costs related to the consequences of drug use, it is difficult to determine the causal relationship between drug use and the claiming of welfare benefits. UK estimations of the costs to the welfare system seem to imply a simple causal relationship; if a problematic drug user claims welfare benefits this is due to his or her drug use. Expenditure estimates of the cost of welfare benefits have tended to use data from treatment cohort studies as a basis. Godfrey et al. (2000) and Gordon et al. (2006) used data on unemployment from the National Treatment Outcomes Research Study (NTORS) and Hay and Bauld (2008) used data from the Drug Treatment Outcomes Research Study (DTORS) to estimate the number of problematic drug users receiving each benefit. However, drug treatment cohort studies are limited by the lack of a control group and the assumption that drug users in treatment are representative of problematic drug users out of treatment is untested. Furthermore, it fails to take into account confounding factors such as poverty and social exclusion. For example, DTORS found that 37% of individuals finished school below the age of 16 and there is strong evidence to suggest that low educational achievement is one of the most important risk factors for future unemployment and social exclusion (Bynner and Parsons 2001; Gregg 2001). With the mean age of first use at 16 and mean age of problematic drug use at 21 years old in DTORS, this may suggest that poor educational attainment pre-dates problematic drug use.

However, there is a dearth of UK studies looking at the temporal relationship between drug use and unemployment (Hoffman et al. 2007). Indeed where studies have been conducted, they have often used cross-sectional data (MacDonald and Pudney 2000) rather than longitudinal data. Even the data from DTORS only used the baseline data despite changes in employment status being observed during follow-up (Jones et al. 2009) and evidence from the Department of Work and Pensions suggesting changes in the types of benefits claimed over time and highlighting the disruptive nature of periods spent in prison (Bauld et al. 2010).

[326] Final national detailed PSS expenditure 2010/11. See: http://www.ic.nhs.uk/pubs/pssexpcosts1011
[327] StatsWales. Social services revenue expenditure by client group. See: http://www.statswales.wales.gov.uk/TableViewer/tableView.aspx

Given the lack of evidence of a causal relationship and the under-developed work in this area, the cost of welfare benefits is only calculated where the link with drug use is explicit and so unemployment benefits are excluded.

Drug-related disability benefits

Data on the number of those claiming disability benefits (see section 8.2.2 for explanation of different benefits) because of a main condition of drug use are published quarterly (DWP 2012). Table 12.8 show that the estimated cost of providing welfare benefits due to a drug-related disability was **£170.8 million** in 2010/11.

***Table 12.8**: Estimated cost of providing welfare benefits for a drug-related disability in the UK during 2010/11, by type of benefit*

Benefit	Number of claimants	Cost per annum	Estimated cost per annum
Incapacity benefit/Serious Disability Allowance	36,778	£2,718*	£99,962,604
Employment Support Allowance	9,918	£3,726*	£36,954,468
Disability Living Allowance	9,992	£3,396**	£33,932,832
Total			£170,849,904

*Data from August 2010 with ICD-10 code related to mental and behavioural disorder
**Data from May 2011 using main disabling condition of 'alcohol or drug abuse'
Source: DWP tabulation tool

Total social protection expenditure

Total estimated drug-related social protection expenditure amounted to **£1.62 billion** in 2010/11, the majority of which was for child and family social work.

12.4.5 Total unlabelled drug-related public expenditure

Table 12.9 summarises the expenditure set out in this section and shows that there was an estimated £6.3 billion of unlabelled drug-related public expenditure in 2010/11. Over two-thirds was public order and safety expenditure with policing the most costly element. While the costs for drug-related crime were generally higher, for prison costs the cost of imprisoning drug offenders was higher than imprisoning those for drug-related crime reflecting the sentencing practices for those convicted of drug trafficking offences (see section 9.4.1). As in the 2007 estimate, child and family social work is one the largest individual elements. Despite this, relatively little research has been undertaken around this topic and little is known about the national prevalence. Unlabelled health expenditure accounts for only four per cent of all unlabelled expenditure. Given that health expenditure accounted for 18% of all public sector expenditure on services in 2010/11 and public order and safety only five per cent (HM Treasury 2012), it may be expected that these results would be much different. If data from primary care and Accident & Emergency departments were available, health expenditure may be higher.

***Table 12.9**: Overall estimated unlabelled public expenditure attributable to drugs un the United Kingdom 2010/11*

Category	Expenditure (£m)	% of unlabelled spend	Proactive or reactive
Police – drug offences	£966.0	15.4	Proactive
Police – drug-related crime	£1,664.6	26.6	Reactive
Courts – drug offences	£266.5	4.3	Proactive
Courts – drug-related crime	£459.0	7.3	Reactive
Prison – drug offences	£637.7	10.2	Proactive
Prison – drug-related crime	£430.7	6.9	Reactive
Total public order and safety	***£4,424.5***	***70.6***	
Unlabelled expenditure on drug services from mainstream health budgets	£57.0	0.9	Proactive
Unlabelled substitution treatment prescription costs	£28.0	0.5	Proactive
Infectious disease	£47.3	0.8	Reactive
Neuropsychiatric conditions	£44.4	0.7	Reactive
Cardiovascular disease	£2.3	0.0	Reactive
Maternal drug use	£0.9	0.0	Reactive
Unintentional injuries – motor vehicle	£5.0	0.1	Reactive
Inpatient poisonings	£10.4	0.2	Reactive
Intentional injuries - suicides	£10.3	0.2	Reactive
Assault	£0.8	0.0	Reactive
Infection site wounds	£15.6	0.3	Reactive
Total health expenditure	***£222.0***	***3.5***	
Child and family social work	£1,420	22.7	Reactive
PSS – substance misuse	£27.5	0.4	Proactive
PSS – HIV/AIDS	£0.6	0.0	Reactive
Welfare benefits	£170.8	2.7	Reactive
Total social protection	***£1,618.9***	***25.8***	
Total unlabelled expenditure	**£6,265.4**	***100.0***	

When analysing by proactive and reactive expenditure, the majority of unlabelled expenditure is reactive (68%) with 32% proactive, mainly the upholding of drug laws. A survey of police forces carried out in 2011 found that the majority of respondents thought that proactive police activities aimed at tackling the drug problem would reduce as budget cuts hit (Beck 2011). However, given the results presented here, that is unlikely to have a large effect on unlabelled expenditure levels particularly as the methodology used gives equal weight to the detection of a cannabis possession offence and the detection of a drug trafficking offence.

12.5 Total drug-related public expenditure

In 2010/11 it is estimated that total drug-related public expenditure amounted to £7.37 billion. This accounts for 1.1% of all public sector expenditure on services in 2010/11 (HM Treasury 2012). Of this around £3.1 billion was proactive expenditure with the remainder reactive. Estimated drug-related expenditure accounted for 0.49% of GDP with a cost per capita of £117.57.

12.6 The future of drug-related public expenditure estimates in the UK

As discussed in section 12.3, it is anticipated that there will be difficulties in isolating drug-specific expenditure in the future and it is unclear what the purpose of doing so is. This is particularly the case as the drug problem becomes more integrated with wider public health concerns and as interventions become more focussed on preventative early years work. The analysis presented here shows that, even with the ability to isolate proactive labelled expenditure, the majority of drug-related expenditure is unlabelled and reactive. Budgetary decisions on what drug services to fund will be dwarfed by the cost of policing crime regardless of the definition used for drug-related crime.
Without consensus on the definitions used in a study or the most appropriate method to estimate expenditure, it will not be possible to assess the evolution of non-labelled drug-related expenditure since changes have a significant impact on estimated expenditure. The wide disparity in estimations of unlabelled expenditure on public order and safety come from two main sources:

- Methodology – which is most appropriate, a micro or macro-costing strategy?
- Definition – how to estimate drug-related crime – weekly heroin or crack cocaine use, attribution of all, most or just some of crimes to drug use?

The methodological questions need to take place within a costing, economic sphere but the definitional questions can be answered outside of a public expenditure framework. Even with a fixed definition and methodology, it is unlikely that public expenditure studies will provide much insight into drug policy.

For example, the argument for distinguishing between proactive and reactive expenditure is to map the policy flows between investment in drug services and the outcomes in terms of drug-related consequences. However, reductions in the costs of the consequences could come from a funding decision independent of drug policy and have nothing to do with a reduction in consequences. For example a decrease in estimated drug-related court expenditure may be due to extraneous factors such as a tighter restriction on legal aid eligibility, which decreases the unit cost. This shows how difficult it is to interpret changes in expenditure within a country and comparing expenditure between countries is even more futile. Staying with the same example, a higher expenditure on court in one country may be a reflection of the differing legal aid benefits or that one country has a professional judiciary while the other does not.

Given the resources required to carry out this type of study, it is essential that the rationale behind it is clear and that the methodology and definitions used support that rationale.

PART C

Bibliography and Annexes

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List of tables used in the text

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List of Abbreviations used in the Text

2-DPMP	Desoxypipradrol
A&E	Accident and Emergency
ABMU	Abertawe Bro Morgannwg University
ACMD	Advisory Council on the Misuse of Drugs
ACPO	Association of Chief Police Officers
ADPs	Alcohol and Drug Partnerships
AFM	Adult Family Members
AIDS	Acquired Immunodeficiency Syndrome
APMS	English Adult Survey of Psychiatric Morbidity
ATS	Amphetamine Type Stimulants
AWSCLP	All Wales School Liaison Core Programme
BBV	Blood-borne Virus
BCS	British Crime Survey
BCU	Basic Command Unit
BLF	British Lung Foundation
BMJ	British Medical Journal
BRiC	Building Recoveries in Communities
BZP	Benzylpiperazine
CAF	Common Assessment Framework
CASI	Computer Assisted Self Interviewing
CAPI	Computer Assisted Personal Interviewing
CARATS	Counselling, Assessment, Referral. Aftercare and Throughcare
CAYT	Centre for Analysis of Youth Transitions
CBT	Cognitive Behavioural Therapy
CFE	Curriculum For Excellence
CFI	Central Funding Initiative
CHIS	Covert Human Intelligence Sources
CI	Confidence Interval
CISHE	Cardiff Institute of Society Health and Ethics
CJS	Criminal Justice System
CK	Creatinine kinase
CMO	Chief Medical Officer
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CRC	Capture, Re-Capture
CSEW	Crime Survey for England and Wales
CSSIW	Care and Social Services Inspectorate Wales
D2PM	Diphenyl-2-pyrrolidinylmethanol
DACTs	Drug and Alcohol Co-ordination Teams
DATs	Drug Action Teams
DBS	Dried Blood Spot testing
DCLG	Department for Communities and Local Government
DCSF	Department for Children, Schools and Families
DDN	Drink and Drug News
DDU	Drug Dependency Unit
DDW	Drug Data Warehouse
DfE	Department for Education
DfT	Department for Transport
DFW	Drug Free Wings
DH	Department of Health
DHSSPS	Department of Health, Social Services and Public Safety Northern Ireland
DIP	Drug Interventions Programme

DRD	Drug-Related Deaths
DRR	Drug Rehabilitation Requirement
DSD	Drug Strategy Definition
DSDC	The Scottish Drugs Strategy Delivery Commission
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders
DTORS	Drug treatment Outcomes Research Study
DTTO	Drug Treatment and Testing Order
DWP	Department for Work and Pensions
EACS	Enhanced Addiction Casework Service
EDDRA	Exchange on Drug Demand Reduction Action
EIU	Effective Interventions Unit
ELDO	European Legal Database on Drugs
ELDD	European Legal Database on Drugs
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESA	Employment and Support Allowance
ESF	European Social Fund
ESPAD	European School Survey Project for Alcohol and other Drugs
EU	European Union
FIT	Field Impairment Tests
FSS	Forensic Science Service
GBL	Gamma-butyrolactone
GHB	Gamma-hydroxybutyrate
GIRFEC	Getting It Right For Every Child
GMR	General Mortality Register
GOPR	Getting Our Priorities Right
GP	General Practitioner
GPASS	General Practice Administration System
GROS	General Register Office for Scotland
HBcAg	Hepatitis B surface Antigen
HBSC	Health Behaviour in School Age Children Survey
HC	House of Commons
HDU	Homeless Drug Users
HEAT	Health improvement, Efficiency, Access Treatment
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HM	Her Majesty
HMRC	Her Majesty's Revenue and Customs
HO	Home Office
HPA	Health Protection Agency
HPS	Health Protection Scotland
HRD	Harm Reduction Database
IAC	Intensive Alternatives to Custody
IBSDA	Incapacity Benefit or Severe Disablement Allowance
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
IOT	Injectable Opioid Treatment
IQ	Intelligence Quotient
IRISS	Institute for Research and Innovation in Social Sciences
ISADORA	Integrated Services Aimed at Dual Diagnosis and Optimal Recovery from Addiction
ISD	Information Services Division

JCP	JobCentre Plus
LGBT	Lesbian, Gay, Bisexual and Transgender
LSD	Lysergic Dyethylamide Acid
MDA	Misuse of Drugs Act 1971
MDMA	3,4-Methyldioxy-n-methylamphetamine
MHRA	Medicines and Healthcare products Regulatory Agency
MIM	Multiple Indicator Method
MMT	Methadone Maintenance Therapy
MRC	Medical Research Council
MSM	Men who have sex with men
N-ALIVE	NALoxone InVEstigation
NACD	National Advisory Committee on Drugs
NAOCT	National Anthrax Outbreak Control Team
NCSC	National Care Standards Committee
NDRDD	National Drug-Related Deaths Database
NDTMS	National Drug Treatment Monitoring System
NESI	Needle Exchange Surveillance Initiative
NEX	Needle Exchange service
NHS	National Health Service
NICE	National Institute for Clinical and Health Excellence
NICS	Northern Ireland Crime Survey
NIQUAD	Nationally Integrated Quantitative Understanding of Addiction Harms
NISRA	Northern Ireland Statistics and Research Agency
NOMS	National Offender Management Service
NPIS	National Poisons Information Service
NPS	New Psychoactive Substances
NSD	New Strategic Direction for Alcohol and Drugs
NSP	Needle and Syringe Programs
NTA	National Treatment Agency
OCU	Opiate and/or crack cocaine user
OFMDFMNI	Office of the First Minister and Deputy First Minister of Northern Ireland
OHP	Occupational Health Providers
ONS	Office for National Statistics
OST	Opiate Substitution Therapy
PADS	Peterborough Adolescent and Young Adult Study
PAF	Postcode Address File
PbR	Payment by Results
PCCs	Police and Crime Commissioners
PCR	Polymerase Chain Reaction
PCT	Primary Care Trust
PDI	Partnership Drugs Initiative
PDU	Problem Drug Use(rs)
PHE	Public Health England
PHIRB	Public Health Information and Research Branch
PIED	Performance and Image Enhancing Drugs
PNC	Police National Computer
PSA(s)	Public Service Agreements
PSHE	Personal, Social and Health Education
PSNI	Prison Service Northern Ireland
PTB	Pooled Treatment Budget
PuP	Parents Under Pressure
PWID	People Who Inject Drugs
RCT	Randomised Controlled Trial

RCGP	Royal College of General Practicioners'
RCP	Royal College of Psychiatrists
RIOTT	Randomised Injectable Opioid Treatment Trial
RQIA	Regulation and Quality Improvement Authority
RSM	Residential Substance Misuse treatment/rehabilitations Services
SACDM	Scottish Advisory Committee on Drugs Misuse
SALSUS	Scottish Schools Adolescent Lifestyle and Substance Use Survey
SCDEA	Scottish Crime and Drug Enforcement Agency
SCJS	Scottish Crime and Justice Survey
SCVS	Scottish Crime and Victimisation Survey
SDF	Scottish Drugs Forum
SFAD	Scottish Families Affected by Drugs
SFP	Strengthening Families Programme
SDQ	Goodman Strengths and Weaknesses Questionnaire
SELCoH	South East London Community Health
SMTF	Substance Misuse Treatment Framework
SMR	Special Mortality Register
SOCA	Serious Organised Crime Society
SPS	Scottish Prisoner Survey
SPCR	Surveying Prisoners Crime Reduction
SQ	Standard Questionnaire
ST	Standard Table
STI	Sexually Transmitted Infection
TAC	Throughcare Addiction Services
TC	Therapeutic Community
TCDO	Temporary Class Drug Order
TDI	Treatment Demand Indicator
THN	Take-Home-Naloxone
UAM	Unlinked Anonymous Monitoring survey
UK	United Kingdom
UKBA	United Kingdom Border Agency
UKDPC	United Kingdom Drug Policy Commission
US	United States of America
VCT	Voluntary confidential testing
WAG	Welsh Assembly Government
WCA	Work Capability Assessment
WEDINOS	Welsh Emergency Department Investigation of Novel Substances
WG	Welsh Government
WNDSM	Welsh National Database for Substance Misuse
YJB	Youth Justice Board

List of standard tables

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 related deaths	General Mortality Registers (GMRs) for England and Wales, Scotland and Northern Ireland
ST06	Evolution of acute/direct related deaths	General Mortality Registers (GMRs) for England and Wales, Scotland and Northern Ireland
ST07	National prevalence estimates on problem drug use	Home Office; NHS ISD Scotland; DHSSPSNI; Welsh 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; Northern Ireland Police Service (NIPS)
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); Northern Ireland Police Service (NIPS)

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) 2010/11, the Northern Ireland Drug Prevalence Survey 2010/11 and the Scottish Crime and Justice Survey (SCJS) 2010/11, estimates of drug use for 2010/11 have been produced for the United Kingdom.

Table A.1: percentage of 16 to 59[328] year olds reporting having used individual drugs in lifetime, last year and last month in the United Kingdom, 2010/11

	BRITISH CRIME SURVEY 2010/11	NORTHERN IRELAND DRUG PREVALENCE SURVEY 2010/11	SCOTTISH CRIME AND JUSTICE SURVEY 2010/11	UNITED KINGDOM ESTIMATE 2010/11
Lifetime prevalence				
Any illicit drug	36.3	27.3	31.4	35.6
Amphetamines	11.6	6.3	10.7	11.4
Cannabis	30.7	24.0	28.7	30.3
Cocaine	8.9	6.7	9.9	8.9
Ecstasy	8.3	8.8	10.0	8.5
Heroin	0.6	0.4	1.1	0.6
LSD	5.3	5.1	6.7	5.4
Magic mushrooms	7.2	5.8	7.1	7.1
Last year prevalence				
Any illicit drug	8.8	6.6	9.1	8.8
Amphetamines	1.1	1.1	1.3	1.1
Cannabis	6.8	5.1	7.7	6.8
Cocaine	2.2	1.5	2.6	2.2
Ecstasy	1.4	1.1	1.9	1.4
Heroin	0.1	0.1	0.3	0.1
LSD	0.2	0.24	0.3	0.2
Magic mushrooms	0.4	0.2	0.5	0.4
Last month prevalence				
Any illicit drug	4.8	3.3	4.8	4.8
Amphetamines	0.4	0.3	0.5	0.4
Cannabis	3.8	2.7	4.1	3.8
Cocaine	0.8	0.5	1.0	0.8
Ecstasy	0.4	0.3	0.8	0.4
Heroin	0.0	0.0	0.2	0.0
LSD	0.1	0.0	0.2	0.1
Magic mushrooms	0.1	0.0	0.2	0.1
Net response	*27,452*	*2,535*		

[328] Age 15 to 64 years old for Northern Ireland.

Table A.2: Percentage of 16 to 34[329] year olds reporting having used individual drugs in lifetime, last year and last month in the United Kingdom, 2010/11

	BRITISH CRIME SURVEY 2010/11	NORTHERN IRELAND DRUG PREVALENCE SURVEY 2010/11	SCOTTISH CRIME AND JUSTICE SURVEY 2010/11	UNITED KINGDOM ESTIMATE 2010/11
Lifetime prevalence				
Any illicit drug	43.9	36.9	40.0	43.4
Amphetamines	12.9	8.9	13.2	12.8
Cannabis	38.4	32.2	37.1	38.1
Cocaine	12.8	11.2	15.3	13.0
Ecstasy	12.4	14.2	16.4	12.8
Heroin	0.6	0.2	1.2	0.6
LSD	4.8	5.7	6.8	5.0
Magic mushrooms	7.4	7.7	9.3	7.6
Last year prevalence				
Any illicit drug	15.7	11.8	16.2	15.6
Amphetamines	2.0	1.5	2.6	2.0
Cannabis	12.5	9.4	14.0	12.5
Cocaine	4.2	2.5	5.4	4.2
Ecstasy	3.0	2.0	4.2	3.1
Heroin	0.1	0.1	0.4	0.1
LSD	0.5	0.4	0.6	0.5
Magic mushrooms	0.9	0.3	1.5	0.9
Last month prevalence				
Any illicit drug	8.5	5.7	8.4	8.4
Amphetamines	0.7	0.3	1.1	0.7
Cannabis	6.8	4.6	7.4	6.8
Cocaine	1.6	0.6	2.0	1.6
Ecstasy	1.0	0.6	1.8	1.1
Heroin	0.0	0.0	0.3	0.0
LSD	0.1	0.0	0.4	0.1
Magic mushrooms	0.2	0.0	1.1	0.3
Net response	*9,589*	*855*		

[329] Age 15 to 34 years old for Northern Ireland.

Table A.3: Percentage of 16 to 24[330] year olds reporting having used individual drugs in lifetime, last year and last month in the United Kingdom, 2010/11

	BRITISH CRIME SURVEY 2010/11	NORTHERN IRELAND DRUG PREVALENCE SURVEY 2010/11	SCOTTISH CRIME AND JUSTICE SURVEY 2010/11	UNITED KINGDOM ESTIMATE 2010/11
Lifetime prevalence				
Any illicit drug	40.1	31.5	37.2	39.6
Amphetamines	8.9	8.3	9.9	9.0
Cannabis	34.5	26.8	34.7	34.3
Cocaine	10.1	11.7	13.3	10.4
Ecstasy	9.5	12.3	14.6	10.0
Heroin	0.2	0.0	0.7	0.2
LSD	2.6	3.0	3.9	2.7
Magic mushrooms	5.0	5.0	7.4	5.2
Last year prevalence				
Any illicit drug	20.4	13.4	20.3	20.2
Amphetamines	2.6	1.5	3.8	2.7
Cannabis	17.1	10.8	18.4	17.0
Cocaine	4.5	3.1	5.8	4.6
Ecstasy	3.8	2.7	5.0	3.9
Heroin	0.1	0.0	0.3	0.1
LSD	0.6	0.6	0.5	0.6
Magic mushrooms	1.3	0.6	2.0	1.3
Last month prevalence				
Any illicit drug	10.9	6.5	9.8	10.7
Amphetamines	0.9	0.4	1.5	0.9
Cannabis	9.0	5.2	8.9	8.9
Cocaine	1.6	0.8	2.3	1.6
Ecstasy	1.3	0.7	2.4	1.4
Heroin	0.0	0.0	0.2	0.0
LSD	0.2	0.0	0.2	0.2
Magic mushrooms	0.3	0.0	1.6	0.4
Net response	3,665	346		

[330] Age 15 to 24 years old for Northern Ireland.

Table A.4: Percentage of 16 to 59 year olds reporting having used individual drugs in lifetime, last year and last month in the United Kingdom, 2006/07, 2008/09, 2009/10 and 2010/11[331]

	UNITED KINGDOM ESTIMATE 2006/07	UNITED KINGDOM ESTIMATE 2008/09	UNITED KINGDOM ESTIMATE 2009/10	UNITED KINGDOM ESTIMATE 2010/11
Lifetime prevalence				
Any illicit drug	35.4	36.2	35.9	35.6
Amphetamines	11.9	12.0	11.5	11.4
Cannabis	30.2	30.7	30.3	30.3
Cocaine	7.7	9.2	8.7	8.9
Ecstasy	7.5	8.7	8.5	8.5
Heroin	-	0.7	0.8	0.6
LSD	5.6	5.6	5.4	5.4
Magic mushrooms	7.1	7.3	7.3	7.1
Last year prevalence				
Any illicit drug	10.2	10.0	8.7	8.8
Amphetamines	1.4	1.2	1.0	1.1
Cannabis	8.4	7.9	6.7	6.8
Cocaine	2.7	3.0	2.5	2.2
Ecstasy	1.9	1.8	1.7	1.4
Heroin	-	0.1	0.1	0.1
LSD	0.2	0.2	0.2	0.2
Magic mushrooms	0.6	0.5	0.4	0.4
Last month prevalence				
Any illicit drug	6.0	5.8	5.0	4.8
Amphetamines	0.5	0.4	0.3	0.4
Cannabis	4.9	4.5	4.0	3.8
Cocaine	1.3	1.5	1.1	0.8
Ecstasy	0.9	0.6	0.6	0.4
Heroin	-	0.0	0.1	0.0
LSD	0.1	0.1	0.1	0.1
Magic mushrooms	0.1	0.1	0.1	0.1

[331] See UK Focal Point reports 2008, 2010 and 2011 for details of how these estimates were produced.