UK Drug Situation 2000

The UK report to the
European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

November 2000
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DrugScope November 2000

This report is available via the DrugScope website: [www.drugscope.org.uk](http://www.drugscope.org.uk) until replaced by next year's report. Further information can be obtained from DrugScope's Library & Resource Centre.

**DrugScope**

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Introduction

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

This report contains information on the situation in the United Kingdom up to 2000. In due course, some of this information will be selected for inclusion in the EMCDDA's Annual report on the state of the drugs problem in the European Union 2001. The EMCDDA's report for 2000 contains information collated in 1999. The format is common to all national focal points in the European Union.

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

Contact details for the EMCDDA in Lisbon, Portugal

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Summary

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

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

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

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

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

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

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

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

All the material highlighted in this summary is described and referenced in the main text. See also bibliography.
PART 1

NATIONAL STRATEGIES:
INSTITUTIONAL & LEGAL FRAMEWORKS

1. Developments in Drug Policy and Responses

1.1.1 UK Strategy

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

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

- **young people**
  To help young people resist drug misuse in order to achieve their full potential in society.

- **communities**
  To protect our communities from drug-related anti-social and criminal behaviour

- **treatment**
  To enable people with drugs problems to overcome them and live healthy and crime free lives.

- **availability**
  To stifle the availability of illegal drugs on our streets.

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

1.1.2 Scotland Strategy

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

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

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

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

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

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

1.1.4 Northern Ireland Strategy

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

The key features of the Northern Ireland Drugs Campaign were:

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

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

1.2 Policy implementation, legal framework and prosecution

Since 1998 the government has provided additional funding to increase the number of drug using offenders engaged with treatment services. This included the introduction of Drug Treatment and Testing Order pilot schemes. Under this order courts may, with the offender’s consent, make an order requiring the offender to undergo treatment either as part of another community order or as a sentence in its own right. It is envisaged that such schemes will be available in all courts in England and Wales by 2001.
Police forces in England and Wales are also operating Arrest Referral Schemes whereby problem drug users are identified and encouraged to take up appropriate treatment. These schemes are also currently being expanded, with the target of 100% coverage of all police stations by 2002.

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

1.3 Developments in public attitudes and debates

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

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

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

1.4 Budgets and funding arrangements

The 1998 Comprehensive Spending Review settlement provided an extra £217 million for three years (i.e.1999/2000 to 2001/2002) directed to health, local authorities and criminal justice agencies for targeted anti-drugs activities. This was allocated as follows:

| £133 million to provide for the implementation of the strategy to tackle drug misuse in the criminal justice system. |
| - Prisons receive £60 million for treatment services and £12 million for voluntary drug testing in prisons; |
| - £61 million made available for piloting and implementation of Drug Treatment & Testing Orders. |
£70.5 million will be allocated to health and local authorities to fund new treatment services and to improve community care for drug misusers.

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

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

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

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

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

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

Source: UKADCU
PART 2

EPIDEMIOLOGICAL SITUATION

2. Prevalence, patterns and developments in drug use

2.1 Main developments and emerging trends

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

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

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

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

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

\(^1\) Data sources are provided in the text.
Health consequences
- There has been an increase in the number of drug-related deaths reported in England and Wales and Scotland, with an ongoing trend of deaths becoming more male dominated. The increase may partly be due to changes in reporting practice.
- HIV prevalence is stable and low, although transmission continues to occur.
- Transmission of hepatitis B continues to be a problem, despite the existence of the hepatitis B vaccine.
- Two in five injectors in England and Wales are infected with hepatitis C antibody. In Scotland and England and Wales, there is a clear relationship between prevalence of infection and duration of injecting career, indicating that harm reduction initiatives may be having an impact on hepatitis C transmission. A total of 56% of all known cases of hepatitis C in Scotland (10161) were known to have ever injected drugs (Codere and Shaw 2000).
- An outbreak of illness among IDUs, thought to be due to Clostridium novyi, resulted in the death of at least 43 IDUs in the UK and Ireland in 2000.

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

2.2 Drug use in the population

Adults
The 1998 British Crime Survey, conducted by the Home Office, asked respondents in England and Wales if they had used various drugs (Ramsay and Partridge 1999). The Survey is designed to be representative of the general public in England and Wales, it is conducted every two years, and the main focus is on victimization, though other topics, including drugs, are covered. The response rate for the overall 1998 survey was 78.7%, of whom 97.3% answered the drugs component, with a sample size of just over 10,000. Overall, a third (31.7%) of adults aged 16 to 59 years in 1998 reported having used illicit drugs at some point in the past, compared to 29% in 1996 and 28% in 1994 (Ramsay and Percy 1996; Ramsay and Spiller 1997) Key findings only are presented here as results
were described in detail in last year’s report (ISDD 1999). [The relevant section from the 1999 UK Drug Situation Report can be found in appendix A.]

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

![Bar chart showing drug use by age group](chart.png)

Source: British Crime Survey 1998

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

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

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

<table>
<thead>
<tr>
<th>Age group</th>
<th>16-24 years</th>
<th>25-34 years</th>
<th>35-44 years</th>
<th>45-54 years</th>
<th>55-59 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime</td>
<td>Males</td>
<td>59.8%</td>
<td>Males</td>
<td>59.8%</td>
<td>Males</td>
</tr>
<tr>
<td>Last year</td>
<td>Males</td>
<td>36.3%</td>
<td>Males</td>
<td>36.3%</td>
<td>Males</td>
</tr>
<tr>
<td>Last month</td>
<td>Males</td>
<td>24.3%</td>
<td>Males</td>
<td>24.3%</td>
<td>Males</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>46.1%</td>
<td>Females</td>
<td>46.1%</td>
<td>Females</td>
</tr>
<tr>
<td></td>
<td>34.2%</td>
<td>9.3%</td>
<td>4.5%</td>
<td>4.5%</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

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

**Schoolchildren**

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

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

Prevalence of drug use in the last year for 11 to 15 year olds in England (11.0%) was only marginally lower than lifetime prevalence, possibly reflecting relatively recent initiation to and/or experimentation with drug use by some respondents. Due to different questionnaire designs the data between England and Scotland is not strictly comparable. In Scotland, the figure of 5% of children aged 12 to 15 reporting for drug use in the last 12 months did not include the figures reporting use in the last month. Prevalence of drug use in the last month was 6.7% overall for 11 to 15 year olds in England and 10% for 12 to 15 year olds in Scotland (Table 2). In England and Scotland 1 to 2% of children aged 11 to 12 used drugs in the last month, compared to at least one in six 15 to 16 year olds.
Table 2: Children lifetime and last month use of illicit drugs and solvents by age group, England, Scotland and Wales 1998

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

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

**Prisoners**

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

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

Among Scottish prisoners, there was a large increase in the proportion reporting heroin use in the last six months in prison, from 9% in 1994 to 31% in 1998 (ISD 1999; Wozniak 1999) In both years one in 20 reported injecting drugs in prison in the previous 6 months, and one in 25 (or 82% of those injecting) reported sharing injecting equipment. Although it seems therefore that the preferred route of administration of heroin is by smoking, there is still an ongoing risk of transmission of blood borne viruses among those injecting.

2.3 Problem drug use

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

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

3. Health consequences

3.1 Drug treatment demand

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

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

In terms of country breakdowns, during the six month period ending 30 September 1999, 30,545 individuals started new agency episodes throughout England, an increase of 7% on the equivalent period for 1998 (DoH 2000a). The gender distribution of these individuals showed the familiar male to female ratio of 3:1 overall, and around half (52%) were in their twenties.

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

3.2 Drug related mortality

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

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

<table>
<thead>
<tr>
<th>Year</th>
<th>England and Wales</th>
<th>Scotland</th>
<th>Northern Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Male-female ratio</td>
<td>Number</td>
</tr>
<tr>
<td>1990</td>
<td>2041</td>
<td>1.3</td>
<td>-</td>
</tr>
<tr>
<td>1991</td>
<td>2053</td>
<td>1.4</td>
<td>-</td>
</tr>
<tr>
<td>1992</td>
<td>2287</td>
<td>1.4</td>
<td>-</td>
</tr>
<tr>
<td>1993</td>
<td>2252</td>
<td>1.5</td>
<td>-</td>
</tr>
<tr>
<td>1994</td>
<td>2404</td>
<td>1.7</td>
<td>422</td>
</tr>
<tr>
<td>1995</td>
<td>2563</td>
<td>1.8</td>
<td>426</td>
</tr>
<tr>
<td>1996</td>
<td>2721</td>
<td>2.0</td>
<td>460</td>
</tr>
<tr>
<td>1997</td>
<td>2858</td>
<td>2.1</td>
<td>447</td>
</tr>
<tr>
<td>1998</td>
<td>2922</td>
<td>2.0</td>
<td>449</td>
</tr>
<tr>
<td>1999</td>
<td>-</td>
<td>-</td>
<td>492</td>
</tr>
</tbody>
</table>

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

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

3.3 Drug related infectious diseases

Data on prevalence of antibody to HIV (anti-HIV), HBV and HCV (anti-HCV) among injecting drug users in the UK is available from: the Centre for Research on Drugs and Health Behaviour (CRDHB) at Imperial College (Stimpson et.al 1996); the Communicable Disease Surveillance Centre (CDSC) (DoH 1999a); and the Scottish Centre for Infection and Environmental Health (SCIEH) (Taylor et.al 1994). The three Centres provide complementary data from surveys of IDUs recruited from both treatment and community settings. In addition, CDSC and SCIEH also collect routine information on laboratory reports of HIV infection and AIDS in the UK. (Codere and Shaw 2000; DoH 2000b; SCIEH 2000).
HIV
Cross-sectional surveys conducted throughout the 1990s suggest that prevalence of HIV in the UK has remained relatively stable and low. The number of new diagnoses of HIV infections attributed to IDU has fallen substantially from 447 cases in 1986 to 99 cases in 1999 (DoH 2000b). This has been attributed to the swift introduction of harm reduction interventions, such as needle exchange, early on when prevalence was low (Stimpson 1996).

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

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

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

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

Data on injecting drug users in Scotland undergoing named HIV testing suggest that prevalence of anti-HIV among this group has declined from around 3% in the early 1990s to about 1.5% between 1995-1997. In 1998 25 HIV infected injecting drug users were reported in Scotland (ISD 1999), and annually around 30 cases have been reported since 1994, the vast majority being aged 30 years or over. These data suggest that incidence of HIV infection among IDUs in Scotland is low, although new infections are still occurring.
For the UK as a whole, the number of new diagnoses of HIV infection attributed to injecting drug use continues to decline (DoH 2000b). Injecting drug use has played a much smaller part in the epidemic of HIV in the UK than in many other European countries. Of the 42,125 individuals with HIV infection reported in the UK to the end of June 2000, only 9% were classified as having acquired their infection through injecting drug use.

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

<table>
<thead>
<tr>
<th>Table 4: AIDS deaths attributed to injecting drug use*, England and Wales, Scotland and Northern Ireland 1990-1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country</td>
</tr>
<tr>
<td>England &amp; Wales</td>
</tr>
<tr>
<td>Scotland</td>
</tr>
<tr>
<td>Northern Ireland</td>
</tr>
</tbody>
</table>

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

Hepatitis B virus (HBV)

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

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

There has been an overall decline in prevalence of HBV between the early 90s and 1995, decreasing from around 35% to about 20% (Figure 3). Since then it has remained relatively stable, with around one in five injectors having been exposed to the virus. A slight increase in prevalence was found in 1998, though it remains to be seen whether this is a persistent trend.
Figure 3: Anti-HBc prevalence among IDUs, England and Wales 1990-1998

Source: CRDHB, CDSC
Notes: All percentages are unadjusted. The test sensitivity is estimated to be 82%.

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

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

Hepatitis C virus

Latest results from treatment and community surveys of injecting drug users in England and Wales suggest an overall unadjusted prevalence of antibody to hepatitis C virus (anti-HCV) of 30% (Hope et.al in press). The sensitivity of the test for anti-HCV is estimated to be approximately 80%, so the true prevalence of infection may be nearer 38%.

A strong relationship was found between HCV prevalence and years injecting, with prevalence rising from 7% among those injecting for 0 to two years, to nearly 30% for those injecting for 6 to 8 years, and just over 60% among injectors who have been injecting for 15 years or more (Figure 4).
Figure 4: Prevalence of anti-HCV and anti-HBc by duration of injecting career, England and Wales 1998

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

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

The cumulative total number of people being diagnosed with anti-HCV in Scotland to the end of 1998 was 8,075, being a 36% increase on the total to the end of 1997 (Codere and Shaw 2000). This figure equates to one in 600 of Scotland’s population being known hepatitis C antibody positive, although experts predict that the number of unknown cases exceeds the number of known cases several-fold. Two-thirds (68%) of the known cases were male, 86% were aged between 15 and 44, and around half (53%) were known to have ever injected drugs.

3.4 Other drug related morbidity

Serious unexplained illness among injecting drug users

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

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

4. Social and legal correlates and consequences

4.1 drug offences and drug related crime

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

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

More information from NEW-ADAM (the New English and Welsh Arrestee Drug Abuse Monitoring) indicated a strong correlation between illicit drug use and property crime. Of the 506 sample-providing arrestees, 69% tested positive for at least one drug, 29% tested positive for opiates, and 20% tested positive for cocaine, including crack. The small subgroup (9%) with the costliest drug habits was responsible for 52% of all offences reported by the group (Bennet 1998; Bennet 2000; McKeeganey et.al 2000).
Table 5: Persons found guilty, cautioned, given a fiscal fine or dealt with by compounding for drug offences by type of drug and offence, 1997-1998

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1997</td>
<td></td>
<td></td>
<td>1998</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannabis</td>
<td>Possession</td>
<td>77,943</td>
<td>89,129</td>
<td>14.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other*</td>
<td>8,091</td>
<td>8,120</td>
<td>0.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>86,034</td>
<td>97,249</td>
<td>76.1%</td>
<td></td>
<td></td>
<td>13.0</td>
</tr>
<tr>
<td>Heroin</td>
<td>Possession</td>
<td>7,138</td>
<td>9,429</td>
<td>32.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1,618</td>
<td>1,972</td>
<td>21.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>8,756</td>
<td>11,401</td>
<td>7.7%</td>
<td></td>
<td></td>
<td>30.2</td>
</tr>
<tr>
<td>Cocaine</td>
<td>Possession</td>
<td>2,368</td>
<td>3,461</td>
<td>46.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1,001</td>
<td>980</td>
<td>-2.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>3,369</td>
<td>4,441</td>
<td>3.0%</td>
<td></td>
<td></td>
<td>31.8</td>
</tr>
<tr>
<td>Amphet*</td>
<td>Possession</td>
<td>11,559</td>
<td>12,926</td>
<td>11.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1,772</td>
<td>1,854</td>
<td>4.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>13,331</td>
<td>14,780</td>
<td>11.8%</td>
<td></td>
<td></td>
<td>10.9</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>Possession</td>
<td>3,100</td>
<td>2,373</td>
<td>-23.5</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Other</td>
<td>1,051</td>
<td>750</td>
<td>-28.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>4,151</td>
<td>3,123</td>
<td>3.7%</td>
<td></td>
<td></td>
<td>-24.8</td>
</tr>
<tr>
<td>LSD</td>
<td>Possession</td>
<td>545</td>
<td>477</td>
<td>-12.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>171</td>
<td>135</td>
<td>-21.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>716</td>
<td>612</td>
<td>0.6%</td>
<td></td>
<td></td>
<td>-14.5</td>
</tr>
<tr>
<td>Crack</td>
<td>Possession</td>
<td>388</td>
<td>682</td>
<td>75.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>145</td>
<td>231</td>
<td>59.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>533</td>
<td>913</td>
<td>0.5%</td>
<td></td>
<td></td>
<td>71.3</td>
</tr>
<tr>
<td>Total</td>
<td>Possession</td>
<td>100,80</td>
<td>115,23</td>
<td>14.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>12,346</td>
<td>12,608</td>
<td>2.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(all</td>
<td>Total</td>
<td>113,15</td>
<td>127,84</td>
<td>13.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>controlled</td>
<td>8</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>drugs)</td>
<td>12,346</td>
<td>12,608</td>
<td>2.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>113,15</td>
<td>127,84</td>
<td>13.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Home Office.
Notes: Percentages do not add up to 100% as an offence can involve more than one drug type.
- Amphet = Amphetamine
- * Note that some persons convicted of possession may also have committed other offences.
5. Drug markets

5.1 Availability and supply

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

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

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

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

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

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

In terms of potential measures of international/regional supply, a European flows 2002 feasibility study (DrugScope, HMCE and EMCDDA, not yet available) was carried out in order to move towards development of a methodology for generating information on drug flows and baselines for interpretation of European and UK seizures. This research is intended to measure, for example, drugs ‘destined for the UK’ and ‘UK seizures as a proportion of overall UK availability’ (in accordance with targets cited in UKADCU, 1999).
Customs estimate that the majority (up to 80%) of cannabis resin entering the UK originates from Morocco and travels by sea, although large amounts also arrive from South West Asia, mainly Pakistan. Herbal cannabis most commonly comes from Jamaica (Foreign & Commonwealth Office, 2000).

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

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

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

5.2 Seizures

Statistics on drug seizures made by the police, HM Customs and Excise and other bodies such as the British Transport Police are routinely published by the Home Office (Corkery 2000a). The number of seizures involving controlled drugs rose by 8% between 1997 and 1998, to 149,900, the highest figure yet to be recorded. Of these, the vast majority (76%) involved cannabis, and 12% involved amphetamines, similar to 1997.

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

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

Source: Home Office
Notes: * Amphet = Amphetamine

5.3 Price, purity

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

Other Forensic Science Service data suggest that the average MDMA drug content of tablets was around 80mg between 1996 and 1999, although the number of tablets tested was relatively small and it is not clear how they were selected for testing.
Figure 5: Average purities of drug seizures analysed by the Forensic Science Service by drug type, UK 1992-1998

Source: Home Office

Notes: No data available for quarters 3 and 4 of 1996 and quarter 1 of 1997.

- Amphet = Amphetamine

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

6. Trends by drug

The main sources of information on trends in drug use by drug type are those described in the section earlier entitled ‘Drug use in the population’ (ie the British Crime Survey and school surveys). As the findings from the last British Crime Survey (Ramsay and Partridge 1999) were described in detail in last year’s UK Drug Situation (ISDD 1999) only key findings are presented here. [The relevant section from the 1999 UK Drug Situation Report is reproduced in appendix A.]

Cannabis

The 1998 British Crime Survey asked respondents in England and Wales about their use of various different drugs. Cannabis remains the most frequently reported lifetime drug of use, with a quarter (25.1%) of all adults, and nearly half (44.0%) of 16 to 24 year olds, reporting use of this drug at some point (Figure 6). Reported lifetime use declined steadily with age, with only 5% of adults aged 55 to 59 reporting that they had used cannabis at some point previously. Only 5% of all adults reported using cannabis in the last month, varying from 17.0% for 16 to 24 year olds, to 0.2% for 55 to 59 year olds. In Northern
Ireland cannabis prevalence established by the Northern Ireland Crime Survey increased from 12% in 1995 to 18% in 1998 (Hague et.al. 2000).

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

Cannabis use reported by children in the England, Scotland and Wales school surveys is described in Table 7. Overall, around one in ten English schoolchildren aged 11 to 15 years, compared to one in six Scottish schoolchildren aged 12 to 15 years, reported lifetime cannabis use. As one would expect, prevalence of use increased with age, with under 5% of English 11 and 12 year olds and Scottish 12 year olds reporting lifetime use. In contrast 30 to 40% of 15 to 16 year olds in England, Scotland and Wales reported ever using cannabis, decreasing to between 16% and 23% in the last month.
Table 7: Children lifetime and last month use of cannabis by age group, England, Scotland and Wales 1998

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

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

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

Just under two in five (39.2%) of the youngest group of respondents to the British Crime Survey reported ever having taken hallucinogens (defined as LSD, magic mushrooms and amyl nitrite), whilst one in ten had used amphetamines (21%) and/ or ecstasy (10.7%), and 7.0% cocaine. These percentages decreased with age to almost negligible levels of use for 55 to 59 year olds.
Figure 7: Percentages of adults who indicated that they had ever used hallucinogens, amphetamines, cocaine and ecstasy by age group, England and Wales 1998

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

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

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

<table>
<thead>
<tr>
<th>Country</th>
<th>Time period</th>
<th>Cocaine</th>
<th>Amphetamines</th>
<th>Ecstasy</th>
<th>Hallucinogens</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>Lifetime</td>
<td>2.8%*</td>
<td>7.6%*</td>
<td>2.5%*</td>
<td>6.1%*</td>
</tr>
<tr>
<td></td>
<td>Last month</td>
<td>1.0%*</td>
<td>2.5%*</td>
<td>0.7%*</td>
<td>1.8%*</td>
</tr>
<tr>
<td>Scotland</td>
<td>Lifetime</td>
<td>1.0%*</td>
<td>12.0%*</td>
<td>4.0%*</td>
<td>10.0%*</td>
</tr>
<tr>
<td></td>
<td>Last month</td>
<td>0.0%*</td>
<td>4.0%*</td>
<td>1.0%*</td>
<td>3.0%*</td>
</tr>
<tr>
<td>Wales</td>
<td>Lifetime</td>
<td>1.8%</td>
<td>14.2%</td>
<td>4.5%</td>
<td>13.5%</td>
</tr>
<tr>
<td></td>
<td>Last month</td>
<td>0.5%</td>
<td>6.3%</td>
<td>2.6%</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

Source: England, Scotland and Wales school surveys
Notes: * 15 year olds only
Opiates
Reported lifetime prevalence of opiate use among British Crime Survey respondents was very low, at 1.1% overall. Heroin use remained stable, with an increase in methadone use. Trends in the use of opiates mirrored trends for the other drugs. Use was highest among the youngest age groups and among male respondents. Last month use of opiate drugs was negligible (0.3%) for all but the youngest respondents. Among males, 0.9% of those aged 16 to 24 reported opiate use in the last month, compared to 0.5% for females.

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

7. Conclusions

7.1 Consistency between indicators

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

7.2 Implications for policy and interventions

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

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

In relation to one harmonized indicator, based on the Regional Drug Misuse Database information, regional variations in reporting requirements and inconsistent reporting compliance continue to adversely effect data collection and interpretation. Shifts in drug use patterns and distribution flows, are also generating a need for new information sources. UK priorities for future work relate to the new targets in the EU Action Plan.
PART 3

DEMAND REDUCTION INTERVENTIONS

8. Strategies in Demand Reduction at National Level

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

9. Intervention Areas

9.1 Primary prevention

9.1.1 School programmes

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

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

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

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

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

9.1.2 Youth programmes outside schools

Drug prevention projects, targeted at young people at particular risk of drug misuse, have been commissioned by 11 “Health Action Zones” in the UK. These cover truants and school excludees, young offenders, young homeless people and children of drug misusing parents.
The government is working with Sport England and the Youth Justice Board to set up a range of projects under the “Positive Futures” initiative, which aims to divert vulnerable young people aged 10 to 16 years old into sport and healthy activities and away from drug misuse and antisocial activity.

9.1.3 Telephone help lines

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

9.1.4 Internet

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

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

9.2 Reduction of drug related harm

9.2.1 Prevention of infectious diseases, low threshold services and outreach

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

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

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

9.3 Treatment

9.3.1 Treatments and health care at National level

The UK Anti-Drugs Co-ordinator acknowledged in his First Annual Report that treatment for drug users works, but that the supply of effective treatment services is failing to meet demand. The UK strategy contains a firm commitment to improving the provision of drug treatment across the country, so that all drug users can access appropriate services as they need them.
The Home Secretary, Jack Straw, recently announced the creation of a national treatment agency. It is anticipated that the agency will be funded by the Home Office, Department of Health and local authorities. It will pool the money already spent by the NHS and local authorities on treatment services and the money spent by the Home Office on the testing and treatment of criminals.

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

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

9.3.2 Substitution and maintenance programmes

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

9.4 After-care and re-integration

9.4.1 Education, Training, Employment and Housing

In its 1998 report *Drug Misuse and the Environment* the Advisory Council on the Misuse of Drugs (ACMD) drew attention to the importance of the wider environment in which drug misuse arises. The government have acknowledged the issues raised in the report, and all four UK strategies make reference to social issues, education, housing, employment and stress the need for partnerships between agencies at local level.

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

The Scottish drug strategy emphasises the commitment to creating a more inclusive society across Scotland through a comprehensive and concerted programme of action tackling poor housing, high crime levels, high unemployment and the lack of leisure and recreational facilities.
A key feature of the Welsh strategy is integration and coordination. Action to tackle substance misuse in Wales should assume a key role in wider policy agendas such as social inclusion, economic development, public health and crime disorder.

9.5 Interventions in the Criminal Justice System

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

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

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

10. Quality Assurance

10.1 Quality assurance procedures

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

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

10.2 Research and Evaluation

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

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

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

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

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

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

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

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

- Pilot UK Injectable Methadone Trial. Prof Gerry Stimson, Imperial College.
- Dexamphetamine substitution as a treatment of amphetamine dependence: a two-centre randomised controlled pilot study. Dr John Merrill, Salford NHS Trust.
A national epidemiological study of dually diagnosed substance misuse and psychiatric disorders between 1993-1998, using the General Practice Research Database. Dr Martin Frischer, Keele University.

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

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

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

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


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

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

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

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

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

10.3 Training for professionals

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

A national drug counsellor recruitment campaign, jointly funded by the Department of Health and the Home Office, was launched to fill existing vacancies and to expand treatment
capacity. The aim was to bring between 300-600 new workers into services and provide their initial training.
PART 4

KEY ISSUES

11. Drug Strategies in European Union Member States

11.1 National policies and strategies

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

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

11.2 Application of national strategies and policies

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

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

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

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

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

Scotland has also recently formed a Prevention and Effectiveness Unit within the Public Health Policy Unit of the Scottish Executive to advise on what is and is not working and to disseminate examples of good practice.
In Northern Ireland responsibility for co-ordinating action to implement the strategy is with the Northern Ireland Department for Health, Social Services and Public Safety (DHSS&PS) whilst responsibility for law enforcement issues lies within the Northern Ireland Office.

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

11.3 Evaluation of national strategies

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

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

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

12  Cocaine and base/crack cocaine

12.1 Different patterns and user groups

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

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

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

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

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

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

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

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

Neither tolerance nor heroin-like withdrawal symptoms are recognised in chronic cocaine or crack use. However, this is a narrow definition of drug dependence. The tiredness and depression experienced after stopping the drug, although not medically serious may have a similar effect as a withdrawal syndrome in encouraging further use and dependence, particularly as the feeling of depression goes away when drug use is resumed.
Even if cocaine is not physically addictive, a strong psychological dependence on the good feelings experienced by using cocaine can develop with all the accompanying physical and mental problems of long-term use described above.

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

12.3 Market

12.3.1 Price/purity at users’ level

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

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

12.3.2 Availability

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

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

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

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

12.3.3 Trafficking, dealing, supply routes etc

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

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

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

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

12.4 Intervention projects

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

There are also other reasons that few cocaine and crack users present to agencies. Agencies are more used to dealing with more ‘compliant’ heroin users and often not equipped to deal with more demanding users. Crack users often want immediate help at any time of the day or night and may expect the same kind of instant service they get from a dealer. As paranoia is a frequent consequence of long-term use, this may discourage users from revealing their problems to any ‘authority’. Black users may not feel comfortable attending what are primarily white drug agencies. A few specialist agencies have been set up in inner city areas to support crack users but have only met with limited success.

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

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

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

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

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

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

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

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

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

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

13.2 Determinants and consequences

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

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

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

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

13.3 New developments and uptake of harm reduction

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

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

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

For further information on any of the references in this list, contact DrugScope’s Library and Resource Centre.


UKADCU (United Kingdom Anti-Drugs Coordination Unit) (1999). Second National Plan. London UKADCU.


Appendix A

Section on the British Crime Survey 1998 taken from the UK Drug Situation 1999

7.2 Drug Consumption in the General Population

From 1994 onwards the BCS respondents (England and Wales only) were allowed to self-key their answers using laptop computers rather than filling in tick-box questionnaires. Although a direct comparison with 1992 is difficult due to this change in methodology, figures show that the number of people admitting lifetime use of drugs is still rising. With the data from 1998 now available, we can for the first time compare and observe trends in the new self-key response survey data.

7.2.1 Lifetime use
The BCS data reveals that although lifetime use for the whole sample almost levelled out in 1996, with a rise of only 1 per cent from 1994 (28 per cent to 29 per cent), the overall trend is upwards, with 1998 showing another 3 per cent increase to 32 per cent for the whole sample ever having used a drug.

7.2.2 More recent use
Drug use within the last year however tells a slightly different story, with the levelling out of 1996 continuing into 1998 figures. After the high rise from 1992 to 1994 with the introduction of the laptops during interview, 10 per cent of respondents admitted having used a drug with the last year in 1994 and 1996, with 11 per cent in 1998.

The story is similar for use in the last month, which in comparison to other measures, is likely to indicate more accurately the number of regular users of drugs. In 1994 this figure stood at 6 per cent, remaining the same for 1996 and 1998. It would appear therefore from these figures that drug use within the adult population is stable at one in ten using occasionally, and one in sixteen regularly.

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Table 7.1 Prevalence for 16 to 59 year olds, 1994 to 1998 in percentages.

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<tr>
<td>Lifetime</td>
<td>28</td>
<td>29</td>
<td>32</td>
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<tr>
<td>Within the last</td>
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<td>10</td>
<td>11</td>
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<td>year</td>
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<tr>
<td>Within the last</td>
<td>6</td>
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This apparent levelling out for more recent use, but a stubborn rise in lifetime use, may be indicative of an increase of availability and experimentation, but not regular use. It has been suggested that a possible levelling out of drug use has taken place in the mid-nineties in at least some parts of the country, with the apparent popularity of recreational drugs in the early nineties being caught up by a rise in popularity of ‘designer’ alcohol drinks. What is clear from these surveys, however, is that while the number of individuals trying a drug is increasing, the number using regularly or occasionally is not, ie two-thirds of those who have used are essentially non-users now.

7.2.3 Age matters
The BCS prevalence figures for the general population disguise the more marked rates of use among the under 30s, whose drug use prevalence tends to outstrip that of the older generation by at least 2:1 (49 per cent of 16 to 29 year olds for example have ever tried a drug compared to 25 per cent of 30 to 59 year olds). This becomes more pronounced when prevalence rates for regular use are looked at (16 per cent compared to 3 per cent having used any drug within the last month respectively).

Life time use among the 20 to 24 year olds provides the highest use rates among the BCS adult population, at 55 per cent. This is followed by the 16 to 19 year olds at 49 per cent, and 45 per cent for the 25 to 29s. Roughly half therefore of the under 30s have at some point in their lives tried an illicit substance. Compared to previous years this again shows an increase of roughly 10 per cent on 1996 figures and 25 per cent up on the 1994 figures. As figure 7.1 shows, the trend for lifetime use is steadily upwards, for the under 30s, with rates of use rising from 43 per cent in 1994 to 45 and 49 per cent in 1996 and 1998 respectively.

An interesting development is the emergence of the 20 to 24 year olds as the group with most ever having tried a drug, replacing the under 20s. All of today’s 20 to 24 year olds were the using 16 to 19 year olds of 1994, hence the high rates today. However, it is apparent that many more within this generation have experimented with drugs since the 1994 survey. In other words, yesterday’s 16 to 19 year olds are still the highest group of users today, outstripping the prevalence rates of today’s 16 to 19 year olds.

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As previously discussed, lifetime use does not accurately reflect the proportion currently using drugs on an occasional or regular basis. For this we have to look at use within the last year and month.

Prevalence rates for use within the last month show a small but steady increase of around 1 per cent every two years for the 16 to 29 year old group as a whole. Rates for within the last year have risen from 23 per cent in 1994 to 25 per cent in 1998. Similarly, rates for use within the last month have risen from 14 to 16 per cent in the respective time periods.

But what about the 20 to 24 year olds, whose lifetime use has greatly increased? From figure 7.2 below, it is clear that while quite recent use, within the last year, is not increasing for the under 20s, it is still very much on the increase for the 20 to 24 and 24 to 29 year olds. So while more of 1994’s under 20s would appear to be using drugs today, the new under 20s are not.
Appendix B
Section on the treatment taken from the UK Drug Situation 1999

Heroin, Methadone and Substitution Treatment

16.1 Criteria and target groups for substitution treatment

16.1.2 Criteria

There are no set criteria for the treatment of opiate dependence. Criteria will differ according to health authority and agency objectives. The recently published Clinical Guidelines6 for the treatment of dependency set out basic criteria for prescribing. The guidelines apply to all drugs of substitution. The criteria are as follows:

Who is to be prescribed to:

- An individual will have a physical dependency on heroin, which will normally be confirmed using urine samples, or
- will be using heroin intravenously or
- will have had 6 months of regular non IV use
- the individual must be motivated to change at least some aspects of their drug use

Other considerations include:

- the assessment (history, urine toxicology, drug diary) clearly substantiates the need for treatment
- the doctor is satisfied that the patient will co-operate and demonstrate adequate compliance with the prescribing regime

16.2 Legal basis for treatment

16.2.1 The legal situation

Methadone and diamorphine may only be prescribed by a qualified doctor and dispensed by a pharmacist. Not all but most statutory drug agencies are licensed to prescribe methadone. On the whole however, most employ specialist doctors who prescribe and supervise substitution treatment.

Regulation
There is limited regulation of treatment services by the government in the UK. The medical profession is largely self-regulating and enjoys a large degree of autonomy and discretion in their approach to substitution treatment.

The basis of current legislation
The UK medical profession has always enjoyed a large degree of autonomy with regards treating drug dependence. However, excessive prescribing of diamorphine in the 1960s led to restrictions on who could prescribe the drug. The Dangerous Drugs Act 1968 which followed, prevented non-specialist doctors from prescribing heroin and cocaine for the treatment of dependence. Permission to prescribe the drug had to be sought by such doctors in specialist clinics from the Home Office. Regulations were also issued that enabled hospital based doctors to issue dispensing instructions for substitute drugs from community pharmacists.

Licence to prescribe
Currently any doctor wishing to prescribe heroin or cocaine has to be in possession of a Home Office licence. It has been proposed, as part of the consultation for the clinical guidelines, that this be extended to all controlled drugs, including oral methadone. Concerns that this extension would inhibit doctors from engaging many opiate users in treatment, has lead to the proposals being put to consultation in late 1999. Any changes to the current system require an amendment to the Misuse of Drugs Act. MPs will not be asked to consider new legislation until the end of this year with no new scheme in place until early 2000.

16.2.2 Clinical Guidelines - the minimum requirements

The government launched the guidance document for primary health care workers of problem drug users, last revised in 1991. The guidelines provide treatment guidance for all doctors and drug workers who work with problematic drug users. As guidance, they offer a framework from which to provide good practice, as well as outlining minimum care requirements responsibilities and accountability. Among some of the requirements, they:

- must provide care for both general health needs and drug-related problems, whether or not the patient is ready to withdraw from drugs
- should not be put under duress by colleagues or patients to provide treatment beyond [that] standard unless s/he or she wants to
- should not prescribe alone (medical practitioners)
- should only offer substitute medication without specialist generalist or specialist advice (see below) in exceptional circumstances
- must ensure that the patient receives the correct dose and that appropriate efforts are taken to ensure that the drug is used appropriately and not diverted onto the illegal market
- should supervise consumption for new prescriptions for a minimum of three months.

The guidelines introduce for the first time the concept of levels of expertise in treating drug users. Each level is required to meet certain standards of care, receive training and seek specified support and partnership.

Legal accountability under the guidelines
Although the newly revised guidelines on clinical management of problems drug users⁷ have no defined legal position, they do point out that any disciplinary investigation, any doctor, NHS or private, who departs from the set guidelines and what they call ‘standards and quality of care’, will be liable to judgement under the new powers granted to the General Medical Council under the Medical (Professional Performance) Act 1995. This in effect means that if it is deemed that any doctor has not followed the guidelines by, for example, prescribing a drug substitute without specialised advice or reviews being made, they may be liable under the act, and so can face disciplinary proceedings.

16.3 Organisation, regulation and monitoring of delivery systems

Substitution drugs in the UK are dispensed on the whole by community pharmacists. In 1995 for example, half of all such pharmacists in England and Wales dispensed controlled drugs⁸. The UK is unique in the informality of its dispensing system, with the majority of its substitute drugs administered without direct supervision⁹.

Medical care

It is the responsibility of the doctor to ensure that the patient receives the correct dose and that sufficient steps are taken to ensure that it is used appropriately. Doctors have the authority to choose the dispensing interval for each prescription and patients can be required to attend a community pharmacy 6 or 7 days a week, which is common practice in many areas. For example, in 1995, 37 per cent of pharmacists were instructed to dispense methadone in daily installments¹⁰. Doctors are advised to prescribe no more than one week’s drugs supply at one time. In the 1995 survey of pharmacists for example, a further 37 per cent of all prescriptions were written for at least a week’s supply.

The prescribing doctor is advised to liaise regularly with the dispensing pharmacist about the patient and to discuss the prescribing regime. Clinical reviews are to be taken regularly, at least every three months. Records of prescribing should also be kept for each client.

Dose levels

There are no statutory limits in the UK on permissible substitute dose levels for substitute drugs. However, it is common practice to commence prescribing methadone using low

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doses, moving on to a stable dose of 50 milligrams a day, although daily doses well in excess of that are a day are not uncommon.\[11\]

When to supervise
Although consumption is on the whole unsupervised, supervised consumption is recommended for new prescriptions for a minimum of three months. The patient’s lifestyle and commitments should be taken into account when planning supervision. A number of specialist methadone agencies in Britain have introduced onsite dispensing systems, where methadone is taken under direct staff supervision.

The recognition that supervision early on in treatment helps to ensure compliance, coupled with the potential for small amounts of prescribed methadone being diverted into the black market, has meant that community pharmacies are being encouraged to take on a more active role in supervised consumption. Although no figures as to the extent of supervision among pharmacists is available, there are regions where this is becoming more common. In Glasgow for example, 44 per cent of community pharmacists who reported dispensing methadone, did so under supervision and a further 39 per cent indicated they would do so if given appropriate guidance.

16.4 Choice of drugs for substitution

The primary purpose of substitution in the UK is to prevent the onset of physical withdrawal symptoms associated with opioid abstinence, and to stabilise the user both in terms of craving and the effects that will have on their behaviour. There are a number drugs which can be used:

**Diamorphine**
Although diamorphine (heroin) is claimed to by some practitioners as an effective substitute for illicit heroin, its prescription is a minority practice in the UK, constituting 1.7 per cent of the number of prescriptions for opioid drugs in England and Wales. Formerly unique to Britain, and its use often referred to as the British system, this approach has been in rapid decline over the last 30 years.

**Methadone**
The majority of substitution programmes in the UK use methadone hydrochloride, most of which is orally administered. In 1995 for example, methadone made up 96 per cent of the total number of prescriptions for opioid drugs. In 1998, a total of 1,022,800 oral methadone prescriptions were dispensed in England alone. In Scotland, 215,000 prescriptions of the drug were issued in 1998/1999.

**Dihydrocodeine**
Although not licensed for the management of drug dependence, dihydrocodeine is used by some practitioners to reduce the severity of withdrawal symptoms, usually at the end of a methadone reduction programme. However, the drug is also used in cases where the dispensing of oral methadone is inappropriate, for example when an user is going on holiday for a period longer than methadone storage will allow. The drug is usually dispensed in tablet form.

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Lofexidine
Lofexidine or Britlofex is used as a detoxification facilitating agent typically over a period of 7 to 10 days. It is not used in the same way as methadone, as a substitute for opioid use, but to manage withdrawal. It is dispensed in tablet form, 200 to 400 microgrammes. In 1998, 10,700 prescriptions of the drug were dispensed in England.

Buprenorphine
Recently granted a licence for the treatment of dependence, buprenorphine is used both for detoxification and substitution. As a recently new drug, buprenorphine is currently being assessed in the clinical setting, with results available in 2000.

16.5 Extent and characteristics of substitution programmes

16.5.1 Extent of substitution programmes

There is no up to date census on the number of substitution programmes in the UK. The most comprehensive study in 1994 calculated that in England 188 specialist services were delivering opioid substitution.\textsuperscript{15} Since that survey, the Standing Conference on Drug Abuse (SCODA) have set up a drug service database for England and Wales. Although by no means comprehensive, the database lists 80 bodies who provide methadone (all), diamorphine (7), and dihydrocodeine (2) substitution treatment.

In Scotland, figures from the Scottish Drug Forum, shows that 31 agencies provided a substitution service to clients. There are no equivalent data for Northern Ireland.

16.5.2 Characteristics of substitution programmes

Opiate (detox) detoxification
The aim of detox is to eliminate the drug (usually heroin) from the body prior to some form of extended support to help maintain abstinence. Detox programmes can be administered on an in-patient basis usually in psychiatric units or medical wards, or on a community basis, provided on the NHS by Drug Dependency Units (DDU), Community Drug Teams (CDTs) or by private clinics (some of which take NHS clients). Individuals are usually referred to such clinics either by GPs or drug agencies. On completion of detox, support is provided by CDTs, day programmes and outpatient services.

Methadone reduction programmes
Methadone reduction programmes involve the prescribing of methadone to opiate users to control withdrawal symptoms. The aim is to gradually reduce the quantity prescribed until the user experiences no withdrawal complaints and is drug free. The degree of reduction

and length of time afforded to achieve abstinence can vary greatly from a few weeks to several months, depending on the requirements of the individual. Motivation is key in such programmes.

Participants are regularly asked to review their progress (eg weekly) whilst receiving therapy and support as part of a structured methadone programme. Methadone reduction programmes are delivered in a community setting, with care from nursing staff and doctors. Pharmacies are the main suppliers of the drug, often with supervised consumption.

**Methadone maintenance programmes**

Here the aim of the programme is not to eliminate drug use in the short term, but to stabilise the user by prescribing methadone as a substitute for heroin and other opiates - therefore reducing illicit drug use, the need for criminal activity and the harm caused by injecting.

The programmes are delivered in a community setting and may be structured, as with reduction programmes. The methadone is either supplied by a pharmacy or by specialist drug clinics where consumption is usually supervised. As a general rule, more complex users - ie those with more chaotic lifestyles and problematic use, are treated by drug clinics who provide more support and supervision. Less chaotic users tend to be seen by CDTs who provide structured and supervised off-site dispensing, while those in a more stable situation will be prescribed methadone by their GP to use unsupervised at home. It is not uncommon for a user to be prescribed the drug for several months or years.

**Heroin prescribing**

Because of the well-publicised activities of a few doctors, there is a mistaken belief that heroin prescribing is an established part of the current UK treatment policy. Very few doctors are licensed to prescribe the drug although many consultants working for DDUs are. Most decide not to prescribe the drug however due to cost and the demand its prescription makes on support services.

**Services for young people**

Most drug services in Great Britain are only equipped to deal with adult users, ie those over 18 years of age. There are also a number of legal complications involving confidentiality and parental involvement which can result in agencies refusing to offer care when faced with these complications. New guidelines put forward in 1998 by the Standing Conference on Drug Abuse and the Children’s Legal Centre have set out a number of key principles which should ensure that young people receive appropriate care. This will include appointing staff trained to deal with young people, working within a multi-disciplinary approach to treatment and guidance on drafting confidentiality policies.

Where appropriate, young clients can be administered methadone, either to reduce or maintain their use. This may be done in without parental consent in circumstances where seeking consent may prevent or hinder care.
16.5.3 Strategic approach to substitution in the UK

Responding to demand
In response to the increasing numbers of dependent opioid users in the eighties, the Treatment and Rehabilitation report of the ACMD recommended that non-specialist substitution treatment should be allowed to return, and an expansion of existing services put into action. Local health authorities were provided with funding to help establish and manage new community based services throughout the UK.

The 10 year drugs strategy
Currently the UK government is involved in an active and strategic approach to treatment, both centrally and locally. The 10 year strategy identifies substitution (mainly methadone) as an important community intervention, and has set itself targets for expansion and efficacy of treatment services for the coming decade.

Since 1990, reforms to the NHS have created decentralized arrangements for the purchasing and planning of treatment services. This has meant that such services have had to prove their effectiveness in the face of Best Value for local health authority service provision. The National Treatment Outcomes Research Study is currently carrying out work to establish how well substitution treatments are working.

16.6 Number and profiles of clients

It is not possible from the available data sets to audit the number of individuals receiving substitution treatment in the UK. At best, an estimate can be given using the Regional Drug Misuse Databases (RDMD).

Estimating the client base
From the RDMDs it is possible to ascertain the number of individuals presenting for treatment for the first time in a 6 monthly period who use heroin and methadone, the number receiving them from licit sources, and the number attending establishments likely to provide maintenance or reduction programmes. This method of calculation data has drawbacks, both in terms of reliability and validity.

On the one hand, such data may fail to count individuals presenting, for example, to GPs who fail to submit reporting forms to their local DMD. On the other hand, not all those presenting to these establishments will be receiving substitution treatment. One further complication is the failure of the RDMD to register individuals already in treatment, and presenting for the first time in the time period. The RDMD only covers those individuals reporting for the first time in the reporting 6 monthly period, and not those already in longer term treatment.

The University of Manchester who manage the North West of England DMD however has estimated that the number of new clients reported in the DMD represents only two thirds of the total number of individuals receiving treatment at any one time.
If we can assume that this figure holds for the rest of the UK, a factor of 1.5 can be used to estimate from the RDMD figures the total number of individuals receiving treatment for their heroin and methadone use and who are likely, by implication of the agency they are attending, to be receiving substitution treatment.

In the six months ending September 1998, for example, 1060 individuals presented for treatment who used heroin and methadone as their main drug in England for the first time in that period, and 10,045 presented for methadone use. In England therefore, it can be estimated that in the six monthly period ending September 1998, 11,105 individuals presented for heroin and methadone treatment. Multiplying by the factor 1.5 it can be estimated that for the same period, 16,600 individuals were receiving some form of substitution treatment for their dependence on methadone or heroin in England. The same data is not available as yet for the other nations.

Scotland
The Scottish DMD gives the number of individuals presenting for the first time who are using methadone from legitimate sources. For the financial year 1997/98, 1,539 individuals were reported as being prescribed methadone. This figure, although indicative of the demand for support among these individuals, underestimates the actual amount receiving treatment because it fails to count those already in treatment. Using the multiplier of 1.5 used earlier for England, it can be estimated that 2,300 individuals per anum in Scotland are receiving prescribed methadone for their dependence.

Wales
There are no figures yet available for 1997/8 for Wales. However, we do have a figure for the service demand for those using heroin and methadone. In 1998, 730 new clients presented to services who used heroin as their main drug, and 343 methadone. From these totals, it can be assumed that a large proportion will be receiving some form of substitution medication, although how much is not certain.

Northern Ireland
Similar figures for Northern Ireland show that the number of individuals with problem drug use is increasing. Although no figures for opiate dependence are available,

### 16.7 Evidence on impact of substitution

#### 16.7.1 NTORS

The National Treatment Outcome Research Study (NTORS) commissioned in 1994, provides information on the long term effectiveness of four treatment modalities: methadone maintenance programmes, methadone reduction programmes, residential rehabilitation programmes, and specialist in-patient drug dependence units. Data forms part of the key performance indicator for monitoring the reduction of levels of crime committed to pay for drug misuse, set out as a main strategic objective by the government.

The latest paper presents six-month treatment outcomes for patients who received community-based methadone treatment in either a specialist drug clinic or a general practice setting. A prospective, multi-site follow-up study of treatment outcome was conducted with 452 opiate addicts who had been given methadone treatment in primary health care and specialist clinic settings. Outcome data are presented for substance use behaviours, health, and crime.

Of those who were injecting at intake, the percentage sharing equipment fell from 33 per cent to 14 per cent for residential clients, and from 22 per cent to 12 per cent for non-residential clients. Abstinence rates increased, fewer clients were using regularly and there were improvements in terms of quantity used. Improvements in terms of alcohol use were not so marked however.

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Improvements at follow-up were found among both the GP and the clinic-treated groups in drug-related problems, health, and social functioning. Problems at intake were broadly comparable among the clinic-based and the GP patients. Similar levels and types of improvement were found for both groups at six-month follow-up.

Results demonstrate the feasibility of treating opiate addicts using methadone in primary health care settings, and show that treatment outcomes for such patients can be as satisfactory as for patients in specialist drug clinics. The GPs in the study are unrepresentative in their willingness to be actively involved with problem drug users moreover, several services treated relatively large numbers of drug users.

16.8 Research findings on substitution

This section presents the latest research findings for the reporting year 1999/2000.

16.8.1 Effect of methadone on craving

A study in Camden and Islington Substance Misuse Services\textsuperscript{17} assessed the acute-on-chronic effects of methadone and drug craving, mood and cognitive and psychomotor functioning in patients on long-term methadone substitution treatment.

A double-blind, cross-over design was used to compare the effects of a 33\% increase in patient's daily dosage of methadone with a matched placebo linctus. Eighteen patients completed the study all were assessed pre- and post-drug on two separate testing days.

Methadone significantly increased both positive craving (expected positive effects) and negative craving (expected relief of withdrawal discomfort) for heroin. Patients were unable to distinguish between methadone and placebo treatments. No differences between treatments emerged in cognitive or psychomotor effects. In terms of mood, patients were more alert and more contented following placebo than following methadone. It was concluded that additional methadone may "prime" cravings for heroin in methadone substitution patients.

17.8.2 Motivational factors in clinical success

A recent study in England\textsuperscript{18} found that seventy-seven (71\%) of a group of 109 attenders at an outpatient drug treatment service reported they had used heroin in the 90 days before interview, of whom 24 (31\%) had used every day. Daily users were more likely to explain their use in terms of needing to curb withdrawals than were occasional heroin users. The


latter group were more likely to report availability as a reason for use. From a clinical perspective, it is likely that those who use opportunistically are less likely to change their use as a function of clinical responses (e.g. higher methadone dose) than are those whose use is motivated by the attempt to curb withdrawal symptoms.

### 16.8.3 Lofexidine efficacy

A study in 1998 compares an accelerated 5-day lofexidine regimen with orthodox 10-day lofexidine and methadone regimens in the treatment of opiate withdrawal in 61 polysubstance abusing opiate addicts.

Significant differences in levels of withdrawal symptoms were found on days 11, 13-15 and 17-20, symptoms resolving most rapidly in the 5-day lofexidine treatment group, whilst withdrawal responses in the 10-day lofexidine treatment group were intermediate between the 5-day lofexidine and standard methadone treatment conditions. When the two lofexidine regimens were separately compared with methadone the 5-day lofexidine treatment was significantly more effective on day 10, 11 and 13-20, whilst the 10-day lofexidine treatment was not significantly different from methadone. There were no significant differences in rates of completion of detoxification between the three treatments. Both the lofexidine treatment regimens had a similar effect on blood pressure. Five patients experienced side effects which resolved with dose reduction, all remaining in the study.

An accelerated 5-day lofexidine regimen may attenuate opiate withdrawal symptoms more rapidly than conventional 10-day lofexidine or methadone treatment schedules without exacerbating hypotensive side effects.

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