

2014

United Kingdom Drug Situation

2014 EDITION

UK Focal Point On Drugs



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Annual Report to the European Monitoring
Centre for Drugs and Drug Addiction (EMCDDA)



United Kingdom drug situation: Annual report to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2014

Editors

Robyn Burton, Fay Thomson, Cristina Visintin and Craig Wright

United Kingdom Focal Point at Public Health England

2nd floor, Skipton House, 80 London Road, London, SE1 6LH, UK

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The United Kingdom Focal Point on Drugs

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

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

Further information about the UK Focal Point, including previous annual reports can be found on the Focal Point website at <http://www.nta.nhs.uk/focalpoint.aspx>

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

The structure and content of this report

The structure and content of this annual report are pre-determined by the EMCDDA to facilitate comparison with similar reports produced by the other European Focal Points. Ten chapters cover the same subjects each year.

Each of the first 10 chapters begins with an **Introduction**. This sets the context for the remainder of the chapter, describing the main features of the topic under consideration within the UK. This may include information about the main legislative and organisational frameworks, sources of data and definitions used, the broad picture shown by the data and recent trends.

The remainder of each chapter is concerned with **New Developments and Trends** that have not been included in previous annual reports. Generally, this covers developments that have occurred in the second half of 2013 or the first half of 2014. Relevant data that have become available during this period will also be discussed although these will often refer to earlier time periods.

This report, and the reports from the other European countries, will be used in the compilation of the EMCDDA's annual report of the drug situation in the European Union (EU) and Norway to be published in 2015.

National Contributors – Scotland, Wales and Northern Ireland

Welsh Government Gareth Hewitt
Rhian Hills

Public Health Wales Josie Smith

**Department of Health,
Social Services and Public Safety,
Northern Ireland** Mervyn Wilson
Gary Maxwell

Scottish Government Malcolm Cowie
Biba Brand
Fiona Fraser

**Information Services Division,
National Health Service, Scotland** Lee Barnsdale

Experts on the EMCDDA Key Epidemiological Indicators

Population prevalence	Nicola Singleton	
Problem prevalence	Gordon Hay	Liverpool John Moores University
Treatment demand	Jonathan Knight	Public Health England
Drug-related deaths	John Corkery	University of Hertfordshire
Infectious diseases	Vivian Hope	Public Health England

Other Focal Point Experts and Partners

Home Office Jacqueline Hoare
Anna Richardson

**New Psychoactive
Substances** Amanda Atkinson
Simon Brandt
Liverpool John Moores University
Liverpool John Moores University

Main Contributors for Individual Chapters

Chapter One	Robyn Burton Angela Scrutton	UK Focal Point Home Office
Chapter Two	Craig Wright Nicola Singleton	UK Focal Point
Chapter Three	Cristina Visintin	UK Focal Point
Chapter Four	Robyn Burton Gordon Hay	UK Focal Point Liverpool John Moores University
Chapter Five	Robyn Burton	UK Focal Point
Chapter Six	Robyn Burton Cristina Visintin John Corkery Vivian Hope	UK Focal Point UK Focal Point International Centre for Drug Policy, St George's, University of London, & Department of Pharmacy, University of Hertfordshire Public Health England
Chapter Seven	Robyn Burton Vivian Hope	UK Focal Point Public Health England
Chapter Eight	Cristina Visintin	UK Focal Point
Chapter Nine	Craig Wright	UK Focal Point
Chapter Ten	Craig Wright	UK Focal Point National Crime Agency

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Technical Notes

Standard Tables

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

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

Exchange Rates

There have been considerable changes in the Sterling/Euro exchange rate. Due to the fluctuations in the exchange rate, data within the text are presented in Pounds Sterling only and have not been converted into Euros. Euro values have been provided in relation to drug prices, although care must be taken when interpreting trends in Euros. Euro values have been derived using the annual average spot exchange rate published by the Bank of England for the most appropriate calendar year. (For example, for 2007/08 financial year values the exchange rate for 2007 has been used). The 2014 exchange rate is based on the monthly average the end of September 2014.

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

YEAR	EURO RATE (£1 =)	YEAR	EURO RATE (£1 =)
2004	1.4739	2010	1.1752
2005	1.4629	2011	1.1462
2006	1.4670	2012	1.2337
2007	1.4619	2013	1.1736
2008	1.2588	2014	1.2542
2009	1.1233		

References to Specific Drugs

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

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

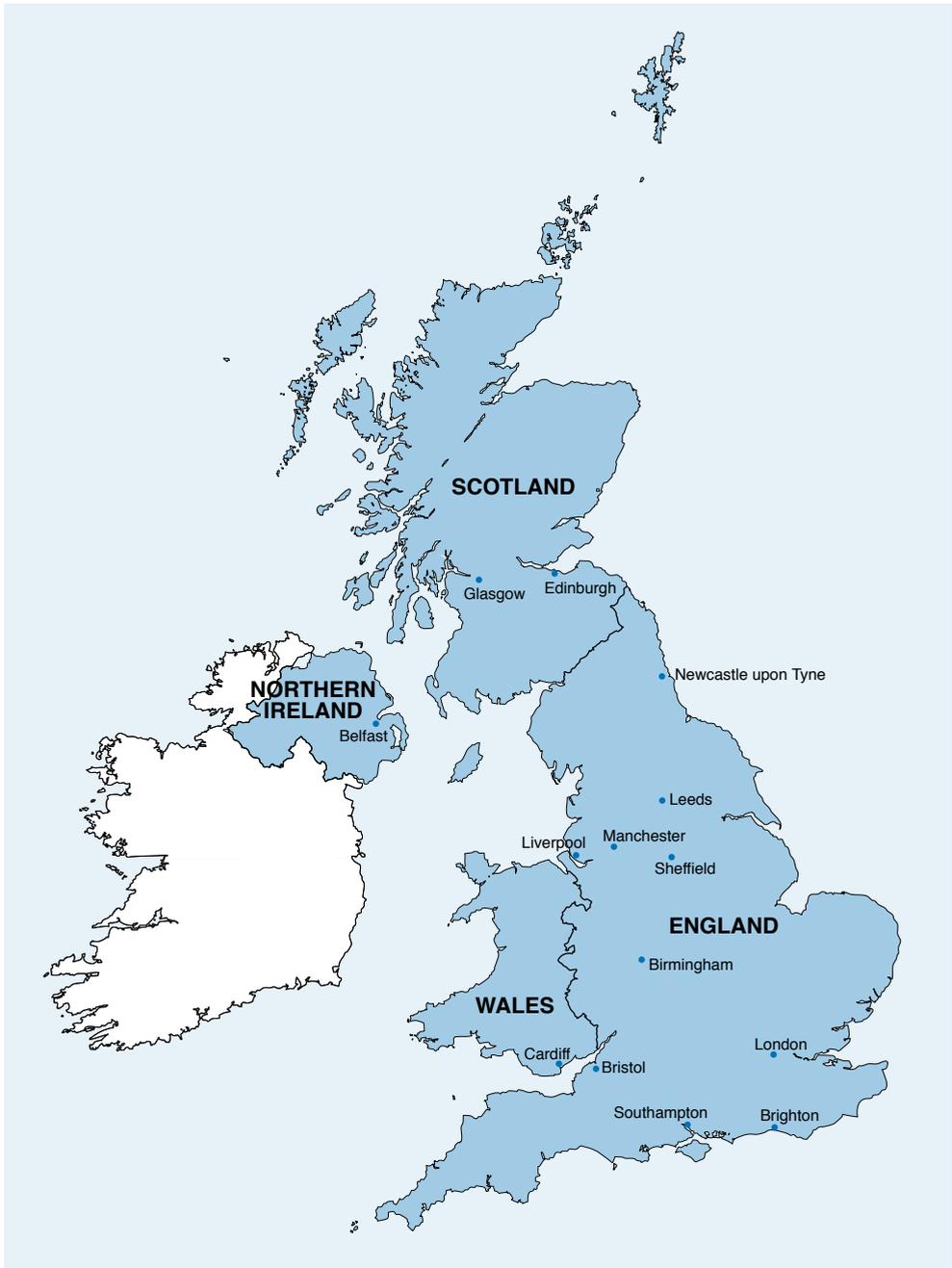
Ecstasy. The term refers to MDMA in any form.

Use of term 'significant'

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

Research

All research articles have been obtained from peer-reviewed journals as a result of a search protocol. A copy of the inclusion criteria is available on request.



The UK population was estimated to be 64.1 million according to the 2013 mid-year estimate. Eighty-four per cent (53.9 million) live in England, eight per cent (5.3 million) in Scotland, five per cent (3.1 million) in Wales and three per cent (1.8 million) in Northern Ireland.

Summary

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

Legal framework

The *Misuse of Drugs Act 1971* was amended to permanently control the NBOMe compounds as Class A drugs having previously been subject to a Temporary Class Drug Order. Ketamine became Class B having previously been Class C. Several other substances were brought under control, including lisdexamphetamine and benzofuran compounds (as Class B) and khat which has been controlled as Class C.

The Government exempted aluminium foil from section 9A of the *Misuse of Drugs Act 1971* to enable the lawful provision of foil in drug services as part of structured steps to engage drug users into recovery-orientated treatment.

Following a consultation, the government has announced its intention to introduce new powers for law enforcement to tackle the trade in chemical substances used as cutting agents. These powers are to include the ability to enter and search premises, with a warrant, if there are reasonable grounds to suspect substances are intended for use in unlawful conduct and to seize and destroy such substances.

The government has set out the limits to apply to specific substances under the new drug driving offence following the recommendations of an expert panel. The limits are expected to come in to force in March 2015.

National action plans and strategies

The Scottish Government responded to a review of opioid substitution treatment by the Drugs Strategy Delivery Commission concluding that the report reinforced the role of opioid substitution treatment (OST) with methadone in the context of recovery. The Scottish Government has also published *Quality Principles for Standard Expectations of Care and Support in Drug and Alcohol Services*.

In its annual review of the drug strategy, the Home Office highlighted the continued focus on all three strands of the strategy; reducing demand, restricting supply and building recovery and emphasised key advances since 2010. The Home Office also published the *Drug Strategy Evaluation Framework*.

A report outlining the progress in tackling the substance misuse problem in Northern Ireland in relation to meeting the short-term outcomes contained within the drug strategy was published. The report found that the majority of outcomes are on track for achievement within the timescale expected. No outcomes were identified as not being on track for achievement.

Treatment funding

Local authorities in England received a ring-fenced Public Health Grant of £2.79 billion for public health services in the 2014/15 financial year. Provisional expenditure on drug misuse services for adults in England in 2013/14 was £572.3m, with a further £75.6m being spent on services for young people.

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

Having been at its lowest level in 2012/13 since the survey started, prevalence of any drug use in the last year reported in the *Crime Survey for England and Wales* rose to 8.8% in 2013/14, with statistically significant increases in use of several individual substances. Last year use of any drug reported in the *Scottish Crime and Justice Survey* was 6.2%.

The proportion of school children (aged 11 to 15) reporting having used drugs in the last year in the *Smoking, drinking and drug use amongst young people in England* survey was 11% in 2013 (a similar level to 2012, 12%). A similar proportion of pupils responding to the *Young Person's Behaviour and Attitudes Survey* in Northern Ireland reported ever using drugs (10.5%) which was down almost five percentage points from the previous survey.

Chapter 3. Prevention

Environmental prevention

Following the publication of an independent review, the Government launched a consultation on proposed regulations regarding standardised packaging of tobacco for which Public Health England has voiced its support. The Scottish Government aims to introduce plain packaging legislation following the results of the UK-wide consultation.

Scotland is taking its policy on the minimum unit price (MUP) of alcohol to the European Court of Justice at the end of 2014. The Welsh Government has published a consultation on proposed legislation related to public health issues including MUP.

Northern Ireland proposed to amend the law relating to drink-driving offences with the introduction a lower blood alcohol limit for drivers.

Universal prevention

Schools

Alcohol and Drug Education and Prevention Information Service (ADEPIS) published a set of quality standards for effective alcohol and drug education in schools. It also published a series of briefing papers covering different aspects of drug education in schools.

Family

The annual report of the Chief Medical Officer (CMO) focused on the impact that early life environment and events have on the wellbeing, social and economic situation of an individual in adulthood, and considered the economic case for a shift to prevention.

Community

In Northern Ireland the Public Health Agency (PHA) updated the *Guiding Effective Drug Prevention* report, which highlights and promotes best practise/approaches in drug prevention.

Selective prevention in at-risk group

Department for Communities and Local Government (DCLG) published data outlining progress of the *“Troubled Families Programme”* up until December 2013. By then the number of families identified for the programme was over 100,000 with 77% of them receiving support from the programme at the end of December 2013. The government plans to expand the program to reach 400,000 families between 2015-2020.

The University of Cambridge published an independent review examining practices and methods employed by Inspiring Scotland in their first five years of activity. Their view of this study is that Inspiring Scotland is a cost-effective model achieving national-level social impact goals.

Chapter 4. High Risk Drug Use

Combining the 2011/12 estimates for England with the most recent estimates for Wales (2009/10) and Scotland (2009/10), it is estimated that there are around 371,279 high risk drug users in the UK (excluding Northern Ireland); equivalent to 9.16 per 1,000 population aged 15 to 64.

In England, in 2011/12, there were an estimated 293,879 opioid and/or crack cocaine users, and an estimated 87,302 injectors who use opioids and/or crack cocaine. Between 2005/6 and 2011/12 there was a significant decrease in the estimated number of opioid and/or crack cocaine users, crack cocaine users, opioid users and injectors of opioids and/or crack cocaine. Between 2010/11 and 2011/12 despite each group showing a reduction in prevalence, the number of injectors of opioids and/or crack cocaine was the only significant decrease.

There are continued concerns about a growing number of people injecting image and performance enhancing drugs (IPEDs) in the UK as highlighted by data from clients accessing needle and syringe exchange programmes across Wales, Scotland and Northern Ireland. There is also evidence of continued polydrug use across the UK as demonstrated by general population surveys in England and Wales and Scotland.

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

England

Following consultation, in February 2014, the Care Quality Commission published new proposals for expert inspections and subsequent ratings of substance misuse treatment services. It is proposed that pilot inspections will be conducted in early 2015 and then the new guidance and model will be rolled out to all providers in April 2015.

Scotland

The Scottish Government has published the *Quality Principles* as part of a newly developed alcohol and drugs treatment quality improvement framework. The principles aim for a person-centred, holistic and recovery-focused approach.

There continues to be a focus on waiting times for accessing treatment and data from January to March 2014 showed that 94% of clients who attended an appointment for drug treatment waited three weeks or less.

Northern Ireland

In November 2013 updated guidelines for the treatment and support of opioid addicted individuals was published by the Public Health Agency. The guidelines made recommendations on patient-centred considerations, good practice and management of care.

Treatment Demand Indicator

Beginning in the reporting year 2014 the UK has changed the period it reports to calendar year from financial year and there have also been significant changes in the Treatment Demand Indicators methodology. This means that data from 2014 are not directly comparable with previous national reports.

There were 101,753 treatment presentations in the UK in 2013 (those starting a new treatment episode).

Around half (50.3%) of all treatment presentations in the UK were for primary opioid use. However, these were disproportionately distributed accounting for two thirds (66.6%) of presentations of previously treated clients in comparison to just under one fifth (19.7%) of those who had never previously received treatment.

Just over one quarter (26.8%) of all treatment presentations were for primary cannabis use with cannabis remaining the most common primary drug reported by first ever presentation to treatment (48.6% of first ever presentations).

The proportion of primary cocaine presentations increased each year from 2003/04 to 2008/09, fell in 2009/10 and 2010/2011 before again increasing in 2011/12 and 2013.

In England, between 2011/12 and 2012/13, there was an increase in the number of new treatment presentations for 'club drugs'. The number of new treatment presentations (aged 18 or over) reporting mephedrone rose from 900 to 1,630.

The number of young people (aged 17 years and under) attending specialist misuse service for drugs or alcohol in England decreased three per cent from 20,688 in 2011/12 to 20,032 in 2012/13.

Treatment Outcomes

In England, amongst clients who received a review in 2012/13, users of crack cocaine only and cocaine powder were most likely to be abstinent at treatment review (58% and 64% respectively). Forty-nine per cent of opioid only users in 2012/13 were abstinent at the time of treatment review. In 2012/13 the number of successful completions in England remained stable at 15% of the total number of people in treatment.

Analysis of treatment outcomes data in Wales showed that on exit from treatment in 2013, 55.1% of primary opioid users were abstinent from opioids and the average number of days of using had decreased by 61.4%.

Chapter 6. Health correlates and consequences

Drug-related infectious diseases

The prevalence of HIV infection amongst people who inject drugs (PWID) remains fairly stable. In 2013, it was 1.1% in England, Wales and Northern Ireland amongst PWID taking part in the Unlinked Anonymous Monitoring (UAM) survey.

Hepatitis C prevalence was 49% amongst PWID taking part in the 2013 UAM survey, with marked regional variations. Amongst PWID surveyed in needle exchanges in Scotland in 2012/13 hepatitis C prevalence was 57%. Hepatitis B prevalence amongst PWID in England, Wales and Northern Ireland, taking part in the UAM survey was 16% in 2013.

Drug-related deaths

Using the EMCDDA definition, 1,946 drug-related deaths were registered in the UK in 2013, an increase of 16.8% since 2012. Numbers of deaths using the former UK Drug Strategy definition and the much wider Office for National Statistics (ONS) definition also showed increase in 2013 compared to 2012.

As in previous years, the largest number of deaths was associated with heroin/morphine. In 2013 the number of heroin/morphine associated deaths rose to 1,011 from approximately around 820 in the previous two years, returning to a level similar to that seen in 2010 ($n=1,063$). In 2013, the number of methadone deaths registered fell to 650, continuing the decrease observed since 2011 ($n=765$). Deaths mentioning cocaine increased again in 2013 (up 19% from the previous year); there was also an increase of 21% in amphetamine-related deaths. Deaths mentioning tramadol continued to increase rapidly, by 24% between 2011 and 2012, and 20% between 2012 and 2013.

Chapter 7. Responses to health correlates and consequences

Reducing drug-related deaths

There are systems in place within each UK country to explore the circumstances around drug-related deaths. The Scottish Government published a report (based on 2012 data from the National Drug-Related Deaths Database (NDRDD)) reviewing the social circumstances and background details surrounding a cohort of 479 drug-related deaths.

In the UK, naloxone is used in hospitals and carried routinely on ambulances to treat patients suffering from severe respiratory depression following an opioid overdose. There are national naloxone programmes in Scotland, Wales and Northern Ireland allowing use of naloxone in non-clinical settings such as hostels as well as facilitating the distribution of naloxone kits to those at risk of overdose or to their families and carers. Between November 2013 and February 2014, the Medicines and Healthcare Products Regulatory Agency (MHRA) ran a consultation on a proposal to allow wider access to naloxone and legislation is expected in 2015.

Needle and Syringe Programmes

Needle and syringe programmes (NSP) continue to be widely available throughout the UK. Wales, Scotland and Northern Ireland routinely publish data on needle and syringe provision and show small reductions in attendance at NSP in Scotland and Northern Ireland, however, data show an increase in attendances in Wales. In 2012/13 two per cent of all pharmacies in Northern Ireland provided NSP compared to 17% of all pharmacies in Scotland and 29% in Wales.

In 2013, 91% of the Unlinked Anonymous Monitoring (UAM) Survey of people who inject drugs (PWID) who had injected during the preceding year said that they had used an NSP during that time.

A sub-survey of people who inject image and performance enhancing drugs (IPED) found lower rates of uptake of hepatitis C testing, HIV testing and poorer adherence to condom use despite greater numbers of sexual partners compared to the main cohort of psychoactive drug injectors.

Strategy and guidance

NICE updated its public health guidance on NSP and makes recommendations on NSP, including those provided by pharmacies and drug services for adults and young people who inject drugs, with specific recommendations for users of IPED.

Chapter 8. Social correlates and consequences

Social exclusion and drug use

In England, 19% of clients starting treatment in 2012/13 reported having serious housing problems. A survey carried out between September and December 2013 showed that a third of the single homeless people participating in the study had problems associated with drug use (33%).

In England, 18% of clients starting treatment in 2012/13 reported being employed. In the same period in Northern Ireland 46% individuals presenting for substance misuse treatment reported being unemployed.

Scottish data from the National Drug-related Deaths Database reported that among the individuals suffering a drug-related death in 2012, 37% were a parent or a parental figure to a child or children under the age of 16, 13% had experienced domestic abuse and 17% had been subject to sexual abuse at some point in their lives.

In Northern Ireland, statistics from the Northern Ireland drug misuse database in 2012/13 showed that around eight per cent of individuals presenting for substance misuse treatment were living with their spouse or partner and children.

Social reintegration

In 2006/07 around 80% of problem drug users in England were likely to be in receipt of one or more of the main Department for Work and Pensions (DWP) benefits. Since 2010, a number of welfare reforms have been implemented within the UK. In 2013 a survey 'State of the Sector 2013' analysing the effect of these and other reforms in the substance misuse field has been published.

Reports evaluating two initiatives, 'Pathways to Employment' in England and the 'Peer Mentoring Scheme' in Wales, which tackled the problem of unemployment among drug users, were published in 2014.

Making Every Adult Matter (MEAM) a coalition of four national charities published in 2014 the second annual evaluation of three pilot programmes designed to improve co-ordination of existing local services for people with multiple needs. In 2014, the MEAM coalition also developed a programme named Voices From the Frontline (VFTF) which aims to give a voice to people with multiple needs and to influence policy on their behalf.

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

The total recorded drug offences in England and Wales and Northern Ireland was 4% lower in 2013/14 than the previous year which was mainly due to a fall in the number of possession offences. There were fewer arrests in England and Wales in 2012/13 than in any year since 2007/08. As in 2011, convictions for heroin continued to be lower in 2012 than in recent years possibly reflecting a decreased availability of heroin indicated by other measures.

The majority of drug offences in 2013 were dealt with outside of a court setting (67%). Of the drug offences settled outside of court, over half were in the form of a cannabis warning (57%).

A comprehensive end-to-end approach to tackling addiction from custody into the community is currently being tested in 10 resettlement prisons in the North West of England as confirmed in *Transforming Rehabilitation: A Strategy for Reform*.

Chapter 10. Drug Markets

Seizures

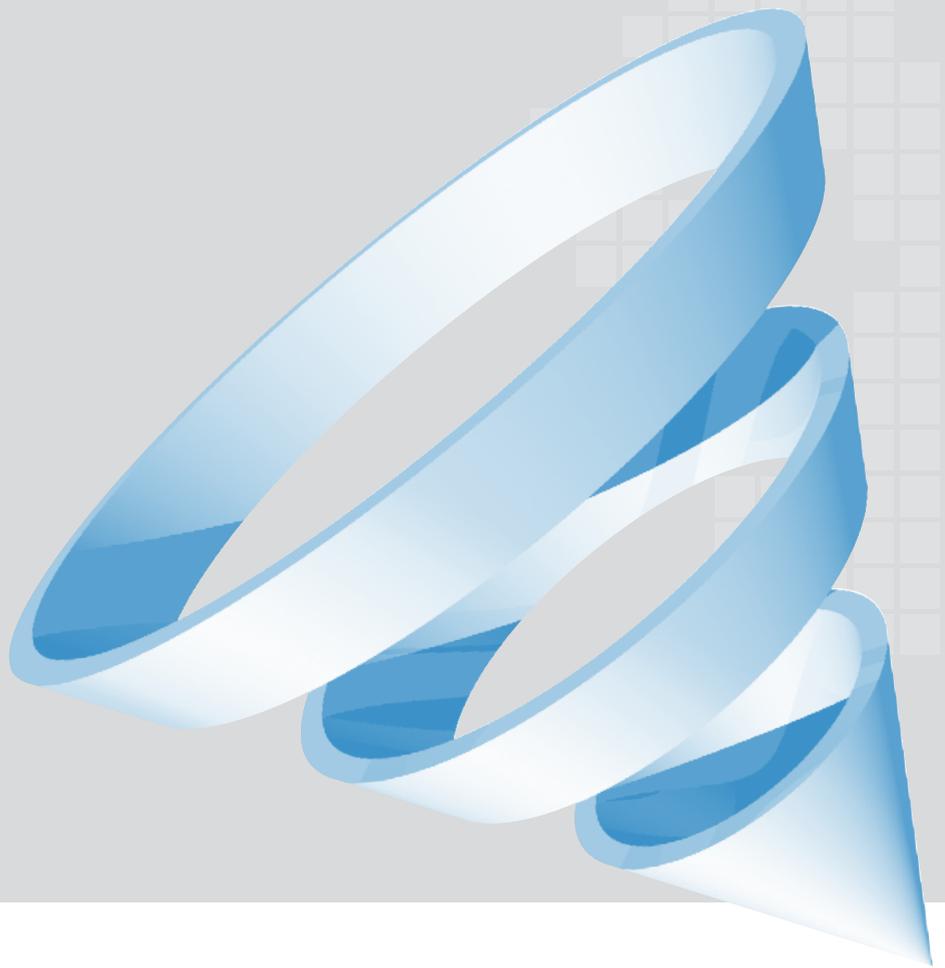
Both number of seizures and quantities seized dropped for most drugs in 2012/13. Cannabis was by far the most commonly seized drug, involved in around 10 times as many seizures as cocaine powder, the next most commonly seized drug. The quantity of cannabis plants seized dropped in 2012/13 having risen each year from 2004 to 2011/12. The quantity of heroin seized in 2012/13 fell by more than 50% on the quantity seized the previous year, but is a similar quantity to that seized in 2010/11.

Price/purity

Having been low during both 2011 and 2012, heroin purity has risen to near the 2010 level. Cocaine powder purity has slightly increased continuing a gradual return to levels seen around ten years ago.

The typical street-level price of mephedrone, which rose from around £10 to £20 after being brought under control, dropped to £15 in 2013. The typical price of heroin has risen from the previous year but is lower when adjusted for purity.

Part A: New Developments and Trends



1. Drug policy: legislation, strategies and economic analysis

1.1 Introduction

The United Kingdom (UK) consists of England, Wales, Scotland and Northern Ireland. Eighty-four per cent (53.9 million) live in England, eight per cent (5.3 million) in Scotland, five per cent (3.1 million) in Wales and three per cent (1.8 million) in Northern Ireland. A number of powers have been devolved from the UK Parliament to Wales, Scotland, and Northern Ireland, but each has different levels of devolved responsibilities.

The Misuse of Drugs Act, 1971 is the principal legislation in the UK for the control and supply of drugs that are considered dangerous or otherwise harmful when misused. This Act divides such drugs into three Classes (A, B and C) to broadly reflect their relative harms and sets maximum criminal penalties for illegal production, possession and supply in relation to each class.

Drugs in Class A include cocaine, ecstasy, heroin, tryptamines (such as LSD), magic mushrooms, methadone, methylamphetamine and injectable amphetamines, as well as NBOMe¹ compounds. Class B drugs include amphetamine, benzofuran compounds, cannabis and synthetic cannabinoids, synthetic cathinone derivatives including mephedrone, ketamine and analogue compounds including methoxetamine, and pipradrol related compounds including desoxypipradrol (2-DPMP) and diphenylprolinol (D2PM). Class C drugs include anabolic steroids, benzodiazepines, GBL/GHB, khat, piperazines (such as BZP) and tranquilisers.

Most drugs controlled under the Act are placed in one of five schedules to the *Misuse of Drugs Regulations 2001* based on an assessment of their medicinal or therapeutic usefulness, the need for legitimate access and their potential harms when misused.²

The *Drugs Act 2005* amended sections of the *Misuse of Drugs Act, 1971* and the *Police and Criminal Evidence Act 1984*, strengthening police powers in relation to the supply of drugs. The *Police Reform and Social Responsibility Act 2011* added provisions for 12-month temporary class drug orders (TCDOs) enabling law enforcement activity against those trafficking and supplying temporary class drugs. From 2013 to June 2014, NBOMe and benzofuran compounds, as well as 5-IT and 6-IT, and their simple derivatives were subject to a TCDO until they became permanently controlled drugs.

The UK Government is responsible for setting the overall strategic approach to reducing drug harms and for its delivery in the devolved administrations only in matters where it has reserved power. The *Drug Strategy 2010*, '*Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life*', (Her Majesty's Government, 2010) places a much greater emphasis than preceding strategies on supporting those who are drug dependent to achieve recovery and also widens the focus of dependence to prescription and over-the-counter medicines and tackling emerging new psychoactive substances (NPS). Within the strategy, policies concerning health, education, housing and social care are confined to England; those for policing and the criminal justice system cover England and Wales. In 2013, the Home Office published the *Drug Strategy Evaluation Framework* (Home Office, 2013b) and are continuing the process of evaluating the *Drug Strategy 2010*.

The Scottish Government and Welsh Government's national drug strategies were published in 2008, (Scottish Government, 2008c, Welsh Assembly Government, 2008a) the latter combining drugs, alcohol and addiction to prescription drugs and over-the-counter medicines. Each strategy aims to make further progress on reducing harm and helping individuals recover from their drug problems. The Scottish and Welsh strategy documents are also accompanied by an action or implementation plan, providing a detailed set of objectives; actions and responsibilities; expected outcomes; and a corresponding timescale for delivery (Scottish Government, 2008c, Welsh Assembly Government, 2008b). Each plan reflects the devolution of responsibilities to the national Government.

¹ NBOMe refers to a family of hallucinogenic drugs

² See: <https://www.gov.uk/government/policies/reducing-drugs-misuse-and-dependence/supporting-pages/classifying-and-controlling-drugs>

Northern Ireland's strategy for reducing the harm related to alcohol and drug misuse, the *New Strategic Direction for Alcohol and Drugs*, was launched in 2006 (Department of Health, Social Services and Public Safety Northern Ireland, 2006). The strategy contained actions and outcomes, at both the regional and local level, to achieve its overarching aims. A review of the strategy was conducted in 2010, and, after consultation, a revised strategy, the *New Strategic Direction for Alcohol and Drugs Phase 2, 2011-2016*, was launched in December 2011 (Department of Health, Social Services and Public Safety Northern Ireland, 2011).

The drug strategies in Wales and Northern Ireland are underpinned by performance management frameworks, including Public Service Agreements (PSAs) and associated sets of performance indicators, which progress is measured against. In Scotland, the 2014/15 *Updated Guidance for Alcohol and Drug Partnerships (ADPs) on Planning and Reporting Arrangements* (Scottish Government, 2013c) aims to support the embedding of outcomes-based planning and reporting at the local level. This guidance identified nationally agreed core outcomes and indicators that all ADPs are expected to deliver against. The Scottish Government are developing National Recovery Indicators to support the tracking of progress towards recovery for individuals in drug (and alcohol) services.

1.2 Legal Framework

1.2.1 Changes to drug misuse legislation

The Misuse of Drugs Act 1971 (Ketamine etc.) (Amendment) Order 2014

In June 2013, NBOMe and benzofuran compounds as well as 5-IT and 6-IT became subject to a TCDO. On 10 June 2014, the *Misuse of Drugs Act 1971* was amended to permanently control the NBOMe compounds as Class A drugs.

The 2014 Order also reclassified ketamine from Class C to Class B, and brought lisdexamphetamine, benzofuran compounds as well as 5-IT and 6-IT under the control of the 1971 Act as Class B drugs. Tramadol, zaleplon and zopiclone also became controlled Class C drugs under the 1971 Act on 10 June 2014.

Following control, tramadol became a schedule III controlled drug exempt from the *Safe Custody Regulations*, lisdexamphetamine became a schedule II controlled drug and zopiclone and zaleplon became schedule IV part I drugs.³

The Misuse of Drugs Act 1971 (Amendment) Order 2014 and the Criminal Justice and Police Act 2001 (Amendment) Order 2014

In July 2013, the Home Secretary announced the Government's decision to control khat as a Class C drug. On 24 June 2014 the *Misuse of Drugs Act 1971* was amended accordingly, making the production, possession, supply, importation and exportation of khat illegal. It is intended that first and second simple possession offences for khat (for personal use) are dealt with using out-of-court disposals in England & Wales, similarly to the policing approach for simple possession offences for cannabis committed by adults. For a first such offence, the intended disposal is a 'khat warning'. For a second offence, the intended disposal is a penalty notice for disorder of £60, under the *Criminal Justice and Police Act 2001* and the *Schedule to the Penalties for Disorderly Behaviour (Amount of Penalty) Order 2002* which have been amended accordingly. The Home Office has published a 'khat factsheet for England and Wales'⁴ to outline these changes. An amended 'khat fact sheet' was also created for Scotland⁵ to reflect the differences in criminal justice disposals available.

³ See: http://www.legislation.gov.uk/uk/si/2014/1275/contents/made?utm_medium=email&utm_source=Royal+Pharmaceutical+Society&utm_campaign=4155214_200514+-+Support+Alert&dm_i=EQ,2H26M,3E4T8K,9042W,1

⁴ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/341917/Khat_leaflet_A4_v12_2_.pdf

⁵ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322357/KhatLeafletScotland.pdf

The Misuse of Drugs (Amendment No. 2) (England, Wales and Scotland) Regulations 2014

In July 2013, the Government announced its decision to exempt aluminium foil from section 9A of the *Misuse of Drugs Act 1971* to enable the lawful provision of foil in drug services as part of structured steps to engage drug users into recovery-orientated treatment through a drug treatment plan, with monitoring arrangements put in place (UK Focal Point, 2013). The required amendment to the *Misuse of Drugs Regulations 2001* (as amended) came into effect on 5 September 2014.

England

Public Health England (PHE) produced a briefing⁶ for local areas to assist them with the implementation of these new regulations. The amount of foil provided and the number of clients receiving foil is currently recorded through PHE's Needle Exchange Monitoring System (NEXMS), with data being collated by the Home Office for on-going monitoring arrangements. In early 2015 the Home Office will also be undertaking interviews with service providers at a sample of needle and syringe programmes (NSP) sites to gain a more detailed understanding of the process through which foil is provided. PHE and the Home Office will also monitor sales of aluminium foil from specialist suppliers.

1.2.2 Advisory Council on the Misuse of Drugs (ACMD)

Government Priorities for inclusion in ACMDs work plan

In September 2013, HM Government wrote to the ACMD to set out the main priorities until 2013/14.⁷ These included commissioning a review on diversion and illicit supply of medicines, focusing on the concept of recovery, continuing to update the legislation around NPS, continuing with the review on the harms of ketamine and of the group (or 'generic') definitions used to control drugs, their derivatives and related compounds under the *Misuse of Drugs Act 1971* for advice on updating them.

ACMD advice on ketamine

The ACMD undertook a review of the available evidence on ketamine and provided advice to the Government in relation to control under the *Misuse of Drugs Act 1971* (Advisory Council on the Misuse of Drugs, 2013b). The ACMD's report, published in December 2013, reviewed the evidence available since the previous 2004 report (Advisory Council on the Misuse of Drugs, 2004), particularly with regards to the evidence of chronic toxicity to the bladder. After reviewing the evidence, the ACMD decided that the evidence presented was sufficient to warrant the reclassification of ketamine to a Class B drug (from Class C) and also reschedule ketamine as a schedule II drug (from schedule IV part I). In June 2014, HM Government reclassified ketamine as a Class B drug. In August 2014, the government held a consultation to seek the views of the public, especially health, social care and veterinary professionals, on the impact of listing ketamine in Schedule II to the 2001 Regulations.⁸

ACMD advice on NBOMe compounds

NBOMe compounds have been previously controlled by a TCDO (see section 1.2.2). The ACMD followed their initial NBOMe assessment in November 2013 with a review of the evidence of associated harms surrounding NBOMe and recommended that NBOMe compounds be controlled under the *Misuse of Drugs Act 1971* as class A substances (Advisory Council on the Misuse of Drugs, 2014a). The report noted that these compounds are associated with fatalities both nationally and internationally, a high potency and a high risk of overdose. Following this advice, a group of NBOMe compounds (by generic definition), were classed as Class A drugs by the Home Office.

⁶ See: <http://www.nta.nhs.uk/uploads/phe-foil-briefing.pdf>

⁷ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/265396/Commissioning_letter_from_Home_Secretary_to_Les_Iversen_2013-.pdf

⁸ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/341725/2014-08-05_-_Ketamine_Rescheduling_Consultation_-_Condoc_-_Final_Proof_1_WEB.pdf

ACMD advice on GHB

At the end of 2013, the ACMD recommended that GHB should be rescheduled under the *Misuse of Drugs Regulations 2001* from schedule IV part I to schedule II (Advisory Council on the Misuse of Drugs, 2013a). It was noted that schedule II has more requirements than schedule IV, however it recognised the high abuse potential of GHB in addition to its low level of medical requirement in the UK.

ACMD advice on the synthetic opioid AH-7921

In June 2014, the ACMD reviewed the synthetic opioid AH-7921 with regards to revising the generic definitions⁹ under the *Misuse of Drugs Act 1971* to control new and emerging NPS (Advisory Council on the Misuse of Drugs, 2014b). The review acknowledged that in the UK there is little evidence of AH-7921 misuse. However, they strongly recommended the permanent control of this opioid (as a Class A substance) principally due to its potential to cause harm, its potency, fatalities widely reported in other European countries, and its highly addictive potential.

ACMD advice on tryptamines

Following the Home Office commission, the ACMD considered evidence available on tryptamines in the context of the *Misuse of Drugs Act 1971* and an expanded definition for tryptamine compounds (Advisory Council on the Misuse of Drugs, 2014b). The ACMD's NPS committee reviewed previous research and existing controls with the aim of identifying tryptamines that may evade these existing legislative controls. Additionally, the ACMD reviewed data provided by the Home Office's early warning systems and networks, clinical toxicology, prevalence and neuropharmacology in arriving at the expanded generic definition. The expanded generic definition brings drugs such as alpha-methyltryptamine (AMT) and 5-MeO-DALT¹⁰ within the scope of the *Misuse of Drugs Act 1971* and control as Class A substances.

ACMD advice on temazepam

In July 2014, the ACMD recommended the removal of current exemptions for temazepam under the 2001 Regulations meaning that it will be in line with, and have the same requirements as, other schedule III drugs under the *Misuse of Drugs Regulations 2001*.¹¹

1.2.3 Proposed revisions to the legal framework

New Psychoactive Substances Review

On 30 October 2014, the Government announced to Parliament new measures to build on the Drug Strategy to reduce the threat posed by new psychoactive substances to the UK. This followed the six-month review of the UK's response to new psychoactive substances undertaken by an independent expert panel. The Government published the panel's report and the response to its 31 recommendations on new and bespoke measures ranging from legislation to prevention, education, information sharing, treatment and interventions, as well as a supporting Home Office document, "*New Psychoactive Substances in England – A Review of the Evidence*" (Home Office, 2014g).

The Government has committed to developing legislative proposals for a blanket ban on sales of new psychoactive substances, similar to that introduced in Ireland in 2010. It is also consulting the ACMD about the adoption of a neurochemical definition to control all synthetic cannabinoids¹² under the *Misuse of Drugs Act 1971* and on the extension of the maximum duration of temporary class drug orders from 12 to 24 months. Other actions announced include the publication of new Public Health England guidance to local authorities, including advice on integrating new psychoactive substances into local drugs education, prevention and treatment work, as well as bespoke professional training to NHS staff on new psychoactive substances (Home Office, 2014d).

⁹ The ACMD were asked to put in place a process by which the range of generic drug definitions is regularly reviewed.
See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/265398/Norman_Baker_to_ACMD_Generic_Definitions.pdf

¹⁰ These are highly potent hallucinogens which act on the 5HT2A receptor, in the same way as LSD

¹¹ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/335306/TamazepamAdviceJuly14.pdf

¹² See: <https://www.gov.uk/government/publications/commissioning-letter-to-the-acmd-synthetic-cannabinoids>

Further updated and new guidance for local authorities to tackle the supply of nitrous oxide was published on 30 October 2014 (Home Office, 2014f).

Drugs: International Comparators

The Government also published the Home Office report "*Drugs: International Comparators*" based on the international study of approaches to drugs misuse and drug addiction undertaken over 18 months in a number of countries: the UK, Portugal, Sweden, Denmark, Switzerland, the Czech Republic, USA, Canada, New Zealand, Japan, South Korea and Uruguay. The report explores a number of policy approaches adopted by each country, including legislation and enforcement, regulated markets, emerging forms of treatment and harm reduction, alternatives to traditional criminal justice approaches, and responses to the threat of new psychoactive substances. It reflects on these in relation to the UK and describes the current and future challenges for policymakers (Home Office, 2014c).

New powers related to cutting agents

The Government ran a consultation from 28th May to 7th July 2013, which sought views on the introduction of new civil powers to allow law enforcement agencies to tackle the trade in chemical substances used as cutting agents to bulk the volume of illegal drugs (UK Focal Point, 2013). In March 2014, the Government published its response from this consultation.¹³ The proposal is to use primary legislation to give law enforcement explicit new powers to enter and search premises, with a warrant, for substances if there are reasonable grounds to suspect they are intended for use in unlawful conduct. Law enforcement will also have the power to seize, detain and destroy such substances. The proposals for consultation involved extending the powers only to particular chemicals specified in secondary legislation. These chemicals were benzocaine, lidocaine and phenacetin, as these are currently the most common cutting agents which mimic the effects of powder cocaine, allowing for maximum adulteration. There were 24 responses to the consultation, the majority of which were supportive of the proposals. The main concern from respondents was that the market in cutting agents would shift to new substances. With these concerns in mind, the proposals were amended such that law enforcement will have the power to seize any chemical they suspect of being used as a cutting agent, rather than only those listed in secondary legislation.

Chemical precursors to the synthesis of narcotic drugs and psychotropic substances

In the UK precursor chemicals are regulated by the *Controlled Drugs (Drug Precursors) (Intra-Community Trade) Regulations 2008* and the *Controlled Drugs (Drug Precursors) (Community External Trade) Regulations 2008*. The legislation covers 23 chemical substances which are divided into three categories:

- category one covering the most sensitive substances;
- category two covering less sensitive substances and pre-precursors; and
- category three covering bulk chemicals that can have different types of uses in the manufacturing process (e.g. feedstock, solvents or impurity removers).

The legislation excludes medicinal products for human use, but covers all natural products and preparations (or mixtures) containing at least one scheduled substance, provided that they can be extracted by 'readily applicable or economically viable means'.

In February 2014, the Home Office released a precursor chemical import and export wall chart to aid companies that import and export such chemicals.¹⁴ A similar wall chart was made available in January 2014 for domestic licensing.¹⁵

¹³ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/298900/Cutting_agents_consultation_response.pdf

¹⁴ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322098/Precursor_Chemical_import_and_export_authorisation_wallchart_Jan_2014.pdf

¹⁵ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322097/PRECURSOR_WALLCHART_Domestic_Jan_2014.pdf

Drug driving legislation

As part of the *Crime and Courts Act 2013*, a specific offence of driving with a concentration of a specified drug over a specified limit will be created. An expert panel was convened to offer suggestions about the best course of action on specified drugs and limits for each drug under the legislation (Wolff et al., 2013).

The Government accepted the expert panel's recommendations on which drugs should be specified in regulations with a further two controlled drugs added. The government also accepted the limits recommended for eight drugs most associated with medical uses but for those drugs most associated with illegal use a zero tolerance approach to the specified limits was proposed. A further shorter consultation was held to propose a suitable limit for amphetamine.¹⁶ A limit of 50µg/L was proposed as it is above the therapeutic range for legitimate amphetamine use. The proposals have been set out in a consultation document¹⁷ and the changes are expected to come in to force in March 2015.

In July 2014, the Department for Transport released guidance for healthcare professionals on drug driving (Department for Transport, 2014b). The guidance is aimed to provide healthcare professionals with:

- a clear explanation of the new legislation including the statutory "medical defence" available to patients who have taken their medicine in accordance with the advice of a healthcare professional and/or the information contained in the leaflet accompanying the medicine; and
- a reiteration of existing advice that healthcare professionals would normally consider giving to patients about taking medicines that could impair their driving.

Legislation in relation to drug driving is devolved to Northern Ireland and the work undertaken by the UK Government will inform any final policy proposals for Northern Ireland.

1.3 National action plan, strategy, evaluation and co-ordination

1.3.1 Implementation and evaluation of national action plans and/or strategies

Scotland

The Scottish Government's national drug strategy, *The Road to Recovery*, published in 2008, is a long-term strategy focused on recovery (Scottish Government, 2008c) and continues to receive cross-party support from Scottish Parliament. Central to the strategy is the concept of recovery. The Drugs Strategy Delivery Commission (DSDC) was established in 2009 by the Scottish Government. The role of the DSDC is to independently assess progress in delivering the Road to Recovery Strategy. In 2013 the then Chief Medical Officer for Scotland, Sir Harry Burns commissioned the DSDC to conduct a review of opioid substitution treatment (OST), *Delivering Recovery-Opioid Replacement Therapies in Scotland* (Lind & Roberts, 2013). In response to the report a Scottish Parliament debate was held in November 2013 which gained cross-party support for the continued prescribing of methadone for opioid dependent individuals.¹⁸ It concluded that the report reinforced the role of opioid substitution treatment (OST) with methadone in the context of recovery, and highlighted good practice. National stakeholder events with ADPs and Primary Care professionals were held in response to the report, in which the Scottish Government called for health boards to designate named Accountable Officers for OST from each health board and for ADPs to produce Key Aim Statements to take forward the OST Review in their respective areas. The DSDC have reviewed their role and work and will be revising its structure and subgroups.

As part of the Scottish Government's focus on quality within treatment and care for drug and alcohol users, national *Quality Principles for Standard Expectations of Care and Support in Drug and Alcohol Services* were published (August 2014).¹⁹ These Principles will form a significant focus for the year ahead, with ADPs being expected to implement them in local services for drug and alcohol users.

¹⁶ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266827/amphetamine-consultation.pdf

¹⁷ See: www.gov.uk/government/consultations/drug-driving-proposed-regulations

¹⁸ See: http://www.scottishparliament.tv/category.aspx?id=0&sort=date&page=66&vid=0_579hxc0x

¹⁹ See: <http://www.scotland.gov.uk/Publications/2014/08/1726/0>

Wales

The Welsh Government published its *Substance Misuse Delivery Plan, 2013-2015* (Welsh Government, 2013c) setting out key actions and performance measures for each of the strategy's key aims: preventing harm; supporting substance misusers to improve their health and aid and maintain recovery; supporting and protecting families; and tackling availability and protecting individuals and communities via enforcement activity. The plan also sets out measures to deliver the strategy and support partner agencies and provides delivery dates for the work. The Substance Misuse Strategy and associated Delivery Plan are overseen by the Substance Misuse National Partnership Board (SMNPB). Progress has been made on all elements within the existing Delivery Plan 2013-15, and development of the final delivery plan for the life of the Substance Misuse Strategy for Wales '*Working together to reduce harms 2008-2018*' is underway.

England

In December 2013, the Home Office published its annual review of the Drug Strategy, *Drug Strategy Annual Review: Delivering Within a New Landscape*, (Home Office, 2013c). The report highlighted the continued focus on all three strands of the strategy; reducing demand, restricting supply and building recovery and emphasised key advances since 2010. The report highlights the continued focus on a universal approach aimed primarily at stopping people taking drugs in the first place, continuing to tackle drug dealing on our streets; strengthening the border; and combating the international flow of drugs to the UK to disrupt drug trafficking upstream; and the support of people in to 'recovery' meaning being free from dependence on drugs and alcohol. The Home Office, at the same time, published the *Drug Strategy Evaluation Framework* (Home Office, 2013b) and are continuing the process of evaluating the Drug Strategy 2010.

Northern Ireland

A report outlining the progress in tackling the substance misuse problem in Northern Ireland was published in June 2014 (Department of Health, Social Services and Public Safety Northern Ireland, 2014). An assessment of the progress achieved in meeting the short-term outcomes contained within the drug strategy, the *New Strategic Direction for Alcohol and Drugs Phase 2* (Department of Health, Social Services and Public Safety Northern Ireland, 2011) showed that the majority of the 86 outcomes are on track for achievement within the timescale expected.²⁰ Eight (nine per cent) of the outcomes have been completed, 60 (70%) of the outcomes are classified as being on track for achievement, and in 18 (21%) of the outcomes, progress is being made but with some delay. No outcomes were identified as not being on track for achievement. All outcomes are monitored and reported on annually.

The main drug-related outcomes that are experiencing some delay include the implementation of roadside drug screening devices, the expansion of needle and syringe provision (NSP), outcomes relating to arrest-referral schemes and the development of a database that will integrate data from drug misuse treatment, opioid substitute prescribing and needle exchange.

Annual Report on the Forensic Early Warning System

The Forensic Early Warning System (FEWS) was set up in January 2011 to forensically identify NPS in a prompt manner, in order to assist the ACMD and the Government to tackle the threat posed by emerging substances (UK Focal Point, 2012). It forms part of the Government's wider action on NPS, as set out in the *NPS Action Plan* (Home Office, 2012b). FEWS collected samples from the internet and head shops, music festivals, the police and border control, to identify which NPS are present in the UK or being offered for sale in the UK market. During 2013/14, two new NPS were identified under FEWS which had not been previously encountered in the UK or Europe (Home Office, 2014a). Two additional substances were identified at only the UK level bringing the total number of substances identified under FEWS to 31. The number of substances identified under FEWS in 2013/14 is low (four) compared to previous years (10 in 2012/13).

²⁰ These include outcomes relating to both drugs and alcohol

A notable proportion of products advertised as 'legal' alternatives to already established drugs were found to contain controlled drugs (19.2%). This proportion was highest in samples collected from festivals (88.1%) but lower in drugs collected from head shops (4.3%) and the internet (3.0%). Of the samples analysed that contained NPS, about 91% were identified as mixtures of either two (61%) or three (30%) different active components. One per cent of samples were identified as containing up to six different active components.

1.3.2 Commentary on drug policy

New psychoactive substances and prescription drugs

The Home Affairs Select Committee (HASC)²¹ of the House of Commons carried out a review of drug policy in 2012 and reported its findings in December 2012 (Home Affairs Select Committee, 2012). Two specific issues were raised in the report; NPS and prescription drugs. A follow-up review of these drugs was conducted in November 2013 and was published in December 2013 (Home Affairs Select Committee, 2013). The report expressed concern about the lack of data collection on NPS in police forces, demonstrated the need for an increased education on NPS for young people and requested a review of regulatory schemes and legislation on these drugs. With regards to prescription drugs, the lack of knowledge on this subject was highlighted and was viewed with concern. The report welcomed the announcement that the British Medical Association (BMA) and the ACMD will shortly carry out work examining dependence on prescription drugs. The report recommended that Royal College of General Practitioners (RCGP) produce guidance for GPs who are treating addiction to prescription drugs stating that all cases should be recorded to the National Drug Treatment Monitoring System (NDTMS). The Government published a response to the HASC report in May 2014 and building on the original report but also disputing the assertion that police forces were unaware of the impact of NPS as they contributed to the information gathering process.

The HASC also carried out a review and published a report on the decision to ban khat in November 2013, recommending that it be reconsidered in favour of an alternative approach. It published the Government's response detailing the proportionality and rationality of the decision in March 2014, and the intention to complete the parliamentary process.

1.4 Economic Analysis

1.4.1 Funding

England

Public Health Grant

Local authorities in England received a ring-fenced Public Health Grant of £2.79 billion for public health services in the 2014/15 financial year.²² Funding for drug and alcohol treatment is not ring-fenced within the Public Health Grant and expenditure on services is determined by an assessment of the local populations' needs by local Health and Wellbeing Boards (HWBs).²³ Local authorities are required to report their annual forecasted and actual expenditure on each public health intervention making up the Grant. The categories for reporting this data include: adult drugs, adult alcohol and young people's drug and alcohol spend.

²¹ See: <http://www.parliament.uk/about/how/committees/select/>

²² See: <https://www.gov.uk/government/publications/ring-fenced-public-health-grants-to-local-authorities-2013-14-and-2014-15>

²³ There is a minimum membership required for a health and well-being board: the local director of public health, a representative from each local clinical commissioning group, the local director of adult social services, the local director of children's social services, a representative nominated by the NHS England, a local elected representative, a representative from the local Healthwatch. Beyond this mandatory membership other interested local stakeholders may also be invited. These may include representatives of third-sector or voluntary organisations, other public services, such as police and crime commissioners, or the NHS.

Provisional expenditure on drug misuse services for adults in England in 2013/14 was £572.3m, with a further £75.6m being spent on services for young people.²⁴ These two elements of expenditure accounted for almost one quarter (24%) of public health spend by local authorities. It is important to note that the data collection is a new exercise and there may be differences with how local authorities report their public health spend.

In September 2014, it was announced that public health allocations for local authorities will remain at £2.79 billion for 2015/16.

Health Premium Incentive Scheme

In September 2014, the Department of Health opened a technical consultation as part of the phased introduction of a Health Premium Incentive Scheme (HPIS), which will reward local authorities for public health improvements made in line with selected indicators from the Public Health Outcomes Framework.²⁵ The limited roll out for 2015/16 proposes the use of one national indicator 'successful completion of drug treatment' which combines data from opioid and non-opioid clients derived from the **Public Health Outcomes Framework** (see section 5.2.1). Local authorities will also be invited to select a local indicator from an approved list. Once responses to the consultation have been received and considered, a summary of the responses to the consultation will be published. PHE will further write to local authorities confirming the details of the agreed national indicator; giving baselines for each of the possible 34 local indicators offered for 2014/15; the level of improvement to be demonstrated for each potential indicator; the process for informing PHE of the locally chosen indicator and details of how payments will be made.

Wales

The Welsh Government invests almost £50 million annually to deliver the commitments within the Substance Misuse Strategy **Working Together to Reduce Harm 2008-2018** and its associated Delivery plan. Alongside the £17.134 million ring fenced funding within the Health Board budget for substance misuse services, the Substance Misuse Action Fund (SMAF) budget for 2014/15 stands at £32.047 million. Over £22 million of this funding goes directly to the seven Substance Misuse Area Planning Boards (APBs) in Wales, which supports a number of projects ranging from education and prevention to treatment services.

Scotland

In 2014/15, £30.4 million was allocated to ADPs to support the delivery of improved outcomes for drugs, similar to the figure for 2013/14 (£30.3 million) and in 2012/13 (£30.2 million). As mentioned in section 1.1, the Scottish Government are in the process of developing National Recovery Indicators to measure outcomes. These indicators will form part of a national Drug and Alcohol Information System known as DAISy planned for 2015/16.

Northern Ireland

In Northern Ireland, public expenditure on alcohol and drug misuse was approximately £16 million in 2013/14; this level of expenditure has remained relatively stable in recent years.

²⁴ See: <https://www.gov.uk/government/statistics/local-authority-revenue-expenditure-and-financing-england-2013-to-2014-individual-local-authority-data-outturn>

²⁵ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/352511/Consultation_Document.pdf

2. Drug use in the general population and specific groups

2.1 Introduction

The *Crime Survey for England and Wales* (CSEW)²⁶ (Home Office, 2014b) provides estimates of the prevalence of drug use in the general population in England and Wales. Scotland²⁷ and Northern Ireland²⁸ also undertake similar surveys. In England and Wales, for which the most complete time series data are available, prevalence of last year use of any illicit drug had been fairly stable at around 12% between 1998 and 2003/04, then decreasing steadily to 9.4% in 2007/08; and then falling again to 8.5%²⁹ in 2009/10 (Home Office, 2014b). Since then, prevalence has fluctuated between eight and nine per cent. In 2012/13 drug use prevalence was at its lowest level since the survey started (8.1%) but rose to 8.8% in 2013/14, with statistically significant increases in use of several individual substances. It is not yet clear whether the rise observed in 2013/14 signals a reversal or stabilisation of the long-term downward trend or merely a fluctuation within it (as seen before in this series between 2007/08 and 2008/09).

As has been shown consistently over time, males are more likely to report drug use than females but the difference varies according to age; the difference being more pronounced in the older age groups (ST01).

Among the school age population, surveys of drug use prevalence are undertaken in each of the four administrations of the UK.³⁰ In England, for which the most extensive time series are available, the proportion of school children (aged 11 to 15) reporting having used drugs in the last year has declined considerably over the last decade from 21% in 2003 to 11% in 2013 (a similar level to 2012, 12%) (Fuller & Hawkins, 2014).

²⁶ The *Crime Survey for England and Wales* (CSEW) (formerly the *British Crime Survey* (BCS)) is an annual survey, which gathers information about experience of crime in England and Wales. It is designed to provide a complementary measure of crime to police recorded crime statistics. It was first carried out in 1982 and since 2001/02 it has been a continuous survey. Since 1996, it has also asked respondents aged 16 to 59 about their use of illicit drugs in a self-completion module using Computer Assisted Self Interviewing (CASI). Since 2009 there has been an additional survey element covering 10 to 15 year olds experience of crime. This includes questions on drinking and cannabis use but the main focus is on victimisation. The annual school surveys are the main source of data on drug use among children.

²⁷ The *Scottish Crime and Justice Survey* (SCJS) (previously the *Scottish Crime and Victimisation Survey* (SCVS) and the *Scottish Crime Survey*) is similar in scope and aims to the CSEW although questions on drug use are asked of all respondents aged 16 years and over. The latest published results are for 2012/13. Surveys were carried out as part of the former BCS in 1982 and 1988; as the independent *Scottish Crime Survey* in 1993, 1996, 2000, 2003; as the SCVS in 2004, 2006; and as the SCJS in 2008/09, 2009/10, 2010/11 and 2012/13. The survey asks questions about drug use using Computer Assisted Personal Interviewing (CAPI).

²⁸ The *Northern Ireland Crime Survey* (NICS) is also similar to the CSEW. Surveys containing a drug use module were carried out in 1994/95, 1998, 2001 and 2003/04 and the survey became continuous from January 2005. However, after March 2009 the drugs module was no longer included hence the last published results on drug use were for 2008/09. In addition, a *Drug Prevalence Survey*, based on the EMCDDA model questionnaire, was carried out in Northern Ireland (and Ireland) in 2002/03, 2006/07 and 2010/11 among people aged 15 to 64 years old using CAPI.

²⁹ The CSEW uses population estimates in calibration weighting to take account of differential response rates between regions and age by sex subgroups. CSEW prevalence estimates from 2001/02 to 2012/13 have been re-weighted using the new 2011 census-based population estimates from the Office for National Statistics (ONS). As such, historical figures reported in this chapter may vary slightly from previously reported data.

³⁰ Among the school age population the main sources of information on drug use prevalence are surveys undertaken in schools. In England, a survey of the prevalence of drug use, smoking and drinking among young people (11 to 15 year old school children) has been undertaken annually since 1998. In Scotland, the *Scottish Schools Adolescent Lifestyle and Substance Use Survey* (SALSUS) is generally undertaken every two years, the most recently published data are for 2010. A review of the questionnaire took place in 2012 and the next survey took place in autumn 2013. Results are expected in November 2014. The *Young Person's Behaviour and Attitudes Survey* was undertaken in Northern Ireland in 2000 for the first time and repeated in 2003, 2007, 2010 and 2013. The *Health Behaviour in School Age Children Survey* (HBSC) provides data from Wales and is undertaken every four years with a two-year interim survey. The most recently published survey results are for 2009/10. Fieldwork for the 2013/14 survey has been carried out with results expected in 2014/15.

Cannabis continues to be the most commonly used drug throughout England and Wales with last year prevalence rates around three quarters that of overall drug use (Home Office, 2014b). Cocaine is the second most commonly reported substance with last year prevalence at 2.4%. The CSEW shows that last year use of cocaine powder increased between 1996 and 2008/09 to a peak of three per cent. It subsequently declined to just under two per cent in 2012/13 but has risen in the last year by half a percentage point. Conversely, there has been a notable decline in amphetamines over the last 18 years.

2.2 Drug use in the general population (based on probabilistic sample)

Prevalence of drug use throughout this chapter is measured using the following recall periods: lifetime (ever used); last year (recent use); last month (current use). Since the last UK Focal Point Report, results have been published for the 2013/14 CSEW (Home Office, 2014b) and the *Scottish Crime and Justice Survey* (SCJS) (Scottish Government, 2014d) for 2012/13 (results were published in July and March 2014 respectively).

2.2.1 Crime Survey for England and Wales

Findings from the 2013/14 survey include:

- lifetime use of any illicit substance among all adults aged 16 to 59 years old was 35.6% (or 35.7% if mephedrone, which is now illegal, is included);
- last year drug use was 8.8%;
- last year drug use among males was around twice as high as among females; and
- cannabis was again the most commonly used drug, reported by 6.6% of adults in the previous year (Table 2.1).

Table 2.1: Percentage of 16 to 59 year olds reporting lifetime and last year use of individual drugs by sex in England and Wales, 2013/14

DRUG	LIFETIME USE			LAST YEAR USE		
	Male	Female	Total	Male	Female	Total
Any drug	41.1	30.3	35.6	11.8	5.8	8.8
Amphetamines	14	8.3	11.1	1.1	0.5	0.8
Cannabis	35.1	24.9	29.9	9.1	4.1	6.6
Cocaine (total, including crack)	12.1	6.9	9.5	3.4	1.4	2.4
Ecstasy	12.1	6.4	9.3	2.3	0.9	1.6
LSD	7.5	3.1	5.3	0.5	0.1	0.3
Magic mushrooms	10.1	4.6	7.3	0.6	0.1	0.4
Opioids	1.6	0.6	1.1	0.3	0.1	0.2
Base	10,037	11,809	21,846	9,941	11,750	21,691

Source: ST01

It is estimated that about 11.2 million people aged 16 to 59 in England and Wales have taken an illicit drug at some point in their lifetime with about 2.7 million people having taken drugs in the last year (Home Office, 2014b).

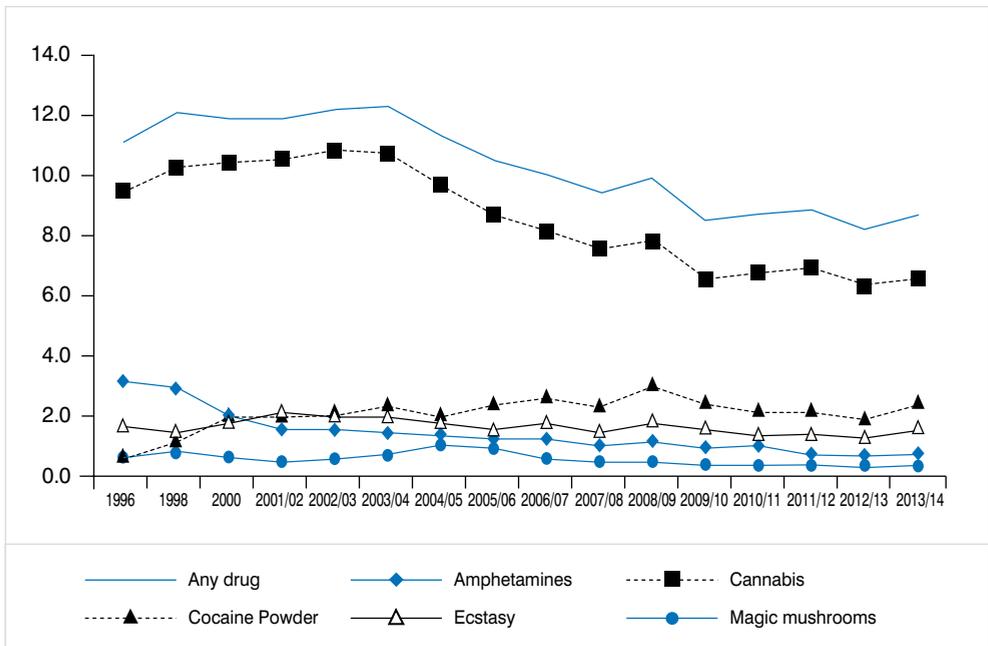
Trends in drug use

Data show that, compared with 1996 (the first year the survey was conducted), lifetime use of most individual drugs was higher in 2013/14 (except heroin, anabolic steroids, LSD and tranquilisers which have been relatively stable over the whole period) although in recent years lifetime prevalence has stabilised (Home Office, 2014b).

As shown in Figure 2.1, in terms of last year drug use, there was a steady decrease in the recent use of any drug between 2003/04 and 2009/10 (from 12.2% to 8.5%) driven mostly by a decrease in cannabis use (recent cannabis use fell from 10.6% in 2003/04 to 6.5% in 2009/10). Thereafter prevalence of any drug use remained fairly stable at between eight and nine per cent. In 2012/13, last year prevalence of any drug was the lowest recorded in the survey at 8.1% but this rose to 8.8% in 2013/14. Fluctuations are common in survey data and hence it is not clear whether the longer-term downward trend has now stabilised, reversed or is continuing. The current level of last year use of any drug is significantly lower than in 1996 when it was 11.1%.

There has been a change in the pattern of stimulant use over the same time period. Since data collection began in 1996, last year use of amphetamines (then the most commonly reported stimulant drug) has decreased considerably from 3.2% to 0.8% in 2013/14. Last year cocaine powder use has increased over the same time period from 0.6% to 2.4%. However, reported cocaine powder use in 2013/14 was lower than the peak prevalence in 2008/09 when prevalence was 3.0% and, although significantly higher than in 2012/13 when it was 1.9%, is at the same level as ten years earlier. The highest reported prevalence of last year ecstasy use was in 2001/02 at 2.1%, but throughout the rest of the period up to 2009/10 fluctuated between 1.5 and 2%. There appeared to be a slight decline in recent ecstasy use after this and in 2012/13 it was 1.2%. However, in 2013/14 it rose again to 1.6% (Figure 2.1).

Figure 2.1: Percentage of 16 to 59 year olds reporting last year use of individual drugs in England and Wales, 1996 to 2013/14



Source: Home Office, 2014b

Emerging substances

Questions on some new psychoactive substances (NPS) were added to the CSEW in October 2009 with mephedrone added for the 2010/11 survey. In the 2012/13 CSEW, questions on salvia and nitrous oxide were added, replacing questions on GBL/GHB, BZP, spice and khat, and these were retained in 2013/14. Recent use of nitrous oxide was 2.3% in 2013/14 similar to the 2.0% reported in 2012/13 (the increase is not statistically significant). There were statistically significant increases observed in recent use of salvia from 0.3% (2012/13) to 0.5% (2013/14) (Table 2.2). Use of both substances was higher among the 16 to 24 age group than among respondents as a whole, with prevalence around three times higher.

Last year use of mephedrone has decreased since being brought under legislative control in 2010. In the 2010/11 survey, mephedrone was the substance with the fourth highest last year prevalence of 1.3% (only marginally behind ecstasy). Between 2012/13 and 2013/14 use remained stable at roughly half the level seen in 2010/11 (0.5% and 0.6% respectively).

Table 2.2: Percentage of 16 to 59 year olds reporting last year use of emerging substances in England and Wales, 2010/11 to 2013/14

	2010/11	2011/12	2012/13	2013/14
Mephedrone	1.3	1.0*	0.5*	0.6
GBL/GHB	0.0	0.1*	-	-
BZP	0.1	0.1	-	-
Spice (and other cannabinoids)	0.2	0.1	-	-
Khat	0.2	0.2	-	-
Nitrous oxide	-	-	2.0	2.3
Salvia	-	-	0.3	0.5*
Base	27,450	26,834	21,621	21,982

*Statistically significant change since previous survey

Source: Home Office, 2012a, Home Office, 2013a, Home Office, 2014b

The rapidly changing nature of NPS and the fact that many users may be unclear about what exactly is in the drugs they use poses a challenge for monitoring the extent of their use. Further questions have been included in the 2014/15 CSEW asking about use of any NPS in order to establish lifetime and recent use of these drugs as a whole. In addition, respondents are being asked about the appearance/form of NPS and how they were obtained.

2.2.2 Scottish Crime and Justice Survey: Drug Use 2012/13³¹

Results from the 2012/13 SCJS self-completion drug use module are summarised below and refer to all adults aged 16 years and over living in private households in Scotland (Scottish Government, 2014d). Latest data show that among adults aged 16 years and over in Scotland:

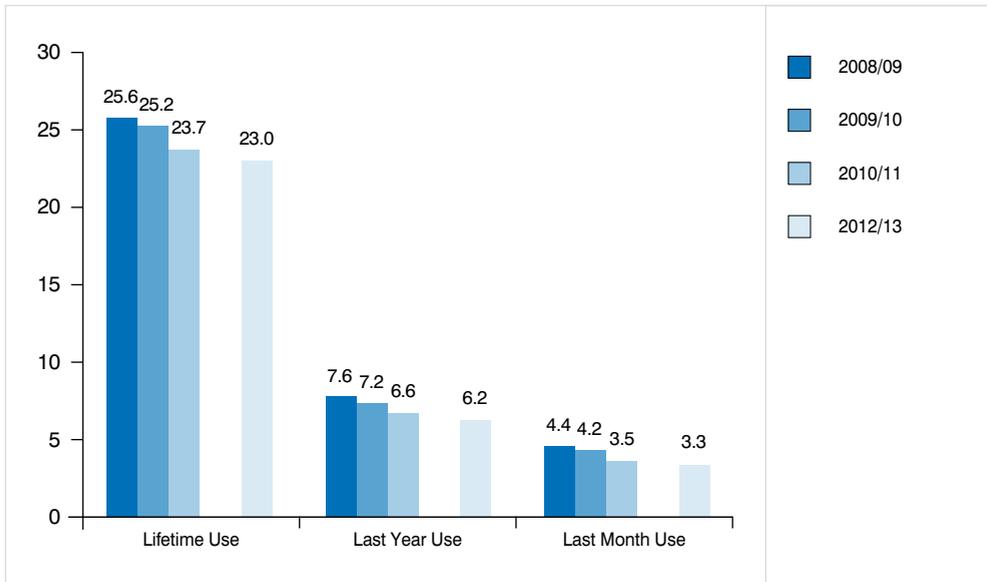
- 23.0% reported that they had taken illicit drugs in their lifetime (ever used);
- 6.2% reported recent (last year) drug use; and
- 3.3% reported current (last month) drug use.

³¹ The survey fieldwork for the SCJS was conducted between April 2012 and March 2013. The final sample size for the survey was 12,045. Of those who participated in the full survey, 10,235 (85%) answered the self-completion section, including questions on drug use which was administered using CASI.

Trends in drug use

Lifetime, recent and current drug use have fallen successively in each survey conducted since 2008/09 (Figure 2.2), with statistically significant reductions in each recall period between 2008/09 and 2012/13 (Scottish Government, 2014d). Statistically significant reductions in last year use of several individual drugs were also seen from 2008/09 levels, including cocaine (-1.0%), cannabis (-1.1%) and ecstasy (-0.5%). Among the youngest group (16 to 24 year olds) for whom recent and current use of illicit drugs is most common, there has been a reduction in recent drug use from almost one in four (23.5%) in the 2008/09 survey to just under one in six (16.4%) in the 2012/13 survey to just under one in six (16.4%). Cannabis remains the most commonly used drug in Scotland with recent use reported at 5.1%.

Figure 2.2: Percentage of respondents aged 16 years and over reporting lifetime, last year, and last month use of drugs in Scotland, 2008/09 to 2012/13



No survey was conducted in 2011/12

Source: Scottish Government, 2014d

Emerging substances

In both the 2010/11 and 2012/13 surveys, respondents were asked about use of a group of new substances: BZP, GBL, synthetic cannabinoids, khat or salvia divinorum (which was added to the group for the 2012/13 survey). Respondents were also asked separately about mephedrone use.

Lifetime use of the emerging substances group was 2.3% in 2012/13 (compared with 1.8% in 2010/11) (Scottish Government, 2014d). Recent drug use was 0.5% in 2012/13 (compared with 0.7% in 2010/11) while frequent use was 0.1% in 2012/13 (compared with 0.2% in the previous survey).

The proportion of people reporting ever having taken mephedrone was higher in 2012/13 (1.4% compared with 1.2% in 2010/11). However, both reported last year and last month use were lower in 2012/13 than 2010/11 (with last year use going from 0.7% to 0.4% and last month use going from 0.2% to 0.1%). However, these apparent differences should be interpreted with caution as only the change in last year use (-0.3%) was statistically significant (on the borderline of significance at the 95% level).

2.2.3 Factors related to drug use³²

England and Wales

As in previous years, last year drug use in the CSEW increased with the frequency of pub/wine-bar visits and frequency of alcohol consumption demonstrating the association between drug and alcohol use (Home Office, 2014b). A quarter (25.5%) of adults visiting a pub nine times or more in the past month used drugs in the last year (compared to five per cent of individuals with no visits). Similarly, last year drug use increased with the frequency of nightclub visits.

Single people were more likely than others to report recent drug use but this may be due, at least in part, to the fact that single people tended to be younger and among younger age groups prevalence of drug use is higher. Unemployed individuals were more likely than those in employment to report recent drug use and, among occupational groups, those in routine and manual occupations were more likely to report recent drug use than those in managerial and professional or intermediate occupations. The majority of this difference was largely accounted for by a higher prevalence of cannabis use among those in routine and manual occupations.

As in previous surveys, respondents living in urban areas reported higher prevalence of drug use than those living in rural areas (9.3% compared to 6.5% respectively).

Scotland

Associations between drug use and socio-economic, experiential and area factors were investigated using simple one-to-one relationships (Scottish Government, 2014d).³³ Those working in routine and manual occupations (8.6%) were significantly more likely to report using illicit drugs in the last year than those in managerial and professional occupations (5.3%) or those in intermediate occupations (6.2%). Those who had never worked or who were long-term unemployed were least likely to report recent drug use (4.7%).

Those living in private rented accommodation as well as those in social housing were significantly more likely to report having used drugs in the last year (12.2% and 10.5% respectively) compared with those who were owner-occupiers (3.5%). Respondents living in urban areas (7.0%) were significantly more likely to have used drugs recently than those living in rural areas (2.7%). Those living in the 15 most deprived areas of Scotland were significantly more likely to be recent drug users than those living elsewhere (8.8% compared to 5.7%). Victims of crime³⁴ were significantly more likely to have used drugs recently than non-victims (10.8% and 5.2% respectively).

Men reported higher levels of illicit drug use than women over each recall period. Recent drug use was 9.4% for men compared to 3.3% for women in 2012/13.

³² While these comparisons provide useful information, many of these factors are interrelated or relate to other factors such as age or sex, which also have an association to the likelihood of drug use and indeed may be responsible for these observed associations.

³³ Results should be interpreted with caution since it is not possible to determine the role of additional factors like the age or sex profiles of different groups using simple one-to-one relationships.

³⁴ As measured by the SCJS 2012/13.

2.2.4 Scottish Crime and Justice Survey 2012/13: Drug Use amongst adults aged 16 to 64³⁵

To closer align the SCJS data with the EMCDDA reporting requirements on age, a standard table reporting the prevalence of self-reported drug use amongst adults aged 16 to 64 in Scotland has been submitted (ST01). Data show that, in 2012/13:

- 28.4% reported that they had taken illicit drugs at some point in their lives;
- 7.8% reported recent drug use; and
- 4.2% reported current drug use (Table 2.3).

Table 2.3: Percentage of 16 to 64 year olds reporting lifetime, last year and last month use of individual drugs in Scotland, 2012/13, by gender

DRUG	LIFETIME USE			LAST YEAR USE			LAST MONTH USE		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug	35.1	21.9	28.4	11.5	4.3	7.8	6.4	2.0	4.2
Amphetamines	13.0	6.7	9.8	1.4	0.3	0.9	0.4	0.2	0.3
Cannabis	32.6	19.7	26	9.5	3.6	6.5	5.2	1.7	3.4
Cocaine	12.7	5.6	9.1	3.3	1.1	2.2	1.5	0.2	0.8
Ecstasy	13.3	6.5	9.8	2.6	0.7	1.7	0.7	0.1	0.4
LSD	9.5	3.5	6.5	0.4	0	0.2	0.1	0	0.1
Magic mushrooms	10.7	3.8	6.7	0.7	0.1	0.4	0.5	0	0.2
Opioids	1.9	1.0	1.4	0.6	0.2	0.4	0.4	0.2	0.3
Base	3,245	4,341	7,586	3,245	4,341	7,586	3,245	4,341	7,586

Source: ST01

2.3 Drug use in the school and youth population

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

³⁵ Results reported here have been taken from ST01 provided on an EMCDDA age band basis, i.e. referring to 16 to 64 year olds. Therefore, data differ slightly from the published SCJS report (Scottish Government, 2014d) which presents data for adults aged 16 and over. It is also worth noting that this age range is slightly different from that covered by the CSEW (which only asks the drugs self-completion questions of those aged 16 to 59). Comparable data for the 16 to 59 age range were used in the UK estimate.

2.3.1 Crime Survey for England and Wales

Last year drug use was 14.7% among 16 to 34 year olds and 18.9% among 16 to 24 year olds (Table 2.4). After age 25, there was a steady decline in drug use with age (Home Office, 2014b).

Table 2.4: Percentage of 16 to 24 year olds, 16 to 34 year olds and 25-34 year olds reporting last year use of individual drugs in England and Wales, 2013/14 by gender

DRUG	16-24 YEAR OLDS			16-34 YEAR OLDS			25-34 YEAR OLDS		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug	22.8	15	18.9	19.1	10.3	14.7	15.9	6.5	11.2
Amphetamines	2.3	1.0	1.7	2.1	0.9	1.5	1.9	0.7	1.3
Cannabis	18.8	11.2	15.1	14.9	7.4	11.2	11.5	4.4	7.9
Cocaine	5.5	2.9	4.2	5.7	2.7	4.2	5.9	2.6	4.2
Ecstasy	5.2	2.4	3.9	4.3	1.8	3	3.4	1.3	2.3
LSD	1.2	0.5	0.9	1.1	0.2	0.7	1	0	0.5
Magic mushrooms	1.2	0.5	0.8	1.2	0.3	0.7	1.1	0.1	0.6
Opioids	0.3	0.0	0.2	0.5	0.0	0.3	0.7	0.1	0.4
Base	1,266	1,422	2,688	3,360	4,321	7,681	2,094	2,899	4,993

Source: ST01

Recent cannabis use was also much lower among 25 to 34 year olds (7.9% compared to 15.1% for 16 to 24 year olds). The difference between age groups was most pronounced among females where more than twice as many 16 to 24 year olds were recent cannabis users compared to 25 to 34 year olds (11.2% compared to 4.4%) (ST01).

2.3.2 Smoking, drinking and drug use amongst young people in England

Data from *Smoking, drinking and drug use amongst young people in England* (SDD) (Fuller & Hawkins, 2014) show that in 2013, 16.1% of pupils aged 11 to 15 years old had ever taken drugs, 11.3% had used drugs in the last year (recently), and 6.1% had used drugs in the last month (Table 2.5). Cannabis was the most prevalent drug with 7.0% of pupils using it in the last year. Volatile substances³⁶ were the second highest, with 3.6% of pupils having used them recently. Recent use of all other drugs was below one per cent. There was no significant difference between boys and girls in overall prevalence of drug use.

³⁶ Glue, gas, aerosols or solvents

Table 2.5: Percentage of pupils aged 11 to 15 years reporting lifetime, last year and last month use of individual drugs in England in 2013, by gender

DRUG	LIFETIME USE			LAST YEAR USE			LAST MONTH USE		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug	16.6	15.7	16.1	11.6	11	11.3	6.5	5.7	6.1
Amphetamines	0.6	0.5	0.5	0.5	0.3	0.4	0.1	0.1	0.1
Cannabis	9.1	7.5	8.3	7.4	6.5	7.0	4.2	3.7	4
Cocaine powder	1.1	0.7	0.9	0.7	0.6	0.7	0.3	0.2	0.2
Crack cocaine	0.5	0.5	0.5	0.3	0.5	0.4	0.2	0.2	0.2
Ecstasy	0.9	0.6	0.7	0.7	0.5	0.6	0.5	0.2	0.3
LSD	0.7	0.3	0.5	0.6	0.3	0.4	0.3	0	0.2
Magic mushrooms	0.9	0.6	0.8	0.6	0.4	0.5	0.3	0.1	0.2
Mephedrone	0.7	0.5	0.6	0.5	0.4	0.4	0.3	-	0.1
Opioids	0.6	0.6	0.6	0.4	0.4	0.4	0.3	0.1	0.2
Volatile substances	7.0	8.1	7.6	3.5	3.6	3.6	1.4	1.4	1.4
Base	2,735	2,433	5,168	2,735	2,433	5,168	2,735	2,433	5,168

Source: Fuller & Hawkins, 2014

Type of drug by age

As in previous years, volatile substances were the most commonly used drug in the last year among the younger pupils, however the use of cannabis increased substantially at age 13 years and was the most commonly used drug from 14 years on (Table 2.6). Use of other drugs was relatively low compared with these two drugs with prevalence of no other drugs exceeding 2% among pupils of any age.

Table 2.6: Percentage of pupils aged 11 to 15 years reporting last year use of individual drugs in England in 2013, by age

DRUG	11YRS	12YRS	13YRS	14YRS	15YRS
Any drug	3.0	4.4	6.8	12.4	23.7
Amphetamines	-	0.1	0.5	0.4	0.8
Cannabis	0.4	0.5	2.7	7.5	18.7
Cocaine powder	0.1	0.1	0.4	0.7	1.6
Crack cocaine	-	0.2	0.4	0.4	0.8
Ecstasy	-	-	0.3	0.4	1.8
LSD	0.1	0.1	0.2	0.5	0.9
Magic mushrooms	0.1	0.2	0.3	1.0	1.0
Opioids ³⁷	0.3	0.2	0.2	0.1	0.9
Volatile substances	2.1	3.3	3.5	4.0	4.4
Mephedrone	-	0.1	-	0.4	1.3
Base	825	1,040	1,028	1,028	1,247

Source: ST2; Fuller & Hawkins, 2014

Frequency of use

Most (70%) of those reporting drug use only used drugs once or rarely. However, two per cent of all pupils reported having taken drugs on more than 10 occasions and three per cent reported using drugs at least once a month (Fuller 2013). Pupils aged 15 years were more likely to report having taken drugs on more than 10 occasions (6%) and using drugs at least once a month (6%).

2.3.3 Young Person's Behaviour and Attitudes Survey in Northern Ireland

The *Young Person's Behaviour and Attitudes Survey* (YPBAS) in Northern Ireland was carried out in 2013 and top line results were published in 2014 (Northern Ireland Statistics and Research Agency, 2014c).³⁸ A tenth of pupils (10.5%) aged 11 to 16 year olds in the survey had ever used drugs. This was a decrease of almost five percentage points from 2010 and a decrease of almost nine percentage points from 2007. In total, 6.5% of respondents had used drugs in the last year, a decrease of almost five percentage points from 2010 and seven percentage points from 2007. In relation to current drug users, the prevalence rate was 3.7% in 2013, which was approximately half the 2010 (7.1%) and 2007 (7.7%) levels.

The main drug of misuse for all three prevalence time periods and all survey years was cannabis with 4.8% reporting having ever used them compared with 9.3% and 7.5% in 2007 and 2010 respectively. The next most common was solvents; in 2013 the proportion reporting using them at least once in their lifetime was 4.6%, having reduced from the 2007 (8.5%) and 2010 levels (7.0%). Between 2010 and 2013, the lifetime, last year and last month prevalence of use of legal highs halved.

³⁷ Heroin and methadone

³⁸ The 2013 YPBAS was conducted on 7,076 pupils in Northern Ireland between September and December 2013. There were two versions of the questionnaire assigned to different schools with the questions on drugs and solvents included on only one of them. There were 3,092 respondents to this version of the questionnaire representing a response rate of 86%.

Table 2.7: Lifetime, last year and last month use of individual drugs amongst schoolchildren in Northern Ireland, 2007, 2010 and 2013

DRUG	LIFETIME			LAST YEAR			LAST MONTH		
	2007	2010	2013	2007	2010	2013	2007	2010	2013
Any drug	19.3	15.2	10.5	13.7	11.3	6.5	7.7	7.1	3.7
Amphetamines	1.8	2.1	1.0	1.0	1.4	0.8	0.4	0.7	0.4
Cannabis	9.3	7.5	4.8	6.9	5.8	3.4	3.9	3.3	2.0
Cocaine	2.6	2.7	1.1	1.9	2.0	0.6	0.9	1.0	0.4
Crack	1.6	1.5	0.6	1.1	0.9	0.3	0.6	0.6	0.2
Ecstasy	2.9	2.3	1.1	2.3	1.7	0.6	1.2	0.8	0.2
LSD	1.6	1.3	0.9	1.0	1.0	0.6	0.4	0.5	0.3
Magic Mushrooms	1.3	2.0	0.7	0.7	1.5	0.4	0.3	0.6	0.2
Heroin	1.1	1.0	0.6	0.6	0.7	0.4	0.4	0.4	0.2
Solvents	8.5	7.0	4.6	4.6	4.3	2.5	2.3	2.4	1.2
Tranquillisers	1.1	1.3	1.0	0.8	0.9	0.6	0.4	0.5	0.3
Poppers	6.1	1.5	1.0	4.1	0.9	0.4	1.8	0.6	0.2
Anabolic Steroids	0.8	0.9	0.8	0.5	0.7	0.4	0.4	0.4	0.2
Mephedrone	-	2.0	0.7	-	1.7	0.6	-	0.9	0.4
Legal Highs	-	3.8	1.9	-	2.3	1.1	-	1.2	0.6
Base	3,225	3,546	3,902	3,225	3,546	3,902	3,225	3,546	3,902

Source: Northern Ireland Statistics and Research Agency, 2008; Northern Ireland Statistics and Research Agency, 2011; Northern Ireland Statistics and Research Agency, 2014c

2.4 Drug use among targeted groups/settings at national and local level

2.4.1 Drug use among university students

Bennett and Holloway analysed data from student ($n=304$) and non-student ($n=975$) respondents aged 20 to 22 years from the CSEW 2010-11 (Bennett & Holloway, 2014). The rates of drug use among students and non-students were not generally significantly different, although students were 4.3 times more likely than non-students to have consumed ketamine in the last 12 months. The study confirmed a number of correlates of drug use identified in studies from other countries, for example that use was higher among students living away from home and who were not religious. Students who frequently visited clubs were 3.4 times more likely to take drugs than those who reported less frequent night-time activities. The article highlights the fact that drug use among students is a neglected topic area in the research literature in UK.

2.4.2 Drug use among men who have sex with men

Hunter et al undertook a questionnaire study to investigate the pattern of recreational drug use in patients attending a genitourinary medicine clinic, and to determine whether drug use was greater among men who have sex with men (MSM) patients, when compared to non-MSM male patients (Hunter et al., 2014). A questionnaire was given to all patients attending the genitourinary medicine clinics at two

inner city teaching hospitals in London over three months (July to September 2011). A total of 1,328 individuals completed questionnaires which represented 15.5% of attendances over the period. Of the male respondents ($n=729$), 475 (65.2%) were identified as non-MSM and 254 (34.8%) were identified as MSM. Lifetime and last month use of mephedrone, ketamine, volatile nitrites ('poppers'), sildenafil (Viagra), GHB, and GBL were all significantly higher in the MSM group compared to the non-MSM group. Lifetime use of cocaine powder, MDMA, amphetamine, and methamphetamine were also significantly higher in the MSM group; however, there was no significant difference in last month use of these drugs between MSM and non-MSM groups. There was also no difference in the prevalence of cannabis use for either time period between the two groups. The authors conclude that sexual health clinics may provide an opportunistic encounter to identify patterns of recreational drug use, explore motivations for use, and implement strategies to reduce harms related to drug use.

Last year drug use by sexual orientation was also reported in the CSEW and was based on a combined dataset compiled using responses from over the last three surveys to strengthen the validity of estimates despite the relatively small proportion of respondents who completed the module identifying themselves as gay or bisexual (2.6%) (Home Office, 2014b). Gay or bisexual respondents were more likely to report using drugs in the last year than those identifying themselves as heterosexual or straight, with gay or bisexual men having the highest prevalence (33.0%), followed by gay or bisexual women (22.9%) then heterosexual or straight men (11.1%). The contrast was particularly pronounced when looking at any stimulant drug³⁹ with prevalence of 16.0% among the gay or bisexual group compared with 2.9% among heterosexual or straight respondents, and ketamine with prevalence of 3.0% and 0.4% respectively.

2.4.3 Other studies relating to drug use in the general population

Detecting drugs used through pooled urine analysis

Archer et al. analysed pooled urine samples collected from portable street urinals in London over a six month period (Archer et al., 2014).⁴⁰ A total of 13 NPS were detected during the six months. Mephedrone and methylhexanamine were detected consistently each month. Other commonly detected NPS included methiopropamine (detected in five months), pipradrol (detected in four months), cathinone (detected in four months), 5-(2-aminopropyl) benzofuran (detected in three months) and 4-methylethcathinone (detected in three months). With regards to classic recreational drugs, those detected were consistent with use-data from UK population surveys. The authors conclude that the study demonstrates that analysis of anonymous pooled urine samples from stand-alone urinals can be used to detect and monitor trends in the use of classical recreational drugs and NPS in a large city centre over time.

The Welsh Emerging Drugs & Identification of Novel Substance

The Welsh Emerging Drugs & Identification of Novel Substances (WEDINOS) project, launched in October 2013, is a web-based, public access system for the submission and testing of samples of drugs where users have experienced negative or unexpected effects or have 'unknown' substances. Over 1,900 samples have been submitted, analysed, and the results published online.⁴¹ The profile of samples contained illicit drugs, primarily cocaine, NPS including mephedrone and synthetic cannabinoids and non-controlled stimulants including ethylphenidate and methiopropamine. NPS submissions to WEDINOS between October 2013 and June 2014 were predominantly by males (72%) with an average age of 28 (range: 14 to 61) (personal communication – Public Health Wales).

Between October 2013 and June 2014, the most commonly identified controlled substance was cocaine, followed by mephedrone and the most commonly identified substance that is not under legislative control was the synthetic cannabinoid receptor agonist 5F-AKB48. Caffeine was the most identified bulking/cutting agent.

³⁹ 'Any stimulant drug' comprises cocaine powder, crack cocaine, ecstasy, amphetamine, methamphetamine and amyl nitrite.

⁴⁰ Samples were analysed with a method based on high-performance liquid chromatography coupled to high-resolution accurate mass spectrometry (LC-HRAM-MS).

⁴¹ See: www.wedinos.org

The Chemsex Study

The Chemsex⁴² Study is an exploratory, mixed method research project that explored drug use in sexual settings among gay and bisexual men (Bourne et al., 2014). Between October 2013 and January 2014 researchers conducted 30 in-depth interviews and two focus groups with gay and bisexual men who lived in Lambeth, Southwark and Lewisham, areas of high HIV prevalence in London with a large gay social scene. In addition the study undertook secondary data analysis of the 2010 international self-selecting *European Men-who-have-sex-with-men Internet Survey* (EMIS). The analysis of EMIS data showed that prevalence of the drugs most associated with chemsex (mephedrone, crystal methamphetamine and GHB/GBL) was higher among respondents in London than in the rest of England and higher still among those living in Lambeth, Southwark and Lewisham. In this particular sample of MSM, crystal meth use was very strongly associated with HIV risk as was injecting drug use. The report made a number of recommendations regarding harm reduction and prevention (see section 7.4.3 and section 6.2.5).

⁴² "Chemsex" is a common term used by gay or bisexual men to describe sex that occurs under the influence of drugs, which are taken immediately preceding and/or during the sexual session.

3. Prevention

3.1 Introduction

The central Government's *Drug Strategy 2010* (Her Majesty's Government, 2010) puts emphasis on establishing a whole-life approach to prevention covering early years, family support, drug education and targeted, specialist support. Furthermore, the focus in prevention policy has shifted in recent years away from interventions aimed specifically at drugs, to strengthening general resilience factors associated with reducing the desire to explore risky behaviours such as drug use.

The Home Office and the Department of Health are now jointly leading the 'Reducing Demand' section of the *Drug Strategy 2010*. They have used this opportunity to broaden the range of prevention activities both in terms of widening the age range and also developing more targeted interventions. They are refreshing the 'Demand Reduction' section with the aim of creating an environment where the vast majority of people who have never taken drugs continue to resist any pressures to do so and to make it easier for those that do use drugs to stop.

In England, the Troubled Families programme has worked with over 100 thousand families identified as both having problems and causing problems to the community around them. Interventions within the programme include improving parenting skills; drugs education for children; helping the family stay together; and in some cases intensive interventions. The programme is being expanded to cover families with children under five and to increase its health focus. Since 2007, the Family Nurse Partnership has provided support to young mothers from pregnancy to the baby reaching two, with structured home visits by trained nurses.

Similar approaches to prevention are adopted by the devolved administrations, in Wales through *Rights of Children and Young Persons (Wales) Measure 2011* (Welsh Government, 2011a). The Getting It Right For Every Child (GIRFEC) programme⁴³ provides the methodology for delivering the Scottish Government's three social policy frameworks: the *Early Years Framework*; *Achieving our Potential*; and *Equally Well* (Scottish Government, 2008a,b,c), which aim to develop the prevention and early intervention agenda. More recently updated practice guidance was developed in Scotland for agencies and practitioners working with children, young people and families affected by substance use, *Getting Our Priorities Right* (Scottish Government, 2013a). This built on original guidance produced in 2003 (Scottish Government, 2006). In Northern Ireland, *Our Children and Young People – Our Pledge: A 10 year strategy for children and young people in Northern Ireland, 2006-2016* (Office of the First Minister and Deputy First Minister for Northern Ireland, 2006) sets a framework for addressing the needs of young people. Improved education and early interventions for young people and families (especially those most at risk) and improved public information about drugs are priority areas.

There are several universal prevention communication programmes in the United Kingdom (UK), such as 'Talk to FRANK'⁴⁴ in England and 'Know the Score'⁴⁵ in Scotland, that provide factual information and advice to young people and their families. In Northern Ireland, the Public Health Agency⁴⁶ develops public information campaigns for various target groups and settings, and in Wales a bilingual (Welsh and English) helpline, 'Dan 24/7'⁴⁷ is available and frequently runs targeted campaigns.

Universal drug prevention is also included in the national curriculum in England, where it is a statutory part of the science curriculum for schools and can be expanded through the non-statutory Personal Social and Health Education (PSHE) programme (Department for Education, 2013c).⁴⁸ In Scotland education has developed to encapsulate broader life learning for children and young people through the Curriculum for Excellence⁴⁹ where traditional education is integrated with wider life learning for three to 18 year olds.

⁴³ See: <http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright/publications/practice-guide>

⁴⁴ See: <http://www.talktofrank.com/>

⁴⁵ See: <http://knowthescore.info/>

⁴⁶ See: <http://www.publichealth.hscni.net/>

⁴⁷ See: <http://www.dan247.org.uk>

⁴⁸ The National Institute for Health and Care Excellence (NICE) provided evidence to the DfE for a review of PSHE.

The evidence emphasised that effective programmes of alcohol and drug education contribute to reducing the risks associated with alcohol or drug use.

⁴⁹ See: <http://www.educationscotland.gov.uk/thecurriculum/whatiscurriculumforexcellence/index.asp>

There have been concerns, however, that austerity and the move to localism could have a detrimental effect on wider services for children and young people (United Kingdom Drug Policy Commission, 2012). Since April 2013, local authorities in England and Wales are no longer required to produce a Children and Young People's Plan, with some areas opting to cover the provision of services for young people, including treatment and prevention within their broader Health and Wellbeing Plans. Funding for such services is no longer being ring-fenced.

3.2 Environmental prevention

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

3.2.1 Alcohol and tobacco policies in the United Kingdom

Across the UK there are a number of policies and strategy documents concerned with licit substances such as tobacco and alcohol. In some UK countries, such as Wales and Northern Ireland, there are global strategies covering both illicit and licit substances. A summary of the situation across the UK was provided in the UK Focal Point Report 2012 (UK Focal Point, 2012).

Standardised packaging of tobacco

In March 2014, Sir Cyril Chantler published a report on standardised packaging of tobacco.⁵⁰ The evidence-based report concluded that standardised tobacco products would reduce the rate of children taking up smoking and would not increase overall tobacco consumption. The evidence shows that over time, standardised packaging in conjunction with the current tobacco control regime is likely to lead to a modest but important reduction in the uptake and prevalence of smoking with a positive impact on public health.

In July 2014, the Government published a consultation on the proposed regulations (in line with the recommendations given by the Chantler review) for the introduction of plain, standardised packaging for tobacco products across the UK.⁵¹ The consultation closed in August 2014.

In its response⁵² to the consultation on the standardised packaging of tobacco products, Public Health England (PHE) expressed the view that the current evidence suggests that standardised packaging, in conjunction with the current tobacco control regime, is an effective measure to reduce the uptake of smoking in addition to encouraging smokers to reduce and stop smoking. PHE also expressed the view that standardised packaging could bring an economic benefit by helping to reduce spending on tobacco, especially in the most deprived communities.

As part of the Scottish Government's objective to have a smoke-free Scotland by the 2030s, in autumn 2013, the Scottish Government announced that it would continue its plans for plain packaging legislation.⁵³ The Scottish Government aims to introduce the legislation following the publication of the outcomes from the UK-wide consultation. They continue to implement the public smoking ban in Scotland and are taking guidance from the World Health Organisation (WHO) regarding e-cigarettes.

Minimum unit pricing

The Scottish Government is currently taking its policy on Minimum Unit Price (MUP) to the European Court of Justice at the end of 2014 to regulate the pricing structure on alcohol with the aim of reducing alcohol consumption and related harmful health impacts in Scotland.

⁵⁰ See: <http://www.kcl.ac.uk/health/10035-TSO-2901853-Chantler-Review-ACCESSIBLE.PDF>

⁵¹ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323922/Cons_doc.pdf

⁵² See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/341309/PHE_response_to_the_government_consultation_on_the_introduction_of_regulations_for_standardised_packaging_of_tobacco_products.pdf

⁵³ See: <http://scottishgovernment.presscentre.com/News/Tobacco-plain-packaging-3ce.aspx>

The Welsh Government in June 2014, published a consultation on a White Paper '*Listening to you – Your Health Matters*' (Welsh Government, 2014c). The paper presents a series of proposals for primary and secondary legislation which seek to address priority public health issues such as tobacco, alcohol misuse and obesity. These proposals include recommended actions on tobacco and electronic cigarettes and the introduction of a MUP of alcohol in Wales.

Drink driving legislation

In May 2014, Northern Ireland proposed to amend the law relating to the prescribed limit of alcohol for drink-driving offences.⁵⁴ Under the plans, the permitted blood alcohol limit would be reduced to 50mg of alcohol in 100ml of blood, down from the current UK limit of 80mg and would be more similar to most of the UKs European counterparts. The bill also proposed the further provision of breath testing.

Scottish Families Affected by Alcohol and Drugs

In September 2013, the Scottish Government awarded funding to one of its four drugs commissioned organisations, to increase their remit to also work with those affected by alcohol. Scottish Families Affected by Drugs has now changed their name to Scottish Families Affected by Alcohol and Drugs to reflect this change of remit. They are also managing an enhanced helpline which has increased its uptake since the change. Funding has continued in 2014/15 and includes provision of a National Alcohol Liaison Officer, who took up post in September 2014.

3.3 Universal prevention

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

3.3.1 Schools

England

Alcohol and drug education in England

The Department for Education (DfE) encourages all schools to deliver drug education within the non-statutory PSHE in addition to the mandatory drug education delivered as part of the national science curriculum. It has outlined this expectation in The *National Curriculum in England Framework* published in September 2013 (Department for Education, 2013c).

In 2013, Ofsted published a report evaluating the strengths and weaknesses of PSHE in primary and secondary schools in England (Ofsted, 2013). The report concluded that in 40% of the schools examined, the PSHE curriculum required improvement or was inadequate, and many teachers did not have sufficient experience and training on drug education.

To address Ofsted's concerns and provide practical support and guidance to schools and external organisations involved in the delivery of alcohol and drug education and prevention, the DfE has commissioned the Alcohol and Drug Education and Prevention Information Service (ADEPIS)⁵⁵ to provide a set of evidence-based quality standards. These standards were published in March 2014 following a consultation in autumn 2013 (Alcohol and Drug Education and Prevention Information Services, 2014b). They covered the delivery of an effective alcohol and drug education within the classroom and the environment in which the school operates and safeguarding policies (covering employed staff, volunteers and external agencies).

⁵⁴ See: <http://www.niassembly.gov.uk/Assembly-Business/Legislation/Primary-Legislation-Current-Bills/Road-Traffic-Amendment-Bill/Road-Traffic-Amendment-Bill-As-Introduced/#2>

⁵⁵ See: <http://mentor-adepis.org/drug-education-prevention-primary-school-perspective/>

Alcohol and Drug Education and Prevention Information Service seminar series: drug education and prevention

Alcohol and Drug Education and Prevention Information Service (ADEPIS) has organized a seminar series⁵⁶ to explore practical and efficient ways to deliver alcohol and drug education and prevention in primary schools, through the encouragement of a healthy lifestyle and positive behavioural choices. The seminars promote the fact that social development programmes, especially if started at an early age and continued throughout schooling, cannot only increase pupils' interest in school, improving academic performance, but also can improve social skills, reduce aggressive or disruptive behaviour and risk factors associated with alcohol and drug misuse.

The Risk-Avert programme

In April 2013 a pilot study "Risk-Avert"⁵⁷ was commissioned by Essex County Council. The study aimed to explore different ways of helping young people to understand and manage risk, to support teachers in identifying those vulnerable to multiple risk taking before they engage, or have the opportunity to participate, in such activities (such as alcohol and drug use, unprotected sex etc.) and to improve their relationship with young people.

An initial cohort of 10 schools took part in the pilot. The reports from pilot schools and young people demonstrate that the "Risk-Avert" programme had a positive effect on influencing risk-taking behaviour in the short-term. In 2014 the programme has been extended to multiple local authority areas engaging with over 5,000 young people in over 30 schools.

'Legal Highs' and new psychoactive substances

Due to the growing concerns about the use of new psychoactive substances (NPS), a new briefing paper (*Legal Highs' and Novel Psychoactive Substances*)⁵⁸ was published in June 2014 by Mentor ADEPIS. This paper was intended to provide basic information for teachers and practitioners on how to cover NPS in their alcohol and drug education programmes.

The briefing paper addressed three main issues. Firstly, what NPS are, giving some examples and descriptions of substances. Secondly, it described the prevalence of NPS use in a school aged population. Finally, the briefing provided guidance on what schools can do to minimize the risks posed by NPS, for example how to perform risk and needs assessment, and how to include the subject of NPS in an effective alcohol and drug education programme.

Re-Solv guidance on volatile substance abuse policy for schools

In June 2014, Re-Solv published a revised version of their guidance on volatile substance abuse (VSA) for Schools.⁵⁹ The guidance highlights the high prevalence of VSA among the school aged population and encourages schools to include reference to VSA in their alcohol and drug education programmes. The guidance emphasised the associated harms of VSA in addition to listing a number of commonly misused substances which teachers should be aware of.

Making it inclusive: alcohol and drug education in multicultural settings

To help teachers deliver alcohol and drug education within a multicultural context Mentor ADEPIS in July 2014⁶⁰ published a briefing paper that outlines key requirements to facilitate the coverage of culturally sensitive alcohol and drug education within the classroom, and how the school can engage with parents or carers for the delivery of such sensitive issues.

⁵⁶ See <http://mentor-adepis.org/get-involved/events/>

⁵⁷ See: <http://www.risk-avert.org/>

⁵⁸ See: <http://mentor-adepis.org/wp-content/uploads/2014/06/Legal-highs-and-Novel-Psychoactive-Substances-briefing-paper1.pdf>.

⁵⁹ See:<http://www.re-solv.org/wp-content/uploads/2013/07/VSA-Lesson-Plan.pdf> and <http://www.re-solv.org/wp-content/uploads/2013/01/Policy-Guidance.pdf>.

⁶⁰ See: <http://mentor-adepis.org/wp-content/uploads/2014/07/Making-it-Inclusive1.pdf>

Early intervention and prevention

In September Mentor ADEPIS published a new briefing paper⁶¹ as part of a series on alcohol and drug education and prevention for teachers and practitioners. This briefing paper draws on academic sources reviewing evidence-based educational programmes and governmental publications (such as the latest Chief Medical Officer's (CMO) report (Davies, 2013)). It focuses on the importance of early years' education, paying attention to the distinction between early intervention and prevention. In the briefing paper Mentor ADEPIS evidences that formal education settings (nursery and primary school) are also key environments in determining the response that children and young people will have to challenges in later life (Allen, 2011). The briefing paper suggests that the use of rigorous evidence-based early intervention and prevention programmes, give children and young people the opportunity to acquire the social and emotional life skills that will help them in adult life.

Building children and young people's resilience in schools

PHE commissioned University College London (UCL) Institute of Health Equity to review the evidence concerning the role of schools in building resilience in children and young people (Public Health England, 2014f). The review, which was published in September 2014, is intended primarily for directors of public health, public health teams and local authorities and includes examples of interventions within schools which the evidence-base suggests may be effective at promoting well-being generally as well as for building resilience. Interventions can aim at increasing pupils' achievements, supporting them through transitions and promoting healthy behaviours and better interpersonal behaviours particularly between parents or carers and children. The report concludes that schools have a key role to play in enabling children and young people to build resilience.

Scotland

Choices For Life

Choices For Life (CFL) is a diversionary and educational initiative delivered by Police Scotland, funded by Scottish Government and supported by Education Scotland and Young Scot. The main objective is to raise awareness amongst young people aged 11 to 18, about the risks and dangers of substance use and misuse, including smoking, alcohol consumption and drugs.

Choices For Life webcast events

Webcasts are organised by Police Scotland and broadcast via Glow (Scotland's national intranet for learning)⁶² and made available to all primary seven school children. These webcasts utilise TV-style dramas, highlighting choices faced by young people and their possible consequences. Interactive panel discussions are held as part of the webcast, allowing young people to post questions online to expert panel members.

Choice for life Website⁶³

CFL website provides learning and age appropriate materials for young people, teachers and parents/carers, on drugs, alcohol, tobacco and online safety. Over the last year, an enhanced partnership with Young Scot has ensured that the website is a youth-led, co-designed, interactive hub. A YouTube channel has been created to allow young people to watch short dramas and video diaries based on real experiences of young people smoking, drinking alcohol or taking drugs.

⁶¹ See: <http://mentor-adepis.org/wp-content/uploads/2014/09/Early-Intervention-and-Prevention-briefing-paper.pdf>

⁶² See: <http://www.educationscotland.gov.uk/usingglowandict/glow/whatis/index.asp>

⁶³ See: <http://choicesforlifeonline.org/>

Divisional police events

Over the last year Police Scotland has increased the penetration of CFL messages by designing and delivering a number of divisional pilot programmes. Police Scotland divisions are given the autonomy to work with local partners to identify and create local CFL events to be delivered in their own communities.

Through a successful NPS pilot event in Aberdeen, effective and early media co-ordination ensured that the CFL messages around NPS were not only covered in the North East but were shared and promoted nationally. These divisional events will be further developed during 2014/15.

Choices For Life and operation Redwall

During August 2014 the risks associated with NPS or so called “legal highs” were targeted by Police Scotland and partners through nationwide operational activity and an awareness-raising campaign. In addition to 58 NPS retailers searched and visited across Scotland during the operation, the dangers and the risks to young people from the use and availability of NPS were highlighted by CFL through the following:

- a two-week nationwide CFL marketing campaign to help raise awareness of the dangers of taking NPS. The campaign was aimed at young people aged 11 to 18 years as well as their key influencers such as parents and teachers. It also targeted young professionals aged 25 to 35 years;
- campaign adverts broadcast on a popular radio station;
- posters and digital screens highlighting the issues displayed in train stations and on local buses across the country;
- the design and delivery of a nationwide Police Scotland and CFL resource highlighting dangers with key partners including the National Health Service (NHS), Education Scotland, Scottish Drugs Forum, Re - Solve and the Angelus Foundation. The resource was hosted on online platforms including the CFL and Police Scotland websites. Part of the content featured secondary school pupils who were able to ask a studio panel of experts questions about NPS, solvents and stimulant drugs, thus ensuring the product content was not only accurate but also interesting and engaging;
- a range of events took place with local community officers visiting schools, youth groups and community events to present the bespoke NPS resources and to answer questions;
- close working with YoungScot highlighting the activities on their social media platforms and actively encouraging young people to visit CFL website; and
- the CFL website also featured a week long online ‘Ask an expert’ session to encourage not only young people, but also parents and carers to interact and learn more about the dangers and risks of NPS and where to find additional advice, guidance and support.

Greater Glasgow and Clyde Substance Misuse Toolkit

In December 2013, the Greater Glasgow and Clyde Substance Misuse Toolkit (SMT) was launched. The Toolkit aims to prepare school staff with the knowledge and confidence to teach about substance misuse using a range of materials and methodology and to encourage pupils to make informed decisions about alcohol, drugs and tobacco. The toolkit highlights the risks associated with alcohol and drug misuse and identifies examples of effective alcohol and drug education programmes across Greater Glasgow and Clyde. To ensure that the toolkit maintains a high quality content, a process of consultation with key stakeholders regarding uptake, content, pupils’ needs and suggestions for improvement has been established. This is an online tool containing quality assured resources, information on local partner organisations and training opportunities developed by a working group comprising of NHS and Education staff from across the Greater Glasgow and Clyde area.⁶⁴

⁶⁴ See: <http://www.phru.net/smt/default.aspx>

Wales

All Wales School Liaison Core Programme

The Welsh Government's *Substance Misuse Delivery Plan 2013-15* (Welsh Government, 2013c) includes a key action: to ensure appropriate educational programmes are available across Wales (see section 1.3.1). The All Wales School Liaison Core Programme (AWSLCP)⁶⁵ which is jointly funded by the Welsh Government and the four Welsh police forces, targets pupils aged between five and 16, and reaches over 98.5% of schools in Wales. The programme is part of the 10 year substance misuse strategy, '*Working Together to Reduce Harm*' (Welsh Assembly Government, 2008a).

Research

The Good Behaviour Game

Mentor has been funded by the Education Endowment Foundation to run a two-year RCT as part of a four-year project to measure the impact of the Good Behaviour Game (GBG).⁶⁶ The GBG is a primary school intervention programme aimed at improving children's willingness to learn. The RCT will take place over two years, starting with children in year three (seven to eight year olds), commencing in September 2015. At the beginning of the school year the pupils are divided into teams and given four class rules (such as: we will work quietly; we will be polite to each other; we will ask permission to move from our seats and we will follow directions). The teams will be rewarded with small prizes if they adhere to the class rules.

The GBG is a classroom management method derived from longitudinal research in the USA (Kellam et al., 2011). This research showed that implementation of the GBG led to reduced risk-taking behaviours in later life, such as criminality, alcohol and drug dependence and health and family problems, and additionally increased the number of students continuing into further education. The GBG was first piloted in Oxfordshire schools (2012/13) to assess whether it could be implemented successfully in UK.

The intervention includes intensive teacher training and classroom intervention activities to improve children's behaviour and their social skills. The trial will be evaluated by Manchester Institute of Education, Manchester University, and an evaluation report will be published in autumn 2017.

3.3.2 Family

England

Prevention pays - our children deserve better

The annual report of the CMO (Davies, 2013) set out to provide an assessment of the state of the public's health and to advise the government on where action is required. In the report, Professor Davies focused on what happens early in life and how it is associated with social and economic consequences in adulthood.

The report drew on the expertise of a broad range of experts, academics, clinicians and service providers. The report concluded that compared to other developed countries, children and young people in England are not doing as well as they could; with high mortality, morbidity and inequality. The report gave a series of recommendations which cover three main areas:

- the voice of children and young people;
- building and joining services; and
- the economic case for a shift to prevention.

⁶⁵ The AWSLCP is a substance use education programme running in Wales since 2004. It is delivered across the majority of primary and secondary schools in Wales by a partnership between specialist police liaison officers and teachers. In addition to substance use, it aims to reduce anti-social behaviour and problems associated with personal safety. See: UK Focal Point Reports 2008 to 2013.

⁶⁶ See: <http://educationendowmentfoundation.org.uk/projects/the-good-behaviour-game/>

Of particular interest within the context of this chapter are the recommendations aimed at building resilience. The report provided evidence that resilience and 'feeling connected' (having a sense of belonging to the school, and feeling that teachers are interested in you as a person) have a positive effect in reducing the desire to explore risky behaviours (Brooks, et al., 2011; Clea et al., 2002). The report also identifies connections between different types of risky behaviours, and suggests that in order to reduce these, prevention strategies should not focus on individual risky behaviours in isolation but view them together in the context in which they occur. Therefore, the report supports the proposed PHE initiative to develop a youth social marketing programme 'Rise Above', which will engage young people to address issues around risky behaviours through multiple platforms. The PHE objective is to develop a new holistic adolescent health framework that explores risky behaviours in combination rather than as single issues. It aims to build a social movement, developed from a series of media activities organised by young people, designed to empower them to build their resilience against pressure and tendency to make unhealthy lifestyle choices.

Wales

Strengthening Families Programme 10-14

A RCT based on the universal family-based alcohol, drugs and tobacco prevention programme "*Strengthening Families Programme 10-14*" is currently on-going in Wales. Researchers at Cardiff University in collaboration with Swansea University and Oxford Brookes University are aiming to assess whether the positive effects obtained by the original United States of America (USA) study are applicable when the programme is applied to a UK context (Kumpfer, 1999; Kumpfer et al., 1996). This trial will investigate the impact that *Strengthening Families Programme 10-14* UK has on protective factors for alcohol and tobacco use within the family, on school performance, and mental health and well-being. It will also evaluate the cost effectiveness of the programme and how it can be best implemented. This trial is expected to be completed by the end of 2014.

3.3.3 Community

Northern Ireland

Guiding effective drug prevention

The Public Health Agency (PHA) published in March 2014 a revised edition of the *Guiding Effective Drug Prevention* report (Public Health Agency, 2014) aimed at people working across tiers one and two within the voluntary, statutory and community sectors and people working with young people. The report highlighted and promoted best practise/approaches in drug prevention, exploring the nature of prevention work in the world of drugs and alcohol. The document is primarily aimed at drug prevention in young people; however, many of the principles also apply within an adult context. It recommended 12 principles of best practice for effective drug prevention based on the concept that understanding risk and protective factors is central to deliver effective drug prevention.

Scotland

CashBack for Communities

CashBack for Communities is a unique Scottish initiative that uses money recovered through the *Proceeds of Crime Act 2002* and invests them in community programmes, facilities and activities largely, but not exclusively, for young people at risk of turning to crime and anti-social behaviour.

CashBack for Communities has invested over £74 million into partner organisations to provide free sporting, cultural, youth-work, employability and educational activities for children and young people throughout Scotland. Since its inception in 2007, the CashBack for Communities Programme has provided over 1.5 million activities and opportunities for young people

Individual CashBack projects and the overall programme are now subject to an outcome focused evaluation of their impact. This work supports a qualitative approach to measuring short, medium and longer-term outcomes. The National Evaluation of the CashBack for Communities Programme (April 2012 to March 2014)⁶⁷ was published in May 2014. The aim of this exercise was to examine the changes in the programme following the 2011 review, the impact of the programme, and the lessons learned. The evaluation concluded that amendments to the process introduced since 2011 have strengthened the programme. Its increased focus on outcomes has established learning processes that can ensure that the programme is as effective as possible. The evaluation report also provides recommendations for the implementation and evaluation of future work, suggesting a review in the 2015/16 financial year.

3.3.4 Workplace

Wales

The Welsh Government continues to develop its work and health programme, '*Healthy Working Wales*' (HWW)⁶⁸, which includes the Corporate Health Standard and the Small Workplace Health Award. The programme aims to provide free support and advice to employers in developing health and well-being policies and initiatives in the workplace (including substance misuse). To date, 73 employers have achieved the Corporate Health Standard and 178 smaller businesses/organisations have achieved the Small Workplace Health Award.⁶⁹

3.3.5 Sources of information about drugs

England

The *Smoking, Drinking and Drug Use Survey 2013* (Fuller & Hawkins, 2014) (see section 2.3.2) asked pupils a question about sources of helpful information on drug use. Pupils were most likely to cite teachers as a source of helpful information on drugs (69%) followed by parents (68%) and television (59%). Helplines were considered the least helpful source of information (15%). The survey also reported that boys were more likely than girls to mention other relatives, general practitioner (GP), TV or radio as sources of useful information. Otherwise, there were no significant differences by gender. Older pupils were more likely to mention most sources of information compared with younger pupils with an increase by age in the proportion of pupils who mentioned friends (from 29% of 11 year olds to 57% of 15 year olds), teachers (from 56% to 74% respectively), the internet (from 38% to 63% respectively) and FRANK (from five per cent to 33% respectively). This data aligns with the data reported in previous years.

3.4 Selective prevention in at-risk groups and settings

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

3.4.1 At-risk groups

Substance misuse services for young people

Specialist substance misuse treatment for young people is recognised as a form of prevention in the UK as it aims to stop drug and alcohol use escalating, to reduce harm to young people or others and to prevent them becoming drug or alcohol-dependent adults. The Young People's Statistics from the National Drug Treatment Monitoring System (NDTMS) showed that in 2012/13 20,032 young people (under 18 years) accessed specialist substance misuse services with the majority having presented with cannabis (68%) or alcohol (24%) as their primary problem substance (Public Health England, 2013e).

⁶⁷ See: <http://www.scotland.gov.uk/Resource/0045/00452165.pdf>

⁶⁸ See: <http://www.healthyworkingwales.com/e-home>

⁶⁹ See: <http://www.healthyworkingwales.com/e-awards>

Young people with multiple vulnerabilities

Young people presenting to specialist substance misuse services frequently have multiple vulnerability factors such as being a looked after child, having a history of self-harm or offending behaviour. The Young People's Statistics from NDTMS identify 10 of these vulnerability factors.⁷⁰ Of the 14,382 new presentations in 2012/13 74% had two or more of these vulnerability factors (Public Health England, 2013e).

Identifying and supporting children affected by parental substance use

In November 2013, ADEPIS launched a resource⁷¹ aimed at providing good practice and evidence-based examples to help understand the key issues affecting children whose parents are substance users, and to identify how schools can support them. This resource is mainly aimed at school governors and head teachers, but can also be relevant to the work of other members of staff.

Inspiring Scotland

The Inspiring Scotland 14 to 19 fund has been running since 2008. The Scottish Government is one of many investors from the public and private sectors, alongside high net-worth individuals and other trust funding. Since 2013, £27 million was invested in 24 ventures; £17 million of public money, £10 million of private philanthropy. A total of 6,067 vulnerable young people, including those with issues with drug use, were assisted across the 24 ventures which helped them into education, training or employment.⁷² Since 2008, 25,263 vulnerable young people engaged with the programme, of which 12,372 individuals (49%) are reported to have achieved 'positive destinations'. In December 2013, the University of Cambridge published an independent research report on the *Practices, Impact and Implications of Inspiring Scotland's First Five Years* (Isserman, 2013). The view of this study is that Inspiring Scotland is a cost-effective model achieving national-level social impact goals, and its achievements are generating interest from policymakers in North America, Europe, and Asia.

3.4.2 At-risk families

Troubled families

Troubled families are defined as families who both have problems and cause problems to the community around them putting high costs on the public sector. Offspring are often truanting or excluded and these families tend to be associated with crime, anti-social behaviour and unemployment. They also tend to have other problems including domestic violence or drug and/or alcohol abuse. In 2011, the "**Troubled Families Programme**" was launched in England (UK Focal Point, 2012, UK Focal Point, 2013) with the aim of improving the lives of 120,000 families by 2015.

In April 2014, the Department for Communities and Local Government (DCLG) published data outlining progress of the programme up until December 2013.⁷³ By then the number of families identified for the programme was 101,895 and the number of families that received support from the programme at the end of December 2013 was 78,289 (77% of all identified families).

⁷⁰ The 10 vulnerability factors are: a young person
– began using primary substance aged under 15;
– reports involvement in offending behaviour;
– reports self-harming;
– is a looked after child (LAC);
– reports using opioids and/or crack;
– is not in education or employment;
– report unsettled accommodation status or has no fixed abode (NFA);
– reports using two or more drugs in combination (poly drug use);
– is pregnant or a parent; and
– reports almost daily drinking or drinking in excess of 8 units (males) or six units (females) on an average drinking day when drinking 13 or more days of the month.

⁷¹ See: http://www.adfam.org.uk/cms/docs/adepris_psu_schools.pdf.

⁷² See: <http://www.inspiringscotland.org.uk/Home>

⁷³ See: <https://www.gov.uk/government/publications/troubled-families-programme-progress-by-31-december-2013>

In July 2014 “Understanding Troubled Families” (Department for Communities and Local Government, 2014) a report on the Troubled Families programme was published. The data revealed that such families are facing complex issues that should not be considered as freestanding problems, but are likely to be interconnected and overlapping. For instance, of the families participating in the programme, 13% included at least one adult with substance misuse problems. Of these families, 23% also had a child with a substance misuse problem compared to 13% where there was no adult drug user. The report suggested that the public services tend to work with single individuals separating their problems, but with troubled families it might be more effective to look at the family and its problems as a whole. If not, different services may be working to different ends with different family members, making it unlikely that families with so many issues will be effectively helped.

The government announced in August 2014 that the Troubled Families programme will be expanded to include working with children under five and will have an increased health focus. The work will begin in 2014 in 51 of the best performing areas. The Family Monitoring Data will continue to be collected as part of the ongoing national evaluation and will be used to shape the development of the expanded Troubled Families Programme from 2015. It is aimed to reach 400,000 families between 2015 and 2020 with initial funding of £200 million for 15/16 and will include young people and adult’s substance misuse as key criteria.

Integrated Family Support Service Wales

The Integrated Family Support Service (IFSS)⁷⁴ provides intensive support for families that have been identified as having parental substance misuse issues, and helps co-ordinate action from relevant services. IFSS is part of broader support for disadvantaged families with complex needs, complementary to the Flying Start,⁷⁵ and Families First⁷⁶ programmes. The IFSS has been rolled out across the majority of Wales, with implementation in the last two areas due in 2014.⁷⁷

Preventing the harm to children from parental problem drug use

In April 2014 Adfam⁷⁸ published a report (funded by an educational grant from Reckitt Benckiser Pharmaceuticals Ltd (RBP)) that examined cases of children who have died or come to harm from ingesting opioid substitution treatment (OST), primarily methadone. The report showed that even if the risk of children ingesting OST is low (the review found 20 serious case reviewed between 2003 and 13) and the number of children that can be exposed to OST is unknown, OST could present as a risk factor for the children living in families with people receiving OST treatment. It recognised that there is a lack of data on the subject and further research is needed (including data collection). The report ended with the recommendation that there should be adequate training for drug services, pharmacies and GPs which highlights the possible dangers of OST to children. It also recommended better implementation of the recommendations from the National Institute for Health and Care Excellence (NICE) good practice and medicines practice guideline MPG1 (National Institute for Health and Care Excellence, 2012) and safeguards such as use of safe storage boxes.

3.4.3 Recreational settings

Letter from the Home Office to festival organisers about new psychoactive substances

Earlier this year the Home Office once again wrote out to festival organisers to alert them to the dangers of so-called ‘legal’ highs and that they may contain illicit or harmful substances. The letter reminded them that analysis of samples from festivals by the Home Office’s Forensic Early Warning System (FEWS)

⁷⁴ See: <http://wales.gov.uk/topics/health/socialcare/working/ifst/?lang=en>

⁷⁵ Flying Start programme is targeting families with children under 4 years of age in some of the most deprived areas of Wales. It aims to make a decisive difference to the life chances of children aged under 4 in the areas in which it runs. It includes four core elements free quality childcare, parenting support, intensive health visitor support, and support for early literacy. See: <http://wales.gov.uk/docs/dhss/publications/120913fsguidanceen.pdf>

⁷⁶ Families First is a programme that provides funding to local authorities to improve outcomes for children, young people and families. See: <http://wales.gov.uk/topics/childrenyoungpeople/parenting-support-guidance/help/familiesfirst/?lang=en>

⁷⁷ See: <http://wales.gov.uk/about/cabinet/cabinetstatements/2013/ifss/?lang=en>

⁷⁸ See: <http://www.adfam.org.uk/>

confirm that the more established illicit drugs such as MDMA, cocaine, cannabis and amphetamines remain the majority of drugs detected at summer festivals. The letter also highlighted the Home Office's concerns about the availability of nitrous oxide and asked that they take steps to prevent its availability and sale. Organisers were also encouraged to collaborate with the police, to tackle illicit drugs and to take action to limit open sale and availability of NPS.

Nightclubs

The Manchester Warehouse Project in collaboration with the School of Applied Social Sciences at Durham University has introduced a monthly drug testing pilot scheme which involves testing drugs posted in the amnesty box or confiscated by security in and around the venue. If any particularly dangerous substances are found, the club will be informed so that warnings can be put out on social media and on signs inside the venue. The results from the study are expected to be published in 2014/15.

3.5 National and local media campaigns

England

*FRANK*⁷⁹

The government is committed to providing information on new psychoactive substances through the national drugs information and advice service - FRANK. The Home Office has now run two targeted campaigns aimed at people aged 15 to 21. The campaigns direct young people to the FRANK website for help, information or advice about the risks of drug use and raised awareness on the harms associated with a range of NPS including nitrous oxide (commonly known as "laughing gas"). In 2013/14, nitrous oxide was the second most popular drug among young adults (Home Office, 2014b). FRANK now also has a page dedicated to nitrous oxide and the messaging is clear that, as with all other drugs, there are health risks attached and nitrous oxide should not be experimented with. In addition to the 2014 campaign, a resource-pack will be developed that supports informal educators to challenge drug taking behaviour in our target audience and prompt them to reflect on the risks and harms of these drugs, ultimately helping them to break the cycle of use.

Rise Above

PHE will launch 'Rise Above'⁸⁰ (an online resource and social movement for young people) in November 2014 to build young people's resilience and empower them to make positive choices for their health (including drugs, alcohol, smoking, body confidence, relationships and exam stress). Starting at a younger age (11-16), 'Rise Above' will build young people's skills by encouraging them to complete a range of situational tools and skills based resources rather than providing information only. This approach is in line with the evidence base and PHE is working with key academics to assess the effectiveness of the programme.

Video podcasts, drug videos and drug education

In January 2014 Mentor launched a series of video podcasts (*Ask Andrew*)⁸¹ answering popular questions from parents and advising them on how to speak to their children about alcohol and drugs and how to answer their questions.

⁷⁹ The Talk to FRANK drugs internet information and advice service funded by the Department of Health, the Home Office and the Department for Education has been running in England since 2003. See: <http://www.talktofrank.com> and <http://www.homeoffice.gov.uk/media-centre/news/frank-campaign>.

⁸⁰ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/326548/PHE_StrategyDoc_2014_10.pdf

⁸¹ See: <http://www.mentoruk.org.uk/2014/01/ask-andrew/>

Wales

Know the Score campaign

In March 2013 the campaign “Know The Score”, run by helpline DAN 24/7, was launched by advertisements on Real Radio Wales. The campaign aims to raise awareness about the different types of drugs, their effects, the law on drugs and help and support. It was tied to the Six Nations Rugby tournament with advertisements displayed on boards at two of the games. In 2014 the campaign continued its rugby theme and was endorsed by a Welsh international rugby player, who helped promote awareness with radio adverts, press adverts in local North and South Wales newspapers and on social media events during the Six Nations games. The “Know the Score” campaign ended on the 31st March 2014.

Northern Ireland

‘Drug dealers don’t care, do you?’ campaign

In February 2014 a multi-agency campaign ‘*drug dealers don’t care, do you?*’ was launched in Northern Ireland. It was aimed at tackling drugs in communities by encouraging the reporting of drug-related activity. The campaign was launched by Belfast Policing and Community Safety Partnership (PCSP), in partnership with Crimestoppers and the Police Service of Northern Ireland (PSNI). The campaign was promoted on billboards, buses and taxis across Northern Ireland as well as on radio and online.

Scotland

Know the Score

The Scottish Government’s Know the Score⁸² website and free helpline offers credible and non-judgemental information on drugs and this includes information on New Psychoactive Substances. Facebook adverts are also being run on the dangers of drugs which encourage people to access Know the Score.

⁸² See: <http://knowthescore.info/>

4. High Risk Drug Use

4.1 Introduction

In the United Kingdom (UK), information about the number of people who use illicit drugs such as heroin, other opioids or crack cocaine is a key element of the evidence base used to formulate policy and inform service provision. It additionally provides a context in which to understand the population impact of interventions to reduce drug-related harm. Direct enumeration of those engaged in a largely covert activity such as the use of heroin is not possible and household surveys such as the *Crime Survey for England and Wales* (CSEW) (see section 2.2.1) tend to underestimate numbers of those individuals whose drug use is the most problematic. However, indirect techniques can be applied to provide estimates of drug use prevalence.

The European Monitoring Centre for Drugs and Drug Addiction's (EMCDDA) definition of high risk drug use (HRDU) is 'injecting drug use or long-duration/regular use of opioids, cocaine and/or amphetamines'.⁸³ In England, estimates are produced for opioid and/or crack cocaine users (OCUs) and injecting among users of those drugs. In Scotland, HRDU refers to the problematic use of opioids⁸⁴ and/or the illicit use of benzodiazepines and drug injecting; in Wales it is long duration or regular use of opioids, cocaine powder and/or crack cocaine; and in Northern Ireland high risk opioid and/or problem cocaine powder use. For the purpose of this chapter, HRDU will be used to encompass all of these definitions from across the UK and to enable cross-European comparisons to be made by the EMCDDA.

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

Latest national and regional estimates for England are for 2011/12 for OCUs, with separate estimates available for opioid use, crack cocaine use, and injecting drug use. It should be noted that the case definition focuses on the 'use' of opioids and/or crack cocaine rather than the 'misuse'/addiction to these drugs. The estimates therefore include people using prescribed opioids such as methadone or buprenorphine. In Scotland, the latest national and regional estimates for problematic opioid and/or benzodiazepine use are for 2009/10 (UK Focal Point, 2011). In Wales, local and national estimates for 2009/10 for long duration or regular use of heroin, other opioids, crack cocaine and/or cocaine powder were published in 2011 (UK Focal Point, 2011). Estimates for Northern Ireland for 2004 were published in 2006 and cover problem opioid and/or problem cocaine powder use (UK Focal Point, 2006).

Based on the 2011/12 English estimate (Hay et al., 2014) and the 2009/10 Scottish and Welsh estimate (Information Services Division, 2011, Welsh Assembly Government, 2011), it is estimated that there are 371,279 (CI: 364,418 – 388,306) HRDUs in the UK (ST07).⁸⁵

4.2 Prevalence of and trends in high risk drug use

4.2.1 Estimates of high risk drug use in England

In England, new national and subnational estimates of the prevalence of OCU⁸⁶ for 2011/12 were published, with separate estimates available for opioid use, crack cocaine use and injecting drug use (Hay et al., 2014).

⁸³ See: <http://www.emcdda.europa.eu/stats11/pdu/methods>

⁸⁴ Including illicit and prescribed methadone

⁸⁵ Excluding Northern Ireland (see section 4.2.4)

⁸⁶ HRDU according to the EMCDDA definition

Of the estimated 293,879 OCUs in England (equivalent to 8.4 per thousand population aged 15 to 64), 256,163 (87%) use opioids (many in addition to being crack cocaine users). While a slight majority of OCUs are estimated to use crack cocaine, the proportion who are estimated to only use crack cocaine (i.e. who do not also opioids) is relatively small (13%) compared with those only using opioids and not crack cocaine (43%). It is estimated that 87,302 OCUs inject; equivalent to 30% of the total high risk drug use population.

Table 4.1: The estimated number of opioid and/or crack cocaine users, opioid users, crack cocaine users and drug injectors and rates per 1,000 population aged 15 to 64 in England, 2011/12

	ESTIMATE	95% CI	RATE	95% CI
Opioid and/or crack cocaine users (OCUs)	293,879	291,029 - 302,146	8.40	8.32 - 8.63
Opioid users	256,163	253,751 - 263,501	7.32	7.25 - 7.53
Crack cocaine users	166,640	161,621 - 173,706	4.76	4.62 - 4.96
Injectors of opioids and/or crack cocaine	87,302	85,307 - 90,353	2.49	2.44 - 2.58

Source: Hay et al., 2014; ST07

Table 4.2 outlines changes in the prevalence of the nationally produced estimates of HRDU published in England since 2004/05. Between 2010/11 and 2011/12 all estimates showed a decrease in the number of HRDUs and this decrease was statistically significant⁸⁷ for the number of injectors of opioids and/or crack cocaine.

Table 4.2: The estimated number of opioid and/or crack users, opioid users, crack cocaine users and drug injectors aged 15 to 64 in England; 2004/05, 2005/06, 2006/07, 2008/09, 2009/10, 2010/11 and 2011/12

	2004/05	2005/06	2006/07	2008/09	2009/10	2010/11	2011/12
Opioid and/or crack cocaine users	327,466	332,090	328,767	321,229	306,150	298,752	293,879
Lower bound	325,945	324,546	322,128	316,684	299,094	294,858	291,029
Upper bound	343,424	346,345	340,196	329,025	316,916	307,225	302,146
Opioid users	281,320	286,566	273,123	262,428	264,072	261,792	256,163
Lower bound	279,753	281,668	268,530	258,782	260,023	259,260	253,751
Upper bound	292,941	299,394	283,560	268,517	271,048	269,025	263,501
Crack cocaine users	192,999	197,568	180,618	188,697	184,247	170,627	166,640
Lower bound	188,138	190,786	175,823	182,894	177,534	165,877	161,621
Upper bound	210,763	208,322	189,442	196,506	195,526	176,692	173,706
Opioid and/or crack cocaine users who inject	137,141	129,977	116,809	n/a	103,185	93,401	87,302
Lower bound	133,118	125,786	114,637	n/a	100,085	90,974	85,307
Upper bound	149,144	137,034	121,279	n/a	107,544	96,757	90,353

Source: Hay et al., 2008; Hay, et al., 2010, 2011; Hay et al., 2013; Hay et al., 2014; ST07

⁸⁷ P<0.05 level

Variation in high risk drug use across government regions

Similar to previous years, estimates of HRDU show marked variation in prevalence rates across the English government regions for all estimates (Hay et al., 2014). Yorkshire and Humber had the highest rates of both opioid use and opioid and/or crack use (9.30 per 1,000 [CI: 8.91 – 9.86] and 10.44 per 1,000 [CI: 10.05 – 11.02] respectively). The East of England had the lowest rates for opioid and/or crack use and injecting drugs use (4.99 per 1,000 [CI: 4.60 – 5.43] and 1.75 per 1,000 [CI: 1.58 – 1.95] respectively). The North East had the lowest rates of crack cocaine use (3.24 per 1,000 [CI: 2.69 – 3.83]) but the highest rates of injecting drug use (3.70 per 1,000 population [CI: 3.47 – 3.95]). The highest rates of crack cocaine use were observed in London (6.96 per 1,000 population [CI: 6.65 – 7.29]) and was more than double that of the area with the lowest rates.

Variation in high risk drug use across age groups

Since 2006/07 there has been a series of statistically significant decreases in the estimated number of OCUs aged 15 to 24 years old between each of the sweeps (Table 4.3). Between 2010/11 and 2011/12 there were statistically significant decreases in the estimated number of 15 to 24 year old OCUs in the East of England, North East, North West, West Midlands and Yorkshire and Humberside (Hay et al., 2014). In the 25-34 age group, there have also been a series of statistically significant decreases since 2006/07. For this age group between the years 2010/11 and 2011/12 these decreases were significant in the North East, North West and South West. Since 2006/07 there has been a statistically significant increase in the number of estimated OCUs aged 35-64 years. And for this age group between 2010/11 and 2011/12 significant increases were observed in the North East, North West and South West. This year-on-year increase in the estimated numbers of OCUs in the oldest age group, along with reductions in the youngest age group, is suggestive of an ageing cohort of OCUs and is in line with treatment data that suggests new presentations for OCUs are declining, particularly among young adults (see section 5.4.1).

Table 4.3: The estimated number of opioid and/or crack cocaine users by age group in England, 2006/07, 2008/09, 2009/10, 2010/11 and 2011/12

Year	15 TO 24 YEARS		25 TO 34 YEARS		35 TO 64 YEARS	
	Estimate	95% CI	Estimate	95% CI	Estimate	95% CI
2006/07	60,672	59,245-63,598	139,284	136,139-144,344	128,810	125,982-133,641
2008/09	55,145	55,104-58,618	129,141	126,101-131,926	136,943	134,091-140,083
2009/10	47,173	46,944-50,798	121,636	117,920-125,442	137,341	133,424-141,512
2010/11	41,508	39,859- 43,141	113,466	110,867 -116,238	143,778	140,952- 147,331
2011/12	32,628	31,168-36,992	109,124	106,530-111,795	152,127	148,576-155,156

Source: Hay et al., 2008, 2010, 2011, 2013, 2014; ST07

Despite increases in the estimated numbers of OCUs aged over 35 years old, the highest prevalence rate continues to be amongst those in the 25 to 34 age group (Table 4.4).

Table 4.4: Prevalence rate per 1,000 population of opioid and/or crack cocaine users by age group in England, 2011/12

15 TO 24 YEARS			25 TO 34 YEARS			35 TO 64 YEARS		
Rate	95% CI		Rate	95% CI		Rate	95% CI	
4.71	4.50	5.35	15.18	14.82	15.56	7.28	7.11	7.43

Source: Hay et al., 2014; ST07

4.2.2 Estimates of high risk drug use in Scotland

National and local estimates of the prevalence of HRDU in Scotland for 2012/13 are due to be published in October 2014. Estimates are for problematic opioid and/or illicit benzodiazepine use amongst individuals aged between 15 and 64 years old.⁸⁸ Previous estimates have been published for the calendar years 2000, 2003, 2006 and financial year 2009/10 (Information Services Division, 2011). For the most recent estimate, see UK Focal Point report 2012 (UK Focal Point, 2012).

4.2.3 Estimates of high risk drug use in Wales

National HRDU estimates for Wales for the period 2009/10 were published by the Welsh Government in October 2011 covering 'long duration or regular use of opioids, cocaine powder and/or crack cocaine' (UK Focal Point, 2012, Welsh Assembly Government, 2011). Work is on-going, utilising the 2009/10 problematic drug use data for Wales, to establish and agree robust methods for estimating the prevalence of both problematic and injecting drug use in future years. These refreshed estimates are due to be published late October 2014.

4.2.4 Estimates of high risk drug use in Great Britain

In 2014, the UK Focal Point revised the methodology to calculate UK estimates of HRDU. Previous UK estimates have taken the approach of summing published figures of both the reference population, and the number of HRDUs from each devolved administration, to arrive at a UK estimate of HRDU. These estimates were based on different years of data and this approach created an artificially derived UK population estimate. From 2014 onwards, population estimates that correspond to the latest year of HRDU estimate will be utilised when calculating a UK HRDU estimate. Furthermore, as opposed to summing the number of HRDU for each of the published estimates, the latest published rates of HRDU from each devolved administration will be applied to the most recent population estimate. This slight methodological change is unlikely to result in any major changes to the estimate.

Following the UK 2011 census, the Office for National Statistics (ONS) published updated population estimates covering the period 2001-2010.⁸⁹ Considering the changes to the UK HRDU methodology, and in turn the resulting comparability of trends, the UK Focal Point have retrospectively amended all UK HRDU estimates based on these refreshed population estimates with the aim of increasing comparability across years.

Based on the above approach, combining the 2011/12 estimate for England (Hay et al., 2014) and the 2009/10 estimates for Scotland and Wales (Information Services Division, 2011, Welsh Assembly Government, 2011)⁹⁰ it is estimated that there are a total 371,279 (CI: 364,418 – 388,306) HRDUs in the UK,⁹¹ a rate of 9.16 per 1,000 population (CI: 8.99 – 9.58) aged 15-64 (Table 4.5).

Table 4.5: The estimated number of high risk drug users in Great Britain: number and rate per 1,000 population aged 15 to 64, by country

COUNTRY	ESTIMATE*	95% CONFIDENCE INTERVAL		RATE	95% CONFIDENCE INTERVAL	
England	293,879	291,029	302,146	8.40	8.32	8.63
Scotland	59,600	58,300	61,000	17.15	16.78	17.55
Wales	17,589	13,850	25,580	9.08	7.15	13.21
Great Britain	371,279	364,418	388,306	9.16	8.99	9.58

*These refer to published estimates except in the case of Great Britain which is derived using the method outlined in section 4.2.4

Source: Hay et al., 2014; Information Services Division, 2011; Welsh Assembly Government, 2011; ST07

⁸⁸ High risk drug use is defined as the "problematic use of opioids (including illicit and prescribed methadone use) and/or the illicit use of benzodiazepines and implies routine and prolonged use as opposed to recreational and occasional drug use".

⁸⁹ See: http://www.ons.gov.uk/ons/dcp171778_345500.pdf

⁹⁰ Published national estimates are listed in the corresponding rows of table 4.5

⁹¹ Northern Ireland have been excluded due to the age of latest estimate

Trends in the prevalence of high risk drug use in Great Britain

Table 4.6 shows the HRDU estimates for Great Britain since 2007 based on the revised methodology listed in section 4.2.4.⁹² The 'year of estimate' refers to the year the estimate was reported by the UK Focal Point rather than the year the estimate is for. Please see footnotes for the year that the estimates correspond to.

Between 2007 and 2009, there was an increase in HRDU in Great Britain from 399,150 (CI: 397,267 – 420,767) to 404,876 (CI: 393,088 – 430,575) but this has since declined and is now estimated to be 371,279 (CI: 364,418 – 388,306) in the 2014 estimate. This also represents a reduction in the rate per 1,000 population from 10.41 (CI: 10.36 – 10.98) in the 2007 estimate to 9.16 (CI: 8.99 – 9.58) in the 2013 estimate. These decreases are in line with general decreases in drug-related deaths (see section 6.4.1) and the number of new presentations to treatment for the problematic use of opioids (see section 5.4.1).

Table 4.6: The estimated number of high risk drug users: number and rate per 1,000 population, aged 15 to 64 in Great Britain, by year of estimate*

YEAR OF ESTIMATE**	ESTIMATE	95% CONFIDENCE INTERVAL		RATE	95% CONFIDENCE INTERVAL	
2007 ⁹³	399,150	397,267	420,767	10.41	10.36	10.98
2008 ⁹⁴	404,832	396,566	424,904	10.45	10.23	10.96
2009 ⁹⁵	404,876	393,088	430,575	10.34	10.04	11.00
2010 ⁹⁶	396,793	386,600	418,982	10.04	9.78	10.60
2011 ⁹⁷	379,953	369,114	399,647	9.54	9.27	10.04
2012 ⁹⁸	385,067	373,827	404,498	9.62	9.34	10.11
2013 ⁹⁹	378,269	370,101	395,347	9.40	9.19	9.82
2014 ¹⁰⁰	371,279	364,418	388,306	9.16	8.99	9.58

*Data has been revised according to new methodology and will therefore not match previous reports

**Refers to the year in which the estimate was produced rather than the year the estimate relates to

Source: ST07

⁹² Due to the revised methodology, these estimates will not match previous reports

⁹³ 2007 estimate is based on estimates of opioids and/or crack cocaine use in England for 2004/05 (Hay et al., 2006), and opioid and/or benzodiazepine use in Scotland, 2003 (Hay, Gannon, McKeganey, Hutchinson, & Goldberg, 2004). Estimates for Wales are extrapolated from the estimates for England.

⁹⁴ 2008 estimate is as 2007 above except for England which refers to 2005/06 (Hay et al., 2007).

⁹⁵ 2009 estimate is based on estimates of opioids and/or crack cocaine use in England for 2006/07 (Hay et al., 2008), opioid and/or benzodiazepine use in Scotland for 2006 (Hay, Gannon, Casey, & McKeganey, 2009) and long duration or regular use of opioids, powder cocaine and/or crack cocaine in Wales for 2006/07 (Welsh Assembly Government, 2009).

⁹⁶ 2010 estimate is as 2009 above except for England which is based on estimates of opioids and/or crack cocaine use for 2008/09 (Hay, Gannon, Casey, & Millar, 2010).

⁹⁷ 2011 estimate is based on estimates of opioid and/or crack cocaine use in England for 2009/10 (Hay, Gannon, Casey, & Millar, 2011), opioid and/or benzodiazepines use in Scotland for 2006 (Hay et al., 2009), and long duration or regular use of opioids and/or crack cocaine/cocaine powder in Wales for 2009/10 (Welsh Assembly Government, 2011).

⁹⁸ 2012 estimate as 2011 above except for Scotland which is based on estimates of opioid and/or benzodiazepine misuse in Scotland for 2009/10 (Information Services Division, 2011).

⁹⁹ 2013 estimate is as 2012 above except for England which is based on estimates of opioid and/or crack cocaine use in 2010/11 (Hay, Rael dos Santos, & Millar, 2013).

¹⁰⁰ 2014 estimate as 2013 above except for England which is based on estimates of opioid and/or crack cocaine use in England for 2011/12 (Hay, Rael dos Santos, & Worsley, 2014).

4.2.5 Research

Estimating the number of people who inject drugs in Scotland

Overstall and colleagues explored methods to estimate the prevalence of injecting drug use in Scotland using data from hospital records, the Scottish Drug Misuse Database (SDMD) (see section 5.4.2) and the hepatitis C virus (HCV) diagnosis database (Overstall et al., 2014). The authors note the difficulties that arise when using figures such as the HCV data whereby people who inject drugs (PWID) were identified as those who had listed injecting as their HCV risk factor, thus including former PWID in addition to the target population of current PWID. The authors present a method to account for the possibility of censoring occurring for a single data-source (i.e. a single data-source may observe non-target individuals) by explicitly accounting for the censoring within the modelling structure for the HCV diagnosis database and compare these estimates to previously produced estimates.

4.3 Characteristics of high risk drug use

4.3.1 Characteristics of clients accessing needle and syringe programmes

PWIDs in the UK are considered HRDUs as they are at elevated risk of fatal and non-fatal overdose, contracting blood-borne virus (BBV) and are subject to poorer health-related quality of life. There are emerging concerns of injecting drug use by people who inject image-and-performance-enhancing drugs (IPED).

Drugs injected by clients accessing needle and syringe programmes in Scotland

Information on the type of drug injected by service users was reported in the *Injecting Equipment Provision (IEP) in Scotland Survey* (Information Services Division, 2014b) (see section 7.3.1). Information on the type of drug injected was collected by 160 (55%) of the 290 IEP outlets in 2012/13.¹⁰¹ Of the IEP outlets that provided information on the type of drug injected, the vast majority reported that at least some clients injected opioids; 158 (99%). Seventy-two per cent ($n=115$) of all IEP outlets reported that some clients attending their service injected stimulants, and this was comparable to 2011/12. Eighty-one per cent ($n=130$) of all IEP outlets who collected information on type of drug injected reported that some of their clients injected IPED. This has decreased slightly from 84% of outlets that reported clients who injected IPED in 2011/12.

Clients accessing needle and syringe programmes in Northern Ireland who use image-and-performance-enhancing drugs

Information on the type of drug injected by service users from the Northern Ireland Needle and Syringe Exchange Scheme (see section 7.3.1) suggests a significant number of visits are made for people accessing needle and syringe programmes (NSP) to inject IPEDs (personal communication - Health and Social Care Northern Ireland). In 2012/13, visits for IPEDs accounted for 53% of all known visits compared to 58% of all known visits in 2011/12.

Drugs injected by clients accessing needle and syringe programmes in Wales

Data from the Welsh Harm Reduction Database (HRD) (see section 7.3.1) showed that in 2013/14 just under 10,000 PWID regularly accessed statutory and voluntary sector NSP services. Of these, 48% reported a primary drug of IPEDs; 41% opioids; eight per cent stimulants and two per cent new psychoactive substances (NPS). The gender profile varied by primary drug type with males accounting for 98% of IPED use compared with 79% of primary opioid use, 77% of primary stimulant use and 69% of primary NPS use. The age of PWID was also associated with primary drug type: IPED use accounted for 25% of those aged under 25 years whilst the majority of PWID reporting primary opioid use were aged between 25-44 years.¹⁰²

¹⁰¹ 18 of the 160 reporting areas reported 2011/12 figures.

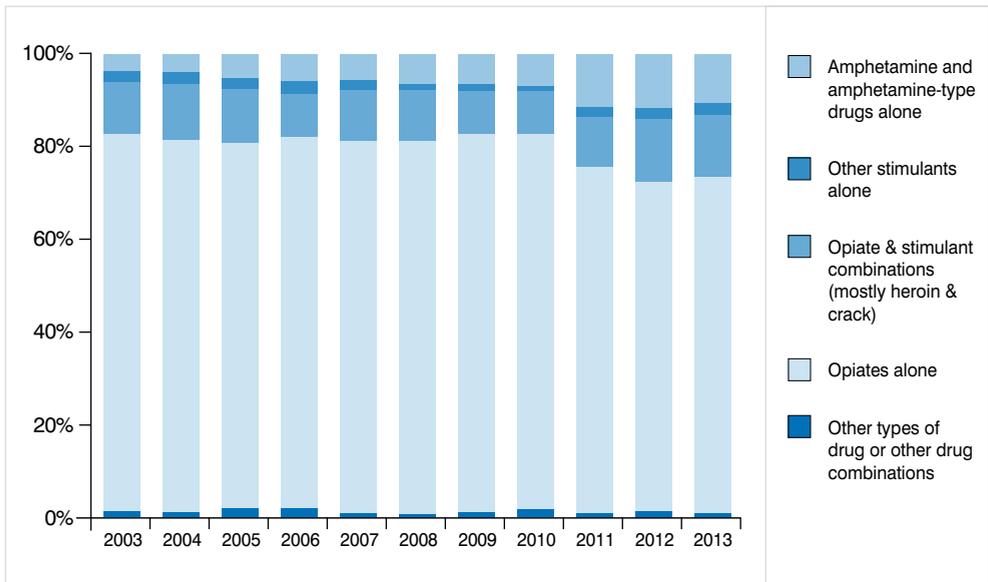
¹⁰² Harm Reduction Database Wales; Needle and Syringe Programme 2013-14 available at: www.publichealthwales.org/substancemisuse

The illicit use of anabolic steroids among people accessing needle and syringe programmes in the UK

Data from the Unlinked Anonymous Monitoring (UAM) sub-survey of injectors of IPEDs show that in 2012/13, 95% had injected anabolic steroids, 35% had injected growth hormones, 24% had injected human chorionic gonadotropin (hCG) and 12% had injected melatonin (Public Health England, 2014b). The 2013/14 *Crime Survey for England and Wales* (CSEW) (see section 2.2.1) estimated that 0.2% of people aged 16–59 years had used anabolic steroids in the past year, but there is an emerging consensus that this is an under-estimate (Home Office, 2014b).

Kimergard and McVeigh conducted face-to-face interviews with 24 users of anabolic steroids who engaged with NSP in the UK (Kimergard & McVeigh, 2014). Principal aims of the study were to explore the experiences of anabolic steroid users and investigate how ‘risk environments’¹⁰³ produce harm. The authors highlighted that body satisfaction was an important factor in deciding to initiate the use of anabolic steroids. It was shown that many users were unaware of the potential dangers of using drugs from the illicit market, whereas some had adopted a range of strategies to negotiate the hazards relating to the use of adulterated products. These included self-experimentation to gauge the perceived efficacy and unwanted effects of these drugs. Viewpoints, first-hand anecdotes, norms and practices among groups of steroid users created boundaries of ‘sensible’ drug use, but also promoted practices that increased the chance of harms occurring. Established users encouraged young users to go to harm reduction services but, at the same time, promoted risky injecting practices in the belief that this would enhance the efficacy of anabolic steroids. The authors conclude that current steroid-related viewpoints and practices contribute to the risk environment surrounding the use of these drugs and may undermine the goal of current public health strategies including harm reduction interventions.

Figure 4.1: Primary drug type injected*: England, Wales & Northern Ireland, 2003-2013



*Among those who had injected during the preceding 28 days.

Data Source: (Public Health England, Health Protection Scotland, Public Health Wales and Public Health Agency Northern Ireland, in press)

¹⁰³ A ‘risk environment’ framework promotes an understanding of harm, and harm reduction, as a matter of contingent causation. Harm is contingent upon social context, comprising interactions between individuals and environments.

4.3.2 Types of psychoactive drugs being injected

The types of psychoactive drugs being injected in the UK are changing. The main drugs injected in the UK are opiates and crack-cocaine (usually in combination with heroin) however there is evidence that the injection of amphetamines and amphetamine-type drugs has become more common in recent years. The proportion of people in England, Wales and Northern Ireland participating in the UAM Survey of people who inject drugs reporting injecting amphetamines and amphetamine-type drugs as their primary drug rose from 3.5% (56/1,603) in 2003 to 11% (150/1,395) in 2013, though opiates remained the most common primary drug (see figure 4.1). This is a concern as the injection of amphetamines and amphetamine-type drugs has been associated with higher levels of risk behaviours and lower levels of intervention uptake (see section 6.2.5).

4.3.3 Polydrug use among drug users in the UK

Polydrug use refers to the use of two or more psychoactive drugs in combination. Individuals often use more than one drug with the intention of enhancing or countering the effect of another drug. Risks of polydrug use are elevated due to an increase in side effects and drug synergy.

Data from the *Scottish Crime and Justice Survey* (SCJS) (see section 2.2.2) suggest that among those who take drugs in Scotland, polydrug use is common (Scottish Government, 2014d). Of those taking more than one drug in the last year,¹⁰⁴ 54% of all adults reported that they had taken more than one different drug at the same time. Of those reporting taking at least one drug in the last year,¹⁰⁵ around three in five (64%) reported that they had consumed alcohol at the same time as taking drugs. Taking alcohol in combination with drugs was more common in males than females (66% and 60% respectively), and those aged 16-24 were more likely to report consuming alcohol at the same time as taking drugs in the last year (68%) in comparison to 64% of those aged 25-44, 52% of those aged 45-59 and 54% of those over 60.

Data from the CSEW (see section 2.2.1) show that in the years 2010/11 and 2011/12 combined, seven per cent of respondents who used drugs in the last year said that the last time they used drugs, they used more than one drug at the same time (Home Office, 2012a). Similar to the Scottish data, 61% of respondents who used drugs in the last year used alcohol at the same time the last time they took drugs. Almost all (95%) cases of simultaneous polydrug use involved the use of one or more of the following substances; cannabis (73%); powder cocaine (49%); ecstasy (37%); and/or amphetamines (19%).

4.3.4 Groin injecting in England, Wales and Northern Ireland

In 2013, 38% of the participants in the UAM Survey (see section 6.2) reported injecting into their groin during the preceding four weeks and this has remained relatively stable since 2003 (Public Health England, 2014a). By country, the proportion injecting in to the groin is as follows: England 39% (95% CI, 36%-41%); Wales, 29% (95% CI, 22%-37%); and Northern Ireland, 26% (95% CI, 15-42%). Across England, there are differences in the proportion reporting injecting into their groin ranging from 27% (95% CI, 20%-34%) in London to 49% in Yorkshire and Humber (95% CI, 42%-56%).

4.3.5 High risk drug use among specific groups

Substance misuse in looked after children

Since 2006, the Department for Education¹⁰⁶ has collected information on the number of looked after children (LAC) in England that were identified as having a substance use problem. In the year ending 31 March 2013, 3.5% of LAC ($n=1,660$) were identified as having a substance misuse problem (drugs or alcohol) compared to 4.1% in 2012 and 4.2% in 2011 (Department for Education, 2013a). Of those identified as having a substance use problem, 58% ($n=950$) received an intervention for the problem with a further 34% ($n=570$) refusing the intervention which was offered (compared with 55% and 31%

¹⁰⁴ Base: 206

¹⁰⁵ Base: 490

¹⁰⁶ Previously known as the Department for Children, Schools and Families (DCSF)

respectively in 2012). Substance misuse was more common amongst older LAC with 11% ($n=1,130$) of those aged 16 and 17 who had been looked after continuously for 12 months, being identified as having a substance misuse problem. Similarly to data outlining young people in structured treatment for substance misuse (see section 5.5.1) boys in this age group were more likely to have a substance misuse problem than girls (12% and nine per cent respectively). Data from the National Drug Treatment Monitoring System (NDTMS) in England (see section 5.4.1) show that in 2012/13, 923 young people aged 18 and under in specialist substance misuse services were recorded as being looked after, representing five per cent of all young people in treatment (Public Health England, 2013d).

The use of benzodiazepine and methadone use during and after pregnancy in Scotland

Chandler and colleagues aimed to explore the ways in which opioid-dependent parents accounted for their use of opioids (namely methadone) and benzodiazepines during and after pregnancy using longitudinal qualitative interviews ($n=19$) (Chandler et al., 2014). Participants were recruited in Scotland and interviews were held during the antenatal and post-natal period and focused on parenting within the context of problem drug use. Findings suggested that the majority of participants described using benzodiazepines in addition to opioids with almost all reporting a desire to stop or reduce opioids. The desire to stop or reduce the use of benzodiazepines was rarely prioritised and was often portrayed as unproblematic and acceptable within a family context. This was in stark contrast to the opinions expressed by participants regarding the use of opioids. The authors suggest that careful attention should be paid to the way in which policy and practise influences the diversion of attitudes and beliefs towards use of opioid substitution treatment (OST) and benzodiazepines in the parental context.

Substance misuse among men who have sex with men

Data indicate that drug use is generally more common among LGBT communities, including MSM, than in the general population. Historically injecting drug use was thought to be less common among MSM. Recently there have been concerns about emerging patterns of drug use, including injecting drug use, and risk among some groups of MSM (see section 6.2.5).

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

5.1 Introduction

United Kingdom (UK) drug strategies identify treatment as being effective in tackling problem drug use and therefore seek to improve its quality and effectiveness. *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (Department of Health England and the devolved administrations, 2007) continues to provide guidance for clinicians delivering drug treatment in the UK. With an increasing focus on recovery oriented treatment, UK countries have developed further guidance to support treatment delivery, including, in England, *Medications in Recovery* (National Treatment Agency for Substance Misuse, 2012).

Drug treatment in the UK encompasses a range of available treatments and services including community (and primary-care) based prescribing, community one-to-one and group-based psychosocial interventions to support recovery, inpatient treatment, day programmes, and quasi and fully residential drug treatment and rehabilitation support. Prescribing (principally methadone) for drug dependence is provided for stabilisation, detoxification, maintenance and relapse prevention. The National Institute for Health and Care Excellence (NICE)¹⁰⁷ also provides guidance on a number of drug-treatment related topics and these are reviewed and updated regularly based on the latest evidence. Treatment interventions in any given area are expected to include advice and information, care planning, psychosocial interventions, community prescribing, inpatient drug treatment and residential rehabilitation. In addition, drug misusers should be offered relapse-prevention and aftercare programmes; hepatitis B vaccinations; testing for hepatitis B and C and HIV; access to hepatitis and HIV treatment; and needle exchange. Oral opioid substitution treatment (OST) with methadone is the most common pharmacological treatment used in treating heroin addiction; buprenorphine is also prescribed and injectable opioids, such as injectable methadone and injectable diamorphine, are also available but are not commonly used. Naltrexone¹⁰⁸ is recommended as a treatment option to prevent relapse in detoxified formerly opioid-dependent people who are highly motivated to remain in an abstinence-based programme.

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

Treatment Demand Indicator (TDI) data on numbers presenting to treatment are from four separate systems: the National Drug Treatment Monitoring System (NDTMS) in England, the Scottish Drug Misuse Database (SDMD); the Welsh National Database for Substance Misuse (WNDSM); and the Northern Ireland Drug Misuse Database (NIDMD). Data from the four systems are combined into UK totals for reporting to the European Monitoring Centre Drugs and Drug Addiction (EMCDDA). Continuous national data are available from 2003/04.

5.2 General description, availability and quality assurance

5.2.1 Strategy and policy

Public Health England

On 1st April 2013, the National Treatment Agency for Substance Misuse (NTA)'s functions transferred to a new organisation, Public Health England (PHE), an executive agency of the Department of Health (DH). PHE was established to bring together public health specialists from more than 70 organisations into a single public health service (UK Focal Point, 2013). The first full year as PHE concluded at the end of March 2014 and in 2014, the Alcohol and Drugs Division expanded and became the Alcohol, Drugs and Tobacco Division.

¹⁰⁷ Formerly the National Institute for Health and Clinical Excellence

¹⁰⁸ A drug that blocks the effects of opioids and alcohol

Public Health Outcomes Framework England

The *Public Health Outcomes Framework* (PHOF)¹⁰⁹ sets out the Secretary of State's strategic direction in meeting two high level objectives:

- to increase healthy life expectancy; and
- to reduce differences in life expectancy and healthy life expectancy between communities.

This includes indicators which are explicitly related to drugs; successful completion of treatment for opioid and non-opioid users who do not return within six months.

5.2.2 Quality Standards

A review of how treatment services are monitored inspected and regulated

In June 2013 the Care Quality Commission (CQC) conducted a consultation, 'A new start',¹¹⁰ to examine how care services, including substance misuse treatment services based in hospitals, communities and residential rehabilitation, are monitored, inspected and regulated. Following the consultation it was proposed that five key questions should be asked of all services; are they safe; effective; caring; responsive to people's needs; and well-led. Under new proposals substance misuse treatment services will be subject to expert inspections and be rated on a four point scale (outstanding, good, requires improvement and inadequate) for each of the five key questions. These ratings will be shared with service users and their families and carers, the public, treatment providers, commissioners and other stakeholders.

The CQC are planning to conduct pilot inspections in early 2015 which will be evaluated and used to draft guidelines to providers of substance misuse treatment services. It is proposed that the new guidance and model will be rolled out to all providers in April 2015.

National Institute for Health and Care Excellence review of public health guidance

In April 2014, NICE reviewed the guidance '*Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people*'.¹¹¹ Stakeholders and an expert group agreed that there is sufficient evidence to update several of the recommendations. The expert group and stakeholders also felt that there should be standardisation of specified age group bands to reflect current public sector practice, and additionally, that the language of the recommendations needs updating to reflect the current policy context and delivery structures.

Scotland Health Improvement, Efficiency, and Access to Services and Treatment standard

Scotland's Health Improvement, Efficiency, and Access to Services and Treatment (HEAT)¹¹² alcohol and drug treatment waiting times standard states that 90% of clients will wait no longer than three weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (Information Services Division, 2014c). Getting people into treatment quickly for drug-related problems is a priority for the Scottish Government as evidence suggests this is likely to result in improved client outcomes. The HEAT target was introduced, and exceeded (in March 2013). This target requires the National Health Service (NHS) (and wider partners) to reduce waiting times for drug (and alcohol) treatment to three weeks. The Scottish Government expects sustained performance, and the target evolved into a HEAT Standard for 2013/14 and beyond.

¹⁰⁹ See: <https://www.gov.uk/government/publications/public-health-outcomes-framework-february-2014-quarterly-data-update>

¹¹⁰ See: http://www.cqc.org.uk/sites/default/files/documents/cqc_consultation_2013_tagged_0.pdf

¹¹¹ See: <http://www.nice.org.uk/guidance/PH4>

¹¹² HEAT is an internal NHS performance management system that includes targets that support National Outcomes.

NHS Boards are accountable to the Scottish Government for achieving HEAT targets.

See: <http://www.scotland.gov.uk/Topics/archive/law-order/Drugs-Strategy/recovery/HEAT>

Data from January to March 2014 showed that 94% of the 4,032 people who attended an appointment for drug treatment waited three weeks or less (Information Services Division, 2014c).

Scotland - Quality Principles

The Scottish Government has developed an alcohol and drugs quality improvement framework to ensure quality in the provision of care, treatment and recovery services, as well as quality in the data that will evidence the outcomes people are achieving (Scottish Government, 2014f).

The *Quality Principles* are the first step towards making the quality improvement framework a reality, setting out what people can expect when they access a drug and alcohol treatment or support service in Scotland. Fundamentally, the principles aim for a person-centred, holistic, recovery-focused approach where services and those seeking to address their problematic substance use work in partnership to achieve agreed outcomes.

There are eight overarching principles, each with a set of supporting statements and all underpinned by a recovery philosophy. The broad ethos of the principles being:

- an emphasis on high-quality, evidence-informed interventions;
- workers who are appropriately trained and supervised;
- comprehensive strengths-based assessments;
- person-centred recovery plans that are agreed and regularly reviewed; and
- the opportunity for family members to be involved in recovery (if this is helpful to the individual).

5.2.3 Guidelines

Optimising opioid substitution treatment

In January 2014, PHE issued its fourth briefing in the *Turning Evidence into Practice* series with a focus on OST (Public Health England, 2014o). The briefing acknowledges that even though OST is the most effective intervention for heroin use and dependence, the medication itself, and accompanying psychosocial/recovery interventions, need to be optimised to give the user the best chance of recovery and sustained abstinence. The briefing focuses on elements that can be improved and provides key messages to help achieve this. The content is drawn from authoritative guidance, published evidence and service provider feedback.

Improving access to mutual aid

In May 2014, PHE issued a new toolkit of resources for use by commissioners and the drug treatment workforce with the intention of strengthening the sector's links with mutual aid organisations and to ensure that everyone in treatment has access to this mode of support (Public Health England, 2014e). The guide clarified the role that commissioners and service managers can play in supporting the further development of mutual aid, and the practical steps they can take to ensure all service users are provided with the opportunity to explore and engage with local mutual aid groups. The report acknowledges the NICE recommendation that treatment staff should not only routinely provide service users with information about mutual aid groups but also encourage and facilitate all their clients to engage with mutual aid.

The role of addiction specialist doctors in recovery oriented treatment services

PHE published a new resource designed to assist commissioners, providers and clinicians in maximising the value that addiction specialist doctors can bring to local recovery orientated treatment systems (Public Health England, 2014m). The resource was developed by a working group and builds on the standards described in *Delivering Quality Care for Drug and Alcohol Users: the roles and competencies of doctors* (Royal College of General Practitioners and Substance Misuse in Management in General Practice, 2013). The resource includes a checklist to support commissioners and providers in implementing the standards described in the resource, and the source publication.

Guidance for the use and reduction of misuse of benzodiazepines and other hypnotics and anxiolytics in general practice

In July 2014, Substance Misuse Management in General Practice (SMMGP) released a report to aid all clinicians and other practitioners in the use of, and reduction of misuse of benzodiazepines aimed at primary care. Other hypnotics and anxiolytics, including the “Z-drugs” (zopiclone, zolpidem, zaleplon and eszopiclone) are also briefly covered (Ford & Law, 2014).

Northern Ireland primary and secondary care opioid substitution treatment guidelines

In November 2013, the Public Health Agency (PHA) released refreshed guidelines intended for all those involved in providing pharmacological interventions as a component of drug misuse treatment (Health and Social Care Information Centre, 2013). The guidelines provide a framework for the treatment and support of opioid addicted individuals and inform the setting of benchmarks for establishing and maintaining a minimum standard of care.

The guidelines include detailed recommendations on a number of key topics which broadly fall under the following headings and can be seen below; patient-centred considerations, recommendations of good practice; and management of care.

Patient-centred considerations;

- patient eligibility;
- assessment of suitability;
- factors influencing the type of therapy (maintenance and detoxification);
- drug choice in maintenance;
- induction risks; and
- criteria for inpatient treatment

Recommendations of good practice;

- initiation of treatment;
- supervision vs take-home supply;
- on-going review and monitoring of stable patients;
- prescription validity;
- dispensing medications;
- supervision; and
- storage and disposal of methadone and buprenorphine

Management of care;

- management of patients across specialist services and primary care;
- missed doses;
- lost prescription/medicine;
- travelling abroad;
- reporting to regional database;
- sharing care with pharmacy;
- new patients;
- communication between pharmacists, prescribers and keyworkers;
- patient medication records;
- controlled drugs register;
- prescription processing;
- pharmacy standard operating procedure; and
- health information

Non-medical prescribing in the management of substance misuse

Since 2012, non-medical practitioners have been able to assess, diagnose and independently prescribe for the treatment of drug dependence.¹¹³ In 2014, PHE published guidance describing the systems and processes that enable safe and effective delivery of non-medical prescribing which replaces a 2007 NTA publication (National Treatment Agency for Substance Misuse, 2007, Public Health England, 2014i). The publication is intended for non-medical prescribers and all those with an interest in non-medical prescribing including aspiring non-medical prescribers, consultants and clinical leads, service managers, colleagues from different professions and service commissioners. The publication was prepared by an expert group convened by PHE alcohol, drugs and tobacco and the National Substance Misuse Non-Medical Prescribing Forum (NSMNMPF). The document defines clear parameters within which non-medical prescribing can be delivered safely and effectively within a recovery-oriented drug and alcohol treatment system.

Guidance for substance misuse management

The Substance Misuse and Associate Health (SMAH) unit worked with partners to produce and distribute guidance relating to key areas in substance misuse management and primary care. In 2014, as part of this series, SMAH produced four factsheets specifically on addiction to medicines. The factsheets focus on the problem;¹¹⁴ prevention;¹¹⁵ identification;¹¹⁶ and treatment.¹¹⁷ In summary, the factsheets aim to increase awareness among healthcare professionals for the potential misuse of prescription and over-the-counter medicines, identify risk factors associated with prescription medicine and over-the-counter abuse, explain how individuals abusing these classes of drug may be identified, guide the treatment of such individuals and provide practical advice on prescribing practices to reduce the risks of addiction to such medicines.

¹¹³ Prescribing diamorphine, cocaine and dipipanone for the treatment of addiction continues to be restricted.

¹¹⁴ See: http://www.rcgp.org.uk/courses-and-events/~media/Files/SMAH/RCGP%20Factsheet%201_artwork_v3_28Apr.ashx

¹¹⁵ See: http://www.rcgp.org.uk/courses-and-events/~media/Files/SMAH/RCGP%20Factsheet%202_artwork_v3_28Apr.ashx

¹¹⁶ See: http://www.rcgp.org.uk/courses-and-events/~media/Files/SMAH/RCGP%20Factsheet%203_artwork_v3_28Apr.ashx

¹¹⁷ See: http://www.rcgp.org.uk/courses-and-events/~media/Files/SMAH/RCGP%20Factsheet%204_artwork_v3_28Apr.ashx

5.2.4 Evaluations and Reviews

Advisory Council on the Misuse of Drugs Recovery Committee

The Recovery Committee of the Advisory Council on the Misuse of Drugs (ACMD) was formed in response to an invitation from the Inter Ministerial Group on Drugs (IMG). It has been created as a standing committee of the ACMD with membership drawn from the Council plus co-opted external expertise. The second report from the Committee was published in November 2013 entitled '*What recovery outcomes does the evidence tell us we can expect from drug and alcohol dependence?*' (Advisory Council on the Misuse of Drugs, 2013d). The paper builds on the Committee's first report which scoped evidence around the topic of recovery: '*Recovery from drug and alcohol dependence: an overview of the evidence*' (Advisory Council on the Misuse of Drugs, 2013c). The most recent report suggests that the concept of recovery encompasses more than overcoming drug dependence alone and covers a number of other wider outcome domains such as paid employment and leading a meaningful life. The committee proposed that definitions of recovery that do not include reference to a wide range of outcomes are likely to lead to ineffective intervention strategies and should be considered inadequate.

5.3 Access to Treatment

5.3.1 Changes to the Treatment Demand Indicator and reporting

The TDI records the number of clients presenting to a treatment centre in a particular year, but does not provide information on clients who remain in treatment without starting a new treatment episode.¹¹⁸ Data presented are from the NDTMS in England, the SDMD in Scotland, the WNDSM¹¹⁹ in Wales and the NIDMD in Northern Ireland. Data are presented for the UK as a whole unless otherwise stated.¹²⁰ Continuous national data are available from 2003/04.

From the reporting year 2014, the UK has changed the period it reports from financial to calendar year primarily to align with other EU member states¹²¹ and the TDI methodology underwent significant change.¹²² Due to changes in the TDI protocol, data from 2014 are not directly comparable to previous national reports.¹²³

In 2013, 101,753 clients presented to treatment in the UK.¹²⁴ Similarly to previous years, 75.6% were male and 34.6% had never received treatment previously.

5.3.2 Treatment centres

A total of 1,212 treatment centres reported through national treatment monitoring systems in the UK during 2013. Of these, 79.2% provided outpatient services ($n=960$), nine per cent provided inpatient services ($n=112$) and six per cent were general practitioner (GP) services ($n=75$) (ST34).

Table 5.1 shows that 85% of all clients presenting to drug treatment in the UK during 2013 were treated in outpatient centres. Opioid users make up a larger proportion of clients within inpatient and GP services than within outpatient services.

¹¹⁸ See: <http://www.emcdda.europa.eu/html.cfm/index65315EN.html>

¹¹⁹ Data from Wales include less structured treatments

¹²⁰ Percentages quoted are valid percentages

¹²¹ Northern Ireland and Scotland continue to report financial year

¹²² See: <http://www.emcdda.europa.eu/publications/manuals/tdi-protocol-3.0>

¹²³ Scotland does not include data for Glasgow and Clyde and Tayside

¹²⁴ Excluding Greater Glasgow and Clyde and Tayside

Table 5.1: Primary drug by centre type in the United Kingdom, 2013

DRUG	OUTPATIENTS		INPATIENTS		GP*		OTHER		TOTAL	
	n	%	n	%	n	%	n	%	n	%
Amphetamines	2,355	2.7	27	2.2	20	1.4	90	2.1	2,585	2.6
Benzodiazepines	1,643	1.9	24	1.9	10	0.7	231	5.4	2,577	2.6
Cannabis	24,048	27.7	44	3.5	89	6.1	1,222	28.3	26,618	26.8
Cocaine**	8,508	9.8	120	9.7	34	2.3	407	9.4	9,283	9.4
Crack cocaine	3,156	3.6	131	10.5	32	2.2	117	2.7	3,473	3.5
Opioids	42,696	49.3	861	69.3	1,249	85.6	1,969	45.6	49,871	50.3
Other	4,260	4.9	35	2.8	25	1.7	278	6.4	4,779	4.8
Sub Total	86,666	100	1,242	100	1,459	100	4,314	100	99,186	100
Not Known	213		2		3		11		2,567	
Total	86,879	85	1,244	1.2	1,462	1.4	4,325	4.3	101,753	100

*data are for England only

**includes cocaine powder and cocaine unspecified

Source: ST34

5.3.3 Characteristics of treated clients

The following data outlines the characteristics of clients seeking treatment in the UK and is based on data from ST34 and TDI.

Source of referral

As in previous years, the most common source of referral amongst clients starting a new episode of treatment in 2013 was self-referral (38.0%) with referral from the criminal justice system the next most common referral source (28.3%). Those presenting to treatment for the first time were more likely to have been referred by a GP than those previously receiving treatment (10.4% and 6.4% respectively). Those who had previously received treatment were more likely to have a criminal justice referral than first ever treatments (31.2% and 23.3% respectively).

Among all treatment presentations, referrals to treatment for opioids were more than twice as likely to occur from the criminal justice system as referrals to treatment for cannabis (52.1% and 25.8% respectively). Opioid referrals accounted for 71.1% of referrals made to treatment from drug treatment centres.

Drugs used

In 2013, around half of all treatment presentations in the UK were for primary opioid use (50.3%), with just over one quarter (26.8%) for primary cannabis use. However, the pattern is markedly different between those who report that they have been previously treated and those who do not, with cannabis being the most frequently reported primary drug amongst first ever presentations (48.6% compared to 15.3% of those reporting previous treatment). Almost one-fifth (19.7%) of new treatment presentations reported primary opioid use, compared to over two-thirds (66.6%) of previously treated clients.

New treatment entrants were more likely to report the primary use of stimulants compared to those who had been previously treated (6.5% and 3.8% respectively), and were also more likely to present with a primary substance of benzodiazepines (3.8% of new treatments compared to 1.9% of previously treated).

Secondary drugs

Crack cocaine

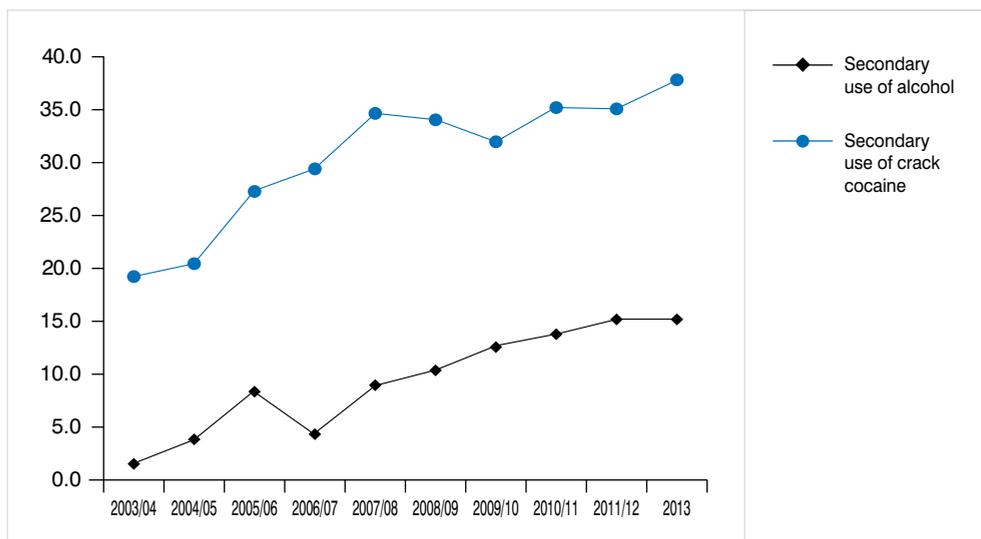
The number of primary heroin clients reporting secondary use of crack cocaine has been increasing since 2003/04 and in 2013 accounted for 37.7% of all primary heroin presentations (Figure 5.1).

Alcohol

Primary cocaine¹²⁵ clients were most likely to report secondary alcohol problems (38.8% of all clients). Other frequent secondary citations of alcohol occurred alongside cannabis and crack cocaine (32.5% of all presentations for both drugs). This supports evidence from general population surveys suggesting a link between alcohol and drug use (Home Office, 2014b). Overall, 22.7% of all clients presenting to treatment in 2013 reported a secondary alcohol problem.

Figure 5.1 shows the increase in the percentage of primary heroin presentations reporting a problem with alcohol (from 8.9% in 2007/08 to 15.6% in 2013). It is uncertain if this reflects an increase in prevalence of alcohol problems amongst this group or whether it is due to an increased awareness of the importance of alcohol issues amongst treatment providers and a change in recording practices. Given the prevalence of secondary alcohol problems amongst the general treatment population and the research evidence that suggests higher levels of alcohol problems amongst methadone users than the treatment data suggests (33%) (Sebanjo, Wolff, & Marshall, 2007), alcohol problems may be under-reported amongst this group.

Figure 5.1: The percentage of all heroin clients reporting secondary use of alcohol and secondary use of crack cocaine in the United Kingdom, 2003/04 to 2013



Source: ST34

Benzodiazepines

The number of presentations to treatment in the UK in 2013 reporting a secondary benzodiazepine problem ($n=6,038$) was over two and a half times greater than the number of presentations reporting a primary benzodiazepine problem ($n=2,577$). A large percentage of primary benzodiazepine users also reported secondary problems with other drugs; cannabis being the most frequently reported secondary drug (18.8% of primary benzodiazepine users, $n=459$). A large number of primary benzodiazepine users also cited problems with alcohol (10.9% of all primary benzodiazepine clients who reported use of a secondary drug; $n=267$).

¹²⁵ Cocaine powder and cocaine unspecified

Age

The mean age of treatment presentations in 2013 was 31.5 years (+/- 10.6 years). However, those who had never previously received treatment tended to be younger (27.2 years +/- 11.3 years). Of all clients accessing treatment males tended to be older than females (31.7 years +/- 10.5 years and 30.9 years +/- 10.8 years respectively), but the age across genders were more similar in new treatment entrants (27.0 years +/- 11.0 years in males and 27.6 years +/- 12.2 years in females).

Of all clients accessing treatment in 2013, those accessing treatment for heroin tended to be older than those accessing treatment for cannabis (35.4 years +/- 8.2 years and 23.3 years +/- 9.8 years respectively) and this was similar for newly presenting clients.

Age of first use

Among all those in treatment, the average age of first use of a drug was 20.0 years (+/- 7.6 years) and this was similar for males (19.8 years +/- 7.5 years) and females (20.4 years +/- 8.1 years) and was also similar among those who were new to treatment as well as those who had previously received treatment. In general, the age of first use of cannabis and volatile substances was lower than for other drugs (14.4 years +/- 3.8 years and 14.6 years +/- 5.6 years respectively for all those in treatment). This was similar regardless of gender and history of previous treatment.

Injecting status

The majority (62.5%) of clients presenting to treatment reported that they had never injected drugs with 13.6% reporting current injecting.¹²⁶ However, this varied as a function of treatment status (see Table 5.2). Primary opioid users account for 92.1% of current injectors with amphetamine users accounting for 2.5%.

Table 5.2: Injecting status amongst all clients entering treatment in the United Kingdom, 2013

INJECTING STATUS	NEW TREATMENT CLIENTS		PREVIOUSLY TREATED CLIENTS		ALL CLIENTS	
	n	%	n	%	N	%
Ever injected, but not currently	2,144	6.6	20,523	32.7	22,813	23.8
Currently injecting (in last month)	1,597	4.9	11,387	18.1	13,060	13.6
Never injected	28,719	88.5	30,884	49.2	59,854	62.5
Sub Total	32,460	100	62,794	100	95,727	100
Not known/missing	2,712		2,533		5,864	
Total	35,172		65,327		101,591	

Source: ST34

¹²⁶ Data on current injecting are not available for Wales as the item asks for ever injected (which has been mapped to ever but not currently) and never injected

5.3.4 Treatment Demand Indicator trends

Due to the introduction of a new methodology for calculating TDI, differences between 2013 data and previous years should be interpreted with caution.

Since 2003/04, the percentage of primary cannabis presentations has steadily increased from 10.7% of all presentations through to 26.8% in 2013 (Table 5.3). Conversely, there have been decreases in the percentage of all clients accessing treatment for primary opioids from a peak of 71.4% in 2003/04 to 50.3% in 2013. Presentations for primary crack cocaine increased from 5.4% in 2003/4 to 6% in 2008/09. However, they have since declined and accounted for 3.5% of the treatment cohort in 2013.

Table 5.3: The percentage of all drug treatment presentations by primary drug in the United Kingdom, 2003/04 to 2013

DRUG		2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2013
Amphetamines	%	3.7	3.6	3.5	3.8	3.5	3.2	3.2	3	2.8	2.6
Benzodiazepines	%	2.1	2.4	1.9	1.8	2	1.9	2	2.1	2.5	2.6
Cannabis	%	10.7	14.1	15.8	15.6	16.4	17.1	19.6	20.3	22.4	26.8
Cocaine*	%	4	4.9	5.8	6.9	8	8.5	7.6	7.4	8	9.4
Crack cocaine	%	5.4	5.6	5.8	5.8	5.9	6	4.5	4.8	4.6	3.5
Opioids	%	71.4	67	65.1	63.7	61.9	61.2	60.8	59.3	56.4	50.3
Other	%	2.7	2.5	2.1	2.4	2.4	2.1	2.6	3	3.4	4.8
Not known	%	7.2	11	7.3	4.7	3.5	3.9	3.7	4	3.8	2.6
Total	n	99,763	117,781	128,446	128,208	132,003	139,390	127,993	119,652	113,814	101,753**

*includes cocaine powder and cocaine unspecified

**figures are not directly comparable to previous years due to changes in TDI protocol

Source: ST34

Among first ever treatment presentations, the increase in the percentage of primary treatment presentations for cannabis is more pronounced and now accounts for 48.6% of all new presentations (Table 5.4). In 2011/12, a greater proportion of new treatment entrants were reported from primary cannabis than primary opioids and this remained the same in 2013. The overall decrease in the percentage of primary opioid clients is also more apparent among new treatment entrants decreasing from a peak of 57.8% in 2003/04 to 19.7% in 2013. Both the increase in proportion of cannabis presentations and the decrease in opioid presentations in 2013 could be exaggerated by the introduction of the new TDI protocol.

Table 5.4: The percentage of first drug treatment presentations by primary drug in the United Kingdom, 2003/04 to 2013

DRUG		2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2013
Amphetamines	%	5.1	4.1	3.9	4.3	4.4	3.8	3.3	3.6	3.3	2.8
Benzodiazepines	%	2.3	3.1	2.5	1.9	2.9	2.5	3	3.1	3.9	3.8
Cannabis	%	18.6	22.1	24.8	24	27.2	28	32.5	32.4	37.1	48.6
Cocaine*	%	5.8	7.7	9.1	10.5	13.3	15.1	12.4	11.4	12.9	14.6
Crack cocaine	%	6	6.6	6.7	6.1	6.3	6.7	4.6	4.6	4	2.4
Opioids	%	57.8	52.3	50	45.7	42.5	41	40.4	40	33.4	19.7
Other	%	4.6	3.9	3.3	3.1	3.5	3.1	3.8	4.9	5.4	8.1
Not known	%	3.5	8.0	6.6	4.2	3.4	3.0	4.3	5.4	5.6	2
Total	n	29,865	42,497	49,625	47,165	46,601	45,048	44,924	47,566	43,110	35,229**

*includes cocaine powder and cocaine unspecified

**figures are not directly comparable to previous years due to changes in TDI protocol

Source: ST34

5.4 Clients in treatment

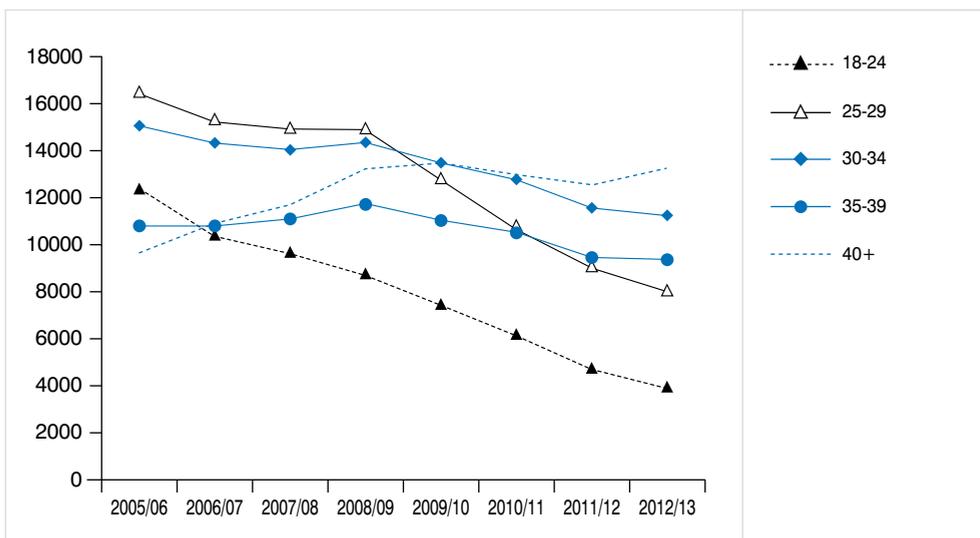
Data on clients in treatment for substance misuse are available from England, Wales and Scotland. In Northern Ireland, a census of those in treatment on a certain day is carried out every two years with the most recent carried out in 2012 (UK Focal Point, 2012).

5.4.1 Data from the National Drug Treatment Monitoring System in England

Almost all clients accessing treatment for substance misuse in England do so within three weeks (98% of all clients entering treatment in 2012/13) (Public Health England, 2013a). This has increased from 2006/07 where 87% of all clients waited less than three weeks until their first intervention and may suggest a sufficient treatment capacity for demand.

In 2012/13 there were 193,575 individuals over the age of 18 in drug treatment in England; a two per cent decrease from the previous year ($n=197,110$) and a continuation of the decreasing trend in numbers in treatment that started in 2009/10 (Public Health England, 2013a). This reduction is principally driven by decreases in the number of new treatment journeys for opioids and/or crack cocaine. Between 2005/06 and 2012/13, decreases in treatment presentations for opioids and/or crack have occurred in all age groups except those over 40 (Figure 5.2). These decreases mirror reductions in estimates of the prevalence of problem drug use (PDU) (see section 4.2) and suggest an ageing cohort of opioid and/or crack cocaine users. In contrast, the number of new journeys for cannabis increased from 10,544 in 2011/12 to 11,280 in 2012/13.

Figure 5.2: The number of new treatment presentations for opioids and/or crack cocaine by age group in England, 2005/06 to 2012/13



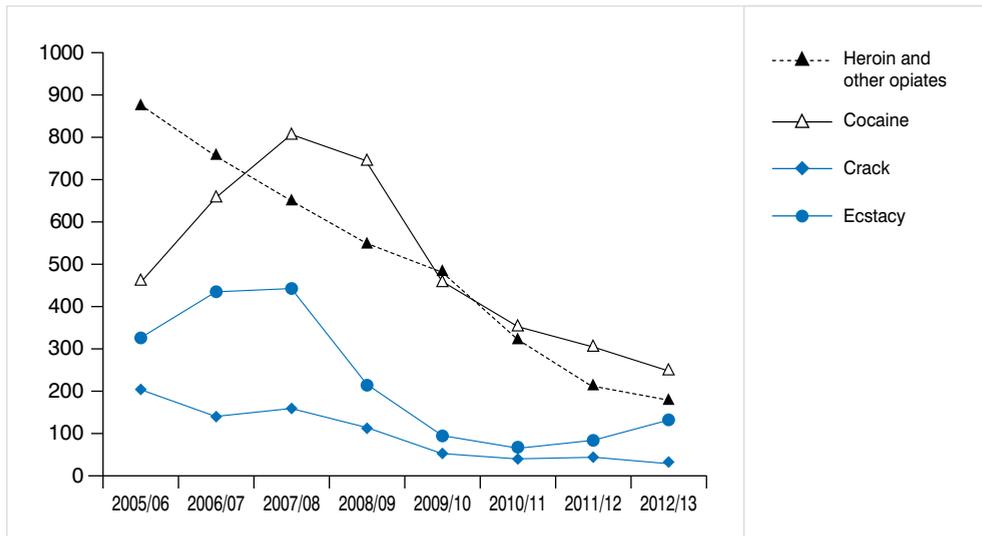
Source: Public Health England, 2013a

Young people in treatment in England

The number of young people (aged 17 years and under) attending specialist substance misuse services for drugs or alcohol during 2012/13 was 20,032, down from 20,688 in 2011/12 (a three per cent decrease) (Public Health England, 2013d). This decrease is in line with decreases in self-reported alcohol and drug use among young people (see section 2.3.1). Of the young people entering specialist services during the year, 99% waited less than three weeks from the point of referral to the first appointment, with the average wait of just under two days.

Cannabis remains the most cited primary drug for which young people present to treatment in England and accounts for 68% of all young people presenting to specialist services in 2012/13 (Public Health England, 2013d). In 2012/13, the number of young people citing heroin as their primary substance fell to a historic low of 175 continuing the decreasing trend since 2005/06 and mirroring the adult treatment data (Figure 5.3). Decreases in powder cocaine presentations were also observed; 245 in 2012/13 from 300 in 2011/12. Conversely there were increases observed between 2011/12 to 2012/13 in the number of presentations for primary substance of both amphetamines (493 to 755) and ecstasy, which rose from 80 to 130. Despite the rise in the number of ecstasy presentation the numbers remain lower than numbers observed between 2005/06 and 2009/10 (Public Health England, 2013e).

Figure 5.3: The numbers of under-18s in treatment for the primary problematic use of individual class A drugs in England, 2005/06 to 2012/13



Source: Public Health England, 2013e

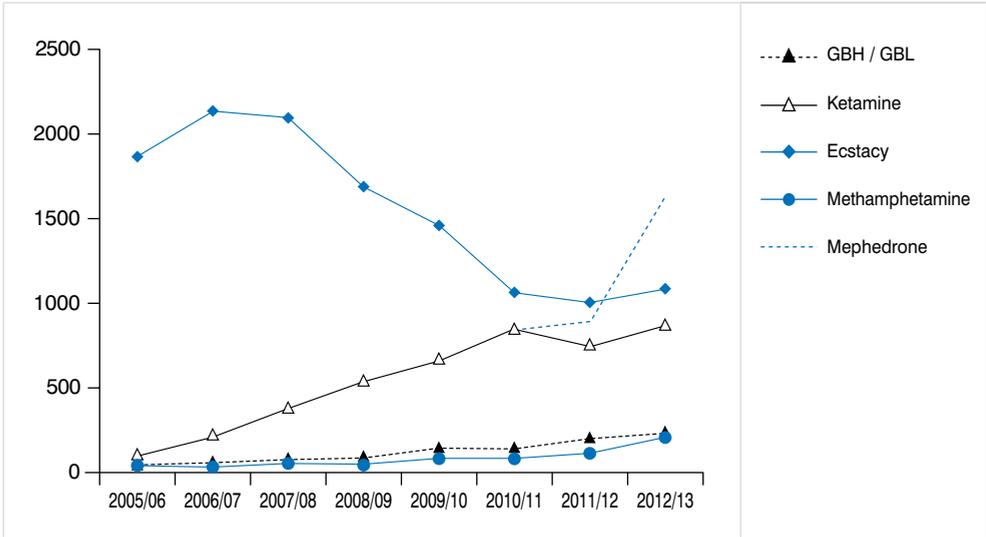
Club drugs users in treatment in England

'Club drugs' is a collective term for a number of different substances, including GHB/GBL, ketamine, ecstasy, methamphetamine and mephedrone, typically used by young people in bars and nightclubs, at concerts and parties.

Between 2011/12 and 2012/13, there was a steep increase in the number of new cases aged 18 or over reporting mephedrone from 900 to 1,630 (Figure 5.4). (Public Health England, 2013a)¹²⁷ There were also small increases in methamphetamine from 116 to 208. Presentations for ketamine treatment have increased from 114 in 2005/06 to 868 in 2012/13. However, self-reported use in the last 12 months has remained stable since 2010 (0.5%), (see section 2.2.1). The overall numbers entering treatment for these club drugs remains relatively small in the context of the entire treatment population (five per cent of new journeys).

¹²⁷ Taken mephedrone in the last 12 months

Figure 5.4: The number of new treatment presentations for club drugs in England, 2005/06 to 2012/13

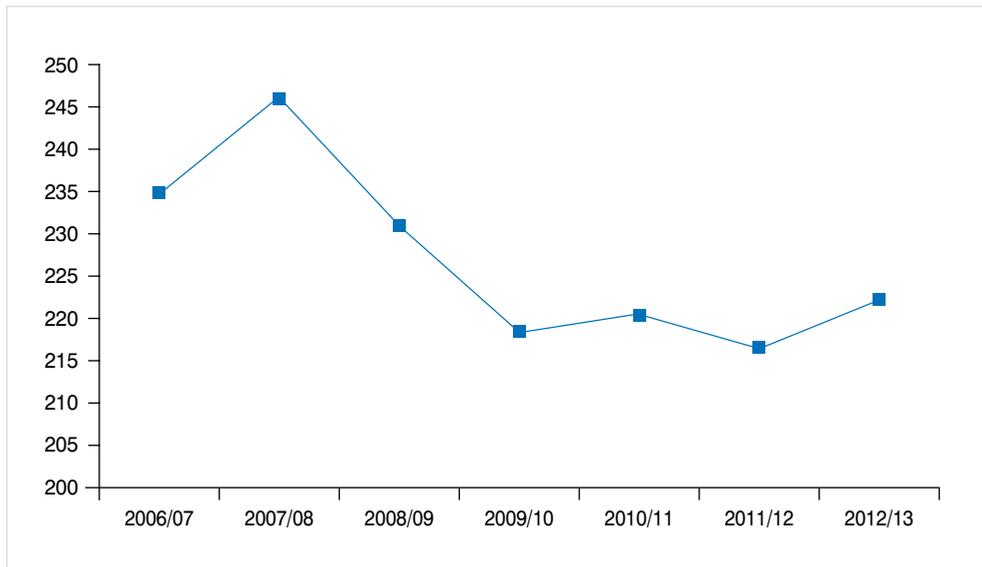


Source: Public Health England, 2013a

5.4.2 Data from the Scottish Drug Misuse Database

In 2012/13, 11,861 individuals had an initial assessment for specialist drug treatment, equivalent to a European Age-sex Standardised Rate (EASR) of 222 per 100,000 population (Information Services Division, 2014e). The overall EASR has fluctuated since 2006/07, reaching a maximum of 246 in 2007/08, but has been stable at approximately 220 per 100,000 population since 2009/10 (Figure 5.5). Similar to the pattern observed in English data, since 2006/07, an increasing proportion of individuals from older age groups have been assessed for specialist drug treatment each year. In 2006/07, half (51%) of the individuals were aged 30 and over, compared with two-thirds (66%) in 2012/13.

Figure 5.5: Clients entering treatment in Scotland, 2006/07 to 2012/13, European Age-sex Standardised Rate per 100,000 population



Source: Information Services Division, 2014e

In the majority of Scottish Health Boards, the proportion of individuals reporting heroin as their main illicit drug used in the past month decreased between 2011/12 and 2012/13. In almost all Health Boards, fewer younger people are reporting heroin use at their initial assessment. Again, this is in line with the trend reported over recent years (in 2006/7, 58% of those under the age of 25 reported using heroin falling to 34% in 2011/12). There was no change in injecting behaviour in the majority of health boards between 2011/12 and 2012/13, but the percentage of people who reported injecting in the previous month fell notably across most Health Boards between 2006/7 and 2012/13.

In almost all NHS Health Boards, methadone was currently prescribed in over half of assessments where a prescription drug was reported. Diazepam was the second most commonly prescribed drug reported at assessments for drug treatment in 2012/13. In 2013/14, there were almost 549,000 OST items dispensed in the community; some 464,600 of these were for methadone treatments. Overall the number of OST items dispensed decreased by just under two per cent (-1.8%) compared to 2012/13. Methadone dispensing decreased by just under five per cent (-4.98%) and has been decreasing year on year since 2010/11.

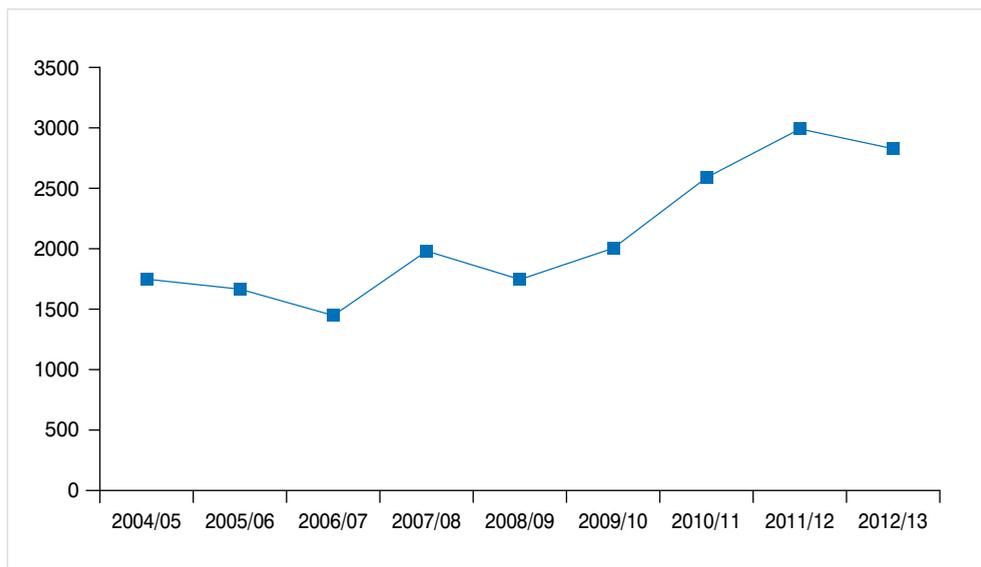
Prescription cost analysis shows that the prescribing of drugs other than methadone for the treatment of opioid dependency has been steadily increasing. For example, the number of items dispensed for the combined drug buprenorphine and naloxone increased by over 28% between 2012/13 and 2013/14.

In 2013/14 over three quarters of NHS pharmaceutical services spend on methadone was for safe dispensing and supervision in line with the UK Guidelines on Clinical Management, and not on the actual product itself: approximately £17.9 million from a total of £22.8 million.

5.4.3 Data from the Northern Ireland Drug Misuse Database

In Northern Ireland in 2012/13, a total of 2,824 clients presented to services for problem drug misuse; six per cent lower than in 2011/12 (2,999 clients) (Department of Health, Social Services and Public Safety Northern Ireland, 2013). The number of clients in treatment has increased from 1,746 in 2004/05 (Figure 5.6).

Figure 5.6: The number of new presentations to treatment in Northern Ireland, 2004/05 to 2012/13



Source: Department of Health, Social Services and Public Safety Northern Ireland, 2013

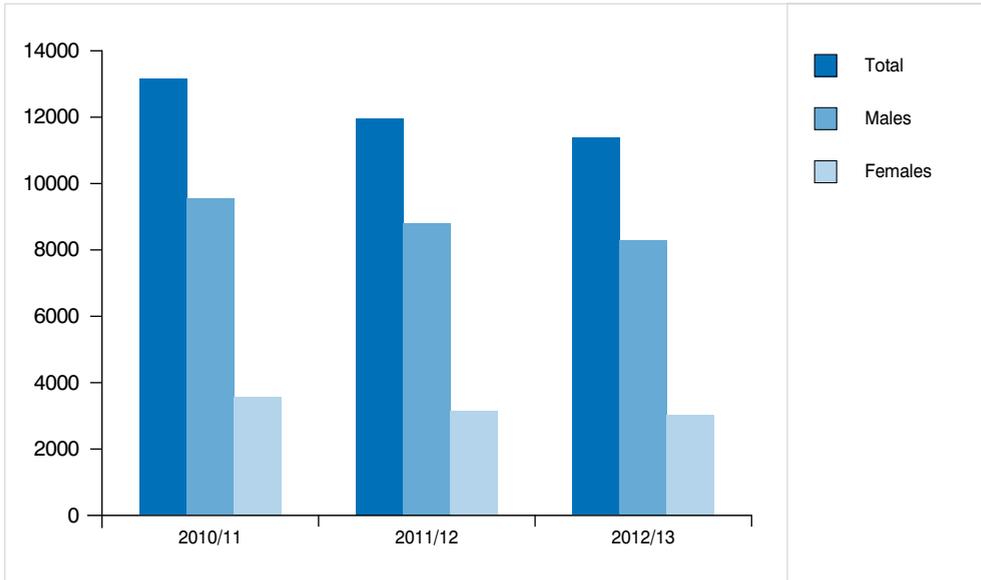
5.4.4 Data from the Welsh National Database for Substance Misuse

In 2012/13, the number of new referrals to treatment citing drugs¹²⁸ in Wales was 11,393, a decrease from 13,201 in 2010/11 (Welsh Government, 2013a).¹²⁹ The distribution of males/females has remained broadly consistent across the years; 73% of all clients were male and 27% female in 2012/13 (see Figure 5.7). Similarly to English data, the number of clients citing problematic use of opioids has declined from 6,401 in 2010/11 to 4,931 in 2012/13, however, heroin remains the most cited drug at treatment referral accounting for 37% of all referrals in 2012/13. Whilst the overall number of referrals to treatment is decreasing, the number of older people (aged 50 years and above) referred to specialist substance misuse services for treatment has increased by 15.8 % over the five year period 2009-10 to 2013-14.

¹²⁸ Where there is a known substance type

¹²⁹ Figures will not match referenced figures as they exclude alcohol as a primary drug type

Figure 5.7: The number of new referrals to treatment in Wales by gender, 2010/11 to 2012/13



Source: Welsh Government, 2011b; Welsh Government, 2012; Welsh Government, 2013a

5.4.5 Comparisons of clients accessing treatment across the United Kingdom

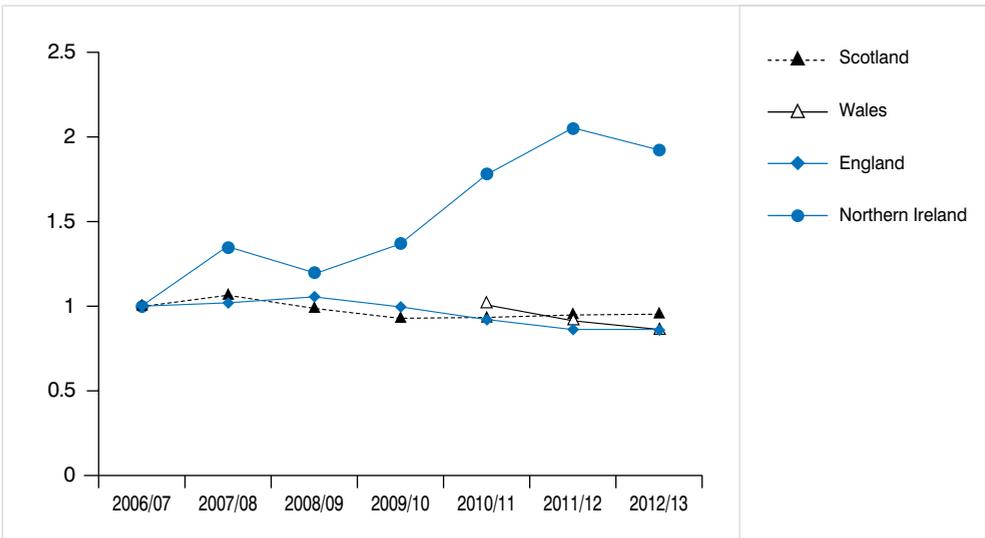
While England, Wales and Scotland have all seen decreases in the number of referrals to treatment since 2006/07, Northern Ireland has seen concurrent increases (Figure 5.8).¹³⁰ Opioids are the most commonly cited drug group for those entering treatment in England (62%), Scotland (50%) and Wales (37%);¹³¹ however, this group accounts for only seven per cent of those accessing treatment in Northern Ireland. Instead, Northern Ireland has a greater number of clients citing problematic use of hypnotics,¹³² accounting for 48% of all clients starting treatment.

¹³⁰ Data indexed to 2006/07

¹³¹ This figure excludes alcohol and will therefore not match published figures

¹³² Principally cannabis and benzodiazepines

Figure 5.8: The number of new presentations to treatment in England, Wales, Northern Ireland and Scotland, 2006/07 to 2012/13 (data indexed to 2006/07)



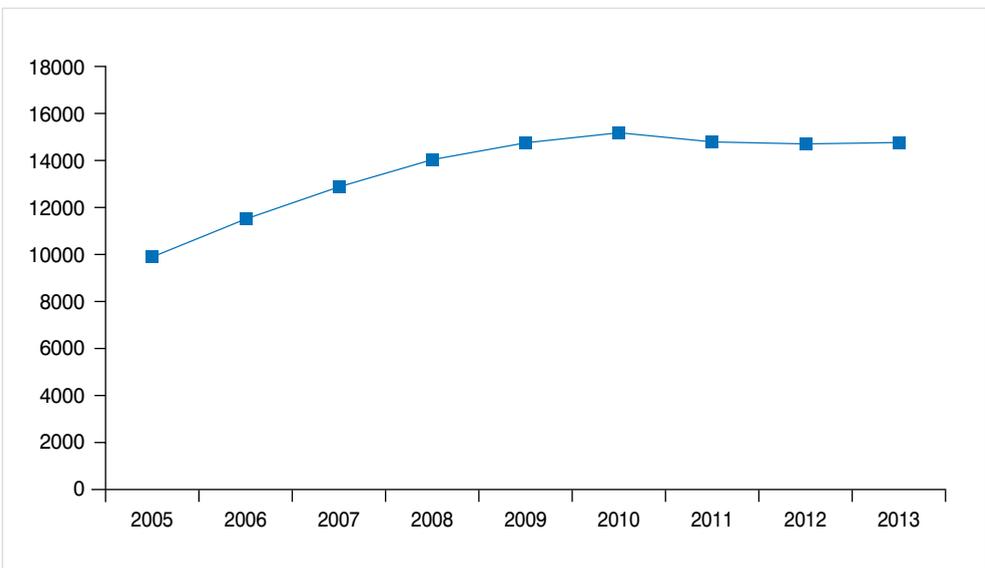
Source: Public Health England 2013; Information Services Division, 2014; Welsh Assembly Government, 2013

5.4.6 Opioid substitution treatment

England

Data show that the number of opioid users in prescribing treatment increased from 98,991 in 2005 to 152,828 in 2010 (Figure 5.9) (ST24). It has since stabilised and OST was prescribed to 147,640 clients in 2013.

Figure 5.9: The number of opioid users in prescribing treatment in England, 2005 to 2013



Source: ST24

Wales

In 2013 OST was prescribed to 2,042 clients, a slight decrease from 2011/12 where there were 2,151 clients and 2010/11 where there were 2,192 clients. This follows a steep increase since 2005 where there were just 370 clients in OST (ST24).

5.4.7 Treatment outcomes

The Treatment Outcomes Profile (TOP) is a clinical tool that enables clinicians and drug workers to keep track of the progress individuals make through their treatment journey.¹³³ It measures drug use and gives an early indication about clients' progress in overcoming problems with work, education or housing through a set of 20 questions.¹³⁴ TOP was introduced in England in 2007 and has also been used in Wales since 2009. In Scotland, from 2008 an enhanced, web-based SDMD follow-up reporting system was introduced to collect information on individuals throughout their treatment, not just at initial assessment. TOP data from England and Wales is not directly comparable due to difference in reporting methodology.

Treatment Outcomes Profile data in England

Table 5.5 shows the mean number of days use of a drug reported at treatment start and review and the percentage of clients reporting abstinence of that drug at treatment review in England (Public Health England, 2013a). The mean day's use¹³⁵ of a drug at treatment start was highest for cannabis (22 days), followed by opioids (21 days), amphetamines (16 days), crack cocaine (11 days) and cocaine powder (nine days).

Table 5.5: Self-reported drug use by Treatment Outcome Profiles and the percentage of abstinent clients at treatment start and review in England

	MEAN DAYS USE OF DRUG AT TREATMENT START	MEAN DAYS USE OF DRUG AT TREATMENT REVIEW	PERCENTAGE OF CLIENTS ABSTINENT AT TREATMENT REVIEW
Opioids	21.0	5.9	49%
Crack	10.5	3.8	58%
Powder cocaine	9.2	2.2	64%
Amphetamines	15.8	6.4	53%
Cannabis	22.2	11.7	33%

Source: Public Health England, 2013a

English data revealed that users of both opioids and crack cocaine reduced their days of illicit opioid use by less than opioid only users (mean of seven days compared to six days out of the last 28 days) (Public Health England, 2013a). Users of only crack cocaine and users of cocaine powder were most likely to be abstinent at review (58% and 64% respectively) with cannabis users least likely to be so (33%).

Treatment Outcomes Profile data in Wales

Based on TOP data in Wales, for those with a main problematic substance of heroin, the average number of days of heroin use fell from 22.7 to 8.8 (-61.4%), with 55.1% having not used heroin at all in the 28 days prior to the exit TOP (Welsh Government, 2013a). Reductions were greater in clients citing use of powder cocaine where the average number of days of powder cocaine use fell from 10.0 to 2.6 (a 73% reduction). Reductions were also seen in clients who used cannabis from 22.6 days to 14.0 (a 38.0% reduction), with 28.6% not having used cannabis at all in the 28 days prior to the exit TOP. Finally, the change in frequency in the use of amphetamines between start and exit TOPs fell from 18.1 to 9.2 days (a 49.5% reduction), with 62.8% having not used amphetamines at all in the 28 days prior to the exit TOP.

¹³³ A TOP assessment is completed at treatment entry and then should be completed every three months and on treatment exit.

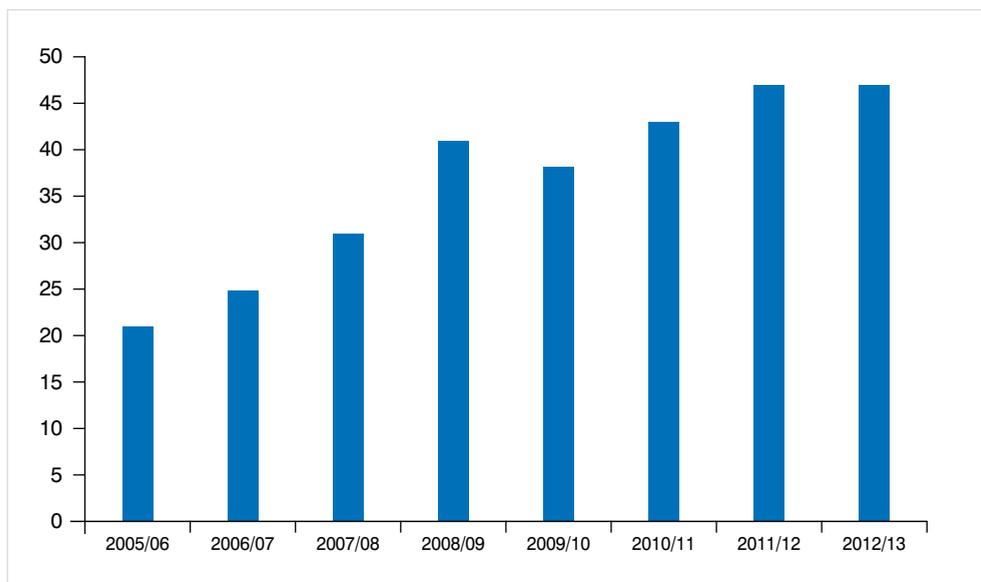
¹³⁴ See: <http://www.dtmu.org.uk/sph-files/top/TOP-form-v1.1-Aug%202008.pdf>

¹³⁵ Self-reported use in the 28 days prior to starting treatment.

Clients leaving treatment successfully in England in 2012/13

The number of clients leaving treatment successfully in England has levelled off following an increasing trend since 2005/06 (Figure 5.9) (Public Health England, 2013a). A small decrease was observed between 2011/12 and 2012/13 from 29,855 to 29,025 and this may in part result from the reduction in the number of people in treatment. Successful completions as a percentage of the total number of people in treatment remain at around 15% in 2011/12 and 2012/13. Since 2005 around 31% of people who have come into treatment have successfully completed and not since returned.

Figure 5.10: The proportion of clients leaving treatment free from dependency in England, 2005/06 to 2012/13



Source: Public Health England, 2013a

Research

Drug treatment provision for lesbian, gay, bisexual and transgender people in England

London Friend, a charity focussing on the health and well-being of lesbian, gay, bisexual and transgender (LGBT) people in England conducted a scoping study that aimed to examine how drug and alcohol treatment services could better meet the requirements of LGBT people (London Friend, 2014). The study drew on qualitative methods including discussions with substance misuse commissioners and other key stakeholders, focus groups and questionnaires from LGBT service users, roundtable discussions and conversations with local services. The study concluded that in general, there is poor representation of LGBT health needs within published Joint Strategic Needs Assessments (JSNA) on London local authority websites and there is poor inclusion of LGBT needs in relation to drugs and alcohol. Furthermore, the paper concludes that planning tools for local commissioners do not prompt for LGBT inclusion, and treatment data supplied by PHE is not currently disaggregated or analysed by sexual orientation or gender identity. The report recommends mandated collection of sexual orientation across all regions, along with steps to sensitively implement collection of gender identity data.

Medication assisted treatment and recovery

Using audit data, Dale-Perera and colleagues looked at the views of 544 respondents (physicians, patients in medication assisted treatment [MAT] and out-of-treatment patients) across a range of topics (Dale-Perera, Alam, & Barker, 2014);

- patient motivations for seeking treatment;
- levels of awareness and informed choice about treatment options;
- whether psychosocial support is being accessed;
- levels of illicit drug use;
- self-reported health and well-being;
- rates of employment; and
- rates of imprisonment due to drug-related crime

Data was collected in the first 12 months following the introduction of the *Drug Strategy 2010* (Her Majesty's Government, 2010). Results showed that patient motivations for commencing treatment were as follows; 68% stated a reason to improve health and 60% wanted to end their dependence. Other reasons included; to stop committing crimes (47%); gain employment (40%); and take better care of their family (36%). When asked about their personal treatment goals, the most common answer given by patients was to become drug-free (56%). When asked to indicate positive aspects of MAT, the reasons most frequently stated by patients were to achieve a drug-free state. More than half of patients used illicit drugs on top of their prescription with heroin use being most common. It was also noted that 40% of patients were not receiving key working or psychosocial support in addition to their prescriptions. Physicians reported the most common barriers to recovery being the continued use of illicit drugs (91%), misuse and diversion (83%), treatment rules and regulations (62%) and sub-optimal dosing (52%).

Injectable opioid treatment

Groshkova and colleagues (Groshkova et al., 2013) carried out research to investigate patient's pre-treatment expectations of, and post-treatment satisfaction with, supervised injectable opioid treatment delivered within the UK Randomised Injectable Opiate Treatment Trial (RIOTT) (Strang et al., 2010). Data were collected from 127 chronic heroin addicts recruited to RIOTT and randomised to receive supervised injectable (heroin or methadone) treatment or optimised oral maintenance treatment. Of 127 RIOTT patients, 89% provided responses to structured enquiry about treatment expectations, and 74% provided subsequent responses about treatment satisfaction (at six months). Results showed that patients were hoping that injectable heroin treatment would: reduce substance misuse (81%); help achieve normality, routine and structure (16%); and increase education and work prospects (15%) suggesting that patients previously considered non-responsive to treatment appear to have similar treatment expectations and aspirations as other drug users in treatment. The most commonly self-reported area of treatment satisfaction reported by all three trial groups was reduced substance misuse (supervised injectable heroin 59%, supervised injectable methadone 56% and optimised oral methadone 54%). Supervised injectable opioid treatment patients consistently reported treatment satisfaction but also that more could be done to optimise aspects of current arrangement. The authors conclude that this raises the challenging issue of the extent to which opinions of patients need to be taken into consideration in shaping future treatment provision. They recommend that future research may need to examine the extent of expectations 'fit' and the relationship between treatment sought and received.

6. Health correlated and consequences

6.1 Introduction

The number of new HIV diagnoses in the United Kingdom (UK) associated with injecting drug use has been low in recent years, with 112 diagnoses reported for 2013 (Public Health England, Health Protection Scotland, Public Health Wales and Public Health Agency Northern Ireland, in press). The overall prevalence of HIV seen amongst people who inject drugs (PWID) in 2013 was similar to that seen in recent years, and remains higher than that found in the late 1990s. The prevalence of HIV amongst the current and former PWID taking part in the Unlinked Anonymous Monitoring (UAM) Survey¹³⁶ across England, Wales and Northern Ireland during 2013 was 1.1% (Public Health England, 2014a). A HIV prevalence of 0.3% was found amongst PWID attending needle and syringe programmes (NSP) in Scotland during 2011/12 (ST09, 2013).

The prevalence of hepatitis C infection amongst PWID remains relatively high (Public Health England, 2014a). In the UAM Survey in 2013 the hepatitis C prevalence amongst the participants in England was 50%; in Wales 47% and in Northern Ireland it was 32% (Public Health England, 2014a). In Scotland, the estimated prevalence of antibodies to hepatitis C was 58% amongst current and former PWID surveyed at needle exchanges across the country as part of the Needle Exchange Surveillance Initiative (NESI) in 2013/14 (ST09).

The impact of drug use on health services is difficult to measure. Hospital inpatient data are available across the UK using International Classification of Disease (ICD-10) coding but no similar data exist for general practitioner (GP) or hospital emergency departments. Data from the UK shows increases in the number of hospital discharges recording poisoning by drugs over the last year.

Prevalence and attribution of dual diagnosis remain difficult to estimate. Depression, anxiety disorders, personality and psychotic disorders are commonly reported amongst drug users, although prevalence varies with setting and specific sub-populations. Data on drug-related deaths in Scotland suggest that more than half of the known cases who died a drug-related death in 2012 had a known psychiatric condition (Hecht et al., 2014).

Data on drug-related deaths submitted to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) by the UK are based on three different definitions. The EMCDDA definition refers to deaths caused directly by the consumption of at least one illicit drug.¹³⁷ The UK Drug Misuse Definition (DMD)¹³⁸ is where the underlying cause is drug abuse, drug dependence, or poisonings where any of the substances scheduled under the *Misuse of Drugs Act 1971* are involved. The definition used by the Office for National Statistics (ONS) is much wider and includes legal drugs.¹³⁹ For methodological considerations around the reporting of drug-related deaths and the impact of registration delays see UK Focal Point Report 2013 (UK Focal Point, 2013).

¹³⁶ The survey aims to measure the changing prevalence of HIV, hepatitis B and hepatitis C in PWID who are in contact with specialist drug agencies (e.g. needle exchange services and treatment centres). The programme also monitors levels of risk and protective behaviours amongst PWID. The data are used to assess and develop appropriate preventative and health education campaigns, evaluate the impact of such interventions, and to assist in the provision of services for PWID in the UK. Survey data have been collected annually since 1990. Each participant is asked to complete a short questionnaire and to provide a dried blood spot sample. Samples are tested for the presence of antibodies to HIV (signalling current infection), and antibodies to the hepatitis C and hepatitis B viruses (which can indicate current or previous infection). Participants are asked to provide information regarding their HIV diagnosis status (if known), their patterns of drug use (including treatment for drug addiction and participation in needle exchange services) and their sexual behaviour. This information is used to assess the association between risky activities (such as needle sharing) and the prevalence of HIV and hepatitis C amongst PWID.

¹³⁷ These deaths are known as 'overdoses', 'poisonings' or 'drug-induced deaths'. See: <http://www.emcdda.europa.eu/themes/key-indicators/drd>

¹³⁸ Formerly known as the Drug Strategy Definition (DSD) and originally adopted to measure progress against an aim in a former UK Drug Strategy (Home Office, 2002).

¹³⁹ For ONS definitions See: ONS (2013) <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-314585>

The UK DMD has been adopted by the General Mortality Registers (GMRs) across the UK and is a subset of the ONS definition. Information on deaths is also available from a Special Mortality Register (SMR).¹⁴⁰ In the UK, based on the EMCDDA definition, drug-related deaths rose steadily from 1996, when 1,152 deaths were registered (ST06). Following a period of decline between 2001 and 2003, death registrations increased again between 2004 and 2008 when they reached their highest level (2,231). There has been a year-on-year decrease since 2008 and 2012 however, the latest figures for 2013 show an increase to 1,956 deaths registered (compared to 1,666 in 2012).

6.2 Drug-related infectious diseases

Information on infectious disease is principally based on that presented in *Shooting Up: Infections amongst people who inject drugs in the United Kingdom 2013* (Public Health England, Health Protection Scotland, Public Health Wales and Public Health Agency Northern Ireland, in press) and provided to EMCDDA in ST09.

6.2.1 HIV and viral hepatitis

HIV

The overall prevalence of HIV seen amongst PWID in 2013 was similar to that seen in recent years, and remains higher than that found in the late 1990s. The prevalence of HIV amongst the current and former PWID taking part in the UAM Survey across England, Wales and Northern Ireland in 2013 was 1.1% (95% CI, 0.77%-1.5%) (Public Health England, 2014q). Between 2002 and 2013, prevalence varied between 1.1% and 1.6% (Public Health England, 2014a); (see Figure 6.1). The HIV prevalence in Wales was 0.50% (95% CI, 0.01%-3.1%) and in Northern Ireland 0.62% (95% CI, 0.01%-3.8%) during 2013. In England, it was 1.2% (95% CI, 0.81%-1.6%) in 2013, which was the same as the prevalence reported in 2003 (Public Health England, 2014a).

The UAM Survey indicated an overall HIV prevalence in England and Wales of 1.1% in 2013 (ST09). The prevalence of HIV was higher among men than women; 1.2% and 0.7% respectively. Prevalence increased with age from 0.5% amongst those aged less than 25 years to 1.3% amongst those aged 35 years and over.

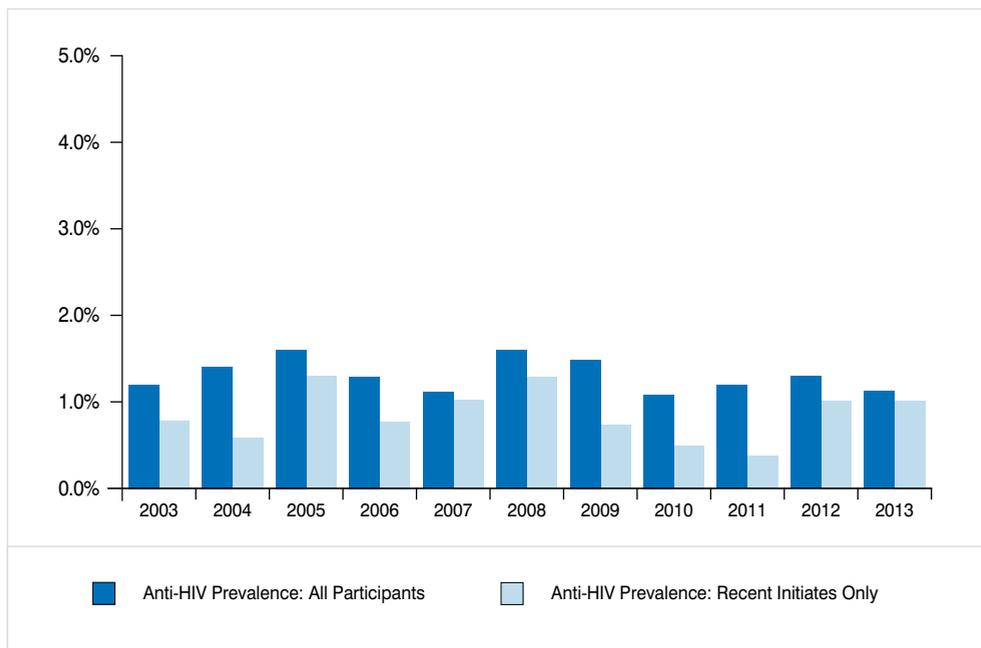
HIV prevalence amongst "recent initiates" to injecting drug use (those who first injected during the preceding three years) is an indicator of recent HIV transmission. The prevalence amongst the recent initiates participating in the UAM Survey across England, Wales and Northern Ireland was 1.0% (95% CI, 0.2%-3.0%) in 2013 (Public Health England, 2014q). This is similar to that found in recent years, but higher than in the late 1990s, indicating ongoing HIV transmission amongst PWID within the UK (Public Health England, 2014a) (Public Health England, 2014a) (see Figure 6.1).

In Scotland, among those attending NSP during 2011/12, only 0.3% were found to be HIV antibody positive (Public Health England, Health Protection Scotland, Public Health Wales and Public Health Agency Northern Ireland, in press).

There were 112 new HIV diagnoses associated with injecting drug use reported in the UK during 2013; 18 of these diagnoses were reported from Scotland (Public Health England, Health Protection Scotland, Public Health Wales and Public Health Agency Northern Ireland, in press). There were also 17 reported HIV diagnoses that were associated with sex between men, for which injecting drug was also reported as a risk (Public Health England, Health Protection Scotland, Public Health Wales and Public Health Agency Northern Ireland, in press).

¹⁴⁰ The National Programme on Substance Misuse Deaths (NPSAD) publishes data from inquests into drug-related deaths reported by coroners in England, Wales, Northern Ireland, Guernsey, Jersey and the Isle of Man; Procurators Fiscal in Scotland and the Scottish Crime and Drug Enforcement Agency (SCDEA).

Figure 6.1: The prevalence of antibodies to HIV amongst all participants and recent initiates* in the Unlinked Anonymous Monitoring Survey of people who inject drugs: England, Wales and Northern Ireland, 2003 to 2013



*A recent initiate is someone who first injected during the preceding three years

Source: Public Health England, 2014a

Hepatitis C

PWIDs are the group with the highest prevalence of hepatitis C in the UK. Around 90% of the hepatitis C infections diagnosed in the UK will have been acquired through injecting drug use. During 2013, 13,758 hepatitis C infections were diagnosed across the UK (Public Health England, Health Protection Scotland, Public Health Wales and Public Health Agency Northern Ireland, in press). There has been a marked increase in the annual number of new diagnoses throughout the UK over the last decade, reflecting the increased availability and easier access to voluntary confidential testing (VCT) (see section 7.3.3).

The prevalence of hepatitis C infection amongst PWID remains relatively high. The overall prevalence of antibodies to hepatitis C amongst the current and former PWID participating in the UAM Survey across England, Wales and Northern Ireland was 49% (95% CI, 47%-51%) in 2013 (Public Health England, 2014a). This proportion has remained relatively stable over the last decade (see Figure 6.2). In 2013 in England anti-hepatitis C virus (anti-HCV)¹⁴¹ prevalence was the highest of the three countries at 50% (95% CI, 48%-52%) followed by Wales, 47% (95% CI, 40%-54%) and Northern Ireland 32% (95% CI, 25%-39) (Public Health England, 2014q). While in England and Northern Ireland the hepatitis C prevalence amongst the participants in the UAM Survey has remained relatively stable over time, in Wales there has been an increase from 19% in 2003/05 to 47% in 2013. In England there were very marked regional variations from 37% in the North East region to 68% in the North West region (Public Health England, 2014c).

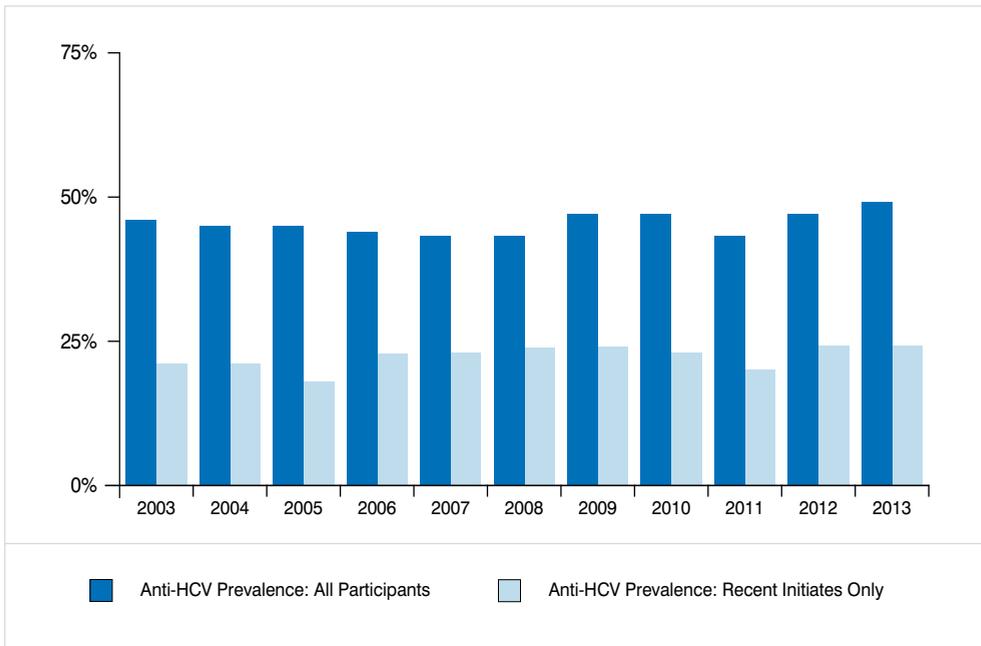
¹⁴¹ Anti-HCV is a marker of previous or current hepatitis C infection.

Of the PWID participating in the UAM Survey in England, Wales and Northern Ireland the proportion that had antibodies to hepatitis C was slightly lower amongst men than women (48% and 51%). Prevalence increased with age, from 28% amongst those aged under 25 years to 55% amongst those aged 35 years and over (Public Health England, 2014a).

In Scotland, the estimated prevalence of antibodies to hepatitis C was 57% among current and former PWID surveyed at services providing injection equipment across mainland Scotland in 2013/14. This compares to 52%, 55% and 53% who tested positive in 2008/09, 2010 and 2011/12, respectively (Public Health England, 2014c).

The level of hepatitis C transmission among PWID in the UK appears to have changed little in recent years. The prevalence of antibodies to hepatitis C amongst recent initiates has also been fairly stable. Amongst those in this group participating in the UAM Survey from across England, Wales and Northern Ireland prevalence was 24% (95% CI, 20%-29%) in 2013. Over the last decade the prevalence in this group has ranged between 18% and 24% (Public Health England, 2014q). Incidence of hepatitis C infection among PWID in England, Wales and Northern Ireland is currently estimated to be between six to 18 infections per 100 person years of exposure (Public Health England, 2014c). In Scotland, the incidence of hepatitis C infections among PWID has been monitored since 2008, and it was estimated to be 10 infections per 100 person years of exposure during 2013/14; this compares with an incidence of 13 infections per 100 person years found during 2008/09 (Public Health England, 2014c).

Figure 6.2: The prevalence of anti-HCV amongst all participants and recent initiates* in the Unlinked Anonymous Monitoring Survey of people who inject drugs: England, Wales and Northern Ireland, 2003 to 2013



*A recent initiate is someone who first injected during the preceding three years

Source: Public Health England, 2014a

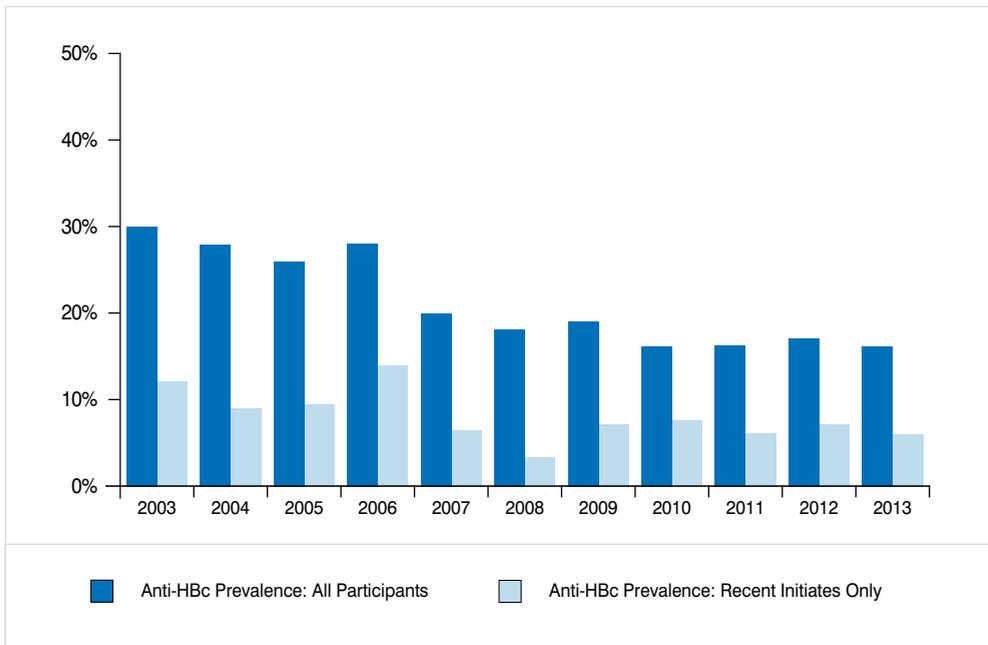
Hepatitis B

In 2013, 16% (95% CI, 15%-18%) of the current and former PWID who took part in the UAM Survey in England, Wales and Northern Ireland had antibodies to hepatitis B core antigen (anti-HBc, a marker of previous or current hepatitis B infection) (Public Health England, 2014q). This proportion has remained relatively stable in recent years, but it is lower than the level seen ten years ago where prevalence was 30% (Public Health England, 2014a); (see Figure 6.3). The prevalence of anti-HBc varied by country; in 2013 the prevalence in England was 17% (95% CI, 16%-19%; down from 31% in 2002), in Wales it was 13% (95% CI, 8.9%-18%; it had been 12% in 2002), and in Northern Ireland it was 6.8% (95% CI, 3.7%-12%; prevalence for Northern Ireland had been 3.1% in 2002/03) (Public Health England, 2014a). The overall decrease may reflect the impact of increased uptake of the hepatitis B vaccine amongst injecting drug users (Public Health England, 2014q); (see section 7.3.4).

The samples collected by the UAM Survey of PWID during 2013 that had anti-HBc detected were also tested for hepatitis B surface antigen (HBsAg), a marker of current infection. In 2013, of the samples from the UAM Survey of PWID with anti-HBc 3.4% (95% CI, 2.2%-5.5%) had HBsAg detected indicating current infection; this represents 0.57% (95% CI, 0.36%-0.91%) of all the PWID surveyed in England, Wales and Northern Ireland that year (Public Health England, 2014q).

The available data on reports of acute hepatitis B infections indicate that currently few of these are among PWID, with most UK acquired cases associated with sexual activity. These findings indicate that current hepatitis B infection is now rare among PWID, probably reflecting the impact of the marked increased in the uptake of the hepatitis B vaccine among PWID (Public Health England, 2014p; see section 7.3.4).

Figure 6.3: The prevalence of anti-HBc amongst all participants and recent initiates* in the Unlinked Anonymous Monitoring Survey of people who inject drugs: England, Wales and Northern Ireland, 2003 to 2013



*A recent initiate is someone who first injected during the preceding three years

Source: Public Health England, 2014a

Blood borne viral infections amongst people who inject image and performance enhancing drugs

Following a pilot UAM Survey of people who inject image and performance enhancing drugs (IPEDs) that was undertaken during 2010/11, (Hope et al., 2014) the first biennial monitoring survey was performed in 2012/13 (Public Health England, 2014a). This sub-survey of the main UAM Survey (which is focused on those who inject psychoactive drugs) is co-ordinated by Public Health England (PHE), with support from Public Health Wales (PHW) and the Centre for Public Health at Liverpool John Moores University (LJMU). The participants were principally recruited through NSP across England and Wales over an 18 month recruitment period.¹⁴² The participants provided a dried blood spot (DBS) specimen that was tested anonymously for HIV, hepatitis C and hepatitis B (the main tests used were for antibodies to HIV, hepatitis C and the hepatitis B core antigen). Behavioural and some demographic information were collected using a short subject completed questionnaire.

During the 2012/13 sampling period 249 individuals took part in the IPED survey from across England and Wales, of these 2.0% (95% CI, 0.74%-4.9%) had HIV (compared with 1.1% in PWID using psychoactive drugs), 2.8% (95% CI, 1.2%-5.9%) anti-HBc (compared with 16% in those PWID using psychoactive drugs), and 3.6% (95% CI, 1.8%-7.9%) had anti-HCV compared with 49% in those PWID using psychoactive drugs) (Public Health England, 2014q). Though the prevalence of antibodies to both hepatitis B and C were lower than the prevalence found in people who inject psychoactive drugs, the prevalence of HIV was similar in both groups.

The prevalence of blood-borne virus (BBV) infections amongst IPED injectors in Scotland and Northern Ireland is currently not known.

6.2.2 Tuberculosis

In total there were 7,892 cases of tuberculosis (TB) reported across the UK in 2013 (Public Health England, 2014n). Amongst the cases with known information on the four 'social risk factors' monitored among TB cases in the UK: 3.2% (227/7,007) had either a history of, or currently had, a problem with drug use; 3.9% (272/6,987) of alcohol misuse, 3.3% (231/7,067) of homelessness and 2.9% (200/6,885) of imprisonment. A total of 9.6% of cases (642/6,682) had at least one of these social risk factors, one-third of whom (203/642) had more than one risk factor (Public Health England, 2014n). A higher proportion of the UK born TB cases had at least one social risk factor when compared to non UK-born cases (17% versus 7%).

6.2.3 Infections due to spore-forming bacteria

Severe infections caused by spore-forming bacteria continued to occur among PWID in the UK during 2013. These bacteria produce spores which can contaminate drugs such as heroin. There were two wound botulism, two tetanus, and two Anthrax cases reported among people who inject drugs in the UK during 2013 (Public Health England, Health Protection Scotland, Public Health Wales and Public Health Agency Northern Ireland, in press).

6.2.4 Other injection related bacterial infections

Staphylococcus aureus and Group A streptococcal infections continue to cause severe illnesses among people who inject drugs. Data from the mandatory enhanced surveillance of meticillin-sensitive S. aureus (MSSA) and meticillin-resistant S. aureus (MRSA) bacteraemias, for example, indicate that in 2013, of those with risk factor information, 8.0% of the MSSA bacteraemias were associated with injecting drug use as were 4.8% of the MRSA bacteraemia (Public Health England, Health Protection Scotland, Public Health Wales and Public Health Agency Northern Ireland, in press).

¹⁴² An 18 month recruitment period was used, instead of 12 months in the main UAM Survey of people who inject psychoactive drugs, due to the cyclic nature of some of the forms of drug use among this target population.

In 2013, over one-quarter (28%) of PWID participating in the UAM Survey in England, Wales and Northern Ireland reported that they had experienced an abscess, sore or open wound, all indicating symptoms of injecting-site infection, during the preceding year (Public Health England, 2014a). This was similar to the level seen in recent years. The proportion of people reporting symptoms increased with age, from 20% amongst those aged under 25 years to 31% amongst those aged 35 years and over, with more women (35%) reporting symptoms than men (26%). Among those attending needle and syringe programmes in Scotland during 2013/14, 28% reported that they had experienced an abscess, sore or open wound, during the last year.

Among the participants in the 2012/13 UAM sub-survey of people who inject IPEDs, 16% reported that they had ever experienced symptoms of injecting-site infection, with the proportion highest among the 25 to 34 age group (22%) (Public Health England, 2014a).

6.2.5 Behavioural data: infection risks

Sharing of injecting equipment: people who inject psychoactive drugs

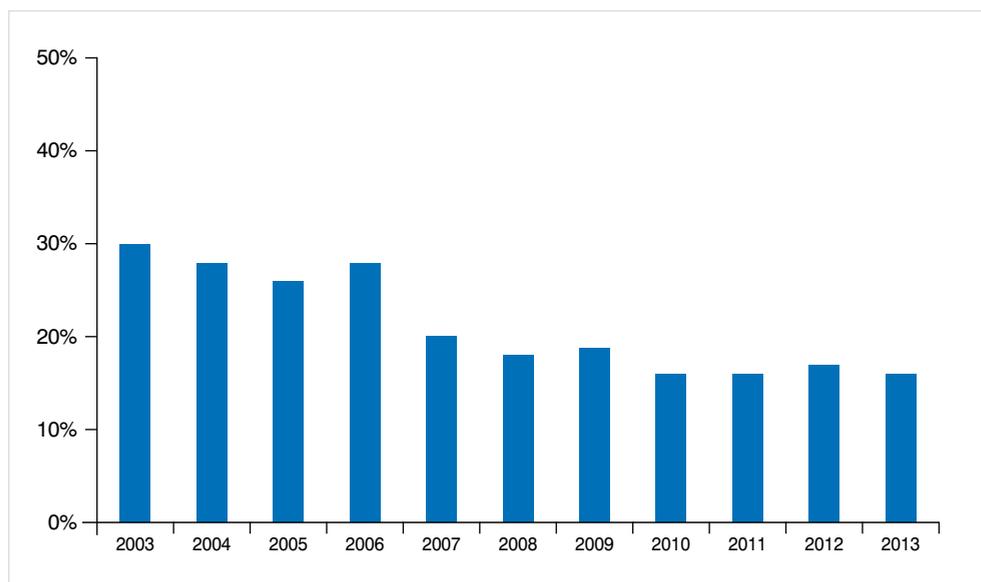
The level of needle and syringe (direct) sharing reported by participants in the UAM Survey in England, Wales and Northern Ireland has declined from 29% (95% CI, 27%-32%) in 2003 to 16% (95% CI, 15%-18%) in 2013 (Public Health England, 2014q); (Figure 6.4). Direct sharing levels were considerably higher amongst those aged under 25 years than amongst older participants; in 2013, 31% (95% CI, 24%-40%) of those aged under 25 years reported direct sharing compared with 17% (95% CI, 14%-20%) of those aged 25 to 34 years and 13% (95% CI, 11%-16%) of those aged 35 years and over. Direct sharing was found to vary across England (16%), Wales (21%) and Northern Ireland (31%). In England regional variation were reported, ranging in 2013 from 12% (95% CI, 6.6%-20%) in the East of England to 31% (95% CI, 18%-48%) in Northern Ireland.

Sharing of any of the injecting equipment asked about in the UAM Survey (i.e. needles, syringes, mixing containers, or filters; direct and indirect sharing) was reported by 39% of those participating in the survey in 2013, this was not significantly different from the previous year. Sharing of any of this equipment was reported by 39% of the participants in England (regional range: 32% to 54%), by 44% in Wales, and by 35% in Northern Ireland in 2012.

In Scotland, data from the Scottish Drug Misuse Database (SDMD) indicates sharing of needles/syringes among those injecting drugs in the past month was generally low (less than 10%, ranging from two per cent to nine per cent between National Health Service (NHS) Health Boards) and remaining constant from the values reported in 2011/12 (Information Services Division, 2014e). However, the percentage of injectors reporting having shared needles/syringes in the past, but not in the previous month was higher (ranging from 18% to 44% between NHS Health Boards), remaining broadly similar to the previous year.

Among the injectors reporting sharing of injecting paraphernalia in the past month the percentages were low, with similar variation between NHS Health Boards (ranging from four per cent to 12%). Similar low values were reported in all NHS Health Boards of injectors reporting recent sharing of paraphernalia since 2010/11 and decreasing from a higher percentage in 2006/07 (44%).

Figure 6.4: The percentage of current injectors* in the Unlinked Anonymous Monitoring Survey of people who inject drugs reporting needle and syringe sharing: England, Wales and Northern Ireland, 2003 to 2013



*Those reporting injecting in the four weeks preceding survey participation

Source: Public Health England, 2014a

In England, Wales and Northern Ireland, 8% (164/2,077) of those surveyed as part of the UAM Survey in 2013 reported that they had injected mephedrone at some point during the preceding year. Those who had injected mephedrone during the preceding year were twice as likely to report having injected drugs with a needle or syringe that had previously been used by someone else; with 32% (48/152) of those injecting mephedrone during that time reported this during the preceding year, compared with only 16% (277/1718) of those who had not injected mephedrone ($p < 0.001$) (Public Health England, 2014q).

Sharing of injecting equipment: people who inject image and performance enhancing drugs

Among the participants in the 2012/13 UAM sub-survey of people who inject IPEDs only 13% (95% CI, 9.3%-18%) reported ever sharing of any injecting equipment (Public Health England, 2014q).¹⁴³ Sharing levels were slightly higher amongst those aged 25 to 34 years than amongst the other age groups in the 2013 sub-survey¹⁴⁴ with 10% of those aged under 25 years reporting sharing compared with 16% of those aged 25 to 34 years and 12% of those aged 35 years and over (Public Health England, 2014a).

Condom use and sexual behaviour in people who inject drugs

In 2013, over two-thirds (70%, 95% CI, 68%-72%) of the PWID participating in the UAM Survey across England, Wales and Northern Ireland reported having anal or vaginal sex during the preceding year, and this level has changed little over time (Public Health England, 2014a). Of those who had sex in the last year, 41% (95% CI, 39%-44%) reported having had two or more sexual partners during that time. Of these individuals, only 18% (95% CI, 15%-21%) reported always using condoms for anal and vaginal sex. This suggests increased efforts are required to improve the use of condoms in PWID.

¹⁴³ Needle, syringe or vial

¹⁴⁴ Age was not provided by all participants to the sub-survey.

Among the participants in the 2012/13 UAM sub-survey of people who inject IPEDs nine-tenths (92%, 95% CI, 87%-95%) reported having anal or vaginal sex during the preceding year suggesting this cohort are more sexually active than participants in the main UAM Survey who inject psychoactive drugs (Public Health England, 2014a). Of those, 54% (95% CI, 47%-60%) reported having had two or more sexual partners during that time and of these, only 13%, (95% CI, 8%-21%) reported always using a condom; a smaller proportion than in the main UAM Survey of PWID.

Men who have sex with men

Gay, bisexual and other men who have sex with men (MSM) constitute an estimated 5.5% of the male population in the UK. They are the group most affected by HIV in the UK. In recent years, the number of new HIV diagnoses among MSM in England has risen steadily reaching, an all-time high of 3,250 in 2013¹⁴⁵ a rise of 10% from 2,950 in 2011 (51% of all new diagnoses) (Public Health England, 2014i; Public Health England, 2014j; Public Health England, 2014i; Public Health England, 2013c). The same trend has been observed in sexual health clinics in England in 2013 where 12% of all newly diagnosed people with a sexually transmitted infection (STI) were MSM compared to eight per cent in 2009 (Public Health England, 2014d). There is also an increased risk of hepatitis C infection among MSM, which has been associated with having HIV and certain sexual practices. Data from the Hepatitis C in the UK: 2014 report shows that newly acquired hepatitis C infection in England among MSM is ongoing. Among the HIV-positive MSM population transmission of hepatitis C is predominantly due to sexual transmission. In England the estimated incidence of infection in this population declined significantly over the four years up to 2012, and was 2.4 per 1,000 person years in 2012 (Public Health England, 2014c).

PHE has convened a stakeholder group to look at monitoring and responding to the needs of MSM, including health risks posed by a set of interlinked drug use and sexual behaviours, often referred to as 'chemsex', and the impact of these on the transmission of STIs and BBVs. PHE identified three distinct, but overlapping, areas in which MSM bear a disproportionate burden of ill-health. These are: sexual health and HIV; mental health; and the use of alcohol, drugs and tobacco. In response to these health issues, PHE published a summary document which promoted the health and wellbeing of MSM with the overall vision that MSM enjoy long, healthy lives, to have respectful and fulfilling social and sexual relationships and significantly reduce the annual number of new HIV infections in MSM by 2020 (Public Health England, 2014j). The summary document represents the first in a trio of documents which will collectively set out PHE's vision, evidence base and recommendations for action. Further to the summary publication, PHE published its initial findings document which notes the higher prevalence of drug use and injecting drug use among MSM and sets out the scope of the challenge ahead (Public Health England, 2014j).

6.3 Other drug-related health correlates and consequences

6.3.1 Non-fatal overdoses and drug-related emergencies

Data on drug overdoses and drug-related emergencies are provided using hospital inpatient data and ICD-10 codes. It is difficult to assess the full extent of non-fatal overdoses and drug-related emergencies due to the use of illicit drugs. This is because the ICD-10 coding system includes some legally available drugs such as codeine, which is available without prescription at pharmacies. Conversely, ICD-10 codes do not include new psychoactive substances (NPS). Also, data from hospitals are only available for those who are admitted to hospital and stay as an inpatient. Evidence shows that fewer than one-third of individuals attending hospital with acute recreational drug toxicity are admitted to hospital and even those admitted may not be assigned an appropriate ICD-10 code (UK Focal Point, 2011; Wood, Conran, & Dargan, 2011)

¹⁴⁵ This reflects both on-going high levels of HIV transmission and an increase in HIV testing.

In 2012/13, hospital inpatient data showed that there were 38,342 inpatient discharges recording poisoning by drugs in the UK, a six per cent increase since 2011/12 (Table 6.1).¹⁴⁶ As in previous years, over half (58.6% or 22,472) were due to 'other opioids including morphine and codeine'. Discharges linked to other opioid poisonings have increased each year from 2007/08 when there were 16,452. Heroin poisoning accounted for 6.1% (2,338) of discharges, cocaine for 5.8% (2,226) and methadone for 4.0% (1,543). Almost all drug poisonings were emergencies (99%). The number of discharges recording heroin poisoning has decreased since 2009/10 (3,155). Methadone poisoning discharges fell in 2012/13 to 1,543 from 1,833 in 2011/12.

Table 6.1: Inpatient discharges recording poisoning by drugs in the United Kingdom, 2007/8 to 2012/13

DRUG	2007/08		2008/09		2009/10		2010/11		2011/12		2012/13	
	n	%	n	%	n	%	n	%	n	%	n	%
Other opioids including morphine and codeine	16,452	50.6	17,902	57.2	19,266	62.9	21,509	63.5	22,102	61.0	22,472	58.6
Heroin	3,071	9.4	3,053	9.8	3,155	10.3	2,500	7.4	2,453	6.8	2,338	6.1
Cocaine	2,477	7.6	2,627	8.4	1,986	6.5	2,247	6.7	2,139	5.9	2,226	5.8
Methadone	1,365	4.2	1,493	4.8	1,533	5.0	1,954	5.8	1,833	5.1	1,543	4.0
Total	32,511	100.0	31,319	100.0	30,618	100.0	33,889	100.0	36,255	100.0	38,342	100.0
Emergencies	n/a	99.0	30,991	99.0	30,311	99.0	31,794	93.7	35,897	99.0	37,908	99.0

Source: Personal communication – Health and Social Care Information Centre, Department of Health, Social Services and Public Safety Northern Ireland, Information Services Division Scotland, Public Health Wales

Respondents from the Global Drugs Survey 2013¹⁴⁷ were asked whether or not they had sought emergency medical treatment and whether or not they had been admitted to hospital as a result of drugs. These questions are a proxy for the acute harms experienced following the use of drugs. In the previous 12 months, 0.8% of respondents had sought emergency medical treatment after taking MDMA and 0.4% after using cannabis.

6.3.2 Psychiatric co-morbidity in drug-related death

Scotland

Data from the National Drug Related Deaths Database (NDRDD) (see section 6.4.3) show that of the 479 drug-related deaths in 2012, more than half (56%) had a known psychiatric condition ($n=267$) (Hecht et al., 2014). Depression was the most commonly reported known psychiatric condition (40%) followed by anxiety (27%) and personality disorder (six per cent) (Table 6.2).

This distribution has remained stable since 2009 with the exception of small increases in the proportion of clients diagnosed with anxiety (from 15% to 27%) and depression (from 23% to 40%).

¹⁴⁶ Using ICD-10 diagnosis codes T40 and T43.6

¹⁴⁷ See: <http://www.globaldrugssurvey.com/facts-figures/the-global-drug-survey-2014-findings/>

Table 6.2: The number and percentage of drug-related deaths with a known psychiatric condition in Scotland, 2012

PSYCHIATRIC CONDITION	NUMBER OF DEATHS	% OF INDIVIDUALS WITH KNOWN PSYCHIATRIC CONDITION*
Depression	190	39.7
Anxiety	130	27.1
Personality Disorder	30	6.3
Schizophrenia	19	4.0
Post-Traumatic Stress Disorder	12	2.5
Bipolar Disorder	11	2.3
Other psychiatric conditions	25	5.2
Total	267	55.7

*Does not sum to total due to double counting of conditions

Source: Hecht et al., 2014

6.3.3 Suicide by drug poisoning in Scotland

Death by poisoning which includes drug overdose is the second most common method of suicide in Scotland and accounted for 32% of all suicides between 2009 and 2012. Drug poisoning accounts for almost half of all suicides in females (49%) compared to just over a quarter (26%) of all male suicides (Information Services Division, 2014f).

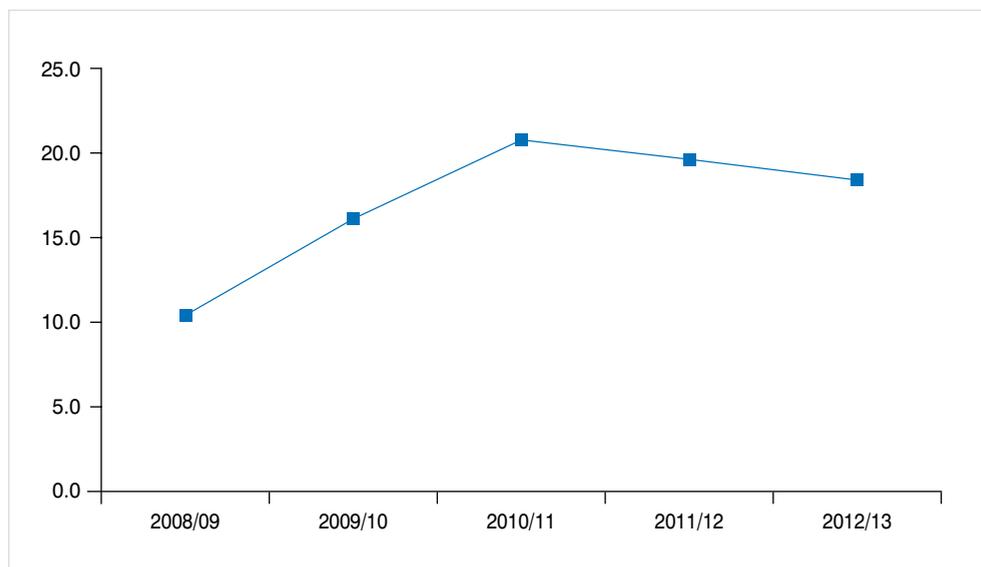
Of the suicides between 2009 and 2012, 14% of cases had been discharged from a mental health speciality with the main diagnosis of mental and behavioural disorders due to psychoactive substance use within 30 days of death compared to 19% within 12 months of death and 23% within five years of death.

6.3.4 Maternities born to drug misuse in Scotland

The number of maternities¹⁴⁸ recording drug misuse was 1,027 (18.5 per 1,000 maternities) in 2012/13, a slight decrease from the previous years' figure of 1,126 (19.6 per 1,000 maternities) (see Figure 6.5) (Information Services Division, 2014a). In the last five years, rates have increased from 10.4 per 1,000 in 2008/09 to 18.5 per 1,000 in 2012/13 but this change is in part due to better recording of data. In 2012/13, 1.8% (around 1 in 54) of maternities in Scotland recorded drug misuse. Nearly half (48%) of those recorded the misuse of opioids. The rate of maternities recording drug misuse was four times as many in the most deprived area (28.8 per 1,000 births) as in the least deprived (7.1 per 1,000 births) in 2012/13.

¹⁴⁸ A maternity is defined as a pregnancy which results in a live or stillbirth

Figure 6.5: The rate per 1,000 maternities citing drug misuse in Scotland, 2008/09 to 2012/13



Source: Information Services Division, 2014a

In 2012/13, of the 1,044 births to mothers recording drug misuse, 80% were reported as having a full-term normal birth weight ($n=832$). This compared to 90% of all births recorded as having a full-term normal birth weight. Thirteen per cent of births recording drug misuse were preterm; almost double that for all births at seven per cent.

6.3.5 Enquiries to the National Poisons Information Service

In the year 2013/14, the National Poisons Information Service (NPIS) monitored telephone enquiries and TOXBASE¹⁴⁹ accesses related to 61 substances, which included traditional drugs of misuse (such as cocaine, cannabis, opioids and stimulants) and NPS. NPIS reported 1,561 telephone enquiries and 58,469 online sessions on TOXBASE to obtain information related to the substances monitored. This was three per cent of all NPIS telephone enquiries, and four per cent of all TOXBASE activity (Public Health England, 2014h).¹⁵⁰ The largest number of telephone enquiries and TOXBASE accesses were for cocaine. There was a 13-fold increase in telephone enquiries and 253% increase in TOXBASE accesses relating to cannabinoid receptor agonists compared with the previous year. An increase has also been observed of 63% and 66% respectively, in telephone enquiries and TOXBASE accesses for 'legal highs' (not otherwise specified substances)¹⁵¹ compared to 2012/13.

¹⁴⁹ TOXBASE[®] is a specialist online database of poisons and drug toxicity information for use by health care professionals in the UK. It is co-ordinated by the National Poisons Information Service. A telephone enquiry service is also provided for health care professionals. See: <http://www.npis.org/toxbase.html>

¹⁵⁰ The data reported are related only to the 61 substances monitored in 2013/14, so they do not represent all NPIS activity pertaining to drugs of misuse

¹⁵¹ With this terminology NPIS refers to enquiries where the specific substance has not been identified but has been described as a 'legal high' or the 'legal high' page on TOXBASE[®] has been accessed.

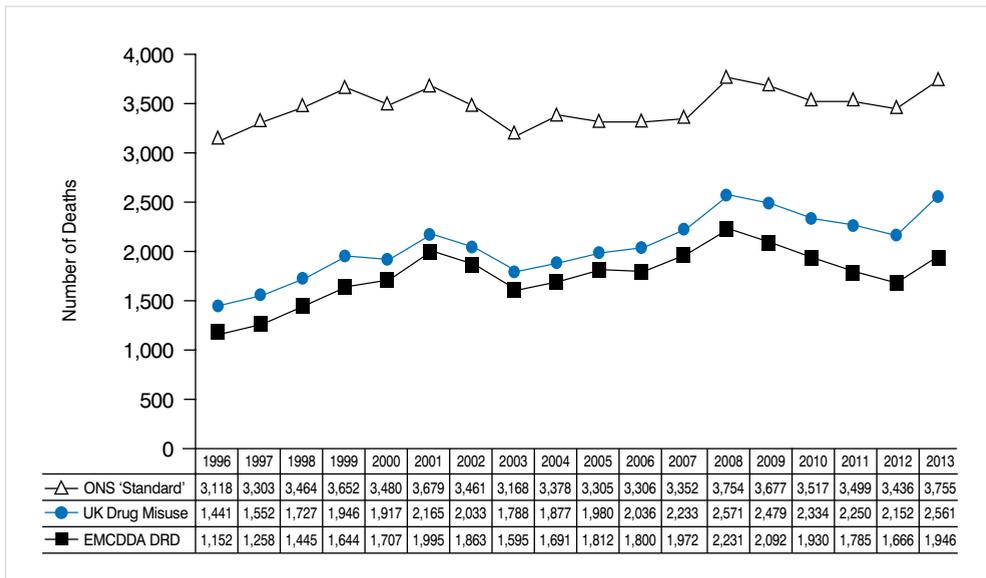
6.4 Drug-related deaths and mortality of drug users

6.4.1 Direct overdoses and indirect drug-related deaths

Using the EMCDDA definition, the total number of drug-related deaths registered in the UK during 2013 was 1,946, a 16.8% increase since 2012 ($n=1,666$) (ST06). Using the slightly different definition of drug misuse, originally adopted to measure the impact of the former UK Drug Strategy (Home Office, 2002), there were 2,561 drug-related deaths registered in the UK (up from 2,152 in 2012). Using the much wider ONS definition, there were 3,755 drug-related deaths registered in the UK in 2013 (up from 3,436 in 2012). Figure 6.6 shows the number of drug-related deaths registered in the UK from 1996 to 2012, using three different definitions for comparison.

From 1996, when there were 1,152 drug-related deaths (using the EMCDDA definition), the number of deaths rose each year to reach 1,995 in 2001 (Figure 6.6) (ST06). Numbers reduced in 2002 and again in 2003 (when they arrived at 1,595), before gradually increasing over the following five years to reach 2,231 in 2008. Since 2008, drug-related deaths have gradually fallen each year to reach 1,666 registered in 2012; however, they increased between 2012 and 2013 and now stand at 1,946, a figure more comparable to 2010.

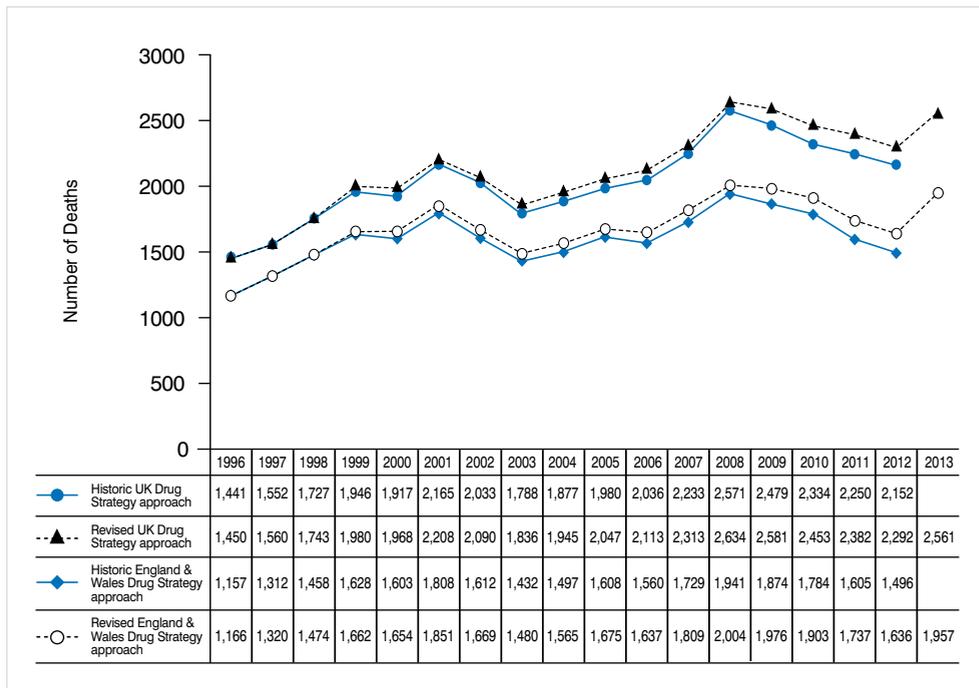
Figure 6.6: Drug-related deaths in the United Kingdom, 1996 to 2013 by definition



Source: ST06

In the reporting year 2014, ONS updated the definition of 'Drug Misuse' for England and Wales to include new substances controlled by the *Misuse of Drugs Act* (see section 1.1). The effect of this revision can be seen in the Figure 6.7.

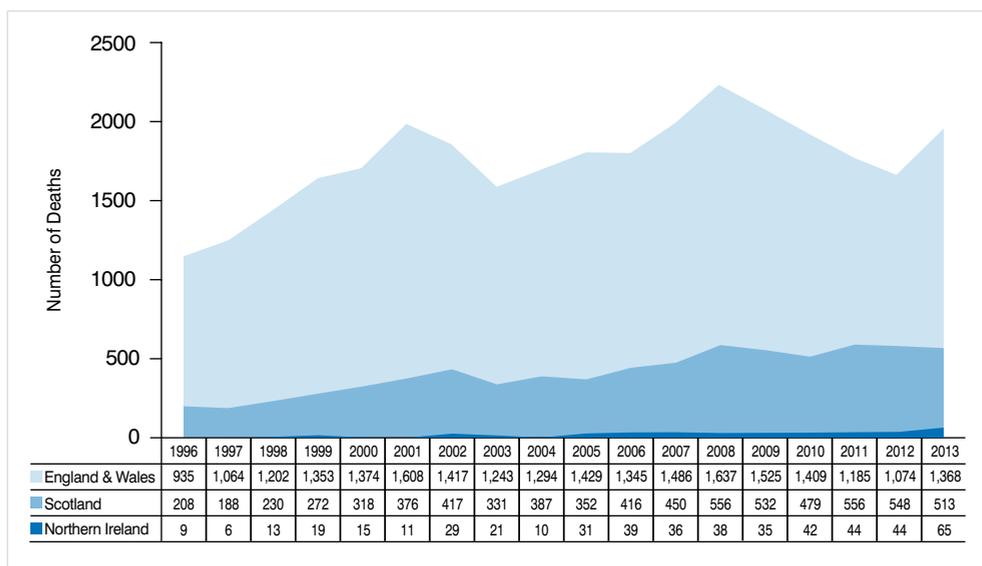
Figure 6.7: A comparison of the total number of deaths using the historic and revised Drug Misuse definition, England and Wales and the United Kingdom, 1996 to 2013



Source: Personal communication – ONS

Figure 6.8 shows the number of drug-related deaths separately for Northern Ireland, Scotland and England and Wales from 1996 to 2013 using the EMCDDA definition. Drug-related deaths in England and Wales fell between 2008 and 2012; however, they increased in 2013 according to the EMCDDA definition (+27.4%) (ST06). Drug-related deaths in Northern Ireland rose slightly between 2008 and 2012 (+15.8%) however, rose markedly between 2012 and 2013 (+47.7%), nevertheless the absolute number of deaths remains small ($n=65$). There was a decline in drug-related deaths in Scotland between 2012 and 2013.

Figure 6.8: A comparison of the total number of drug-related deaths in the United Kingdom using the European Monitoring Centre for Drugs and Drug Addiction definition, 1996 to 2013 by country



Source: National Records of Scotland, 2014; Northern Ireland Statistics and Research Agency, 2014a; Office for National Statistics, 2014b

Age and gender

Of the deaths registered in 2013, three-quarters ($n=1,479$) were males and one-quarter ($n=467$) were females (ST05). The highest percentage of males was 76% in England & Wales closely followed by Scotland at 75%, and the lowest in Northern Ireland at 72%. The number of deaths amongst males in the UK has increased by 17.7% between 2012 and 2013 and by 14.2% amongst females.

In 2013, the average age of those dying was 41.6 years, with males tending to be about five years younger than females (40.5 years and 45.2 years respectively). The average age at death has increased from 31.5 years in 1996. Deaths of males tended to occur in younger age-groups in Northern Ireland. Overall, most deaths registered in the UK in 2013 occurred in the 40 to 44 years age-group, increasing by 17% from the previous year. Since 2008, when drug-related deaths were at their peak, deaths decreased for all age groups apart from those aged over 50 years old in the period to 2012, but all age groups experienced an increase in numbers in 2013.

Drugs mentioned on death certificates in the United Kingdom¹⁵²

Most drug-related deaths are associated with opioids (chiefly heroin/morphine and methadone). There are also large numbers of deaths involving benzodiazepines such as diazepam. Deaths often involve a combination of drugs, with alcohol also commonly mentioned; around two-fifths of deaths involving heroin, methadone, cocaine or benzodiazepines in England and Wales during 2013 also mentioned alcohol (Office for National Statistics, 2014c).

After a large decrease in deaths mentioning heroin in 2011, following reports of a reduced supply of heroin, the number of deaths mentioning heroin remained stable in 2012, but increased again in 2013 (Table 6.3). The number of deaths mentioning methadone continued to decrease after a large increase in 2011. Deaths involving ecstasy-type substances continue to increase, although the number remains lower than in 2007 and earlier years. Deaths mentioning cocaine increased again in 2013; there was also an increase in amphetamine-related deaths. These general patterns are also evident in the National Programme on Substance Abuse Deaths (NPSAD) data (see below).

¹⁵² Drugs mentioned on death certificates include licit and illicit drugs

Table 6.3: Mentions of selected drugs on death certificates*, United Kingdom, 2003 to 2013**

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Heroin/morphine	883	977	1,045	985	1,130	1,230	1,215	1,063	820	825	1,011
Methadone	292	300	292	339	441	550	586	535	765	660	650
Cocaine	161	192	221	224	246	282	239	181	152	174	215
Amphetamine	43	53	62	60	62	72	57	52	72	67	85
Ecstasy-type	66	61	75	62	64	52	32	9	24	44	62
Mephedrone	0	0	0	0	0	0	1	14	9	14	22
Cannabis	32	24	25	22	20	20	22	11	7	18	13
All benzos, of which:	427	385	321	297	345	414	442	469	514	527	535
Diazepam	282	216	210	187	223	277	302	315	336	410	373
Temazepam	114	88	55	56	57	50	48	38	45	45	35
Antidepressants	524	565	484	454	436	512	528	528	529	618	611
Antipsychotics	77	94	96	104	114	117	110	116	143	148	147
Paracetamol	547	632	490	376	306	319	302	251	257	223	272
Tramadol	51	56	75	109	116	126	135	185	205	254	304
All ONS definition deaths	3,168	3,378	3,305	3,306	3,352	3,754	3,677	3,517	3,499	3,436	3,755

*A revised data collection form was introduced in Scotland in 2008 which has resulted in more specific drugs being identified than in previous years; ONS revised how they deal with paracetamol in compounds in 2010, and revised their figures retrospectively. ONS have made revisions to their historic data; data for Northern Ireland have been extracted for us by NISRA and are slightly different in some years to what had been previously extracted

**Year of registration of death, not year when death occurred

Source: National Records of Scotland, 2014; Northern Ireland Statistics and Research Agency, 2014a; Office for National Statistics, 2014b

Deaths mentioning tramadol continued to increase rapidly, by 24% between 2011 and 2012, and 20% between 2012 and 2013. Mentions of tramadol doubled between 2004 and 2006, and then increased steadily before significantly increasing in 2010 to 2013.

It is important to note that drug deaths in Wales, whilst remaining at higher rates per population for both males and female than England, do not follow a consistent pattern with England. Drug misuse deaths in Wales have decreased since 2010 and remained stable for 2012 and 2013 with a total of 135 deaths each year (Public Health Wales, 2014b).

6.4.2 Information from the National Programme on Substance Abuse Deaths

Data from the UK-wide SMR database, which includes data from Police Scotland, are broadly consistent with those from ONS. NPSAD reports on deaths throughout the UK based on the year of death rather than the year in which the death was registered. The NPSAD annual report recorded 1,613 notifications of drug-related deaths occurring in 2012 in the UK and Islands (Corker et al., 2014). This represents a decrease of 144 (eight per cent) notifications over the same reporting period in 2011, but does not necessarily reflect a fall in deaths.

The overall pattern in the types of psychoactive drugs implicated in death has remained similar to previous years. Heroin/morphine continues to be the substance most commonly implicated in death, although the proportion of deaths in which the drug was implicated rose from its lowest level in 2011 to 36% in 2012. This increase of almost five per cent from last year contrasts with the steady decline that was seen between 2009 (53%) and 2011 (32%) for deaths involving this drug.

The proportion of cases involving methadone in 2012 fell to 28% which is in contrast to the steady rise seen from 2008 to 2011 (22% to 31%). Deaths involving hypnotics/sedatives, such as benzodiazepines, continue the consistent rise seen in previous years from 22% in 2008 to 30% in 2012.

The slight increase in deaths noted in 2011 in which stimulants such as cocaine and ecstasy were implicated has continued into 2012 (accounting for three per cent and one per cent respectively, up from one per cent and 0.7% respectively), whilst deaths involving amphetamines stabilised.

In 2012, there was a single case where mephedrone was the only drug implicated in death and a further 13 deaths where it was implicated in addition to other substances. This represents a decrease from a peak of 33 deaths in 2010 where mephedrone was implicated and mirrors decreases in self-reported last year use of mephedrone in those aged 16 to 59 (see section 2.2).

Between 2011 and 2012 there has been a steep increase in the number of deaths involving parmethoxyamphetamine (PMA) from five to 19 deaths. Increases across this time period were also observed for benzofurans from one to nine deaths which was principally accounted for by APB compounds¹⁵³

6.4.3 Drug-related deaths in Scotland reported by the National Drug-Related Deaths Database

The fourth report from the NDRDD (see section 7.2.1) in Scotland was published in March 2014, examining the personal circumstances of those who died a drug-related death in Scotland in 2012 (Hecht et al., 2014). The drug-related deaths in the NDRDD report are a sub-set of the 581 drug-related deaths published by National Records of Scotland (NRS) August 2013 (National Records of Scotland, 2013).¹⁵⁴

In 2012, there were 479 cases identified as eligible for inclusion in the main NDRDD cohort (an increase from 438 in 2011). As with previous years, three-quarters (75%) were male. Between 2009 and 2012, there has been a small increase in the proportion of deaths occurring in the most deprived quintile (52% to 57% respectively) with concurrent small decreases in deaths occurring in the second most deprived quintile (24% to 21% respectively).¹⁵⁵ The proportion of deaths occurring in the less deprived areas has remained stable since 2009 at around four per cent of all deaths. Drug-related deaths in those aged 45 and over were higher in 2012 (26%) than in 2011 (14%) and lower in those aged under 25; eight per cent in 2012 compared to 12% in 2011. This is broadly in line with the picture of the rest of the UK and suggests an ageing cohort of drug users.

Of those individuals who were known drug users ($n=419$), the majority had used drugs for over 10 years (64%). A small proportion of deaths occurred in individuals who had used drugs for less than 12 months (three per cent) and this represents a similar proportion (three per cent) in 2011. Of those using drugs intravenously ($n=246$), those who had used drugs for more than ten years accounted for the most drug-related deaths (59%).

In 2012, the vast majority of people who had died had not received drug detoxification treatment in the year prior to death (92% of all known drug users). The majority of cases were not in receipt of opioid substitute treatment (OST) at the time of death (72%) and in the instance that OST was prescribed, methadone was the most commonly prescribed drug; 96% of all OST prescriptions. This represents an increase from 90% in 2011. Concurrent with this increase, there was a decrease in the proportion of supervised OST dispensing; 80% of all methadone prescriptions in 2011 to 74% in 2012.

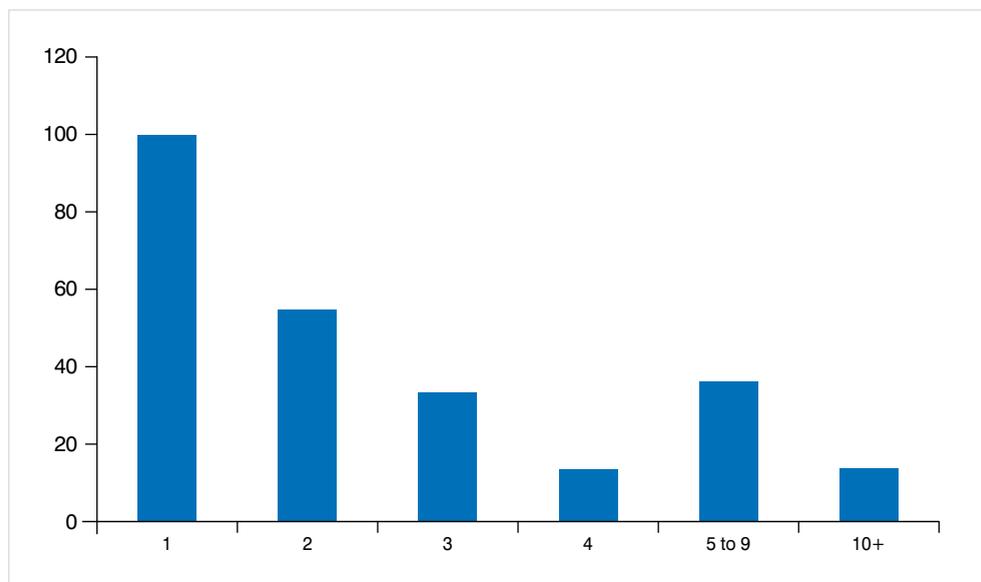
¹⁵³ Benzofuran-like compounds, such as 6-APB, 5-APB, 5-APDB and 6-APDB

¹⁵⁴ Since the latest NDRDD report was published, the NRS has published figures for 2013 (National Records of Scotland, 2014)

¹⁵⁵ The Scottish Index of Multiple Deprivation (IMD) classified postcode area by deprivation on a scale of one to five with one being the least affluent

Of those with a known previous experience of non-fatal overdose ($n=251$, 53% of all deaths), most of these had previously overdosed once (40%) and five per cent of all cases had experienced 10 or more overdoses (Figure 6.9). In most cases where the individual had experienced a previous overdose, they had done so over three years before the point of death (44% of all cases known to experience previous overdose) but a quarter of those who died had experienced a previous non-fatal overdose less than six months prior to their death (25%).

Figure 6.9: The number of individuals experiencing previous non-fatal overdose and the number of overdoses they experienced in Scotland, 2012



Source: Hecht et al., 2014

As in previous years, in almost all cases (97%) there was more than one drug present in the body at death and in 69% of cases more than one drug was deemed to be implicated in death, indicating a high presence of polydrug use amongst this cohort.¹⁵⁶ This is in line with data from the *Scottish Crime and Justice Survey* (SCJS) (section 4.3.2) where, of those people taking more than one drug in the last year, 54% of those aged 16 and over reported that they had taken different drugs together at the same time (Scottish Government, 2014d). This is also in line with the NPSAD findings (Corkery et al., 2014). Of the polydrug citations at death, the most common drug combination in 2012 was methadone and diazepam (43%), followed by heroin and diazepam (41%) and diazepam and alcohol (36%) (Table 6.4). This was the same in 2011; however, in 2009 and 2010 the most common polydrug citation was heroin and diazepam, accounting for 58% and 50% of all polydrug deaths respectively.

In 2012, diazepam was the drug most frequently found to be present in the body at death (79%) but methadone was the drug most frequently *implicated* in the death (46%). Considering only 28% of all deaths were of individuals receiving OST, the high prevalence of methadone implicated in overall death would suggest incidences of methadone use without a prescription. This again is in line with previous NPSAD findings and previous research in Scotland (Corkery et al., 2014).

¹⁵⁶ The 2012 report (Hecht, Barnsdale, & McAuley, 2014) includes data on drugs 'present' in the body and drugs 'implicated' in the death. The presence of a drug in the toxicology of the deceased individual does not necessarily mean that the drug was implicated in (contributed to) the death.

Table 6.4: The drug combinations present at death in Scotland, 2009 to 2012

DRUG COMBINATION FOUND IN BODY AT POST MORTEM	% OF DEATHS			
	2009	2010	2011	2012
Heroin & Methadone	18	17	22	19
Heroin & Alcohol	44	33	21	22
Heroin & Diazepam	58	50	45	41
Methadone & Alcohol	19	20	19	23
Methadone & Diazepam	33	37	49	43
Diazepam & Alcohol	44	38	29	36
Heroin, Diazepam & Alcohol	34	24	18	19
Methadone, Diazepam & Alcohol	14	15	16	19

Source: Hecht et al., 2014

The second most common drug implicated in death was heroin/morphine (41%), diazepam (30%), alcohol (19%), dihydrocodeine (13%) and antidepressants (12%). Methadone was implicated in a lower, and diazepam in a higher, percentage of deaths than in 2011 (53% and 23% respectively). Other drugs were roughly similar in terms of implication from 2011 to 2012.

There were 36 cases with an NPS¹⁵⁷ *present* in the body at death. They were categorised into two main types: benzodiazepine-type drugs (mainly phenazepam) and stimulant-type drugs (e.g. BZP, mephedrone). This represents a presence of almost eight per cent of all deaths.

6.4.4 Drug-related deaths in Northern Ireland

In 2013, there were 78 deaths due to drug misuse registered (Northern Ireland Statistics and Research Agency, 2014b). The nature of these deaths is qualitatively different from the picture in the rest of the UK. Whereas the vast majority of drug-related deaths in the UK are linked to drugs such as heroin and morphine, in Northern Ireland most relate to benzodiazepines (28%) with anti-depressants accounting for the same proportion of drug-citations at death as heroin/morphine (16%). Indications of polydrug use in Northern Ireland are significantly lower than in Scotland with 42% of cases having only one substance cited at death.

Research

Tramadol deaths in Northern Ireland; a review of cases from 1996 to 2012

Randall and Crane published a review of all deaths associated with tramadol in Northern Ireland (Randall & Crane, 2014). The review highlighted 127 cases from 1996-2012. A 10% increase in deaths due to tramadol was noted. In 2001, tramadol deaths represented nine per cent of all drug misuse deaths rising to 40% in 2011. The majority of deaths occurred in males (62%), with a median age of 41 years, living in the Belfast city area (36%). Tramadol deaths were observed in combination with other drugs/medicines (49%), alcohol (36%) or alone (23%). In just over half of the deaths, tramadol had not been prescribed by a medical practitioner (53%). Depression, anxiety and seizures were recognised as risk factors. The authors noted that an increase in awareness of tramadol toxicity is needed amongst the public and doctors.

¹⁵⁷ The NDRDD adopts the following definition (as is also used by NRS) when including NPS within the dataset: "The term 'New Psychoactive Substances' (NPSs) is meant to cover the kinds of substances that people have, in recent years, begun to use for intoxicating purposes. NPSs include so-called 'legal highs' (by which is meant substances which were legally available at the time of the death, whether or not they have since become controlled). In general, when an NPS first became available, it would not have been a controlled substance under the *Misuse of Drugs Act 1971*. Some NPSs may still not be controlled under the Act. The definition of NPSs therefore includes current so-called 'legal highs', and also substances which used to be described as 'legal highs' but are now controlled".

Debate around the definition of New Psychoactive Substances in drug-related death reporting

In March 2014, King and Nutt, writing on behalf of the Independent Scientific Committee on Drugs (ISCD) published a commentary entitled; *Deaths from Legal Highs: a problem of definitions* (King & Nutt, 2014a). The authors suggest that national reporting of NPS in drug-related deaths such as the NPSAD (Corkery et al., 2014) and ONS reports (Office for National Statistics, 2014c) presents misleading estimates of the number of UK deaths linked to NPS and additionally there is no nationally adopted definition in the reporting of these deaths. They highlight that many of the deaths recorded in the report which were widely attributed in the media to “legal highs” (NPS) were, in fact, attributable to substances which are already illicit in the UK, such as PMA, which has been a controlled drug in the UK since 1977. Further examples include deaths attributed to khat or anabolic steroids, which are either not new, or not classed as psychoactive.

The authors of the NPSAD report responded that the section on NPS in the report describes trends over the period 2009 to 2012 “in a range of emerging substances, including former pharmaceutical or therapeutic drugs that could be misused and substances that have subsequently become controlled drugs” (Goodair et al., 2014). They defended the inclusion of anabolic steroids and DNP (2,4-dinitrophenol) as NPS due to them having potential similarities to other psychoactive substances or causing psychiatric side-effects or neuropsychotic complications. It was further argued that these differing evaluations of psychoactive status “emphasises the range of opinions on these new and re-emerging psychoactive substances”.

In their response, King & Nutt (King & Nutt, 2014b) “agree... that a debate about definitions of NPS is needed, but the purpose of that debate should be to select, as a standard, one of the several existing definitions of new substances”. In their view, that standard should be the one adopted by the European Union (EU) on May 10, 2008, and that since this Council Decision is a legally binding document on Member States, they do not accept, as suggested by Ian Cope (Cope, 2014), that there is no official definition of new psychoactive substances.

6.4.5 Deaths from HIV/AIDS

In England and Wales, up to the end of December, 2012,¹⁵⁸ there were 1,512 AIDS deaths of people who injected drugs (PWID), accounting for 7.9% of AIDS deaths recorded up to that date ($n=19,186$). In Northern Ireland, AIDS deaths of PWID accounted for 7.3 % of all AIDS deaths (eight deaths, $n=110$) but in Scotland, the percentage was much higher at 47.0% of AIDS deaths (847 deaths, $n=1,800$). In the year to end of December 2012, there were 46 reported AIDS deaths amongst PWID in the UK but this figure is likely to rise as further reports from that period are received. Numbers of AIDS deaths for PWID in the UK each year since 2006 have been fairly steady at between 60 and 65 each year (apart from in 2009 when there was a slight increase), much lower than the peak level of 212 deaths in 1995 (Public Health England, unpublished data).

6.4.6 Deaths from hepatitis C

Both hospital admissions and deaths from HCV-related end stage liver disease and hepatocellular carcinoma are continuing to rise in the UK (Public Health England, 2014c). Hospital admissions rose from 608 in 1998 to 2,390 in 2012, while deaths rose from 98 in 1996 to 428 in 2012. This increase is particularly notable in Scotland where liver-related deaths among people diagnosed with hepatitis C increased at an annual rate of nine per cent in the last five years compared to an average UK annual rate of five per cent. Linking records from Scotland's National Hepatitis C Diagnoses Database to the national register of deaths, showed that only 764 (49%) of the total 1,555 liver-related deaths during 1996-2012 among people diagnosed with hepatitis C, had any mention of hepatitis C on their death certificate. Among the 141 liver-related deaths in 2012, 97 (69%) had liver disease recorded as the underlying cause of death (alcoholic liver disease was the most prevalent underlying cause in 47), and 44 (31%) had liver disease only as a contributing cause of death. It is therefore likely that the total number of deaths recorded as HCV-related end stage liver disease is an underestimate of the true situation.

¹⁵⁸ Numbers for 2012 are likely to increase as further reports are received; data presented are as known at the end of June 2013.

7. Responses to health correlates and consequences

7.1 Introduction

In the United Kingdom (UK), the health harms caused by drug misuse have been well documented. Drug misusers are at risk of both fatal (Hickman et al., 2003) and non-fatal overdose (Gossop et al., 1996), experiencing periods of elevated overdose risk in the immediate period after leaving inpatient treatment and prison (Cornish et al., 2010; Farrell & Marsden, 2008) and experience greater risk of contracting blood-borne viruses (BBV) through injecting drug use (Judd et al., 2004).

The UK Government and devolved administrations have a number of policy and guidance documents outlining best practice for responses to the health correlates and consequences of drug use (often referred to as harm reduction). Generally, harm reduction is the combination of work aimed at reducing the number of drug-related deaths and BBV and other infections, with the wider goals of preventing or reducing drug misuse and encouraging stabilisation in treatment and support for recovery. Principles of harm reduction aim to reduce the risky behaviour of those who are active drug users who are either unwilling or unable to abstain.

In Wales, the ten year substance misuse strategy *Working Together to Reduce Harm* (Welsh Assembly Government, 2008a) was published in 2008, setting out a national agenda for tackling and reducing the harms associated with substance misuse. Key actions included the development of guidance and protocols to introduce naloxone, and in 2008, the Welsh Government announced its intention to establish demonstration sites for take-home naloxone (THN). Several pilot schemes are currently running in Wales to ensure a wide distribution of naloxone including a feasibility study for the distribution of naloxone via paramedics, a pilot within an Accident and Emergency (A&E) department and a pilot within a custodial suite. The *Blood Borne Viral Hepatitis Action Plan for Wales 2010-2015* (Welsh Assembly Government, 2010) was published in 2010. In 2014, Public Health Wales (PHW) issued guidance on *Diagnostic Testing for Hepatitis C, Hepatitis B and HIV* (Public Health Wales, 2014a) aimed at those who work in substance misuse services.

The Scottish Government launched the *HIV Action Plan in Scotland, December 2009 to March 2014* (Scottish Government, 2009) in November 2009. The plan aimed to reduce the number of transmissions occurring in Scotland through increased prevention, increased early diagnosis and the improvement of the treatment and care of those living with the virus. The five year framework, the *Sexual Health and Blood Borne Virus Framework 2011-2015* (Scottish Government, 2011), integrated the aforementioned program with sexual health and hepatitis and sets out the Scottish Government's agenda in relation to sexual health, HIV, hepatitis C and hepatitis B until 2015. The framework adopts an outcomes-based approach anchored by effective shared ownership and joint working with a strong focus on challenging inequalities. Quality standards applicable to all HIV services (Health Improvement Scotland, 2011) and quality indicators applicable to all hepatitis C services (Health Improvement Scotland, 2012) were also published in Scotland. Scotland rolled out its Scottish National Take Home Naloxone (THN) programme following successful local pilots in three areas and evaluated progress so far in 2014 (Scottish Government, 2014e).

In England, the *Drug Strategy 2010, Reducing Demand, Restricting Supply, Building Recovery* (Her Majesty's Government, 2010), includes a key best practice delivery outcome that all drug services are commissioned to prevent drug-related deaths and prevent the spread of BBV. Public Health England (PHE) routinely publishes guidance on best practice and reports annual surveillance on a range of key indicators associated with BBV in the UK. In April 2014, PHE launched its 'Big Ambitions'; which include tuberculosis (TB).¹⁵⁹

¹⁵⁹ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319696/Business_plan_11_June_pdf.pdf for PHE business plan and big ambitions

In Northern Ireland, responses to health correlates and consequences of drug misuse are broadly covered by the overarching strategy for alcohol and drugs misuse; the *New Strategic Direction for Alcohol and Drugs Phase 2, 2011-2016* (Department of Health, Social Services and Public Safety Northern Ireland, 2011). One of the overall aims of the new strategic direction is to reduce drug-related harm and ensure continued support to further develop appropriate harm reduction approaches and strategies.

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

7.2.1 Data collection and information provision

England

In April 2014, PHE published a briefing on '*Preventing Drug-related Death*' (Public Health England, 2014p). The briefing contains practical advice for commissioners and services on preventing drug-related deaths and additionally provides prompts to ensure best practice. The briefing highlights the importance of enhanced treatment engagement and continuity of treatment as well as how to reduce the risk of overdose as a result of changes in treatment setting and stage of treatment. The briefing also highlighted the importance of appropriate responses to overdose, including the use of naloxone among service workers and families and friends of service users. Emphasis is given to the importance of local areas having adequate measures for limiting the risk of the diversion and misuse of prescription drugs and having a robust process of inter-agency communication of drug-related deaths. The briefing also promotes the use of locally driven effective early warning and alert systems that assess the quality of any given intelligence and the likely levels of harm and disseminate accordingly. Furthermore, a section aimed at reducing the mortality risks of new psychoactive substances (NPS) and volatile substances is included, with the recognition that these users are not those who form part of traditional service groups. The briefing also addresses the mortality risks in drug users from delayed or chronic drug-related health problems and suggests that services should offer advice on safer injecting practices, the wider health harms of drug use such as smoking and polydrug use and should promote the testing of HIV and hepatitis C and offer vaccinations where appropriate.

Scotland

Information Services Division (ISD) Scotland published its fourth report from the National Drug-Related Deaths Database (NDRDD) which presents data for the calendar year 2012 (Hecht et al., 2014) (see section 6.4.3). The NDRDD was established to collect detailed information regarding the nature and social circumstances of individuals who have died with the long-term aim of informing future interventions to reduce drug-related mortality. The report supplements the routine reporting of drug-related deaths in Scotland by the National Records of Scotland (NRS)¹⁶⁰ in its annual report. The NDRDD figure of 479 occurring in 2012 is not a national statistics output for Scotland but represents a subset of the 581 deaths recorded by NRS for 2012 (National Records of Scotland, 2013).

Information Services Division (ISD) Scotland continues to capture an increasing proportion of drug-related deaths to generate intelligence that can potentially be utilised to reduce mortality. NDRDD data collection continued to improve in 2012; only 41 deaths which were known to have met the NDRDD inclusion criteria were not included in the dataset.¹⁶¹ Furthermore, ISD Scotland is in the process of developing data-linking projects which aim to match individual deaths to hospital episodes and prescribing activity prior to death. These enhancements will help make data collection more efficient and may be used to explore comorbidities, periods of heightened overdose risk and diazepam prescribing/consumption in more detail.

The Scottish Drugs Forum (SDF) published its annual report 2012/13 detailing its activities over the preceding year, including; observations on the national naloxone programme; developing hepatitis C treatment in the community; sexual and reproductive health; addiction worker training; workforce development; and NPS (Scottish Drugs Forum, 2013). Since 2013, SDF have been carrying out tailored

¹⁶⁰ The National Statistics output for the number of drug-related deaths that are registered annually in Scotland is published by the National Records of Scotland (NRS). NRS was formerly known as the General Register Office for Scotland.

¹⁶¹ Records not included due to non-return to ISD.

work on the ageing cohort of drug users, working with service users and services directly, to understand the needs of this group better, and develop improved service responses to their specific needs. They are also creating a working group to look at the needs of older drug users, to better understand the current and future needs of this group. SDF are also developing a *Death Prevention Strategy*, involving the creation of a death prevention template in conjunction with Alcohol and Drug Partnerships (ADP's) in order for ADP's to take a broader view of drug deaths, leading to improved responses. This will involve SDF carrying out direct support and development work with the ADP's.

The National Forum on Drug-Related Deaths Annual Report 2013¹⁶² was published in March 2014 (National Forum on Drug-Related Death, 2014). The Forum's report includes observations on the Scottish national naloxone programme, opioid substitution therapies (OST), the expansion of detail in publications such as the inclusion of NPS in drug-related death reporting, improvements in pathology and toxicology recording in drug-related deaths and improving the co-ordination and management of the NDRDD. The report offers a number of recommendations including the engagement of older, long-term drug users in to structured treatment and improving prevention strategies of drug-related death in prison.

Wales

The Welsh Government's *Substance Misuse Delivery Plan 2013-2015* (Welsh Government, 2013c) included the specific target of reducing the number of substance misuse related deaths and non-fatal overdoses in Wales. To support this, new proposals to undertake rapid case reviews for both fatal and non-fatal poisonings were developed and formally consulted on (UK Focal Point, 2013).¹⁶³ In June 2014, the Welsh Government published a summary of the consultation responses (Welsh Government, 2014a). The majority of responses to the consultation were in agreement with the proposed guidance and the implementation phase is now progressing. As part of this the Harm Reduction Database Wales has been developed to include a national data collection module for fatal and non-fatal drug poisonings, providing a local and national picture on the type and nature of poisonings across Wales from 2015.

Northern Ireland

In November 2013, the Public Health Agency (PHA) released professional guidance with the aim of reducing stimulant-related death and illness.¹⁶⁴ The guidance includes information on the physical and psychosocial effects of stimulants and also warns against bingeing on drugs and mixing stimulants with alcohol. The guidance aims to support people who work in the community, voluntary and healthcare sectors with the aim of facilitating conversations about stimulants with users of the drugs, and to provide them with harm reduction advice in the form of a fact sheet.¹⁶⁵

Research

National survey of non-fatal overdose among opioid users in Wales

The national survey of non-fatal overdose among opioid users in Wales aimed to understand how many opioid users experience non-fatal overdose each year, what the causes of non-fatal overdose are and how non-fatal overdose can be prevented (Bennett et al., 2014). The survey comprised of two parts; a quantitative questionnaire survey of injecting opioid users ($n=661$) and a qualitative interview survey ($n=15$) of a subset of the respondents.

¹⁶² The National Forum on Drug-Related Deaths Annual Report 2013 is the sixth report from the Forum, which was set up in 2005 in response to one of the actions of the Scottish DRD Strategy (Scottish Advisory Committee on Drugs Misuse, 2005). The forum is independent and has representation from experts in a range of professional fields. It provides advice and recommendations to the Scottish Government and partners on measure to reduce drug-related deaths in Scotland.

¹⁶³ See: http://ico.org.uk/~media/documents/consultation_responses/drug-poisoning-consultation-document-20130923.pdf

¹⁶⁴ See: http://www.publichealth.hscni.net/sites/default/files/stimulants_users_factsheet_version_2.pdf

¹⁶⁵ See: www.publichealth.hscni.net/publications/harm-reduction-drug-users

The aims of the quantitative questionnaire survey of opioid users were to determine;

- the prevalence of non-fatal overdose (one or more per year) among opioid users across Wales;
- the incidence of non-fatal overdose (the number of repeat overdoses);
- the most common identifiers used to determine that a person had overdosed; and
- the most common actions taken in response to an overdose

The aims of the qualitative interview survey of opioid users were;

- to obtain more detail on the characteristics of specific overdose events;
- to explore the perceived causes of overdose;
- to understand the extent to which users were concerned about overdosing;
- to examine users' attitudes to risk taking and risk reduction;
- to find out what affect overdosing had on future behaviour; and
- to elicit users' views on the most effective forms of prevention

Key findings from the quantitative questionnaire survey suggested that almost half (47%) of all opioid users said that they had overdosed at least once in their lives and 15% said that they had done so in the last 12 months. There was little difference in the prevalence of non-fatal overdose among male and female respondents. There was also no difference in the likelihood of non-fatal overdose among younger and older users. There were wide variations in the prevalence of overdose across locations ranging from zero to 75% of respondents across centres. On average, respondents who reported overdosing in the last 12 months stated that they had overdosed twice in that time.

One of the key findings from the qualitative interview survey was that there was no clear consensus among opioid users about what constituted an overdose. Some interviewees said that they had not overdosed, but nevertheless had fallen unconscious or had lost time. It was agreed by many that there is a fine line between 'gouching out'¹⁶⁶ and overdosing. However, there was a general consensus that an overdose was associated with specific symptoms, such as: shallow breathing, blue lips, and being unrousable. Overdosing was perceived to be linked to several factors such as the purity of the drug used, intravenous use, and mixing with other drugs (especially valium). The majority of users implemented harm-reduction techniques, such as: testing the strength of heroin before using it, always using the same amount, using with someone else, finding a trustworthy dealer, using with people they trusted, and judging the physical appearance of the drug.

7.2.2 Provision of naloxone

Naloxone is a drug used to counter the effects of opioid overdose, such as heroin or morphine, specifically the life-threatening depression of the central nervous system, respiratory system and hypotension secondary to opioid overdose. Naloxone is used in hospitals and carried routinely on ambulances throughout the UK to treat patients suffering from severe respiratory depression following an opioid overdose. It can be prescribed to drug users, including those receiving opioid substitution treatments and, with their agreement, supplied to family or carers.

There are national naloxone programmes in Scotland, Wales and Northern Ireland allowing use of naloxone in non-clinical settings such as hostels as well as facilitating the distribution of naloxone kits to those at risk of overdose or to their families and carers (SQ23-29).

¹⁶⁶ Defined as periods of unconsciousness without the users awareness

Between November 2013 and February 2014, the Medicines and Healthcare Products Regulatory Agency (MHRA) ran a consultation on a proposal to allow wider access to naloxone for the purpose of saving a life in an emergency.¹⁶⁷ Responses were very largely supportive of the proposal and legislation to make naloxone more widely accessible is expected to come into force in 2015.

Scotland

In Scotland, anyone can legally administer naloxone in an emergency. However, the drug remains a prescription only medicine (POM) and can currently only be supplied to named patients or their representatives with patient consent. In 2011, the Lord Advocate recognised that it was important for the supply of naloxone to be extended to “services which come into contact with those vulnerable individuals who may be at risk of opioid overdose” and that nurses, pharmacists and medical practitioners making supplies of POM outside the normal regulations should be “immune from prosecution”. This enabled the programme to reach greater numbers of individuals and services in regular contact with those likely to experience overdose.

In 2012/13, there were 3,833 THN kits issued in Scotland through the national naloxone programme (Information Services Division, 2014d). This compares with 3,458 kits issued in 2011/12, an increase of 375 kits (+10.8%). The majority of this increase was accounted for by increases in the distribution of THN in the community ($n=344$) but a slight increase between 2012/13 and 2011/12 was also observed in clients leaving prison ($n=31$). The Scottish Government continue to support the issue of naloxone kits in both community and prison settings, and are continuing to reimburse ADP's for kits issued, to help embed the programme nationally.

The majority of the total kits issued in 2012/13 were issued in the community (3,087, or 80.5%) (Information Services Division, 2014d). Of the 3,087 kits issued in the community, the majority were issued to individuals at risk of opioid overdose ($n=2,680$; 86.8%). Three-hundred and twenty-nine (10.7%) were supplied to service workers and 78 (2.5%) were issued to family and friends (with the recorded consent of the person at risk). Of the 3,087 kits issued in the community in 2012/13, 2,471 (80.0%) were reported as a 'first' supply, 559 (18.1%) a 'repeat' supply and 57 (1.8%) were 'unknown'. These figures are comparable to the 2011/12.

In 2014, the National Naloxone Advisory Group (NNAG)¹⁶⁸ carried out an evaluation of the THN programme. The research was undertaken between August 2013 and March 2014 and included a range of research methods.¹⁶⁹ Key implications and conclusions of the report included;

- the existence of a steering group is useful for local areas;
- there is a need for greater consistency of ADP involvement across Scotland;
- there is a need for greater involvement of general practitioners (GPs) in the programme;
- extending the staff training programme to a greater number of practitioners who are likely to come into contact with people at risk of opioid overdose, in order to enable them to provide naloxone training is required;
- further exploration of how outreach can be undertaken effectively, particularly in rural areas, to reach those who do not use addictions services is required;

¹⁶⁷ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/260242/131119_Naloxone_MLX_383_FINAL.pdf

¹⁶⁸ The NNAG is comprised of a range of experts and is responsible for monitoring the progress and delivery of the naloxone programme at both national and local level on a regular basis.

¹⁶⁹ These included a literature review, initial scoping interviews with key stakeholders, an online survey and interviews with local naloxone co-ordinators to map progress, in-depth work with four case study areas and analysis and synthesis of all elements of the research.

- further exploration of the issues relating to peer training is required to provide guidance for best practice;
- there is need for greater and more consistent involvement of community pharmacies across Scotland;
- consideration is required regarding how to increase the training and take-up of supply for those leaving prison;
- further exploration of the training police receive with regard to naloxone is required; and
- consideration of the potential to gather systematic and widespread data about the incidence and outcomes of the use of naloxone kits is required.

The NDRDD (see section 6.4.3) recorded data on the use of naloxone in drug-related death (Hecht et al., 2014). Opioids (methadone, heroin, morphine or buprenorphine) were present in the body at post mortem in 80% of the 476 drug-related deaths with known toxicology and availability of THN kit was known in 83% ($n=313$) of the opioid deaths. Naloxone was reported to be available in only five of these deaths (two per cent) and was administered in four instances (one per cent) suggesting limited distribution of THN to target groups. Of those administered naloxone, one person was administered naloxone by their partner, one by a family member, one by a friend and one by another person at the scene. Given that over half (54%) of opioid related deaths were found to have someone present at the scene of overdose (Hecht et al., 2014); (see section 6.4.3) increased overdose response training of friends and families of drug users may be beneficial in preventing drug-related death.

Data from the NDRDD (see section 6.4.3) provides data on the number and percentage of drug-related deaths where resuscitation was attempted and revealed that in 2012, resuscitation attempts occurred in less than half of all deaths (39.4%) (Hecht et al., 2014). Of the deaths where resuscitation was attempted, the majority of attempts were made by ambulance staff (64.3% of all attempts), followed by friends (24.7%) and witnesses (24.2%). This further suggests that increased availability and training of naloxone would be beneficial in preventing drug-related death.

Discussions on THN took place at Scotland's first *Harm Reduction Café* event in November 2013¹⁷⁰ and suggested that whilst the naloxone programme was well supported, there were local barriers which still needed addressing.

The SDF commented on the improvement of GP awareness of naloxone in 2013 and highlighted the success of the video campaign 'I'm the Evidence': Naloxone in Scotland (Scottish Drugs Forum, 2013).

Wales

In Wales, THN is available in all community treatment sites and prisons. Since 1st July 2009 4,579 THN kits have been issued to 2,937 unique individuals in Wales – this includes 3,207 kits to new individuals and 1,372 kits as re-supply following use, loss, or expiry of previous kits (Public Health Wales, 2013). A total of 1,802 THN kits were issued in Wales during 2013/14 – an increase of 75 per cent from the previous year. During 2013/14 807 new individuals were supplied THN and 413 existing service users were re-supplied.

From 1st April 2012 the 'HRD – Naloxone' module was implemented to record THN-related activity. A back population exercise was also completed to ensure that all of the data from the pilot project and first year of implementation was securely stored on the HRD. This development allows the recording of all unique individual activity relating to the training and issue of THN, and provides clinicians with the ability to obtain live data relating to THN activity. For each individual accessing services, the database allows the recording of; referral to THN services; completion of training sessions (recognising overdose and how to use THN); and details relating to the supply and re-supply of THN.

¹⁷⁰ See: <http://harmreductioncafe.com/>

Since 1st July 2009 THN has been reportedly used during 381 opioid poisoning events. During 2013/14, THN was reportedly used in 160 opioid poisoning events of which two fatalities were recorded. Sixty-one per cent of all reported opioid poisoning events occurred within a private residence. Follow-on care (ambulance) was requested and provided in 59% of all cases where THN was used in an opioid poisoning event.

During 2013/14 nearly 1,500 individuals in Wales were trained in the administration of THN, of which 81% had never been trained before. Nearly 90% of individuals accessing training were service users.

Of those newly issued with THN 30% were female and around 26% per cent of those issued were aged 30-34 years old. The age range was 18 to 62 years; five per cent of THN kits were issued to 'young people' (under 25 years). Amongst the male client group, 20% were issued THN from Welsh prisons.

Northern Ireland

The Northern Ireland THN programme enables naloxone kits to be provided to anyone who is at risk of opioid overdose in the community regardless of whether the patient is in receipt of OST. The dispensing of naloxone is considered good practice and is included in Northern Ireland's *Primary and Secondary Care Opioid Substitute Treatment Guidelines 2013* (Health and Social Care Information Centre, 2013) (see section 5.2.3).

Research

Training family members to manage heroin overdose and administer naloxone

A non-blinded, randomized controlled trial (RCT) of group-based training versus an information-only control study was conducted to evaluate THN administration for family members of opioid users (Williams et al., 2014). Training events were delivered in community addiction treatment services in three locations in England. A total of 187 family members and carers allocated to receive either THN training or basic information on opioid overdose management ($n=95$ and $n=92$, respectively), with 123 participants completing the study. The primary outcome measure was a self-completion Opioid Overdose Knowledge Scale¹⁷¹ (OOKS; range 0–45). Each group was assessed before receiving their assigned condition and followed-up at three months. At follow-up, study participants who had received THN training reported significantly greater overdose-related knowledge relative to those receiving basic information only (OOKS mean difference; 4.08).¹⁷² At the individual level 35% and 54%, respectively, of the experimental group increased their knowledge and attitudes compared with 11% and 30% of the control group. The study concluded that THN training for family members of heroin users increases opioid overdose-related knowledge and competence and these benefits are retained at three months.

A pre-implementation assessment of knowledge, barriers and enablers for naloxone distribution through general practitioners

Matheson et al gathered baseline data on GPs' knowledge of and willingness to distribute naloxone, using mixed methods (quantitative, postal survey and qualitative telephone interview) (Matheson et al., 2014). A questionnaire was sent to 500 GPs in Scotland which was followed up by a reminder.¹⁷³ Telephone interviews were conducted with 17 GPs covering a range of demographic characteristics and drug user experience. A response rate of 55% was achieved. Results showed some awareness of the naloxone programme however, little involvement (three per cent). Nine per cent currently engaged in the provision of routine opioid overdose prevention. Results suggested that there was some expression of interest to become involved in naloxone prescribing with half of the respondents willing to provide this to drug users or friends/family. The evidence of effectiveness, appropriate training, and addition of naloxone to the local formulary were all identified as factors enabling the distribution of naloxone. Data gathered from interviewees suggested that GPs had limited awareness of what naloxone distribution in primary care may involve and considered naloxone supply as a specialist service rather than a core GP role. The authors conclude that there was poor awareness of the Scottish National Naloxone Programme in participants and that GPs did not currently feel sufficiently skilled or knowledgeable to be involved in naloxone provision.

¹⁷¹ A test designed to evaluate the effectiveness of THN training

¹⁷² 95% confidence interval; 2.10–6.06; $P < 0.001$; Cohen's $d = 0.74$ (0.37–1.10)

¹⁷³ A shortened questionnaire containing seven key questions was posted as a final reminder.

7.3 Prevention and treatment of drug-related infectious diseases

A range of services are provided across the UK that contributes to the prevention of infections amongst people who inject drugs (PWID) (SQ23-29). This section considers the key services involved in this prevention, other than OST and drug treatment, which are considered elsewhere (see section 5.4.6 and 5.3). Additionally, this section outlines the availability and uptake of diagnostic and treatment services for key infections.

7.3.1 Needle and syringe programmes

Needle and syringe programmes (NSP) are provided throughout the UK in a variety of settings, principally through pharmacies and specialist services. These provide a range of injecting equipment and also advice on safer injecting practice. In addition, many offer other services including testing for BBV, vaccinations, injection site care and referral into other specialist drug treatment and sexual health services.

In April 2014, National Institute for Health and Care Excellence (NICE) updated its public health guidance *Needle and Syringe Programmes* (National Institute for Health and Care Excellence, 2014). The new guidance makes recommendations on NSP, including those provided by pharmacies and drug services for adults and young people who inject drugs (including those under 16), with specific recommendations for users of image-and-performance enhancing drugs (IPEDs), (for example, anabolic steroids for bodybuilding or injected tanning agents).

The vast majority (91%) of the participants in the Unlinked Anonymous Monitoring (UAM) Survey of PWID from across England, Wales and Northern Ireland (see section 6.2) reported that they had used a NSP in 2013 (Public Health England, 2014a).

Needle and syringe programmes in England

Data from the UAM Survey of PWID showed that in 2013 the vast majority (82%) of participants who injected in the previous year reported using an NSP while only five per cent had never used an NSP (Public Health England, 2014q). Of those who had injected in the preceding four weeks, just under half (47%) reported receiving more needles than they required from an NSP.¹⁷⁴ Just less than one-third (29%) of participants who had injected in the preceding four weeks had injected with a used needle that they had attempted to clean. These findings may indicate that, in England, the majority of PWIDs are accessing NSP however; equipment provision needs to be increased.

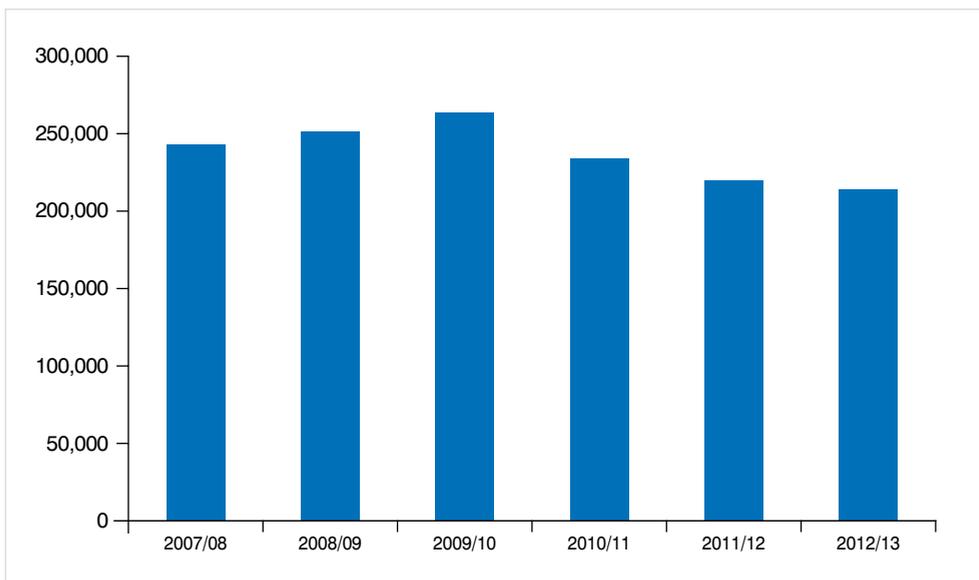
Needle and syringe programmes in Scotland

In May 2014, Scotland published its sixth report on the findings of the survey of injecting equipment provision (IEP) to PWID in 2012/13 (Information Services Division, 2014b). A total of 290 IEP outlets responded to the 2012/13 survey. Of the 290 respondents, 212 (73.1%) were located in pharmacies, and the remaining 78 (26.9%) were as part of other services. Approximately 213,000 attendances were reported across IEP outlets in Scotland in 2012/13. This was a decrease from 219,000 in 2011/12, continuing the trend of decreasing attendances since 2009/10 where there were around 260,000 attendances (see Figure 7.1). Where gender of the client was reported, 64% of attendances were made by males.

Almost 4.0 million needles/syringes were reported to have been distributed by IEP outlets in 2012/13; 2.6 million (65%) by pharmacies and 1.4 million (35%) by agencies (ST10). The number of needles/syringes reported to have been distributed rose between 2007/08 and 2009/10 (to 4.7 million) and then fell by 735,000 between 2009/10 and 2011/12. There was little change in the number of needles/syringes distributed between 2011/12 and 2012/13.

¹⁷⁴ This data should be interpreted with caution as some people receive more needles to pass to friends – known as secondary distribution.

Figure 7.1: Attendances at Injecting Equipment Provision services in Scotland, 2007/08 to 2012/13



Source: Information Services Division, 2014b ST10

Following a change in the legislation in 2003, IEP outlets have been allowed to provide clients with sterile injecting equipment other than needles and syringes. In terms of quantities of additional items that were distributed, wipes/swabs and citric acid/vitamin C were the most commonly distributed by IEP outlets in 2012/13 (3.1 million and 2.6 million items respectively). The number of filters reported to have been distributed increased seven-fold between 2008/09 and 2012/13, whilst the number of spoons reported to have been distributed increased five-fold over this period. There was little difference in the overall quantity of paraphernalia distributed in 2012/13 compared to 2011/12. Although there was a sharp rise in the number of water vials distributed, the number distributed was still low in comparison to other paraphernalia items.

Needle and syringe programmes in Wales

The Harm Reduction Database (HRD) was implemented in all NSP across Wales from 1st September 2010. From April 2014, all NSP services, including those based in pharmacies routinely record activity on the HRD. The database collects data on needle and syringe use and other harm reduction interventions in order to establish a better evidence base on individuals at high risk of infection with BBV due to injecting drug use. In 2013/14, 29% of all pharmacies in Wales ($n=205$) provided NSP (ST10). Across Wales, NSP services ($n=253$ in total) dispensed 5,242,420 syringes. A single, stand-alone NSP vending machine dispensed 1,575 syringes in the same time period. Of the unique clients accessing NSP in 2013/14, demographic data was only recorded for those in contact with statutory and voluntary sector NSP services during 2013/14. There were a total of 9,733 unique individuals regularly accessing NSP (Public Health Wales, in press). Estimated coverage (the provision of sterile injecting equipment for every injecting event) is estimated at 36.7 per cent across Wales.

Needle and syringe programmes in Northern Ireland

In Northern Ireland, in 2012/13 there were 15 pharmacy-based locations providing NSP (ST10). This equates to 2.8 per cent of all pharmacies in Northern Ireland compared to 22.7% of all pharmacies in Scotland and 28.8% in Wales. In 2012/13, a total of 217,750 needles were distributed in Northern Ireland accounted for by 21,411 visits (ST10).¹⁷⁵

¹⁷⁵ A visit does not equate to a single individual and rather an occasion at a service.

7.3.2 Provision of foil in the UK

In response to the evidence presented in a report by the Advisory Council on the Misuse of Drugs (ACMD) (Advisory Council on the Misuse of Drugs, 2010), the Government announced plans for new legislation to allow the provision of foil by drug treatment services as a means of encouraging drug users to engage in structured treatment and also as a harm-reduction measure (see section 1.2.1). Foil is used for smoking drugs rather than injecting so the provision of foil may help discourage people from injecting drugs and thus reduce the harm associated with injecting. The required amendment to the *Misuse of Drugs Regulations 2001* (as amended) for the provision of foil came into effect on 5 September 2014.

7.3.3 Hepatitis C prevention, diagnosis and treatment

In the UK, public health programmes related to hepatitis C focus on four key action areas; prevention of new infections; increasing awareness of infection; increasing testing and diagnosis; and getting diagnosed individuals into treatment and care.

Hepatitis C prevention strategies primarily focus on injecting drug use, as this is presently the most important risk factor for acquisition of the virus in the UK. Reducing the number of individuals who begin injecting drugs, encouraging injectors to stop injecting, reducing risky behaviour, such as sharing needles and syringes, in those who continue to inject, and the early diagnosis and treatment of those who become infected with hepatitis C, are all components of the prevention programme.

Raising public and professional awareness of hepatitis C remains a priority in the UK and represents an important component in reducing the burden of undiagnosed hepatitis C infection. Education programmes have been developed to raise professional awareness in primary care and among other individuals working with at-risk populations. By December 2013, a total of 1,384 individuals had completed the e-module from the Royal College of General Practitioners (RCGP) *Certificate in the Detection, Diagnosis and Management of Hepatitis B and C in Primary Care* (Public Health England, 2014c).¹⁷⁶ Nearly half (47%) had attended face-to-face training days and 615 had completed Level 1 of the certificate.

Hepatitis Scotland used the awareness raising opportunity of World Hepatitis Day to launch the Big Red C campaign to encourage more people in Scotland to get tested for the hepatitis C virus (HCV). The campaign advertises on buses, in supermarkets and hospitals across Scotland and in 2014 it launched a new Facebook page tying in with the campaign website. The campaign is jointly run by Hepatitis Scotland, Waverley Care, The Hepatitis C Trust, Positive Help and Addaction to raise awareness of Hepatitis C around World Hepatitis Day. The campaign specifically targets the 18,000 people in Scotland who have Hepatitis C but do not know it yet by calling on them to get tested. The 2014 campaign will also be pushing for people who know their Hepatitis C status to access treatment, in light of new, more effective and shorter duration treatments which are likely to be available in late 2014.

On 1st July 2014, Scotland launched a new hepatitis C campaign primarily to raise awareness of hepatitis C and other BBV among those aged 18-25 years. The campaign took the form of a YouTube video which depicted the harms associated with sharing needles and was launched via social media with 109 organisations and individuals posting the video to their social media sites. Consequently, the video had a reach of approximately 125,000 people and was supported by numerous National Health Service (NHS) boards, a number of organisations in the voluntary sector and the Hepatitis C Trust.

In Wales, the *Blood Borne Viral Hepatitis Plan* for Wales, published in 2010 (Welsh Assembly Government, 2010) aims to reduce the transmission of hepatitis infection in Wales, increase the diagnosis of infection and improve treatment and support for those infected. The plan sets out actions to be implemented between 2010 and 2015 and the annual report for 2013 (Welsh Government, 2013b) outlines the progress so far. This includes the establishment of the Harm Reduction Database (HRD) which is now operational in all statutory and voluntary NSP services across Wales, the development of an e-learning module for prison officers which has been completed by over 500 staff in a single prison, and a RCGP course on BBV has been promoted and completed by more than 80 individuals working with groups at high risk of infection.

¹⁷⁶ See: <http://www.rcgp.org.uk/courses-and-events/online-learning/ole/hepatitis-b-and-c.aspx>

A commissioning template for estimating hepatitis C prevalence and numbers eligible for treatment by Drug Action Team (DAT) areas in England has been developed.¹⁷⁷ The template was produced to help local authorities and Health and Wellbeing Boards (HWB) estimate the prevalence of HCV infection in their local population, and the likely disease burden and associated treatment costs. Estimates and costs are automatically generated by selecting the relevant DAT name.

Uptake of diagnostic testing

Data from the UAM Survey in England, Wales and Northern Ireland shows a significant increase over the past decade in the self-reported uptake of voluntary confidential testing (VCT) for hepatitis C among survey participants, with the proportion of survey participants ever tested rising from 63% (95% CI, 61%-65%) in 2003 to 82% (95% CI, 81%-84%) in 2013 however this has plateaued in recent years (Public Health England, 2014q). This stabilisation may suggest that there is saturation among the pool of easy-to-access individuals and/or a reduction in awareness raising activity.

The proportion of participants who answered the questions on the uptake of VCT for hepatitis C, reporting that they were aware of their hepatitis C infection was 47% (95% CI, 44%-49%) in 2013. This indicates that around half of the hepatitis C infections in this population remain undiagnosed. However, this varied across England, Wales and Northern Ireland (Table 7.1) (Public Health England, 2014q).

Table 7.1: Uptake of voluntary confidential testing for hepatitis C and the proportion of clients aware of hepatitis C infection in England, Wales, Northern Ireland and combined, 2013

	UPTAKE OF HEPATITIS C VOLUNTARY CONFIDENTIAL TESTING	PROPORTION AWARE OF HEPATITIS C INFECTION
England	82%	47%
Wales	84%	38%
Northern Ireland	91%	55%
England, Wales and Northern Ireland	82%	47%

Source: Public Health England, 2014a

In Scotland, the number of people tested for hepatitis C has increased from approximately 18,000 in 1999 to 48,300 in 2013 with the biggest increase occurring in specialist drug treatment centres at an increase of 28% per year (Public Health England, 2014c). Nevertheless, tests at specialist drug treatment centres account for only a small proportion of all administered tests in Scotland (four per cent).

In Scotland, among 2,331 PWID interviewed at services providing IEP during 2013/14, 88% reported having been tested for hepatitis C in the past with 45% having been last tested during in the previous year (Public Health England, 2014c). When those who reported a previous hepatitis C diagnosis (prior to 12 months ago) were excluded, the percentage of respondents who had been tested for hepatitis C during the last year has been steadily increasing and was 52% in 2013/14 compared to 40%, 45% and 49% in 2008/09, 2010 and 2011/12 respectively.

Across the UK, alternative testing technologies, in particular the use of dried blood spot testing (DBS), are continuing to contribute to the increased uptake of hepatitis C testing among PWID. In England numbers of PWID tested via DBS increased by 46% between 2012 and 2013 (Public Health England, 2014c). In Wales, in individuals thought to have been tested via Substance Misuse Services or in prisons, it is estimated that the numbers tested via DBS increased by 12% between 2012 and 2013 with over 1,800 individuals tested in 2013.

¹⁷⁷ See: <http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HepatitisC/EpidemiologicalData>

The hepatitis C outreach and testing van

Since 2011, a mobile testing unit has been used to test and diagnose hard-to-reach groups who are at risk of hepatitis C.¹⁷⁸ The mobile unit aims to address and overcome some of the main barriers to diagnosis faced by groups who are at risk from hepatitis C but who currently do not, cannot, or will not access testing through the existing means. These groups include; people who use or have used drugs, people who are homeless and people from countries with a high prevalence of hepatitis C.

From the period of 1 April 2011 until 31 March 2014, the testing van visited 165 services across the UK. The majority of these services have been homeless hostels or drugs services and were services that did not already provide hepatitis C tests to their service users. Since 2011, the van has engaged with 3,766 people, raising their awareness and knowledge of hepatitis C, and has provided hepatitis C tests to 1,731 people. Of the 1,731 people tested, 144 (eight per cent) tested positive for hepatitis C antibodies. Of those tested, 380 had previously had a hepatitis C test however 86 of them were unaware of the result. Of these 86 people, 19 (22%) tested positive for hepatitis C.

Employing the use of a mobile outreach van has shown to remove barriers to testing and treatment, improve local pathways from testing to secondary care, increase awareness of hepatitis C, decrease pressure on existing services and has also shown to be cost effective.

Entering care pathways

In England, 69% of participants from the UAM Survey who had received a positive diagnosis and were aware of their hepatitis C status reported that they had seen a specialist doctor or nurse about their infection compared to 62% in Wales (Public Health England, 2014c). Of the English clients, 22% reported receiving any kind of medication related to their infection.

Data collection systems to provide information on the numbers of individuals commencing treatment have been under development in Wales. It is estimated that in 2011 and 2012 over 400 individual's commenced treatment.¹⁷⁹ In England ways of monitoring numbers being treated are being developed, but current data suggest that over 4,000 people with hepatitis C are being treated each year (Public Health England, 2014c).

The number of chronically infected people who began hepatitis C antiviral therapy in Scotland increased from 468 in 2007/08 to 1,049 in 2010/11 (Public Health England, 2014c). The numbers initiated on antiviral therapy exceed the Scottish Government targets of 500 in 2008/09, 750 in 2009/10 and 1,000 in 2010/11. In more recent years, a total of 1,002 people were initiated on hepatitis C antiviral therapy in 2011/12, 1,052 in 2012/13 and 1,000 in 2013/14, which fall short of the increasing Scottish Government targets for those respective financial years.

Research

Views and experiences of hepatitis C testing and diagnosis among people who inject drugs

Jones and colleagues conducted a systematic review of the views and experiences of hepatitis C testing and diagnosis in PWID (Jones et al., 2014). The research was based on the synthesis of qualitative research according to theme. Studies of any qualitative design that examined the views, experiences and attitudes towards HCV testing and diagnosis among PWID, or practitioners involved in their care, were included. In total, 28 qualitative studies were identified and included in the analysis. Overall, three major themes emerged; missed opportunities with clients for the provision of information and knowledge; competing priorities between HCV testing and other complex needs; and testing as 'unexpected and routine'. Synthesis of the 28 studies included in the review identified evidence of missed opportunities for the provision of knowledge and information about HCV and the authors suggest that this may

¹⁷⁸ See: <http://www.hepctrust.org.uk/About%2bUs/Our%2bWork/Increasing%2btesting.html>

¹⁷⁹ This data is provisional and should be treated with caution as data collection systems were under development during this period.

contribute to delays in clients seeking testing and also leads to negative experiences upon diagnosis. Perceptions of the risk associated with HCV and the prioritisation of other needs acted both to encourage and discourage uptake of HCV testing and was mediated by the nature of the client's personal circumstances. With regards to client experience of diagnosis, it was found that an unexpected positive diagnosis exacerbated anxiety and confusion. The authors conclude that there are modifiable factors that affect the uptake of HCV testing in addition to the experiences of HCV diagnosis among PWID. The authors recommend that HCV intervention development should focus on addressing these factors (such as the provision of information) and that further research that engages PWID from a diverse range of populations to identify interventions, strategies and approaches that they consider valuable, is needed.

Modelling the predicted impact of hepatitis C treatment under different scenarios

Harris et al. aimed to estimate the number of people with chronic HCV infection in England that are treated and assess the impact of increasing treatment uptake (Harris et al., 2014). The number of clients treated was estimated using national data sources for pegylated interferon supplied, dispensed or purchased from 2006 to 2011. A back-calculation approach was used to project disease burden over the next 30 years and determine outcomes under various scenarios of treatment uptake. Five-thousand people were estimated to have been treated in 2011 and 28,000 in total from 2006-2011; approximately three per cent and 17% respectively of estimated chronic infections. Results of modelling different scenarios showed that without treatment, incident cases of decompensated cirrhosis and hepatocellular carcinoma were predicted to increase until 2035 and reach 2,290 cases per year. Treatment at current levels was estimated to reduce incidence by 600 cases per year, with a peak around 2030. The authors suggest that large increases in treatment are needed to halt the rise; and with more effective treatment the best case scenario predicts incidence of around 500 cases in 2030, although treatment uptake must still be increased considerably to achieve this. The authors conclude that without large increases in treatment uptake, hepatitis C will be a major public health burden in the future.

The association between a national scale-up in coverage of a combination of harm reduction interventions and the decline in hepatitis C virus incidence

Palmateer and colleagues analysed Scottish national data on the provision of IEP and OST with the aim of understanding if the scaling up of these interventions would lead to measurable declines in the incidence of HCV in PWID (Palmateer et al., 2014). The authors suggest that the observed decline in the estimated HCV incidence among PWID between 2008-09 and 2011-12 could be attributed to a period of development in harm reduction services (OST and IEP) in Scotland. This finding was supported by a similar trend observed in the prevalence of HCV among recent initiates to injecting.¹⁸⁰ The authors also noted that increases in the uptake of injecting paraphernalia were mirrored by significant declines in the self-reported sharing of these items, and the increased uptake of OST was mirrored by a decrease in the self-reported frequency of injecting. More recent data for 2013/14 on hepatitis C incidence from the same source as used in the paper cast some doubt on whether there has been a real decline in incidence (see section 6.2.1) (Public Health England, 2014c).

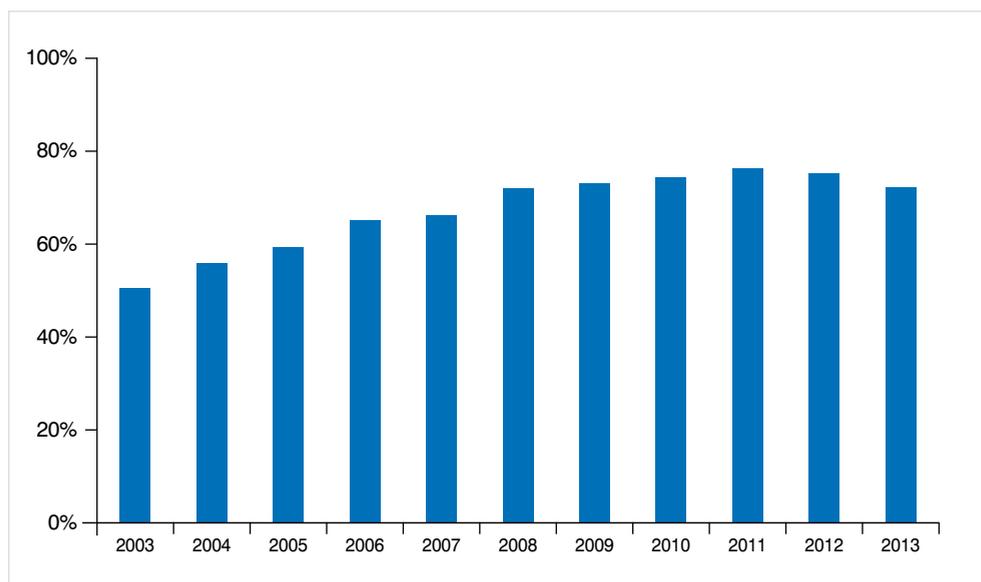
7.3.4 Uptake of hepatitis B vaccination

Hepatitis B is a vaccine preventable infection that can cause long-term liver disease and liver cancer. The UK has a targeted vaccination programme focused on the population groups most at risk, including PWID.

The proportion of the PWID participating in the UAM Survey in England, Wales and Northern Ireland who reported having taken up an offer of the hepatitis B vaccination has increased markedly over time, rising from 50% (95% CI, 48%-52%) in 2003 to 76% (95% CI, 75-78%) in 2011, and then slightly decreased to 72% (95% CI, 70-73%) in 2013 (self-reported data) (Public Health England, 2014a); (Figure 7.3). Uptake of hepatitis B vaccination was comparable in England, Wales and Northern Ireland, (range: 71%-75%).

¹⁸⁰ Considered a proxy for incidence

Figure 7.2: Uptake of hepatitis B vaccination amongst participants in the Unlinked Anonymous Monitoring Survey of People Who Inject Drugs: England, Wales and Northern Ireland, 2003-2013



Source: Public Health England, 2014a

In Scotland, among those attending needle and syringe programmes during 2013-14, 74% reported uptake of the hepatitis B vaccine (Public Health England, Health Protection Scotland, Public Health Wales and Public Health Agency Northern Ireland, in press).

Research

Cash incentive for hepatitis B vaccination in injecting drug users

Weaver et al. conducted a cluster randomised trial, recruiting participants at 12 NHS drug treatment services in the UK that provided OST and nurse-led hepatitis B virus (HBV) vaccination with a super-accelerated schedule (vaccination days zero, seven and 21) (Weaver et al., 2014). Clusters were randomly allocated 1:1:1 to provide vaccination without incentive (treatment as usual), with fixed value contingency management (three £10 vouchers), or escalating value contingency management (£5, £10, and £15 vouchers). Both contingency management schedules rewarded on-time attendance at appointments. The primary outcome was completion of clinically appropriate HBV vaccination within 28 days. Between March 2011 and April 2012, 210 eligible participants were enrolled into the study. Compared with six (nine per cent) of 67 participants treated as usual, 35 (45%) of 78 participants in the fixed value contingency management group met the primary outcome measure,¹⁸¹ as did 32 (49%) of 65 participants in the escalating value contingency management group.¹⁸² These differences remained significant with sensitivity analyses. These results suggest that even modest financial incentives delivered in routine clinical practice significantly improve adherence to, and completion of, HBV vaccination programmes in patients receiving OST. Recommendations were made for drug treatment providers to utilise contingency management to promote adherence to vaccination programmes. It should be noted that the effectiveness of the routine use of contingency management in achieving long-term behaviour change cannot be ascertained from this study.

¹⁸¹ odds ratio 12.1, 95% CI 3.7—39.9; $p < 0.0001$

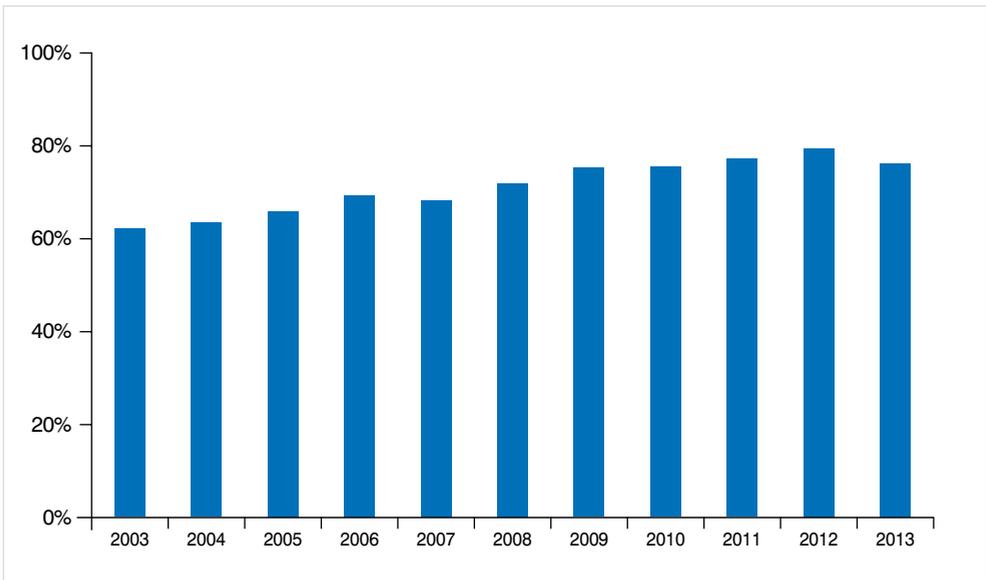
¹⁸² odds ratio 14.0, 95% CI 4.2—46.2; $p < 0.0001$

7.3.5 HIV prevention and diagnosis

In September 2014, PHE issued guidance on how to best commission integrated services for sexual health, reproductive health and HIV, which highlighted the role of drug use across these domains (Public Health England, 2014g). The guide is written for commissioners of sexual health, reproductive health and HIV services in local government, clinical commissioning groups (CCGs) and NHS England.

Amongst PWID, the self-reported uptake of VCT for HIV among the UAM Survey participants recruited from across England, Wales and Northern Ireland has increased significantly since 2003; rising from 62% (95% CI, 60%-64%) in 2003 to 76% (95% CI, 74%-78%) in 2013 (Figure 7.4) (Public Health England, 2014a). In 2013, VCT was comparable across genders; 75% of males and 78% of females self-reported testing. Sixty-four per cent of those under 25 self-reported VCT compared to 75% of those aged 25-34 and 78% of people over 35 years of age. In 2013, of the participants in the UAM Survey who had antibodies to HIV, 96% (95% CI, 81%-99%) reported awareness of their infection.

Figure 7.3: Uptake of voluntary confidential HIV testing amongst participants in the Unlinked Anonymous Monitoring Survey of people who inject drugs: England, Wales and Northern Ireland, 2003-2013



Source: Public Health England, 2014a

In Scotland, among those attending needle and syringe programmes during 2013/14, 78% reported having ever had a VCT for HIV. In 2008-9, 68% of those surveyed in Scotland had reported uptake (Public Health England, Health Protection Scotland, Public Health Wales and Public Health Agency Northern Ireland, in press).

The number of HIV-infected people seen for HIV treatment and care in the UK who had acquired their infection through injecting has increased over the past decade, with 1,829 seen in 2013 (Public Health England, Health Protection Scotland, Public Health Wales and Public Health Agency Northern Ireland, in press). In 2013, 622 people who acquired their HIV-infection through injecting, and who were seen for care, had CD4 counts of 350 cells/mm³ or less; the recommended level to start anti-retroviral therapy. Among those seen for HIV treatment and care with CD4 counts of 350 or less in 2013, 80% of those who had acquired their infection through injecting were on anti-retroviral therapy, this is similar to the level found in other groups.

Responses to injecting drug use and their impact on controlling the transmission of HIV through injecting drug use in England and Wales

Hope and colleagues noted that policy relating to injecting drug use in England and Wales has shifted from a focus on preventing HIV infection in the late 1980s and early 1990s to a focus on criminal justice issues at the end of the 1990s, with an increased emphasis on harm reduction from 2006 onwards (Hope et al., 2014). The authors examined the prevalence and incidence of HIV among PWID in England and Wales in relation to these changes. Data derived from the UAM Survey (see section 6.2) was used to estimate prevalence and incidence trends via generalised linear models, and compared with a policy time-line. Overall results showed that HIV prevalence among 38,539 participations was 1.15% and prevalence was highest among those who started injecting before 1985. Throughout the 1990s, prevalence fell in this group and was stable among those who started injecting later. Prevalence was higher in 2005 than 2000 (odds ratio: 3.56 (95% confidence interval (CI) 1.40–9.03) in London, 3.40 (95% CI 2.31–5.02) elsewhere). Estimated HIV incidence peaked twice, around 1983 and 2005. HIV was an important focus of policy concerning PWID from 1984 until 1998. This focus shifted at a time when drug use and risk were changing. The increased incidence in 2005 cannot be ascribed to the policy changes, but these appeared to be temporally aligned. The authors conclude that policy related to PWID should be continually reviewed to ensure rapid response to increased risk.

7.3.6 Blood-borne virus in people who inject image and performance enhancing drugs

Among the participants in the 2012/13 *Crime Survey for England and Wales* (CSEW) sub-survey of people who inject IPEDs¹⁸³ (Public Health England, 2014b), 41% (95% CI, 35%-47%) reported ever having a VCT for HIV which is significantly lower than self-reported levels in the main UAM Survey of people who inject psychoactive drugs (76%, 95% CI, 74%-78%). This represented an increase from 32% found in 2012/11, and the increase was greatest in those aged less than 25; from 20% in 2010/11 to 35% in 2012/13.

Among the participants in the 2012/13 sub-survey of people who inject IPEDs,¹⁸⁴ 32% (95% CI, 26%-38%) reported ever having a VCT for HCV (Public Health England, 2014b). The reported level of the uptake of VCT for HCV is much lower than that reported among participants in the main survey of people who inject psychoactive drugs (82%, 95% CI, 81%-84%). The level was also lower for uptake of the hepatitis B vaccination, with 40% (95% CI, 34%-47%) of those injecting IPEDs reporting this compared to 76% (95% CI, 75%-78%) of those in the main UAM Survey sample of people injecting psychoactive drugs. Efforts should be made to increase the uptake of vaccination in this cohort.

7.4 Responses to other health correlates among drug users

7.4.1 Mental health

Both the Drug Strategy 2010 (Her Majesty's Government, 2010) and Mental Health Strategy 2011 (Department of Health, 2011) acknowledge the link between mental health problems and drug misuse; also referred to as dual diagnosis.¹⁸⁵ In July, a new national Mental Health, Dementia & Neurology Intelligence Network was launched by PHE in partnership with NHS England, and supported by the Department of Health and key stakeholders (personal communication – Public Health England). Its purpose is to '*put information and intelligence into the hands of decision makers to enable improved mental health and well-being across England*'. Expert reference groups (ERG) on different mental health populations support the work of the network, including one ERG on coexisting substance misuse and mental health issues. This 'dual diagnosis' ERG is collating and presenting a broad range of data that can indicate the extent and complexity of dual diagnosis in local areas, and will be updating national best practice guidance.

¹⁸³ England and Wales only

¹⁸⁴ England and Wales only

¹⁸⁵ Dual diagnosis is a term used for people with coexisting mental health and substance misuse problems.

7.4.2 People who inject new psychoactive substances

In May 2014, the SDF in conjunction with NHS Greater Glasgow and Clyde (GGC) and Frontier Medical created a new advice booklet for people who inject NPS.¹⁸⁶ The guide is intended to inform people of the risks associated with injecting NPS or any unidentified white powders. The report highlights a number of safer injecting practices in addition to providing further information on the harms of injecting NPS and outlines alternatives such as rectal, oral and insufflation routes of administration.

7.4.3 Men who have sex with men and chemsex

Research carried out by the London School of Hygiene and Tropical Medicine (LSHTM) in conjunction with Lambeth council, suggested that the changing trends in drug use among gay men in London have not been matched by a repositioning of harm reduction services to meet their need.¹⁸⁷ The authors suggest that general harm reduction services that have typically catered for opioid users need to take account of both the types of drugs gay men are using and the way in which their use occurs. They suggest efforts should be made to develop or upscale drug services situated within their clinics and improve linkages to psycho-therapeutic services.

Daskalopoulou and colleagues used data from the cross-sectional Antiretrovirals, Sexual Transmission Risk and Attitudes (ASTRA) study, which recruited UK participants aged 18 years and older diagnosed with HIV, to explore patterns of drug use and associations with sexual behaviours in HIV-diagnosed men who have sex with men (MSM) (Daskalopoulou et al., 2014). Data were assessed for the prevalence of recreational drug use and polydrug use in the previous three months and associations with socio-demographic and HIV-related factors. The authors examined the association of polydrug use with measures of condomless sex in the previous three months and with other sexual behaviours. Analysis included data for 2,248 MSM and revealed that over half of the sample had recreationally used drug in the last three months ($n=1,138$). Nitrates were the most commonly used substance with over a quarter of participants citing the use in the last three months (27%), followed by cannabis (21%), erectile dysfunction drugs (21%), cocaine (13%), ketamine (12%), MDMA (12%) and GHB (nine per cent). Of the 1,138 participants who used drugs, almost half (47%) used three or more drugs and over one fifth (21%) used five or more. Prevalence of injecting drug use was three per cent ($n=68$). Drug use was independently associated with younger age, not being religious, having an HIV-positive stable partner, smoking and evidence of harmful alcohol consumption. Increasing polydrug use was associated with increasing prevalence of condomless sex (prevalence range from no drug use to use of five or more drugs was 24% to 78%). Associations were similar after adjustment for socio-demographic and HIV-related factors. The authors conclude that polydrug use is prevalent in HIV-diagnosed MSM and is strongly associated with condomless sex and recommend that specialist support services for MSM with HIV who use recreational drugs may be beneficial in the reduction of harm and prevention of ongoing transmission of HIV and other sexually transmitted infections.

In response to the increases in chemsex, the charitable organisation London Friend established an intensive group programmes called SWAP (Structured Weekend Antidote Programme). The programme is aimed at Gay, Bi, trans or MSM over 18 who feel that their chemsex use is having a negative impact on their lives.¹⁸⁸ The programme consists of intensive weekend group sessions, focusing on a number of issues including relapse prevention, boundary setting, sex and sexuality, and goal setting. The programme accepts self-referral and also referrals from keyworkers or other professionals.

¹⁸⁶ See: <http://www.sdf.org.uk/news-and-media/sdf-news/injecting-nps-advice/>

¹⁸⁷ See: http://www.sigmaresearch.org.uk/files/Adam_Bourne_IAS_Melbourne_2014f_poster.pdf

¹⁸⁸ See: <http://londonfriend.org.uk/get-support/drugsandalcohol/weekend-programme/about-swap/>

8. Social correlates and social reintegration

8.1 Introduction

There is a large volume of evidence from the United Kingdom (UK) showing an association between problem drug use and social exclusion. A high proportion of problem drug users have been socially excluded as children and young people; many are poorly educated; and a high proportion live in inappropriate housing (Seddon, 2006). Research in 2008 suggested that around 80% (267,000) of problem drug users in England in 2006/07 were likely to be in receipt of one or more of the main Department for Work and Pensions (DWP) benefits (Disability Living Allowance (DLA), Incapacity Benefit (IB), Income Support (IS) and Jobseeker's Allowance (JSA)), representing around seven per cent of all those in receipt of one of those benefits (Hay & Bauld, 2008). The effect of parental drug use on children is also a concern, frequently leading to problems in childhood and later life (Advisory Council on the Misuse of Drugs, 2011). A strategic review of health inequalities in England post-2010 showed that the poorest local authorities also tend to have the highest prevalence of problematic drug users aged 15 to 64 (drug-related hospital admission rates and number of individuals in contact with structured drug treatment services per 1,000 population) (Marmot et al., 2010).

Recent drug strategies in England, Scotland and Wales all place a heavy emphasis on the importance of reintegration to sustaining recovery from substance misuse and the need for integrated working between a range of services in order to address the breadth of a client's needs beyond dealing with purely the symptoms of drug misuse. The strategy for Northern Ireland also recognises the need to provide support with housing and employment, and wider support with social reintegration. In Scotland the recovery programme has identified seven core outcomes for Alcohol and Drug Partnerships (ADPs) related to health; prevalence; recovery; families; community safety; local environment and service provision (Scottish Government, 2013c) (Scottish Government, 2008c).

The ability to access suitable and stable accommodation is one of the eight key recovery outcomes of the *Drug Strategy 2010* (Her Majesty's Government, 2010). However, progress in meeting the housing needs of the treatment population remains an area of concern within the drug sector (Drugscope, 2014). While local authorities in England have an obligation to find accommodation for statutory homeless, various concerns have been identified which may cause people to fall through the net (Crisis, 2011). There are further concerns that cuts to local budgets and the competing demands placed upon them will represent a significant risk to raising the standard of accommodation for service users in inappropriate accommodation (Homeless Link, 2014). Similarly, unemployment among drug users remains an area of concern within the UK (Drugscope, 2014). Survey findings from the European Quality Audit of Opioid Treatment (EQUATOR) project showed that the unemployment rate among UK recipients of opioid substitution therapy (OST) was 88.4% compared to 51.3% in Portugal, 47.7% in Italy and 35.9% in France (Goulão & Stöver, 2012).

Given the large number of problem drug users in need of housing and employment support, government welfare reforms represent a significant and challenging development within the substance misuse field. Key reforms include the transfer of clients from IB to Employment Support Allowance (ESA) as well as the staged introduction of Universal Credit.¹⁸⁹ In recognition of the needs of substance misusing claimants, Jobcentre Plus advisers seek to identify claimants with dependency issues and refer them to a voluntary discussion with a treatment provider to discuss recovery-orientated treatment options. DWP has recently developed a new training package to help advisers identify and refer claimants, and engage

¹⁸⁹ Universal Credit is a new single payment for people who are looking for work or on a low income, which brings together a range of working-age benefits into a single payment, replacing the employment benefits, income support benefit, tax credits and housing benefit.

As part of Universal Credit, the Department for Work and Pensions introduced 'tailored conditionality' where work search and work availability requirements can be suspended for a period of up to six months in any 12 month period for claimants actively participating in structured recovery-orientated treatment. This is to give claimants the time and space to engage in treatment, and begin their recovery journey. After the end of the period of 'tailored conditionality', on-going treatment commitments are still taken into account when an individual is looking for employment. This is recognised as a critical step in enabling people with dependencies to become ready for sustainable employment.

with treatment providers to support recovery. DWP is also currently running two trials within the Work Programme to identify ways of improving employment outcomes for drug and alcohol claimants. As a reserved matter in Scotland and Wales, employment support for drug users is also delivered through the DWP. In Scotland, DWP has also been working with the Scottish Government and ADPs to increase referrals of DWP claimants to treatment.

There are a number of responses aimed at addressing neighbourhood problems associated with problem drug use, including drug dealing. For example, the *Anti-Social Behaviour Act 2003* seeks to stop the use of premises for drug dealing.

8.2 Social exclusion and drug use

8.2.1 Housing

In England, analysis of the Treatment Outcomes Profile (TOP)¹⁹⁰ (see section 5.4.7), which forms part of the National Drug Treatment Monitoring System (NDTMS), monitors changes in housing status across an individual's treatment journey.¹⁹¹ In 2012/13, 19% of clients started treatment with either an acute housing problem (i.e. no fixed abode) or housing risk (i.e. risk of eviction), reducing to 13% by six month review (Public Health England, 2013a). Although there is an improvement during treatment, both the levels at start of treatment and at six month review have remained stable since first reported in 2010/11.

Data from the English treatment system's Young People's Statistics (see section 5.4.1) showed that the percentage of young people living with family or other relatives entering services remained constant at around 80% from 2010/11 to 2012/13, while those reporting having unsettled accommodation, a housing problem or no fixed abode remained around three per cent (Public Health England, 2013d).

Homeless Link conducted a 2014 review on the nature of single homeless people in England (Homeless Link, 2014). Fieldwork was carried out between September and December 2013. In total 459 accommodation projects took part (356 via in-depth telephone interviews and 103 online surveys). In addition 218 accommodation projects provided data about their service via a self-completed data return. Findings from this review showed that one-third of the single homeless people using the accommodation projects included in the review had problems associated with drug use (33%). Compared to the previous year, more accommodation projects reported refusing access to those with the highest needs or the most challenging behaviour 40% of projects had refused access to people who were intoxicated by drugs or alcohol, up from 22% in the previous year.

8.2.2 Employment and education

Employment and education in young people and adults

A similarly stable picture to that reported for housing status of adults entering treatment in England (see section 8.2.1) was observed for employment status (Public Health England, 2013b). TOP employment data showed that since 2010/11 the number of people who reported being employed at the start of treatment remained constant over the three year period (around 18%) as did the proportion at the six month review (around 21%). The average days of employment in the last month was 18 in 2012/13 at both start and review, suggesting most of those who are in employment are working full-time or close to full-time.

Data on the number of unemployed individuals presenting for substance misuse treatment in Northern Ireland (Department of Health, Social Services and Public Safety Northern Ireland, 2013) showed that after an increase in the proportion of unemployed individuals in the period from 2008/09 to 2009/10 (66%) unemployment rates then decreased and have remained constant at 46% since 2011/12.

¹⁹⁰ TOP is a clinical tool that aims to evaluate the progress of individuals through their treatment journey, measuring the progress in overcoming problems with work, education or housing through a set of 20 questions.

¹⁹¹ TOP data is recorded at treatment start, at six months following treatment start and at treatment exit.

Data from the Young People's Statistics from the NDTMS showed that in 2012/13 the proportion of young people entering services reporting being in mainstream education remained constant at around 50%, while 19% stated they were not in education or employment (Public Health England, 2013e).

Young people and school exclusions due to substance misuse

England

The Department for Education (DfE) reported that in the 2012/13 academic year in England, there were 360 permanent exclusions and 7,040 fixed period exclusions due to drug or alcohol related issues from state-funded primary, secondary and special schools. While the number of permanent exclusions due to drug or alcohol related issues has fluctuated at around 350 since 2008/09, the percentage of overall exclusions has risen from 5.5% in 2008/09 to 7.8% in 2012/13 as overall permanent exclusions have fallen. The number of fixed term exclusion due to drugs and alcohol reduced from 8,580 in 2008/09 (a reduction of 18%) but has remained a similar proportion of overall fixed period exclusions (around 2.5%) as this reduction has been in line with the general trend. (Department for Education, 2010; Department for Education, 2011; Department for Education, 2012; Department for Education, 2013b; Department for Education, 2014).

Wales

Data from the Welsh substance misuse statistics 2013-14 reported that in the academic year 2012-13 a total of 375 fixed term exclusions and 11 permanent pupil exclusions were imposed in schools in Wales in 2012-13 due to substance misuse. The proportion of all exclusions accounted for by substance misuse rose from 2.4% to 2.8% (Public Health Wales, 2014b).

State benefits for drugs misuse claimants

Since the coalition government has come into office, a number of welfare reforms have been implemented. One such reform which may have particular bearing on drug users who claim benefits and the services that support them is the transfer of claimants from IB¹⁹² and Severe Disablement Allowance (SDA)¹⁹³ to ESA (often referred to as 'ESA migration'), due to the greater conditionality and sanctions¹⁹⁴ associated with this benefit (London Drug and Alcohol Network and DrugScope, 2014). Under ESA, claimants have to undergo a 'Work Capability Assessment' which aims to distinguish between individuals who are not able to work because of physical or mental health problems, from those who are fit for some work, or could return to work with support.

Since 2010, all new unemployment benefits claimants have entered the benefit system under these conditions. The government planned to transfer all the recipients off IB and SDA to ESA by 2014, reassessing between October 2010 and March 2014 all the pre-existing incapacity benefits claimants. The introduction of this new system has resulted in a flow of people from sickness-related benefits such as IB towards JSA.

Data from the DWP in August 2013 show that a total of 34,210 individuals in Great Britain were claiming IB/SDA or ESA with a primary disabling condition of drug misuse representing a decrease of around 13,140 individuals since 2010 (see Table 8.1) (Department for Work and Pensions, 2014).¹⁹⁵

¹⁹² IB is a benefit for individuals that are not able to work because of illness or disability and had previously made National insurance contributions.

¹⁹³ SDA is a benefit for individuals that are not able to work because of illness or disability.

¹⁹⁴ New sanctions regime for Jobseeker's Allowance; see: <https://www.gov.uk/government/collections/jobseekers-allowance-sanctions>

¹⁹⁵ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315256/benefit-claimants-drug-alcohol-condition.pdf

Table 8.1: Incapacity Benefit/Severe Disability Allowance and Employment Support Allowance claimants with a primary disabling condition of drugs misuse, Great Britain 2007 to 2013¹⁹⁶

AUGUST	NUMBER OF BENEFIT CLAIMANTS WITH A PRIMARY DISABLING CONDITION OF DRUGS MISUSE		
	IB/SDA	ESA	IB/SDA OR ESA
2007	50,500	*	50,500
2008	51,020	*	51,020
2009	42,800	n/a	-
2010	37,480	9,870	47,350
2011	33,040	10,620	43,650
2012	18,050	20,610	38,660
2013	6,330	27,880	34,210

*not applicable

Source: Department for Work and Pensions, 2014

Welfare Reform on Scottish drug and alcohol services and their clients

The impact of Welfare Reform on Scottish drug and alcohol services and their service users is currently being conducted through a study initiated by Scottish Government and delivered through the Scottish Drugs Forum (SDF).¹⁹⁷ This captures the views of almost 200 professionals about their experiences and those of their clients resulting from the Welfare Reform, on a range of issues including capacity of services to deal with welfare issues, workforce development on welfare reform, and the impact on service users due to sanctioning, stress, housing benefit changes, work capability assessments, etc. This survey began in July 2014 and is due to report late 2014.

8.2.3 Families and young people

Parental Drug Use

Scotland

Scotland's National Drug-related Deaths Database (NDRDD) reporting deaths occurring in 2012 (see section 6.4.3) showed that 173 (37%) individuals suffering a drug-related death were a parent or a parental figure to a child or children¹⁹⁸ under the age of 16, a decrease from 45% of all deaths occurring in 2011 (this value has been fluctuating since the data were reported in 2009 with 36.5% in 2009, 30% in 2010 and 44% in 2011) (Hecht et al., 2014). Eight per cent ($n=39$) were living with a child or children at the moment of death, which is broadly constant from previous years (range: 8-10%). In total, of the 286 children who lost a parent or parental figure due to drug-related death in 2012, 65 (23%) were living with them at the time of death similar to 2011.

In Scotland, parental substance misuse is the second most common concern identified in children who were on the child protection register in 2012/13 and accounts for 37% of all children registered on 31st July 2013 (Scottish Government, 2014a).

¹⁹⁶ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315256/benefit-claimants-drug-alcohol-condition.pdf

¹⁹⁷ See: <http://www.sdf.org.uk/news-and-media/sdf-news/welfare-reform-and-its-impact-on-services/>

¹⁹⁸ Children to whom the deceased was considered as being a parent including non-biological children who were the deceased's step children and non-biological children of a partner.

In 2012, 5.6% (28) of individuals suffering a drug-related death in Scotland experienced issues with child custody in the six months preceding their death (Hecht et al., 2014).

Northern Ireland

In Northern Ireland in 2012/13, the proportion of individuals presenting for substance misuse treatment who were living with their spouse or partner and children remained constant at around eight per cent since 2010/11 after decreasing from 14% in 2007, 15% in 2008/09 and 12% in 2009/10 (Department of Health, Social Services and Public Safety Northern Ireland, 2013). In the same period, the proportion of individuals with drug problems and solely responsible for children ranged between four and seven per cent (2007/8: 14%; 2008/09: 15%; 2009/10: two per cent).

Wales

There were a total of 4,935 cases of children in need¹⁹⁹ registered with local authorities in Wales where parental substance misuse (including alcohol misuse) was recorded as the relevant parental factor (as at 31 March 2013). This figure was 2 per cent lower than the previous year and represented 25 per cent of all cases of children in need in Wales on that date (Public Health Wales, 2014b).

Identifying and supporting children affected by parental substance use

In November 2013, Alcohol and Drug Education and Prevention Information Service (ADEPIS) launched a resource aimed at providing best practice and evidence-based examples to help schools understand the key issues affecting children whose parents are substance misusers and how schools can support them (Alcohol and Drug Education and Prevention Information Services, 2014). The resource suggested a list of questions that the staff working with children should ask to identify and support such pupils. This resource is mainly aimed at school governors and head teachers, but can also be used as a resource by other members of staff.

Research

An evaluation of the “The Parents Under Pressure” programme

Barlow et al (2013) published a study protocol for a randomized controlled trial (RCT) on the clinical and cost effectiveness of the Parents Under Pressure (PuP) programme (Barlow et al., 2013). The programme aims to support parents who are dependent on psychoactive drugs or alcohol by providing them with methods of managing their emotional regulation, and of supporting their new baby's development. The study is being conducted across six sites in the UK and aims to recruit parents and caregivers of children who are less than 2.5 years old with recruitment concluding in December 2015. Consenting caregivers are randomly allocated to either the 20 week home-visiting programme or standard care. The primary measured outcome is child abuse potential, and secondary measurable outcomes include substance use, parental mental health and emotional regulation, parenting stress and infant/toddler socio-emotional adjustment scale. An evaluation of the PuP programme in Australia with parents on methadone maintenance of children aged three to eight years found significant reductions in child abuse potential, rigid parenting attitudes and child behaviour problems (Dawe & Harnett, 2006). This study will be compared with other studies that have examined new approaches to supporting substance-dependent parents of very young children.

¹⁹⁹ The term 'child in need' is set out in the Children's Act (1989) as a child who is likely to have their health significantly impaired, or who is unlikely to maintain a reasonable standard of health and development without the provision of local authority children's services, or who is disabled. This is distinct from children 'in care' or 'looked after' (where a local authority has taken responsibility for care of a child in place of the child's parents) or 'children on the child protection register' which refers to children for whom there is a plan for protection in place.

Moving Parents And Children Together

Moving Parents And Children Together (MPACT)²⁰⁰ is a programme developed by Action on Addiction, and delivered by a range of UK partner agencies designed to support children and young people (aged eight to 17) whose parents are substance misusers. The aim of the programme is 'to improve the physical and psychological health and well-being of children and young people affected by parental substance misuse', offering a 'whole family approach', working together with parents and children in different group combinations to a maximum of eight families at any one time. MPACT seeks changes in two broad areas:

- modification of parental behaviour, to take into account the effect of their substance misuse on their children; and
- reduction of the impact that parental substance misuse has on their children.

In April 2014 Action on Addiction²⁰¹ published an independent economic assessment of MPACT (Action on Addiction, 2014). The evaluation was carried out by Interface Enterprises over the period August to October 2013. This assessment was performed using an evaluative Social Return on Investment (SROI)²⁰² methodology which provided an estimate of the costs and economic benefits of the programme.

Results from the SROI cost-effective evaluation showed that MPACT provides economic value with £2.76 saved for every £1.00 spent in the first year after a family engages with the programme.

Other positive outcomes, not economically evaluated, were families engaging with services and higher educational accomplishment among children.

8.2.4 Barriers to accessing health and social care

Improving access to health and social care services for people who do not routinely use them

In January 2014 the National Institute for Health and Care Excellence (NICE) published a briefing²⁰³ based on NICE published guidance up to July 2013 on improving access to health and social care services for vulnerable people who do not routinely use them. The briefing was written with advice from the NICE Local Government Reference Group and uses feedback from council officers, councillors and Directors of Public Health (DPH). NICE has suggested that local authorities should identify public health priorities according to the demographic profile, for example by consulting with local health champions and vulnerable people who do not routinely use the services so that they can identify barriers to using services (including cultural and behavioural barriers). They encouraged local authorities to deliver early interventions through accessible health and social care provision for young children and their families. The briefing noted that people who do not routinely use health and social care services do so for a series of reasons. These include marginalised groups such as homeless, drug users and vulnerable migrants, children from some unreached groups, for example travellers or those from families that don't speak English as a first language. Therefore, local authorities have to implement targeted interventions to reach such groups. This briefing is intended to be used as an online resource alongside the local joint strategic needs assessment, to support the development of the joint health and well-being strategy aimed at supporting the entire local authority population.

For further initiatives addressing these issues see section 8.3.

²⁰⁰ See: [http://www.actiononaddiction.org.uk/For-Families/M-Pact-\(UK\)-Project.aspx](http://www.actiononaddiction.org.uk/For-Families/M-Pact-(UK)-Project.aspx)

²⁰¹ See: <http://www.actiononaddiction.org.uk/Home.aspx>

²⁰² Social Return on Investment (SROI) is a method for synthesising the costs and benefits of programmes when a routine economic analysis of financial data is insufficient to provide with an accurate picture of the programme economic impact. There are two types of SROI, the forecast SROI that looks at that might be achieved and evaluative SROI that estimates the return achieved from an assessment of outcomes.

²⁰³ See: <http://www.nice.org.uk/guidance/lgb14/chapter/introduction>

8.2.5 Drug use among socially excluded groups

People with multiple needs

In acknowledgment of the fact that people contacting certain types of support services often have a number of over-lapping needs such as problems with housing, employment support, mental health or substance misuse, the All Party Parliamentary Group on Complex Needs and Dual Diagnosis (APPG) was founded in 2007. The APPG recognise that, even though it is well acknowledged that integrated services are the best way to address the problem of people with multiple needs, it is still very difficult, for a variety of reasons (such as location, competency, the number of individuals involved, priorities of the services etc.) to co-ordinate all the services involved in such cases. As a result, there may be gaps in the provision of services for people with multiple and/or complex needs.

In the summer of 2013 the APPG launched an inquiry into 'complex needs' with the aim to:

- define what the APPG means by 'complex needs' (there is not a national or international definition of 'complex needs');
- consult experts to establish what barriers and challenges people with complex needs experience, and how they have changed with legislation; and
- find examples of good practice that have successfully contributed to overcoming such barriers.

The inquiry will run for 18 months and will combine the use of surveys, evidence sessions, group discussions and constant interaction with stakeholders. APPG will publish a range of factsheets. The first of these, aimed at defining what the APPG means by 'complex needs', was published in July 2014 and gives the following definition:

- a person with 'complex needs' is someone with two or more needs affecting their physical, mental, social or financial well-being;
- such needs typically interact with and exacerbate one another;
- these needs are often severe and/or long standing, and often difficult to ascertain, diagnose or treat; and
- individuals with complex needs are often at, or vulnerable to, reaching crisis point and experience barriers to accessing services; usually requiring support from two or more services/agencies.

Domestic Violence

Scotland's NDRDD (see section 6.4.3) stated that among 478²⁰⁴ cases, 60 individuals (13%) had experienced domestic abuse at some point in their lives, the majority of whom were female (78%) (Hecht et al., 2014). Forty per cent of females (47/118) who died a drug-related death in 2012 had experienced domestic abuse at some point in their lives, compared to only four per cent of men (13/360).

Sexual Abuse

Scotland's NDRDD²⁰⁵ (see section 6.4.3) stated that among the 478,²⁰⁶ 82 individuals (17%) had been subjected to sexual abuse at some point in their lives, the majority of whom were female (61%) (Hecht et al., 2014). Similarly to the data reported for domestic abuse among those who died of a drug-related death (see section above), 42% of females (50/118) who died in 2012 had experienced sexual abuse at some point in their lives, compared to only nine per cent of men (32/360).

²⁰⁴ This refers to drug-related death cases for which it has been possible to ascertain if the individuals have experienced domestic abuse at some point in their lives. Deaths reported to have occurred in 2012.

²⁰⁵ Reporting deaths occurring in 2012

²⁰⁶ This refers to drug-related death cases for which it has been possible to ascertain if the individuals have experienced sexual abuse at some point in their lives. Deaths reported to have occurred in 2012.

8.2.6 Stigmatisation of drug users

Women's experience of alcohol, drugs and sexual violence

Against Violence and Abuse (AVA)²⁰⁷ undertook research that sought the views of women who have experienced sexual violence, investigating how they believed their use of alcohol or other drugs impacted on their capacity to consent, and their involvement (or not) with the criminal justice system (Against Violence and Abuse, 2013). A mixed method approach was used comprising of a literature review, two online questionnaires targeted at practitioners and victims and one-to-one interviews. Findings showed that out of 76 eligible respondents,²⁰⁸ 57% had experienced more than one drug-facilitated sexual assault and 17% experienced ten or more such assaults. Alcohol was the most commonly consumed substance (97%) followed by cannabis (13%), benzodiazepines (eight per cent) and cocaine powder (five per cent). Almost half of those surveyed (47%) believed that they were still physically capable of communicating consent (but that they did not give their consent), 12% stated that it was possible that they were unable to communicate consent, and 41% stated they were unable to communicate consent. The report concluded that those who had consumed substances before sexual assault face greater barriers to achieving justice than those who had not been drinking or taken drugs. The research also suggested that they are less likely to be believed about the harms experienced, and they are at higher risk of stigmatisation than other victims of sexual violence.

Trauma and Recovery amongst Drug Injectors

Richard Hammersley with the Scottish Drugs Forum conducted research on the lives of people who had injected drugs within the past five years with a particular focus on the issues of stigmatisation and trauma (Hammersley & Dalgarno, 2013). They conducted interviews with 55 people (38 men, 17 women recruited in Scotland) using a structured life story format, with the aim of better understanding the complexity of their lives in relation to drug problems and the issues and stereotyping that they encounter.

The research suggests that stigmatization leads people to regard drug users as passive and incapable of making their own choices. The research concluded that it is important to understand the full complexity of drug users' lives in order to see them as people who use drugs, rather than as passive recipients of their drug problems.

Sex Work in Wales

A recent review has been carried out in conjunction with Swansea University and will be published later in the autumn.²⁰⁹ This considered the connection between sex work and problematic drug use in the UK and the legal and policy framework for sex work in England and Wales. The report found that:

- there are clear links between sex work and problematic drug use;
- the need for drug treatment services for drug using sex workers is recognised in sex worker policies in Wales, although there is a lack of comprehensive guidance on the issue;
- sex work is very complex; tackling problematic drug use is likely to be one of many issues for sex workers that need to be addressed simultaneously;
- there is no evidence of what treatment works, for whom, in what circumstances;
- full recovery is desirable but a harm reduction approach to drug treatment for drug using sex workers is essential.

Part two of the study is in development and will focus on more qualitative work with drug using sex workers and professionals who have direct and indirect contact with sex workers. The research will evaluate the needs of sex workers who have substance misuse problems.

²⁰⁷ See: <http://www.avaproject.org.uk/>

²⁰⁸ 167 people responded to the questionnaire, and the answers from 76 respondents were used in the analysis.

²⁰⁹ See: http://www.gibran-uk.co.uk/downloads/Info_to_Stakeholders_August_2010.pdf

8.3 Social reintegration

State of the Sector 2013

In their report *State of the Sector* 2013 (DrugScope, 2014), which took a snapshot of the situation in the UK after the coalition government's reforms, DrugScope highlighted that drug and alcohol services have been affected by the local authority change in responsibilities, (in particular, public health reforms, commissioning and funding arrangements) with the potential of negatively affecting the individual's prospects of making progress in treatment. The report concluded that more time is needed for the system to adjust to these changes. Thus far, there are no clear signs of extensive disinvestment in drug and alcohol treatment in the UK. The report recommended that to maintain effective treatment services, the sector and key stakeholders such as Public Health England (PHE) will need to ensure that local authorities provide the necessary investment including funding for non-mandatory services.²¹⁰ Several concerns have been expressed by the report, such as:

- the influence that such changes, in particularly to employment and/or housing support for clients with drug and alcohol problems and/or complex physical and mental health needs, have on the activities associated with supporting recovery capital; and
- the potential impact of frequent changes to the commissioning system, which can create confusion for clients and operators in the sector and disruption to service provision.

A positive point raised by the report was that agencies active within the sector are willing to create constructive partnerships, engaging with commissioners, funders, policymakers and other stakeholders.

To increase the knowledge gained from the 2013 State of the Sector survey, DrugScope is planning to run a second survey in September 2014. This will expand the remit of the 2013 survey by also covering prison and young people's services.

Second year evaluation of the Making Every Adult Matter pilots

Making Every Adult Matter (MEAM), a coalition of national charities (Clinks, DrugScope, Homeless Link and Mind), have supported three pilot programmes (in Cambridgeshire, Derby and Somerset) since 2011 to improve co-ordination of existing local services for individuals with multiple needs, providing a non-prescriptive framework. The pilots were based on four core elements taken from other multiple needs programmes: co-ordination, flexibility, consistency and measurement. Each pilot site has a co-ordinator to engage with clients and help them gain access to the services they need. The co-ordinators are supported by an operational group and board of local services, providing strategic engagement.

In February 2014 Battrick et al. (Battrick et al., 2014) published the second annual evaluation of the three service pilots. The report indicated that the improvements in well-being of the service users in Cambridgeshire obtained after the first year of the study were maintained in the second year. The total cost per client fell more significantly in the second year than in the first year of the pilot. In Derby, the well-being improved in both first and second year (although results based on a small sample). The cost per client using the service, which increased significantly in the first year of the pilot, fell back below the baseline during the second year. Both areas showed a significant reduction in costs associated with crime. No data were reported by Somerset for the second year of the pilot study.

The pilot services are continuing to operate and MEAM is working to expand the implementation of such programmes across the country.

²¹⁰ To fulfil their public health responsibility, local authorities are required to provide a number of mandatory services and steps that were identified in *Healthy Lives, Healthy People: update and way forward* (Her Majesty's Government, 2011). Alcohol and drugs services are not part of these services. However, substance misuse historically has accounted for 34% of the national spending on public health and this has been recognised in the calculation for the public health grants. Primary funding for alcohol and drugs services comes from a ring-fenced public health grant and local authorities are required to report spending on an annual basis on adult and young people drug and alcohol services.

Voices from the Frontline

The MEAM coalition is running a two-year project called Voices from the Frontline (VFTF)²¹¹ funded by the Lankelly Chase Foundation. The VFTF project is aimed at ensuring that the voices of people with multiple needs have an impact on the national and local policy debate. Over two years VFTF will undertake a programme of engagement and consultation listening to people with multiple needs and individuals working in frontline criminal justice, substance misuse, homelessness and mental health services. In the first year, the VFTF project will focus on two policy topics: access to benefits and access to services and the impact that recent changes had on both. In June 2014 the VFTF project carried out its first survey on the impact of welfare and commissioning reforms on people with multiple needs. The survey's findings were published in autumn 2014 (Making Every Adult Matter, 2014). Over 140 services participated, representing 70,000 individuals. The reporting services were divided into four sectors: criminal justice, housing, substance misuse and mental health, with responses from all English public health regions.²¹² The majority of services reported that recent welfare reforms have negatively influenced their clients' mental health (86% services) and well-being (88% services).

There was not a clear picture emerging from the data reported by the services on the effect that various changes to commissioning were having on clients with multiple needs. On the positive side, 42% of respondents reported that multiple needs had become more important for commissioners in their area over the last two years. The majority of services (72%) identified some type of collaborative commissioning in their area, with several examples of good practice. When asked about the changes to commissioning structures, the services reported that the removal of ring-fencing from funding for the Supporting People programme²¹³ is having a negative impact on people with multiple needs (56% of services reported a negative impact, while less than five per cent reported a positive impact). On the overall impact of changes to commissioning, the majority of services believed the impact was neutral, a significant minority reported a negative impact, and a few believed it was highly positive.

In the next two years, VFTF will continue to study these issues with the aim of helping the government and commissioner to understand the views of services and their users when determining the best way to support people with multiple needs, the impact of welfare reforms on people with multiple needs and explore how the commissioning system can be improved.

England

Pathways to Employment

The London Drug and Alcohol Network (LDAN)²¹⁴ launched the 'Pathways to Employment' project in 2009, funded by Trust for London. The core of the project has been the development of a pan-London network formed of people designing, delivering and using drug and alcohol and Education, Training and Employment (ETE) services in London with the aim of getting people who have gone through drug or alcohol treatment into employment. The second phase of the project from 2011 to 2014 was designed to create employment opportunities for people with drug and alcohol problems, engaging and influencing London employers and educational establishments. The project provided guidance and support to drug and alcohol workers and service users through targeted events and information resources.

In March 2014, a report on *Pathways to Employment* was published (London Drug and Alcohol Network and DrugScope, 2014). The report was promoted nationally but with a particular focus on London. The series of surveys on which the report is based included 155 jobseekers with experience of treatment for drug and/or alcohol use participating in an online survey; 18 jobseekers in treatment or recovery participating in structured group interviews; and 69 employers from a range of sectors participating in an online survey, which was conducted between 2012 and 2013.

²¹¹ See: <http://meam.org.uk/voices-from-the-frontline/>

²¹² The larger number of responses came from London and the north England.

²¹³ Supporting People was a national programme providing local authorities with a ring-fenced budget to spend on housing-related support. Funds for housing-related support now come from a larger grant, the Formula Grant, which is used for a wide range of local services and not only housing. As a consequence of these changes, local authorities are no longer required to provide housing-related support beyond their statutory obligations.

²¹⁴ The network merged with DrugScope in 2009, see: <http://www.ldan.org.uk/index.html>

The majority of jobseekers who participated in the group interviews or survey believed that they were able and willing to work. They believed that more demanding conditionality and more stringent sanctions may drive people to disengage, rather than to get the most out of the funded ETE support. Several participating employers welcomed any advice and support, whether about drugs and drug use, employment law or good practice concerns, and about the availability of services and support locally. In general the participants in the surveys felt that including social value as part of the procurement process might increase job opportunities for people with histories of drug and or alcohol problem. The report also highlighted examples of current good practice, paying attention to developments in policy, service provision and some aspects of welfare reform that affect people with drug and alcohol problems.

Following from the March 2014 report, to gain an understanding of the ETE provision across London (both from the statutory providers and the voluntary sector) LDAN/DrugScope has undertaken a mapping exercise to create a directory of ETE service providers in London with the aim of facilitating communication between professionals in the sector and identifying the services that could help their clients.

Qualitative Evaluation of the London Homelessness Social Impact Bond: First Interim Report

Social Impact Bonds (SIBs) are a type of investment where private and, or non-government investors provide upfront funding for interventions designed to improve social outcomes. As such, they can provide opportunities that might not be possible with conventional financing. Service providers receive payment if they achieve pre-agreed social outcomes, while investors receive a profit on their investment if the outcomes generate savings for the government.²¹⁵

One example is the London Homelessness SIB (LH-SIB), launched in November 2012, which identifies and engages with entrenched rough sleepers in London whose needs have not been met by existing services. Two providers are delivering LH-SIB, each applying a personalised and flexible approach, with keyworkers ('navigators') acting as a single point of contact for clients throughout the life of the programme.²¹⁶ Success is being measured against five social outcomes: reduced rough sleeping; sustained stable accommodation; sustained reconnection (for non-UK nationals); increased employability and employment; and better managed health (measured by reduced accident and emergency (A&E) attendance). The amount paid for each outcome was adjusted according to the likelihood of achieving it.

In September 2014, the Department for Communities and Local Government (DCLG) published the first qualitative evaluation interim report on the LH-SIB, presenting how well the services were performing against their agreed targets (Department for Communities and Local Government, 2014). According to the report, performance in the first year has been variable as providers have experienced a range of challenges. However, clients have been very positive about the navigator role, stating that they identified with their key worker as someone providing a wide range of long term support, co-ordinating services and advocating on their behalf. Successful client outcomes will be the focus of subsequent strands of the evaluation.

²¹⁵ Advantages of the SIB model are: removal of upfront costs of service delivery from the government and the shift of financial risk to private investors; unlike other payment by results mechanisms, providers are paid upfront presenting the opportunity for providers (including not-for-profit and third sectors organisation) to embark on more risky projects or other kinds of service delivery which government might not prioritise for funding. Risks or dangers of the SIB model are: investors seeking to fund projects with easily measurable outcomes; investors having more influence on the project; reduced public responsibility.

²¹⁶ Navigators targeted 831 named homeless people who were identified through the CHAIN database. CHAIN is a multi-agency database recording information about the homeless population in London, it is used by service workers to share information. It collects clients' identifying and demographic information, details of contacts with services, time spend in short term accommodation (including the reasons for leaving them) and information on the support needed (for example drug misuse or physical health problems). See: <http://www.broadwaylondon.org/CHAIN/WhatisCHAIN.html>

European Social Fund Peer Mentoring Scheme

The Peer Mentoring Wales (PMW) project is a £11m EU funded project providing individual mentoring support for adults who use substance misuse services. The project funded by the European Social Fund (ESF) ran between October 2009 and April 2014. The PMW project enabled fully qualified peer mentors to offer intensive support to individuals referred onto the scheme. Many of the mentors were also ex-service users who had successfully turned their lives around. The peer mentors helped project participants to develop the skills and confidence they needed to achieve economic independence and in particular provided continued support to service users reaching the end of their treatment by giving advice and support for participants to enter learning, training and education; assisting participants in finding and remaining in paid employment; helping with relapse prevention; providing a post-treatment focus for parents, wider family and support networks. The scheme also offered a potential career pathway for ex-service users to become peer mentors.

At the end of the project, support had been given to 11,199 participants of which; 1,064 entered employment; 1,200 had entered further learning; 1,540 had gained a qualification and 7,487 had achieved some form of positive outcome.

An evaluation of the project for the period October 2009 to September 2013 has been undertaken by the University of South Wales. It showed that the providers achieved almost all the four-year targets set for the project, developing an effective model of support (Welsh Government, 2014b).

The Welsh Government are currently working on a bid for the next round of European funding (2014 to 2020) to build on the success of the current project, which will include peer support for people with Mental Health and/or substance misuse issues.

Scottish Families Affected by Alcohol and Drugs

Scottish Families Affected by Alcohol and Drugs (SFAD)²¹⁷ is the hub of a network of family support groups across Scotland which provides information and support via a website and helpline to families and friends affected by a close relative or friend's substance misuse. In 2014, SFAD published their fourth annual report, reporting that in 2012/13 there had been an increased demand for their services in terms of both direct contact (telephone calls and emails) and access to their web page (Scottish Families Affected by Drugs, 2014). SFAD have also launched a services toolkit 'A best practice guide to working with family support groups' aimed at the services that are planning to set up and facilitate family support groups. The toolkit contains information on the practical aspects of setting up a group and best practice advice on how to facilitate one. In February 2012, SFAD held the annual conference, 'Families Can Recover Too' attended by both family members and professionals.

²¹⁷ See: <http://www.sfad.org.uk/>

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

9.1 Introduction

Drug use is not a crime in the United Kingdom (UK), but possession, production and dealing, as well as trafficking (including importation and exportation) are specific offences under the *Misuse of Drugs Act 1971*. A prison sentence is the most common outcome when found guilty at court of import/export and trafficking offences but a fine, community sentence or conditional discharge are the most common disposals for possession offences.

Police records on general criminal offences do not contain information on offenders' drug use, neither do records of specific drug law offences. It is therefore not possible to provide an accurate estimate of the number of offences that are drug-related. Despite the complexity of the drugs-crime relationship, there is research evidence of the link between drug use, particularly use of heroin and crack cocaine, and acquisitive crime (Home Office, 2007) (Morgan, 2014). Around two-thirds of those in custody are reported to be recent drug users with an estimated 40% of prisoners received into custody being problematic drug users, 40% of whom identify themselves as people who inject drugs (PWID) (Stewart, 2008).

The Drug Interventions Programme (DIP) was operational in the majority of local areas in England and Wales, from 2003 to March 2013, to tackle Class A Drug misusing offenders, managing around 88,000²¹⁸ into drug treatment in 2011/12. In April 2013 Home Office funding for DIP was devolved to Police and Crime Commissioners (PCCs), elected in each local area, and Department of Health funding to support this programme was assimilated into the local Authority Public Health Grant. DIP is no longer a nationally mandated programme and the decision whether to maintain this provision is now an issue for local authority commissioners and PCCs to determine at a local level.

In Scotland, there are a number of interventions at different levels of the criminal justice system, including diversion from prosecution to drug treatment/education, community payback orders with a drug treatment requirement, Drug Treatment and Testing Orders (DTTOs) for particularly high tariff offenders who are entrenched in their drug use, as well as services for prisoners post-release, including Throughcare Addiction Services. DTTOs provide offenders with access to treatment services which they are required to comply with, combined with regular progress reviews from the Court. A less intensive version (DTTO II) has been developed for lower tariff offenders and rolled out on a pilot basis in Edinburgh and Lothians from June 2008.

There are a range of measures to prevent drugs entering prison including clearly-defined searching procedures covering all possible routes; passive and active drug dogs, with passive dogs available to all prisons; CCTV surveillance of all social visit areas and low-level fixed furniture; and comprehensive measures to tackle visitors attempting to smuggle drugs, including closed visits, visit bans and police arrest. Recently introduced initiatives include drug-free wings and further developments of mobile phone signal denial equipment, including the *Prisons (Interference with Wireless Telegraphy) Act 2012*. In Scotland a comprehensive range of robust security measures are also in place to divert, disrupt, detect and deter the introduction and distribution of illicit substances and associated paraphernalia, including mobile phones from entering prisons.

Since April 2006, in England and Wales, responsibility for prison health services moved gradually to the National Health Service (NHS) and an Integrated Drug Treatment System (IDTS) was introduced in England to improve the availability and quality of drug treatment in prison, bringing it in line with treatment in the community. From April 2011, the Department of Health assumed responsibility for funding both clinical and non-clinical drug and alcohol treatment in all prisons and the community in England. The responsibility for commissioning substance misuse services was devolved to local partnerships in line

²¹⁸ This figure is the number of offenders identified through DIP in the community and in prison in England and Wales, entering Tier 2 and Tier 3/4 drug treatment.

with the key *Patel Review* (Department of Health, 2010) recommendation that integrated and needs-led treatment services are best commissioned at a local level. In April 2013, as part of the new health and care changes set out in the *Health and Social Care Act 2012*, NHS England became responsible for commissioning health services in prisons and other secure accommodation in England.

In Wales, health services are the responsibility of the Welsh Government, with responsibility for commissioning devolved to local Health Boards. The National Offender Management Service (NOMS) retains responsibility for its non-clinical substance misuse services for sentenced offenders. In Scotland, responsibility for the provision of health care services in prisons transferred from the Scottish Prison Service to the NHS in November 2011. A range of health and substance misuse services are now provided within Scottish prisons by the respective local Health Boards.

Those in prison have access to HIV and hepatitis testing, and vaccination against hepatitis B. Hepatitis A vaccination is also offered routinely in Scotland to those who have previously been drug users and those who are hepatitis C positive. In Scotland Take Home Naloxone (THN) is widely available for prisoners at risk of opioid overdose on release and is becoming increasingly available in England and Wales.

9.2 Drug law offences

Data on drug law offences are available at various points in the criminal justice system. Recorded crime data count the number of drug offences brought to the attention of police and represent the widest measure of drug offences available in the UK. However, at present the individual drug involved is not recorded (except for cannabis possession offences). Arrests data record the number of persons who are arrested for a drug offence and represent a smaller proportion of drug offences since some penalties such as formal warnings for cannabis do not constitute an arrest. These data are not available by drug or by offence type. Finally, cautions and convictions data record number of offenders where an individual is found guilty at court or cautioned for a drug offence where this was the principal offence for which they were dealt with. Data from each level of the criminal justice system cannot be compared for a number of reasons including: time lag between offence and conviction; the basis on which the data are provided (offender or offence); counting rules;²¹⁹ and year of data (calendar or financial year). Further information on the recording of drug offence data are contained in a selected issue chapter on sentencing statistics in the UK Focal Point Report 2008 (UK Focal Point, 2008).

The recording of drug offences is dependent on police activities and priorities and is not a reliable indicator of the level of drug offending.

9.2.1 Recorded crime: drug offences

Data on recorded crime for drug offences is reported throughout the UK, however, Scottish data for 2013/14 were not available at the time of writing this report. The total recorded drug offences in England and Wales and Northern Ireland was 202,908 in 2013/14, a four per cent reduction on the previous year (Table 9.1). This reduction was primarily due to a five per cent fall in possession offences which accounted for 84% of the total recorded drug offences. There was a 16% increase in the 'other' drug offences category, however, relatively few offences fall into this category. The number of trafficking offences recorded remained similar to the number in 2012/13.

²¹⁹ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/340313/count-drug-july-2014.pdf

Table 9.1: Recorded crime: Drug offences in the United Kingdom by offence type and country, 2004/05 to 2013/14 ²²⁰

	YEAR									
	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
ENGLAND AND WALES										
Trafficking*	24,190	25,276	26,550	28,323	29,885	33,234	32,336	31,316	29,765	29,461
Possession	120,866	152,602	167,003	200,773	212,528	201,240	199,444	196,656	177,219	167,515
Other drug offences**	781	601	680	816	1,123	1,122	1,142	1,127	1,033	1,200
Total offences	145,837	178,479	194,233	229,913	243,536	235,596	232,922	229,099	208,017	198,176
NORTHERN IRELAND										
Trafficking	375	349	475	530	607	668	762	846	890	968
Possession	2,246	2,594	1,934	2,186	2,364	2,472	2,708	2,924	3,473	3,748
Other drug offences	1	1	4	5	3	6	15	10	15	16
Total offences	2,622	2,944	2,413	2,721	2,974	3,146	3,485	3,780	4,378	4,732
SCOTLAND										
Trafficking	9,333	9,613	10,890	9,827	10,315	9,901	7,138	6,684	5,136	-
Possession	32,268	34,440	31,329	30,559	31,805	29,179	26,960	28,326	29,150	-
Other drug offences***	222	194	203	360	389	328	249	147	402	-
Total offences	41,823	44,247	42,422	40,746	42,509	39,408	34,347	35,157	34,688	-
UNITED KINGDOM										
Trafficking	33,898	35,238	37,915	38,680	40,807	43,803	40,236	38,846	35,791	-
Possession	155,380	189,636	200,266	233,518	246,697	232,891	229,112	227,906	209,842	-
Other drug offences	1,004	796	887	1,181	1,515	1,446	1,406	1,284	1,450	-
Total offences	190,282	225,670	239,068	273,379	289,019	278,140	270,754	268,036	247,083	-

*Trafficking usually includes production, supply, possession with intent to supply, possession on a ship, carrying on ship and unlawful import and export.

**For England and Wales, and Northern Ireland 'other drug offences' mainly concern permitting premises to be used for the production, supply and use of drugs.

***For Scotland 'other drug offences' include production and manufacture of drugs (not illegal cultivation), offences related to money laundering, and other drug offences not designated as trafficking or possession.

Source: Chaplin et al. 2011; Police Service of Northern Ireland, 2013, Scottish Government, 2013b; Smith et al., 2013; Taylor & Bond, 2012; Office for National Statistics, 2014b; Police Service of Northern Ireland, 2014a

²²⁰ Police forces in England and Wales revise their data as further information becomes available and figures in this table therefore may not agree with those previously published.

9.2.2 Arrests for drug offences

The number of arrests for drug offences decreased by seven per cent between 2011/12 and 2012/13 in England and Wales, which saw fewer arrests than have been recorded in any year since 2007/08 (Table 9.2). In England and Wales, 11% of all persons arrested for drug offences were female compared to 15% for all offences. This is lower than the proportion of females amongst those entering treatment in the UK in 2013 (24%) (ST34) and among drug-related deaths (27%) (Office for National Statistics, 2013). Arrests for drug offences in Northern Ireland rose by nine per cent between 2011/12 and 2012/13.

Table 9.2: Arrests for drug offences in England and Wales, and Northern Ireland, 2003/04 to 2012/13

	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
England and Wales	113,100	84,800	88,600	89,400	104,500	115,300	121,000	123,700	120,500	111,600
Northern Ireland	1,754	1,356	1,440	1,726	1,896	2,014	2,250	2,435	2,543	2,784
Total	114,854	86,156	90,040	91,126	103,396	117,314	123,250	126,135	123,043	114,384

Source: Home Office, 2013d; Police Service Northern Ireland, 2004; Police Service Northern Ireland, 2006; Police Service Northern Ireland, 2008; Police Service Northern Ireland, 2010; Police Service Northern Ireland, 2012; Police Service of Northern Ireland, 2014

9.2.3 Convictions and cautions for drug offences

There were 144,428 drug offences where the person was found guilty at court or cautioned in the UK during 2012 (Table 9.3; ST11), a six per cent reduction on the previous year ($n=154,210$). Convictions for heroin decreased by 11% from 2011 during which convictions had already fallen sharply from 2010. The comparatively low number of heroin convictions seen in these two years may reflect the reduced availability of heroin during this period; a pattern seen in other indicators. Having steadily risen between 2007 and 2011, the number of cannabis convictions fell by six per cent in 2012 but are still far higher than in 2007 (+35%). Cocaine powder convictions fell by seven per cent in 2012 and were at the lowest level since 2006.

Table 9.3: Drug offences where the offender was found guilty or issued a caution in the United Kingdom,²²¹ 2003 to 2012 by individual drug

	2003*	2004*	2005	2006	2007	2008	2009	2010	2011	2012
Amphetamines	6,163	6,249	6,864	7,422	7,478	7,822	7,096	7,487	7,831	6,488
Cannabis	85,768	82,845	54,813	55,984	55,563	63,103	66,598	75,284	80,023	75,116
Cocaine powder	7,905	9,382	12,028	15,470	19,216	22,874	22,529	20,034	20,102	18,723
Crack cocaine	2,270	2,450	3,734	4,076	4,613	5,895	4,241	3,679	3,791	3,845
Ecstasy	5,940	6,209	6,337	6,233	7,189	5,107	3,608	1,812	2,512	3,045
Heroin	11,277	12,412	15,629	15,741	16,557	17,926	16,354	16,648	12,816	11,438
LSD	150	90	183	172	165	156	106	69	85	47
Total	117,532	122,459	118,706	124,344	135,655	146,909	147,013	152,451	154,210	144,428

*Data since 2005 are on an all offence basis; data for the years before 2005 are based on principal drug offence. Source: ST11

²²¹ Data from Northern Ireland for 2007 onwards are for cautions only. No court data are available.

9.2.4 Out of court disposals and sentencing of drug offenders

In 2013, there were 172,519 proven drug law offences²²² in England and Wales, representing a six per cent decrease from the previous year (Ministry of Justice, 2014a). The majority of drug offences were dealt with outside of a court setting (67%). Of the drug offences settled outside of court, over half were in the form of a cannabis warning (57%), followed by cautions (31%) with penalty notices for disorder accounting for 12%.

Of the 56,301 individuals sentenced at court for drug offences in England and Wales during 2013, 16% were given immediate custody (Ministry of Justice, 2014a), a similar proportion to previous years. The most common sentence was a fine, meted out in 37% of cases. The vast majority of those convicted of import/export offences received immediate custody (86%) with an average custodial sentence length of 67.4 months for Class A importation offences (Table 9.4).

Table 9.4: Number and percentage of offenders receiving each disposal at court for drug offence type in England and Wales, 2013.

	IMMEDIATE CUSTODY		SUSPENDED SENTENCE		COMMUNITY SENTENCES		FINE		OTHER		TOTAL SENTENCED	
	n	%	n	%	n	%	n	%	n	%	n	%
Import/export	413	85.9	41	8.5	11	2.3	12	2.5	4	0.8	481	100
Trafficking*	7,394	43.6	4,315	25.4	3,330	19.6	1,009	5.9	915	5.4	16,963	100
Possession	1,141	3.0	679	1.8	5,761	15.1	19,526	51.2	11,013	28.9	38,120	100
Other	73	9.9	132	17.9	280	38.0	162	22.0	90	12.2	737	100
Total	9,021	16.0	5,167	9.2	9,382	16.7	20,709	36.8	12,022	21.4	56,301	100

*Includes production, supply and possession with intent to supply.

Source: Ministry of Justice, 2014a

9.2.5 Other drug-related crime

Cutting agents

Following a consultation in 2013, the Government is planning to introduce new primary legislation to tackle the trade in cutting agents used to add bulk to illicit drugs (see section 1.2.3). The proposed legislation will give law enforcement new powers to enter premises, with a warrant, where there are reasonable grounds to suspect chemicals are being used for unlawful conduct, as well as to seize, detain and destroy certain substances.

Drug driving

A new offence was created in the *Crime and Courts Act 2013* which inserts a new section 5A in the *Road Traffic Act 1988* making it an offence to drive with a specified drug over a specified limit. In March 2014, the Government published a summary of responses to a consultation on the regulations that will set out the drugs to be covered by a new offence of drug driving created in the *Crime and Courts Act* and the limits which apply to them (Department for Transport, 2014a) (see section 1.2.3).

²²² Proven offences counted here include where offenders have been issued with a cannabis warning, a penalty notice for disorder, a caution or found guilty in a court.

9.2.6 Research

Heroin and crack cocaine use and acquisitive crime

In July 2014, the Home Office published a study exploring the possible impact of the heroin epidemic of the 1980s and 1990s in England and Wales, and subsequent reductions in use of heroin and crack cocaine, on acquisitive crime (Morgan, 2014). The study employed two exploratory approaches for analysis. The first was a fixed effects regression comparing the Addicts Index and police recorded crime data between 1981 and 1996 at Police Force Area level. This suggested that 40% of the rise in highest-volume offences may be attributed to the rise in heroin users. The second approach, which was to model the number of heroin/crack users and their offending over time, found that use of these drugs may account for at least half of the rise in acquisitive crime up to 1995 and for at least one-third of the reduction up to 2012. The study acknowledges that while the association between use of these drugs and criminality is widely accepted at the aggregate level, the precise nature of the causal relationship remains uncertain and it is certainly not the case that all heroin and crack cocaine users commit acquisitive crime.

9.3 Prevention of drug-related crime

9.3.1 Drug Interventions Programme in England and Wales

The DIP which was established in 2003 has been the primary method of engaging drug misusing offenders with drug treatment services in England and Wales. DIP has referred large numbers of offenders to treatment and, in conjunction with Drug Rehabilitation Requirements (DRR) and improved prison based interventions, has resulted in the criminal justice system becoming the largest referral source into treatment after self-referral (see section 5.3.3).

In November 2012, 41PCCs were elected by the public in England and Wales. Their purpose is to formulate the Police and Crime Plan for the local area, set the police budget and determine the precept (within limits set by the Department for Communities and Local Government), hold the Chief Constable and force to account and bring together community safety and criminal justice partners to ensure local priorities are joined up. Reflecting the increased focus on localism, the Home Office Community Safety Fund (CSF) came into existence on 1st April 2013 which replaced a number of previously ring-fenced crime, community and drugs grants. These included: DIP; DIP Drug Testing Grant; Community Safety Partnership Funding; Youth Crime and Substance Misuse Prevention activities; Positive Futures; Communities against Gangs, Guns and Knives; Ending Gang and Youth Violence programme; Community Action Against Crime: Innovation Fund; and Safer Future Communities. The CSF was not ring-fenced so local PCCs had the flexibility to use the funding according to their assessment of local need. From April 2014, to ensure even greater flexibility, all funding was subsumed into the Police Main Grant. Decisions on how this funding is spent are determined by local need.

Under the national DIP programme, Criminal Justice Intervention Teams (CJITs) provided case management, low threshold interventions and referrals to structured treatment. In October 2013, the responsibility for the central collection of data on CJIT activity in England was transferred from the Home Office to Public Health England (PHE). The majority of local authorities continue to report CJIT activity to PHE suggesting that the provision of such services has largely survived the transition to a locally led commissioning structure (personal communication – Public Health England). However the on-going constraints on police and local authority budgets may represent a threat to these services in the future.

The phased introduction of Liaison and Diversion (L&D) schemes in police custody suites and courts across the country over the next two years may also impact on DIP provision. Although these schemes are primarily targeting individuals with mental health problems, because of the prevalence of offenders with co-existing substance misuse and mental health issues, the possibility of achieving efficiencies by bringing together the two initiatives to create multi-disciplinary teams capable of assessing and referring the full range of health needs is being actively explored by government (personal communication – Public Health England).

Despite the shift to a more locally determined commissioning structure, centrally driven guidance around Joint Strategic Needs Assessment (JSNA) continues to emphasise the importance for local partnerships to ensure that there are a range of interventions available at various stages of the criminal justice system to engage drug misusing offenders with treatment services through legislative sanctions and voluntary programmes, offering support to reduce offending.

9.3.2 Reoffending and reconviction

Although sometimes used interchangeably, there is a difference between re-offending and re-conviction. It is difficult to measure the level of re-offending without self-report data. Data provided here are drawn from administrative systems to identify known re-offending.

Re-offending in England and Wales

Data on re-offending is published quarterly in England and Wales.²²³ Data is no longer published on re-offending rates of drug misusing offenders identified irrespective of index offence type.²²⁴ The last reported reoffending rates for this sub-group were higher than the overall re-offending rates for any reported index offence type. The most recent data show that 58% of drug misusing offenders identified in 2011 reoffended within 12 months (Ministry of Justice, 2013a). The average number of offences per drug misusing re-offender was 4.2.

Reconviction rates in Scotland

Data from Scotland show that the one-year reconviction rate for offenders convicted of drug law offences has fallen since 2005/06 and currently stands at 24% for the 2011/12 cohort.²²⁵ The reconviction frequency rate²²⁶ has also fallen, and is now 37 reconvictions per 100 offenders (Scottish Government, 2014c).

Data on reconvictions for people receiving a DTTO in Scotland can serve as a proxy for drug misusing offenders. Data show that both the reconviction rate and reconviction frequency have decreased from the previous year and now stand at 56% and 145 per 100 offenders respectively amongst the 2011/12 cohort compared to 67% and 160 per 100 offenders in 2010/11. This is a continuation of a general long term trend towards reductions in reconvictions amongst this cohort in recent years.

Factors associated with proven reoffending

In 2013, the Ministry of Justice published a report outlining the findings from the Surveying Prisoner Crime Reduction (SPCR) longitudinal study of prisoners which aimed to understand the factors associated with proven reoffending following release from prison (Ministry of Justice, 2013c). The SPCR study involved a longitudinal cohort of 3,849 adult (18 years and over) prisoners in England and Wales with sentences of up to four years in prison. The study conducted interviews upon reception to prison, in the weeks prior to release and in the community approximately two months after release. Participants were also matched to Police National Computer (PNC) records, enabling reconviction rates to be calculated. Interviews gathered information about a wide range of prisoners' needs, experiences and behaviours at different life stages and included questions on drug use. The study also asked about experiences and behaviour in prison, including participation in interventions and the use of drugs.

²²³ See: <https://www.gov.uk/government/statistics/proven-reoffending-statistics-october-2011-to-september-2012>

²²⁴ Drug misusing offenders were classed as those who had been given drug orders as part of their sentence or tested positive for opiates on arrest.

²²⁵ The cohort is all offenders released from a custodial sentence or receiving a non-custodial disposal in 2011/12 in Scotland. Data are drawn from the Scottish Offenders Index (SOI), which contains data on 518,000 offenders and 1,881,000 from when SOI records began in 1989.

²²⁶ The reconviction frequency rate is the average number of reconvictions within a specified follow-up period from the date of the index conviction per 100 offenders.

Analysis focused specifically on identifying the particular aspects of offenders' experiences before, during and shortly after prison that were most strongly associated with a higher likelihood of reoffending after release. This was done using a multivariate model which allowed several factors to be tested for their association with reoffending at the same time and enables the identification of factors which are independently associated with reoffending when all factors are considered together. Whilst previous offending history was shown to be the most important factor in reoffending, results showed that substance misuse was identified as a good predictor for reoffending even after controlling for criminal history. Specifically, the odds of being reconvicted within one year were found to be approximately 58% higher for those who reported regularly using Class A drugs since release from prison. The report concluded that the findings confirm the need for effective strategies to tackle drug misuse amongst offenders.

Summary of evidence in reducing reoffending

In 2014, within the context of the *Transforming Rehabilitation Programme* (see section 9.4.1) the Ministry of Justice published a review of evidence on reducing reoffending²²⁷ produced to support policy makers, practitioners and others who work with offenders (Ministry of Justice, 2014d). The report highlights the higher rates of reconviction observed among prisoners who had used drugs in the month before custody²²⁸ (Ministry of Justice, 2013c), in addition to the independent association between a recognised drug use problem and the increased likelihood of reoffending (Ministry of Justice, 2013b). The report also focuses on the concept of desistance which describes the process by which those engaged in a sustained pattern of offending give up crime and noted the association between abstinence and desistance. The research summary documents a number of evaluations of the effectiveness of interventions aimed at reducing reoffending which are targeted at a number of factors, including drug misuse.

9.4 Interventions in the criminal justice system

9.4.1 Transforming rehabilitation in England and Wales

Following a consultation,²²⁹ *Transforming Rehabilitation: A Strategy for Reform* was presented to Parliament in 2013 (Ministry of Justice, 2013d). A number of the proposals contained in the *Transforming Rehabilitation* strategy were enacted in the *Offender Rehabilitation Act* that received Royal Assent in March 2014. The new law means that, for the first-time, virtually all offenders will receive at least 12-month's supervision in the community on release from custody. The *Offender Rehabilitation Act* introduces a number of further measures supporting the drive to reduce drug-related reoffending, including:

- a new drug appointment requirement for offenders who are supervised in the community after release; and
- an expansion of the existing drug testing requirement after release to include Class B as well as Class A drugs.

The new legislation is being implemented alongside the Government's wider reforms to probation that will see the introduction of competition into the market for the provision of offender rehabilitation services for medium and low risk offenders. Under this approach, 21 new Community Rehabilitation Companies will work to rehabilitate medium and low-risk offenders, drawing on experience from voluntary organisations as well as the private sector. A new National Probation Service will be tasked with protecting the public from the most high-risk offenders.

²²⁷ A proven reoffence is defined as any offence committed in a one year follow-up period that leads to a court conviction or caution, reprimand or warning in the one year follow-up or within a further six month waiting period, to allow for the offence to be proven in court.

²²⁸ Compared to those who had never used drugs or used drugs less recently.

²²⁹ A summary of consultation responses is available. See: <https://consult.justice.gov.uk/digital-communications/transforming-rehabilitation/results/transforming-rehabilitation-summary-responses.pdf>

A nationwide network of resettlement prisons is also being created that will see the majority of offenders managed by the same provider in custody and the community. This will allow people working with offenders to lay the groundwork for rehabilitation behind the prison walls and continue that work in the community when they are released, encouraging a 'through the gate' approach to rehabilitation (see section 9.7). It is envisaged that these new providers will be in place by 2015.

9.4.2 Alternatives to prison

Drug Rehabilitation Requirement in England and Wales

Under Section 209 of the *Criminal Justice Act 2003*, a DRR, comprising structured treatment and regular drug testing, is available to courts as a sentencing option for offences committed on or after 4 April 2005. A DRR can be made as part of a Community Order (CO) or a Suspended Sentence Order (SSO). These provisions aim to present local providers with flexibility to tailor requirements to individual need, changing patterns of substance misuse and moving towards a recovery-focused approach to treatment. In England, separate provision is not generally commissioned to support DRRs, rather the treatment element of DRRs is provided from drug treatment services commissioned for the mainstream local treatment population. In Wales, the NOMS Director of probation is responsible for the planning and commissioning of drug treatment services. For offenders not on sentence treatment requirements, drug treatment services are commissioned by the PCC.

DRRs are the most commonly used of three treatment requirements available. In 2013 DRRs accounted for five per cent of all CO or SSO requirements made. Over the same period, the total number of DRRs given as part of a CO or SSO was 13,664 (9,138 COs requirements and 4,526 SSOs) (Ministry of Justice, 2014c).

Scotland

There were 630 DTTOs commenced in 2012/13, an increase of 14% on 2011/12. Five-hundred and eighty DTTOs were terminated/completed during 2012/13, 53% of which were completed successfully. People aged over 40 were more than twice as likely (72%) as those aged under 25 (32%) to complete their DTTO successfully. The number of DTTOs in force at 31 March 2013 was 750 (Scottish Government, 2014b).

9.4.3 Drug Courts

Scotland

The Scottish Government currently funds a bespoke drug court in Glasgow. This Drug Court has been running since 2001. Fife also had a Drug Court which closed on 29 November 2013. Fife has reverted to dealing with cases within the DTTO regime, which is the way in which these cases are dealt with in the vast majority of courts across Scotland.

9.5 Drug use and problem drug use in prisons

9.5.1 Drug use amongst prisoners

Data from the Scottish Prison Service (SPS) Prisoner Survey 2013 show that 62% of respondents had taken an illicit drug in the 12 months prior to imprisonment and 38% reported having ever taken an illicit drug while in prison (ST12; Scottish Prison Service, 2014). Drug use varied depending on custodial history. Most of those who had been in prison on a sentence over ten times reported their drug use having been a problem on the outside (58%) compared to only 18% of those who had never been sentenced before. A similar proportion of this group (60%) reported having been under the influence of drugs at the time of their offence (compared with 20% of those that had never been in custody). Prisoners were also more likely to report having been in drug treatment on the outside or to cite getting money for drugs as the reason for their offence as the number of previous custodial sentences experienced increased.

Addiction prevalence testing in Scotland

Data show that, of the 1,227 addiction prevalence tests carried out on reception to prisons in Scotland²³⁰ during 2013/14,²³¹ 77% were positive for illicit drugs, up from 72% in the previous year. Benzodiazepines and cannabis were the most frequently detected drugs with each being detected in 50% of tests compared with 47% for benzodiazepines and 45% for cannabis last year. There was a slight increase in tests positive for opioids on last year (an increase of two per cent) but this proportion is still lower than in previous years. The large increase seen in proportion of tests positive for buprenorphine between 2011/12 and 2012/13 was sustained in 2013/14 (Table 9.5).

Table 9.5: Percentage of positive tests on reception to Scottish prisons, 2008/09 to 2013/14

	2008-09	2009-10	2010-11	2011-12	2012-13*	2013-14**
Amphetamines	2	1	2	1	3	3
Barbiturates	-	0	1	1	0	1
Benzodiazepines	49	38	53	48	47	50
Buprenorphine	3	0	2	3	9	9
Cannabis	42	28	40	35	45	50
Cocaine	6	6	8	9	9	13
Methadone	4	6	11	7	11	9
Opioids	36	36	36	34	31	33
All illicit drugs	71	56	73	70	72	77

*From <http://www.scotpho.org.uk/downloads/drugs/SPS-Addiction-Prevalence-Testing-Stats-Final-2012-13-v2.pdf>

**From <http://www.scotpho.org.uk/behaviour/drugs/data/availability-and-prevalence> (these data are updated quarterly)

Source: Scottish Government, 2010a,b; Scottish Government, 2012

9.5.2 Mandatory drug testing in England and Wales

The target for Mandatory Drug Testing (MDT) was removed in 2011/12 although the information is still collected for management purposes. In England and Wales during 2013/14, 7.4% of prisoners tested positive for drugs through random MDT, an increase from 7.0% in the previous year (Ministry of Justice, 2014b). Male local prisons had the highest rate of positive tests among the various functions (10.9%).

²³⁰ Addiction Prevalence Testing (APT) is conducted across all Scottish prisons annually. Prisoners arriving in custody are tested for the prevalence of illicit drugs during one month of the year. Similarly, those leaving custody during the month are tested to assess progress and distance travelled towards the 'reduced or stabilised' offender outcome.

²³¹ See: <http://www.scotpho.org.uk/downloads/drugs/SPS-Addiction-Prevalence-Testing-Stats-Final-2013-14.pdf>

9.6 Responses to drug-related health issues in prisons and other custodial settings

9.6.1 Drug treatment in prisons

Performance monitoring of healthcare in custodial settings

England

To date, a broad set of indicators, known as the Prison Health Performance and Quality Indicators (PHPQIs), have been used to monitor the quality of healthcare in prisons, as well as the performance of other contributing health and prison services. However, the PHPQIs were not outcome focused and were qualitative measures that largely relied on self-assessment by local healthcare teams. Given this, and the recent changes in the commissioning of healthcare services in places of detention, it was widely agreed that the PHPQIs needed reviewing and updating. To replace the PHPQIs a new set of Health and Justice Indicators of Performance (HJIPs) have been developed by NHS England, PHE and the NOMS (National Health Services England, 2014).

The new indicators are largely quantitative measures and include specific measures for drugs and alcohol. NHS England Area Teams will work with their commissioned providers to collect the HJIPs with the aim of:

- supporting effective commissioning of healthcare services in places of detention;
- enabling national and local monitoring of the quality and performance of healthcare in the secure estate;
- providing a tool for providers to review their performance and identify areas that need improvement;
- providing data for local health needs assessments (HNAs);
- providing assurance to commissioners and partners, including NOMS, that healthcare delivery in prisons is fit for purpose; and
- providing information for the Care Quality Commission (CQC) and the HM Inspector of Prisons (HMIP) to support their inspection work.

Scotland

In Scotland the Better Health Better Lives for Prisoners Framework was published in 2012 and aims to achieve better health for prisoners and a better working environment for staff by defining the need for work across a range of topics, delivered by a number of disciplines and involving prisoners in various capacities, including planning, feedback and peer support.

The framework proposes a vision of the healthy prison and offers a practical guide to achieve improved health outcomes and a reduction in health inequalities while also recognising and linking to offender outcomes relevant to health. The framework provides recommendations consistent with a 'whole prison' approach to health improvement and is built around health promotion pillars which include tobacco, alcohol, and illicit drugs. Since its publication Scottish prisons have actively engaged in the framework on a number of initiatives including the introduction of healthy living areas.

The framework for prisoners is currently being extended to include offenders in the wider community; this is expected to be published by the end of 2014.

Northern Ireland

In 2012/13 703 individuals presented to drug treatment in prisons in Northern Ireland. Primary cannabis use was the most common primary substance cited at presentation (30%), followed by benzodiazepines (19%), heroin (12%) and cocaine (11%). These proportions differ to the proportions of primary substances cited among those presenting for treatment in the community, where benzodiazepines was the most common substance (40%) followed by cannabis (24%) and heroin (8%) with stimulants (other than cocaine) being more commonly cited than cocaine (7% compared with 3%).

9.6.2 Prevention of overdose risk upon prison release

Naloxone

Naloxone is a drug used to counter the effects of opioid overdose, such as heroin or morphine, specifically the life-threatening depression of the central nervous system, respiratory system and hypotension secondary to opioid overdose. Following release from prison, opioid users are at increased risk of opioid poisoning and there are initiatives in the UK to distribute THN kits to prisoners upon release to reduce the risk of fatal overdose.

Scotland

There were 746 (THN) kits issued by prisons in Scotland in 2012/13, all to persons at risk of opioid overdose. This compares with 715 THN kits issued by prisons in Scotland in 2011/12.²³² There was no significant decrease in the percentage of opioid related deaths within four weeks of prison release in 2011 (eight per cent) compared to the 2006 to 2010 baseline indicator (10%) (Information Services Division, 2013). However, in 2012, a significant decrease in the percentage of opioid related deaths occurring within four weeks of prison release was observed (six per cent) compared to the baseline (10%) (Information Services Division, 2014d). Performance against the baseline indicator will continue to be monitored to ensure that the percentage in the post-naloxone period is estimated with sufficient precision.

Wales

Data from the Harm Reduction Database in Wales indicates that 20.5% ($n=116$) of male unique individuals issued with THN between 1st April 2013 and 31st March 2014 were issued with THN upon release from prison. When compared to national Area Planning Board (APB) provision, prisons are amongst the highest distributors of THN within Wales. There are currently no female only prisons in Wales (personal communication – Public Health Wales).

England

The availability of naloxone to prisoners in England has so far been limited. A randomised trial of take-home naloxone led by Kings College London (N-Alive)²³³ was initiated in early 2012 and is currently ongoing (UK Focal Point, 2013). Naloxone has been made available to a limited extent in some prisons not involved in this trial and there are proposals to pilot its use as part of the end-to-end approach to tackling addiction from custody into the community currently being tested in the North West area (see section 9.7) (personal communication – Public Health England).

²³² Note that kits are not issued in prison, rather they are supplied on release.

²³³ See: <http://www.kcl.ac.uk/loppn/depts/addictions/research/drugs/N-ALIVE.aspx>

9.7 Reintegration of drug users after release from prison

Resettlement in England and Wales

In April 2013, the Ministry of Justice and the Department of Health agreed to test a comprehensive end-to-end approach to tackling addiction from custody into the community. This joint agreement was confirmed in *Transforming Rehabilitation: A Strategy for Reform* (see section 9.4.1).

The approach is currently being tested in 10 resettlement prisons in the North West of England and represents an opportunity to develop integrated services for offenders which build on recent health and justice reforms including the creation of NHS England and PHE and the *Transforming Rehabilitation* agenda.

A number of different work streams have developed with a view to delivering:

- improved substance misuse service links between custody and community provision;
- improved engagement of offenders who test positive for illicit drugs, alcohol and dual diagnosis;
- identification of promising practice for dealing with short sentenced prisoners;
- identification of promising practice for addressing alcohol and dual diagnosis interventions;
- evidence of joined up models of commissioning; and
- learning which can be used to inform the commissioning of substance misuse services more broadly and the *Transforming Rehabilitation* Programme.

Throughcare Addiction Service in Scotland

Data from Scotland show that around 1,320 individuals received assistance from the Throughcare Addiction Service²³⁴ on release from prison in 2012/13, similar levels to previous years and representing 50% of all voluntary assistance cases (Scottish Government, 2014b).

In Scotland, the Reducing Reoffending Change Fund has developed mentoring services for offenders to support them on their desistance journey. The mentors begin building a relationship with their mentee up to six months before their release; meet them at the prison gate on release; and work with them to support their reintegration back in to the community. The mentors can, therefore, support their mentee to keep appointments and attend for treatment as part of a holistic plan for release and reintegration (personal communication – Scottish Government).

In addition, the SPS is taking forward the development of a Throughcare Officer role to support individuals in their community reintegration and recovery journey (personal communication – Scottish Government).

Social reintegration of prisoners

Data on education, employment and accommodation of all individuals (not just drug users) released from prison in England and Wales in 2012/13 are available from the NOMS Annual Report (Ministry of Justice, 2014b).

²³⁴ The Throughcare Addiction Service (TAS) commenced on 1 August 2005 and forms part of the voluntary aftercare service. TAS is delivered by local authority criminal justice social work who will work with the offender in the 6 week period prior to release from custody through the 6 week period post-release offering an intensive motivational service to help the offender address their addiction and link them to appropriate services.

10. Drug markets

10.1 Introduction

Most of the identified drug supply chains to the United Kingdom (UK) follow well-established trafficking routes. Cannabis continues to be imported in large quantities to the UK from Europe despite increased domestic cannabis cultivation over recent years. Throughout the UK, large numbers of commercial cannabis cultivation operations have been discovered and there is an increasing recent trend towards smaller operations in multiple locations.

The overall picture of UK drugs distribution is increasingly complex and diverse, and is better described as a network, as distribution often occurs through chains of activity, at various levels, involving diverse groups. Many traffickers in the UK, particularly white British criminals, import and distribute more than one type of drug. London, Birmingham, Liverpool and Manchester continue to be important centres for drugs distribution but other smaller cities and towns are also involved. In Scotland, the main source of heroin is from the North West of England via the Glasgow area. Organised crime groups in Merseyside impact on the drug supplies into Wales.

Cannabis is the most commonly seized drug in the UK. Seizures of herbal cannabis increased in England and Wales alongside an increase in recorded cannabis possession offences following the introduction of cannabis warnings in England and Wales in 2004, although the quantity seized did not show a corresponding rise. Having risen steadily since 2004, the number of cannabis plant seizures dropped in 2013/14, with the quantity of plants seized having already been falling since 2010/11 (perhaps indicative of the trend towards smaller production sites).

Having been low during both 2011 and 2012, heroin purity has risen to near the 2010 level. Cocaine powder purity has slightly increased continuing a gradual return to levels seen around ten years ago. It is now close to double the typical purity seen in 2009, a time at which cocaine purity was particularly low.

The Office for National Statistics (ONS) has estimated household final consumption expenditure in the UK on illegal drugs to average around £6.7 billion a year (Office for National Statistics, 2014a).

10.2 Supply to and within the country

The commentary provided below is from the National Crime Agency (NCA) Expert Evidence Team.

10.2.1 Trafficking patterns

Cannabis

Despite substantial domestic cannabis plant cultivation in the UK, demand continues for cannabis resin (hashish) and is most commonly supplied from production in Afghanistan and Morocco. Herbal cannabis (the non-flowering type) continues to be supplied from South Africa and the Caribbean, while high quality “branded” types of plant cannabis (known as “skunk”)²³⁵ continue to be imported from the Netherlands. It is estimated that 270 tonnes of cannabis, including 175 tonnes of “skunk” are needed to satisfy annual demand in the UK. The provision of 92 tonnes of this (mainly skunk) is estimated to be met by domestic cultivation. Recent years have seen a move away from large scale cannabis cultivations to smaller production especially in living rooms, smaller houses and flats. There is no evidence to suggest the UK exports cannabis in commercial quantities.

²³⁵ Skunk cannabis is a strand of the plant-based drug known as marijuana and tends to have a higher Tetrahydrocannabinol (THC) concentration.

Heroin/Opioids

Afghanistan remains the principal source country for heroin supply to the UK. The familial links between British-based Asian and Pakistani criminals is a problem for the UK with heroin sent directly by parcel, air courier, air passenger or maritime container. Large quantities of heroin are also trafficked through southern Pakistan into Iran, on to Turkey and then onward through Europe; or by sea to eastern and southern Africa where a proportion moves on to western Europe and the UK. Links between British-based Turkish criminals and associates in Turkey have enabled traffickers based there to control the overland supply of heroin to western Europe for the UK. They purchase from upstream Afghan, Iranian or Pakistani suppliers and then organise transportation and supply across Europe to the UK. Some Kurdish, Turkish and Turkish Cypriot traffickers have an established presence in key locations along the supply route including in the UK.

Cocaine

The vast majority of the world supply of cocaine is produced in Peru, Colombia and Bolivia and it is considered that these countries are significant contributors to the UK supply. Venezuela and Ecuador remain significant transit countries for cocaine destined for Europe and the UK, the former connecting easily to the Caribbean; which offers gateways to the UK given strong cultural and transport links. Seaports in Brazil also afford trafficking opportunities towards and to Europe and the UK.

Key nexus points in west and southern Africa are often used prior to onward transportation to Europe and the UK. As in previous years, the Netherlands, Belgium and the Iberian Peninsula are key transport hubs and storage bases for cocaine smuggled into the UK. Within the UK, organised crime groups dominate the supply and distribution of cocaine as well as establishing themselves in key nexus points such as the Netherlands and Spain. There is increasing intelligence that the involvement of these groups extends to organising trafficking logistics from Latin America using yachts and sea containers.

Synthetic drugs including new psychoactive substances

The market for synthetic drugs is the most dynamic of the illicit drug markets in the European Union (EU), featuring a wide range of available substances. The UK is a major market for amphetamine and ecstasy sourced mainly from the Netherlands and Belgium.

Methamphetamine continues to have limited direct impact in the UK. The majority of seizures tend to involve the UK being used as a transit point between production (often in western Africa) and end-user markets (usually in the Far East or Australia).

Although there are many examples of new psychoactive substances (NPS) within the UK, the now controlled mephedrone remains more common. This, like many NPS, is most frequently acquired in China via internet orders and imported via parcel post.

Powder drugs, such as MDMA and ketamine continue to remain widespread and in demand across the UK and tend to be consumed by users traditionally associated with ecstasy use within younger user groups.

10.3 Seizures

10.3.1 Drug seizures in the United Kingdom in 2012/13

The number of mephedrone seizures in the UK rose 44% from 2011/12 due to a large increase in seizures in England and Wales (Home Office, 2013e). The number of seizures of ecstasy type substances also rose in 2012/13 (an increase of three per cent) while the numbers of seizures dropped from the previous year for all other drugs (Table 10.1). As with previous years, cannabis was by far the most commonly seized drug (approximately 180,000 seizures in total), involved in around 10 times as many seizures as cocaine powder, the next most commonly seized drug. However, the number of seizures of all types of cannabis dropped in the last year (a decrease of around eight per cent). The largest fall within types of cannabis as well as overall was observed in cannabis resin; down 30% on the number of seizures in the previous year.

Table 10.1: The number of seizures of individual drugs in the United Kingdom by country in 2012/13 and percentage change from 2011/12

DRUG	ENGLAND AND WALES	SCOTLAND	NORTHERN IRELAND*	UK	% CHANGE FROM 2011/12
Amphetamines	5,748	692	98	6,538	-15.33
Cannabis – herbal	133,203	12,934	2,609	148,746	-4.34
Cannabis – resin	8,161	8,462	737	17,360	-29.84
Cannabis plants	14,510	1,106	230	15,846	-10.06
Cocaine powder	16,075	2,140	377	18,592	-3.80
Crack cocaine	4,477	186	0	4,663	-10.34
Ecstasy type substances	3,020	553	161	3,734	3.75
Heroin	8,266	2,329	53	10,648	-9.06
Ketamine	1,401	19	5	1,425	-3.46
Mephedrone*	3,777	194	129	4,100	44.11

*Police seizures only

Source: ST13

As with the numbers of seizures, the quantity of drugs seized dropped for most substances (Table 10.2). However, changes in one measure are not always reflected in the other. For example, despite the 15% reduction in numbers of amphetamine seizures, the quantity of amphetamines seized rose by 25%. Inversely, despite the small increase in seizures of ecstasy type substances, the quantity of tablets seized was notably down on 2011/12 (-33%).

Table 10.2: The quantity of individual drugs seized in the United Kingdom by country in 2012/13 and percentage change from 2011/12

DRUG	UNIT	ENGLAND AND WALES	SCOTLAND	NORTHERN IRELAND*	UK	% CHANGE FROM 2011/12
Amphetamines	Kg	1,375	92.9	22.8**	1,490.7	25.1
Cannabis – herbal	Kg	12,267	615	361	13,243.0	-43.0
Cannabis – resin	Kg	11,320	1,707	404.6	13,431.6	-35.7
Cannabis plants	Plant	507,401	41,411	6,813	555,625.0	-17.4
Cocaine powder	Kg	3,032	281.3	11.6	3,324.9	-6.8
Crack cocaine	Kg	41	5.5	0	46.5	16.3
Ecstasy type substances	Tablet (000s)	434	32.9	6.3	473.1	-32.5
Heroin	Kg	750	80.4	0.8**	831.2	-57.8
Ketamine	Kg	244	0.1	0.1	244.2	205.3
Mephedrone*	Kg	271	9.1	3.9**	284.0	195.8

*Police seizures only

**Powder only

Source: ST13

10.3.2 Trends in drug seizures in England and Wales

As UK drug seizure data have not been available on a consistent basis in the past six years, data from England and Wales are used to comment on trends. Cannabis has remained the most commonly seized drug throughout the period (Home Office, 2013e). The number of seizures of herbal cannabis increased substantially between 2004 and 2008/09 while the quantity of herbal cannabis seized remained stable (Table 10.3; Table 10.4). Over this period there was also a large rise in recorded possession offences (see section 9.2.1). As quantities seized resulting from possession offences are typically small, the lack of a corresponding rise in quantity of herbal cannabis seized may indicate that the rise in numbers of seizures was primarily due to increased possession offences.

Table 10.3: Number of seizures of drugs by police forces and Border Force in England and Wales, 2004 to 2012/13

DRUG	2004	2005	2006/07*	2007/08	2008/09	2009/10	2010/11	2011/12**	2012/13**
Amphetamines	6,504	7,837	8,477	8,863	7,760	7,302	7,185	6,594	5,748
Cannabis – herbal	43,072	76,157	109,649	137,526	145,353	144,456	139,237	143,832	133,203
Cannabis – resin	35,219	41,454	32,590	30,870	35,795	24,339	18,312	13,962	8,161
Cannabis plants	2,930	4,327	5,805	8,539	9,380	12,920	14,423	16,178	14,510
Cocaine powder	8,279	12,512	16,917	21,346	24,659	21,377	17,710	16,928	16,075
Crack cocaine	5,164	6,705	6,955	7,578	6,623	5,081	5,385	4,864	4,477
Ecstasy	6,256	6,688	8,184	7,173	5,218	3,724	2,537	2,975	3,020
Heroin	11,668	14,072	13,942	14,186	13,302	12,836	10,821	8,869	8,266
Benzodiazepines***	830	1,747	2,261	2,815	4,038	2,957	2,489	2,624	2,027
Ketamine	-	-	-	-	1,269	1,612	1,793	1,430	1,401
Total	112,923	169,802	196,099	228,131	241,473	224,401	212,786	211,165	193,980

*in 2006/07 data moved to a financial year basis

**excludes Hampshire and Surrey

***includes diazepam and other benzodiazepines but not temazepam

Source: Home Office, 2013e

The quantity of heroin seized over the last decade has varied greatly year on year. Following a low in 2011/12 (which may have been indicative of the reduction in the availability of heroin widely regarded to have affected the market during this period) (European Monitoring Centre for Drugs and Drug Addiction, 2013) the quantity of heroin that was seized more than doubled in 2011/12. However, it has since fallen by more than 50% to a similar level in 2012/13 to that which had been seen in 2010/11. Seizures of ecstasy tablets, which similarly increased rapidly in quantity from 2010/11 to 2011/12, have also returned to levels comparable to those reported in 2010/11. Such variation between years in the quantity of drugs seized may reflect varying law enforcement activity between years and should not be assumed to directly reflect the availability, or indeed use, of these substances.

Trends in seizures of cannabis plants over time fluctuate less year on year and reveal long-term trends which may be reflective of market activity. Having risen steadily and steeply almost sevenfold over a five year period from 2004, fewer plants have been seized in each year since the 2009/10 peak and the total is now down 33%. The initial rapid increase may reflect the burgeoning of domestic cannabis production on an industrial scale in the UK. The latter reduction in quantity of plants seized stands in contrast to the trend in the number of seizures of plants, which continued to rise steadily up to 2011/12 only dropping 10% in the last year and remaining higher than any time prior to 2011/12. The divergence in these trends may be indicative of a shift in domestic production towards use of smaller cultivation sites.

Table 10.4: The quantity of individual drugs seized by police forces and Border Force in England and Wales, 2004 to 2012/13

DRUG	UNIT	2004	2005	2006/07*	2007/08	2008/09	2009/10	2010/11	2011/12**	2012/13**
Amphetamines	Kg	1,257	2,091	1,390	1,811	2,939	1,326	711	1,054	1,375
Cannabis – herbal	Kg	21,535	20,583	25,832	20,093	33,363	17,951	20,693	22,206	12,267
Cannabis – resin	Kg	63,234	50,591	19,851	16,710	31,799	12,563	18,659	19,473	11,320
Cannabis plants	Plant	93,469	220,019	363,679	535,888	643,510	758,943	729,502	623,486	507,401
Cocaine powder	Kg	4,640	3,821	3,244	3,453	2,916	2,643	2,387	3,455	3,032
Crack cocaine	Kg	140	51	60	37	33	59	50	34	41
Ecstasy	Tablet (000s)	4,740	3,019	6,685	965	547	171	371	655	434
Heroin	Kg	2,170	1,907	1,030	1,059	1,552	1,516	732	1,846	750
Ketamine	Kg	-	-	-	-	27	293	802	80	244

*in 2006/07 seizures data moved to a financial year basis

**excludes Hampshire and Surrey

Source: Home Office, 2013e

10.3.3 Other seizures data

The Medicines and Healthcare Products Regulatory Agency (MHRA) announced in May that it had seized £3.6 million doses of counterfeit and unlicensed medicines in the UK with a value of £8.6 million.²³⁶ The most commonly seized drugs were: erectile dysfunction medicines (1.2 million doses) and slimming products (383,000 doses) as well as sleeping pills, tranquilisers and antidepressants (330,996 doses). The majority of the medicines seized in the haul originated in India or China. The operation was part of an international crackdown named Operation Pangea which was coordinated through Interpol and targeted the illicit online medicine trade. Seizures of substances in the UK accounted for close to half (46%) of the overall market value of the drugs seized internationally as part of the operation.

²³⁶ See: <http://www.mhra.gov.uk/NewsCentre/Pressreleases/CON418476>

10.4 Availability

10.4.1 Perceived availability of drugs, exposure and access to drugs

Twenty-eight per cent of pupils in the *Smoking, Drinking and Drug Use Survey* 2013 reported that they had been offered drugs in their lifetime (Fuller & Hawkins, 2014) (see section 2.3.2). This is similar to recent years and maintains the overall decline from 2001 when the proportion was 42%. Cannabis (18%) was the most commonly offered individual drug followed by cocaine powder (six per cent). Twelve per cent of pupils reported that they had been offered a stimulant and ten per cent had been offered volatile substances. The likelihood of being offered drugs increased with age. At age 15 just over half of pupils reported having ever been offered drugs (51%) with two-fifths (42%) having been offered cannabis and one-quarter (26%) having been offered a stimulant. Data from the *Scottish Crime and Justice Survey* (Scottish Government, 2014d) (see section 2.2.2) show that 11% of respondents aged 16 or over had been offered drugs in the last year of which the most common was cannabis (eight per cent). Among adults, the likelihood of being offered drugs decreased with age. Of the adults who had taken drugs in the last month, 45% said it was 'very easy' to obtain the drug used most often and a further 39% said this was 'fairly easy'.

Sources of supply

Data from the *Crime Survey for England and Wales* (see section 2.2.1) show that over one-half (57%) of respondents aged 15 to 69, who had used drugs in the last year obtained drugs from someone well known to them other than a family member, such as a friend on the most recent occasion they had used drugs (Home Office, 2014b). Under a quarter (22%) of respondents had obtained drugs from a drug dealer. Despite concerns over the "dark net"²³⁷ as a retail source for drugs, only one per cent of those who took drugs in the last year reported obtaining drugs via the internet. Those in the older age groups were more likely to have sourced drugs via this method with three per cent of the 35 to 44 year old group having done so on the last occasion. A similar question asked in the *Scottish Crime and Justice Survey* shows that 37% of respondents who had obtained drugs in the last month got them on the most recent occasion from someone well known to them who was not a family member, while 31% had obtained drugs from a dealer (Scottish Government, 2014d).

The most common location to have last obtained drugs among respondents in the *Crime Survey for England and Wales* was in a domestic setting, with just over half (51%) having obtained the last drugs they took either at their own home or someone else's (Home Office, 2014b). Young adults aged 16 to 24 were most likely to have obtained drugs on a street or other outdoor area on their most recent occasion (19%).

10.4.2 New psychoactive substances

Advice to local authorities on head shops

In response to a number of local authorities expressing concern over head-shops in their local area, the Home Office issued practical advice in how to respond to them (Home Office, 2014e). The guidance highlights the problems associated with head shops, primarily that a number of the substances sold in these shops are not controlled by the *Misuse of Drugs Act 1971*, and documents case studies of the recommendations in action. The guidance aims to detail the main legal powers available to the police and outlines four types of offences that head shops may be committing. These are selling controlled drugs; selling drugs paraphernalia; breaching the *Intoxicating Substances (supply) Act 1985*; and breaching the consumer protection regulations.

With regards to selling controlled drugs, the report highlights that a number of so-called legal highs are found to contain controlled substances and recommends the implementation of *Section 23 of the Misuse of Drugs Act 1971*. This legislation provides the power for police to search a premise (subject to a warrant) where s/he has reasonable grounds of suspecting a person is in possession of controlled drugs.

²³⁷ A 'darknet' is a private network where connections are made only between trusted peers using non-standard protocols and ports

The guidance states that a number of head shops sell drugs paraphernalia and promotes the use of **Section 9A** of the *Misuse of Drugs Act 1971*, where it is an offence to supply any article which may be used to prepare a controlled drug for administration. The guidance highlights operational advice in relation to enforcement action in the form of *Practical Advice on Tackling Commercial Cultivation and Head Shops* (National Policing Improvement Agency and Association of Chief Police Officers, 2009).

The guidance also outlines how head shops may be breaching the *Intoxicating Substances (supply) Act 1985* which prohibits the sale of substances to those under 18 which the seller has reason to believe may be inhaled for the purposes of intoxication.

Finally, the guidance outlines a number of consumer protection regulations including; the *Consumer Protection from Unfair Trading Regulations*; *General Product Safety Regulations 2005*; *Consumer Protection (distance selling) Regulations (2000)* and *Electronic Commerce (EC directive) 2002*.

Scotland

Police Scotland currently collates the quantity of NPS/adulterants seized and denied to Serious Organised Crime Gangs. Operation Redwall is Police Scotland's overarching investigation looking at NPS. On 22nd August 2014 a national, multi-agency day of action took place to explore current powers and legislation available to the Police and partner agencies in tackling NPS, and provide learning and an evidence base of the current picture regarding the widespread and growing availability of NPS in Scotland. Media and education strategies were progressed and the day of action saw over 50 outlets identified as selling NPS visited in a tiered approach along with partner agencies.

NPS – Evidence Review

In August 2014 the Scottish Government published a report on NPS. This report explored key NPS information, evidence gaps and data on NPS in Scotland from a UK and international context (Scottish Government, 2014c).

10.5 Price/purity

Wholesale and street drug price data are provided by NCA. Wholesale in the context of drug price reporting in the UK focuses on the one kilogram (Kg) amount. Prices reflect what is likely to be paid when acquiring a one Kg unit and take no account of the discount available for multiple unit consignments.

10.5.1 Wholesale price data

Skunk cannabis (the flowering tops/buds of the female plant) continue to be grown indoors under intense artificial conditions across the UK. The wholesale price of the generic UK product, i.e. the dried "skunk", remains the same as last year at around £3,000 to £5,000 per Kg. However, this is not to be confused with the higher quality "branded" types, typically imported from the Netherlands with expectations (according to brand name) of strength, experience and flavour. These can readily wholesale for £6,000 to £8,000 per Kg. Resin and herbal cannabis wholesale for much less at around £1,000 per Kg (personal communication - NCA Expert Evidence Team).

The wholesale price of cocaine has continued to decline since 2012 and is now commonly around £40,000 per Kg. The drop, however, would be expected following a period of particularly high and unsustainable prices encountered between 2010 and 2012 after which prices inevitably settled and have then decreased consistently year by year. Prices remain about £10,000 higher per kilogram than they were in 2008/09 (personal communication - NCA Expert Evidence Team).

Having risen each year from £16,000 in 2009, the typical wholesale price of heroin declined slightly from £30,000 per Kg in 2012 to £28,000 in 2013 (personal communication - NCA Expert Evidence Team).

10.5.2 Street-level price data from law enforcement sources²³⁸

Street-level price data from law enforcement sources suggest that the price of most drugs remained stable in 2013 (Table 10.5; ST16). The retail price of heroin rose to £50 a gram having been £40 for the previous two years during a period which also saw low street-level purity of the drug. The typical retail price of mephedrone dropped to £15 a gram in 2013 from £20 the year before but remains higher than around the time the drug became a controlled substance in 2010 when it was typically £10 a gram.

Table 10.5: Law enforcement agencies: Typical price of street level illicit drugs in the United Kingdom, 2005 to 2013

DRUG	PRICE PER GRAM EXCEPT WHERE OTHERWISE STATED								
	2005	2006	2007	2008	2009	2010	2011	2012	2013
	EXCH. RATE: £1=£1.4629	EXCH. RATE: £1=£1.467	EXCH. RATE: £1=£1.4619	EXCH. RATE: £1=£1.2588	EXCH. RATE: £1=£1.1233	EXCH. RATE: £1=£1.1752	EXCH. RATE: £1=£1.1462	EXCH. RATE: 1=£1.2337	EXCH. RATE: £1=£1.2542
Amphetamines	£10.00	£9.00	£9.00	£10.00	£10.00	£10.00	£10.00	£10.00	£10.00
	£14.63	£13.20	£13.16	£12.59	£11.23	£11.75	£11.46	£12.34	£12.54
Cannabis herb*	£2.64	£2.68	£3.95	£2.85	£2.85	£2.82	£5.00	£5.00	£3.00
	£3.86	£3.93	£5.77	£3.59	£3.20	£3.31	£5.73	£6.17	£3.76
Cannabis resin*	£1.94	£2.12	£2.82	£2.85	£2.85	£2.82	£5.00	£5.00	£3.00
	£2.84	£3.11	£4.12	£3.59	£3.20	£3.31	£5.73	£6.17	£3.76
Cannabis (sinsemilla)*			£6.21	£5.63	£7.15	£7.15	£10.00	£10.00	£8.50
			£9.08	£7.09	£8.03	£8.40	£11.46	£12.34	£10.66
Cocaine powder	£49.00	£49.00	£46.00	£40.00	£40.00	£40.00	£40.00	£40.00	£40.00
	£71.68	£71.88	£67.24	£50.35	£44.93	£47.01	£45.85	£49.35	£50.17
Crack cocaine**	£19.00	£18.00	£65.00	£65.00	£60.00	£50.00	£50.00	£60.00	£60.00
	£27.80	£26.41	£95.02	£81.82	£67.40	£58.76	£57.31	£74.02	£75.25
Ecstasy (per tablet)	£4.00	£3.00	£3.00	£3.00	£2.50	£2.50	£5.00	£3.00	£3.00
	£5.85	£4.40	£4.39	£3.78	£2.81	£2.94	£5.73	£3.70	£3.76
Heroin	£54.00	£52.00	£48.00	£45.00	£45.00	£45.00	£40.00	£40.00	£50.00
	£79.00	£76.28	£70.17	£56.65	£50.55	£52.88	£45.85	£49.35	£62.71
LSD (per dose)	£3.00	£3.00	£3.50	£3.00	£3.00	£3.00	-	-	£3.00
	£4.39	£4.40	£5.12	£3.78	£3.37	£3.53	-	-	£3.76
Mephedrone						£10.00	£20.00	£20.00	£15.00
						£11.75	£22.92	£24.67	£18.81
Ketamine						£25.00	£25.00	£20.00	£20.00
						£29.38	£28.66	£24.67	£25.08

*Before 2007 the cannabis values were based on the price per ounce. In 2007 this changed to being based on a usual street deal of 1/8oz and the price was converted to gram equivalent. In 2011 prices were reported on a gram basis.

**Crack cocaine prices before 2007 were provided per rock (0.2g) not per gram. Prices after 2007 cannot be compared to earlier prices.

Source: ST16

²³⁸ Prices are collected from police services across the UK on a rolling basis by the NCA and also during the course of NCA business. These originate from an array of sources such as detainee debriefing, test purchase deployments, general intelligence, evidence from arrests and searches, expert witness interpretation of criminal ledgers and communications, informants, social surveys and internet forum/website research. Prices are not formally recorded in the UK on an individual receipt basis but are qualitatively assessed as being 'current and representative'. The prices shown from 2007 onwards are the most common (mode) prices and should not be interpreted as means.

10.5.3 Street-level price data from non-law enforcement sources

DrugScope had previously published information on the street-level price of drugs derived from their annual *Street Drug Trends Survey* conducted with drug treatment services throughout the UK (UK Focal Point, 2013). However, questions on price were not included in the 2013 survey. The mean prices reported by DrugScope were similar across years to the typical prices reported by NCA (Table 10.5) for most substances, although the survey reported higher prices in recent years for both heroin and ecstasy tablets.

10.5.4 Purity of drugs and composition of drugs/tablets in the domestic market

Until 2007 drug purity data were provided by the Forensic Science Service (FSS). Following the growth of private forensic services, in 2008 and 2009 data were combined with data from the second largest provider, LGC Forensics. In December 2010 it was announced that the FSS was to be closed down by the end of March 2012 with the Serious Organised Crime Agency (SOCA) taking custodianship of the national drugs intelligence function. Data for 2010 onwards has been provided by SOCA/NCA from an expanded number of forensic agencies. The data are collected from tests conducted on police seizures within the domestic market including seizures of packages at one or two stages above street-level. As such, the mean purities reported for substances may be higher than if data were based on street-level seizures alone.

Data on cannabis potency are not provided due to concerns about the representativeness of samples submitted for forensic analysis. A cannabis potency study was carried out in 2008 (Home Office, 2008). No further study has been carried out. Purity data are shown in Table 10.6 and commentary is provided by individual drug.

Amphetamines

Typical domestic resale purity of amphetamines rose slightly from five per cent in 2012 to seven per cent in 2013 although remains lower than 2011 and earlier years. Almost all amphetamines seized are cut with caffeine while other common diluting agents include lactose and glucose.

Table 10.6: Domestic resale mean percentage purity of certain drugs seized by police in England and Wales, 2003 to 2013

DRUG	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Amphetamines	11	9	10	11	11	8	8	8	10	5	7
Cocaine powder	51	42	43	35	33	29	20	24	26	37	38
Crack cocaine	70	64	65	50	52	43	27	31	26	30	36
Ecstasy*	65	67	66	48	52	33	44	49	71	102	n/a
Heroin (brown)	33	40	47	44	50	43	44	35	18	20	33

*mg of MDMA base per tablet

Source: ST14

Cocaine

Purity of cocaine powder in the domestic market has continued to rise since reaching a low in 2009. Typical purity of cocaine powder is now at 38% compared to 20% in 2009. Purity-adjusted price has continued to fall throughout this period as the unit price has remained stable and is now less expensive when taking purity into account than in the indexed year (Table 10.7). Levamisole is commonly detected in wholesale cocaine seizures (added at the point of production) while benzocaine is used to bulk out the product within the UK. Other adulterants detected by forensic agencies include caffeine and phenacetin.

Purity of crack cocaine followed a similar pattern to that of cocaine in powder form, reducing between 2003 and 2009 although purity of crack cocaine remained higher over this period. The increase in purity of crack cocaine since 2009 has been less pronounced than that of cocaine powder and the current typical purity of crack at 36% is slightly below that of powder cocaine.

Table 10.7: Purity-adjusted price of cocaine powder per gram in the United Kingdom, 2003 to 2013: indexed to 2003

YEAR	£	€
2003	£55	€79.51
2004	£61.58	€90.76
2005	£58.75	€85.95
2006	£72.70	€106.63
2007	£70.94	€103.71
2008	£71.11	€89.51
2009	£100.89	€113.33
2010	£86.05	€101.13
2011	£78.17	€89.60
2012	£55.65	€69.80
2013	£53.89	€67.59

Source: ST14 and ST16

Heroin

After a large decrease in the purity of street-level heroin between 2010 and 2011, which was largely sustained in 2012, the purity of this drug rose sharply to 33% indicating a potential resurgence in the quantity of heroin arriving in the UK and the quality being targeted on UK markets (Table 10.6). Despite the increase in the price per gram at street-level (Table 10.8), the purity-adjusted price has fallen considerably from around £65 a gram in 2012 to around £50 in 2013 as a result of the increased quality of the substance typically being sold at street-level. However, in 2013, heroin remains more expensive than in any year between 2004 and 2010 when adjusting for purity.

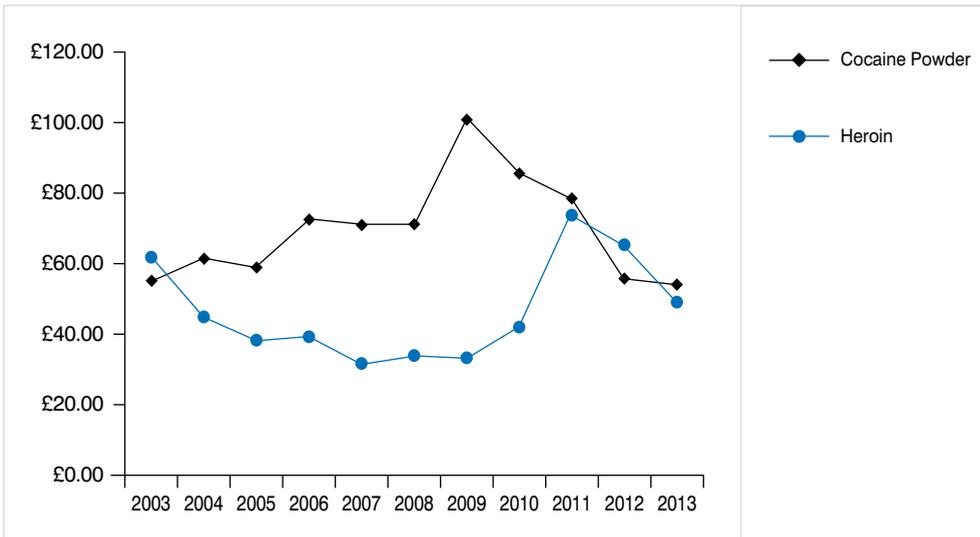
Table 10.8: Purity-adjusted price of heroin per gram in the United Kingdom, 2003 to 2013: indexed to 2003

YEAR	£	€
2003	£62.00	€89.63
2004	£45.08	€66.44
2005	£37.97	€55.55
2006	£39.09	€57.35
2007	£31.52	€46.08
2008	£34.46	€43.38
2009	£33.11	€37.19
2010	£42.16	€49.55
2011	£74.32	€85.19
2012	£65.40	€80.68
2013	£49.55	€62.15

Source: ST14 and ST16

Figure 10.1 shows that purity-adjusted price of cocaine powder and heroin has been at similar levels over the last three years. This is similar to the situation in 2003, after which the purity-adjusted prices of these drugs took divergent paths with heroin being the more expensive in the intervening years.

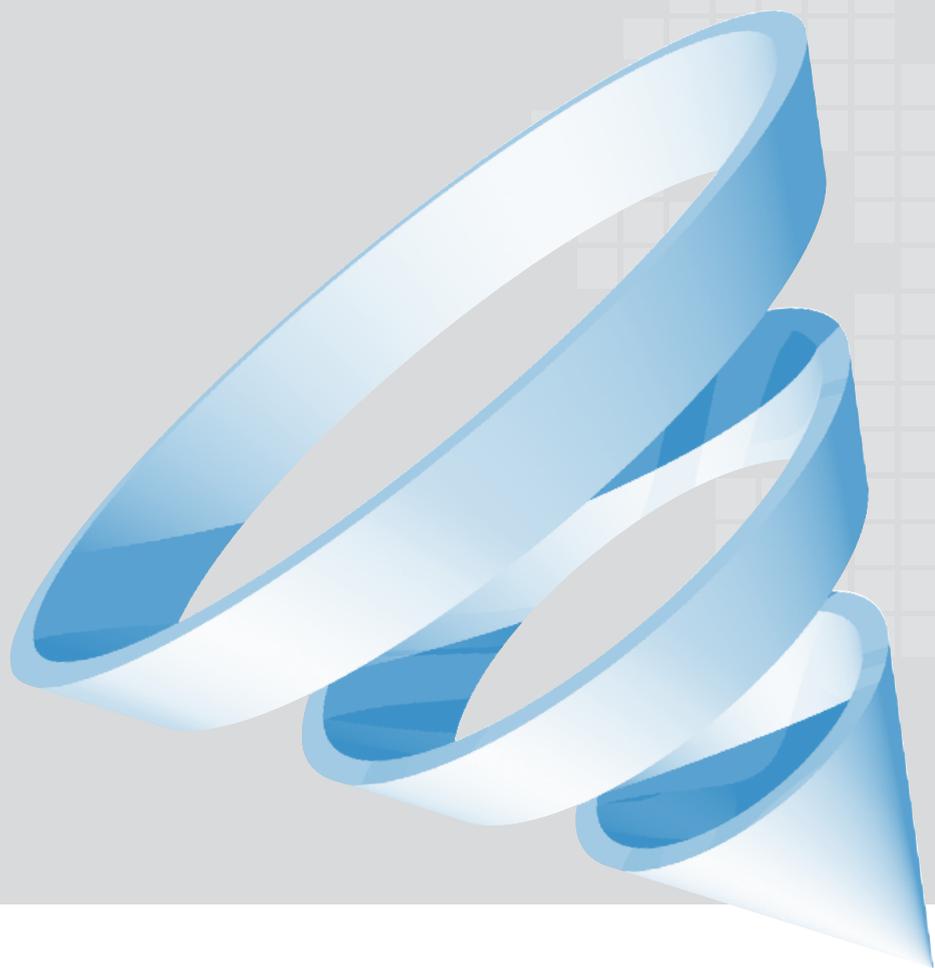
Figure 10.1: Purity-adjusted price of cocaine powder and heroin per gram in the United Kingdom, 2003 to 2013: indexed to 2003



*Since 2008 data have been received from more forensic providers

Source: ST14 and ST16

Part B: Bibliography and Annexes



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List of Abbreviations used in the Text

€	Euro	BZP	Benzylpiperazine
£	Pound sterling (UK)	CCTV	Closed-Circuit Television
2-DPMP	2-diphenylmethylpiperidine	CFL	Choices For Life
5-(2-aminopropyl)	Benzofuran	CI	Confidence Interval
5F-AKB48	N-(adamantan-1-yl)-1-(4-fluorobutyl)-1H-indazole-3-carboxamide	CJIT	Criminal Justice Intervention Team
5-IT	5-(2-Aminopropyl)indole	CMO	Chief Medical Officer
5-MeO-DALT	N,N-diallyl-5-methoxytryptamine	CO	Community Order
6-IT	6-(2-Aminopropyl)indole	CQC	Care Quality Commission
A&E	Accident and Emergency	CRC	Capture, Re-Capture
ACMD	Advisory Council on the Misuse of Drugs	CSEW	Crime Survey for England and Wales
ADEPIS	Alcohol and Drug Education and Prevention Information Service	CSF	Community Safety Fund
ADP	Alcohol and Drug Partnership	D2PM	Diphenyl-2-pyrrolidinylmethanol
AH-7921	3,4-dichloro-N-[(1-dimethylamino)cyclohexylmethyl]benzamide	DAT	Drug Action Team
AIDS	Acquired Immunodeficiency Syndrome	DBS	Dried Blood Spot
AMT	Alpha-methyltryptamine	DCLG	Department for Communities and Local Government
Anti-HBc	Antibodies to hepatitis B virus	DCSF	Department for Children, Schools and Families
Anti-HCV	Anti-hepatitis C virus	DfE	Department for Education
APB	Area Planning Board	DH	Department of Health
APPG	All-Party Parliamentary Group on Complex Needs and Dual Diagnosis	DHSSPSNI	Department of Health, Social Services and Public Safety Northern Ireland
ASTRA	Antiretrovirals, Sexual Transmission Risk and Attitudes	DIP	Drug Interventions Programme
AVA	Against Violence and Abuse	DLA	Disability Living Allowance
AWSCLP	All Wales School Liaison Core Programme	DMD	Drug Misuse Definition
BBV	Blood-borne Virus	DNP	2,4-dinitrophenol
BMA	British Medical Association	DPH	Directors of Public Health
		DRD	Drug-Related Deaths
		DRR	Drug Rehabilitation Requirements
		DSD	Drug Strategy Definition

DSDC	Drugs Strategy Delivery Commission	HBV	Hepatitis B Virus
DTTO	Drug Treatment and Testing Order	hCG	Human Chorionic Gonadotropin
DWP	Department for Work and Pensions	HCV	Hepatitis C Virus
EASR	European Age-sex Standardised Rate	HEAT	Health improvement, Efficiency, Access Treatment
EC	Electronic Commerce	HIV	Human Immunodeficiency Virus
EDDRA	Exchange on Drug Demand Reduction Action	HJIP	Health and Justice Indicators of Performance
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction	HM	Her Majesty/ Her Majesty's
EMIS	European Men-who-have-sex-with-men Internet Survey	HMIP	HM Inspector of Prisons
EQUATOR	European Quality Audit of Opioid Treatment	HNA	Health Needs Assessment
ERG	Expert reference groups	HPIS	Health Premium Incentive Scheme
ESA	Employment and Support Allowance	HRD	Harm Reduction Database
ESF	European Social Fund	HRDU	High Risk Drug Use
ETE	Education, Training and Employment	HSCIC	Health and Social Care Information Centre
EU	European Union	HWW	Healthy Working Wales
FEWS	Forensic Early Warning System	IB	Incapacity Benefit
FSS	Forensic Science Service	ICD-10	International Statistical Classification of Diseases and Related Health Problems-tenth edition
GBG	Good Behaviour Game	IDTS	Integrated Drug Treatment System
GBL	Gamma-butyrolactone	IEP	Injecting Equipment Provision
GGC	Greater Glasgow and Clyde	IFSS	Integrated Family Support Services
GHB	Gamma-hydroxybutyrate	IMG	Inter-Ministerial Group on Drugs
GIRFEC	Getting It Right For Every Child	IPED	Image and Performance Enhancing Drugs
GMR	General Mortality Register	IS	Income Support
GP	General Practitioner	ISCD	Independent Scientific Committee on Drugs
HASC	Home Affairs Select Committee	ISD	Information Services Division
HBsAg	Hepatitis B surface Antigen	JSA	Job Seekers Allowance
HBSC	Health Behaviour in School Age Children Survey	JSNA	Joint Strategic Needs Assessment

Kg	Kilogram	NHS	National Health Service
L&D	Liaison and Diversion	NICE	National Institute for Health and Care Excellence
LAC	Looked After Child	NIDMD	Northern Ireland Drug Misuse Database
LDAN	London Drug and Alcohol Network	NISRA	Northern Ireland Statistics and Research Agency
LGBT	Lesbian Gay Bisexual and Transgender	NNAG	National Naloxone Advisory Group
LH-SIB	London Homelessness Social Impact Bond	NOMS	National Offender Management Service
LJMU	Liverpool John Moores University	NPS	New Psychoactive Substances
LSD	Lysergic Diethylamide Acid	NPIS	National Poisons Information Service
LSHTM	London School of Hygiene and Tropical Medicine	NPSAD	National Programme on Substance Abuse Deaths
MAT	Medication Assisted Treatment	NRS	National Records of Scotland
MDMA	3,4-Methyldioxy-n-methylamphetamine	NSMMPF	National Substance Misuse Non-Medical Prescribing Forum
MDT	Mandatory Drug Testing	NSP	Needle and Syringe Programmes
MEAM	Making Every Adult Matter	NTA	National Treatment Agency
MHRA	Medicines and Healthcare Products Regulatory Agency	OCU	Opioid and/or crack cocaine user
MIM	Multiple Indicator Method	ONS	Office for National Statistics
M-PACT	Moving Parents And Children Together	OOKS	Opioid Overdose Knowledge Scale
MRSA	Meticillin-resistant S. aureus	OST	Opioid Substitution Therapy/Treatment
MSM	Men who have Sex with Men	PCC	Police and Crime Commissioner
MSSA	Meticillin-sensitive S. aureus	PCSP	Police Community Safety Partnership
MUP	Minimum Unit Price	PDU	Problem Drug Use
n/a	Not available	PHA	Public Health Agency for Northern Ireland
NCA	National Crime Agency	PHE	Public Health England
NDRDD	National Drug-Related Deaths Database	PHOF	Public Health Outcomes Framework
NDTMS	National Drug Treatment Monitoring System	PHW	Public Health Wales
NESI	Needle Exchange Surveillance Initiative	PMA	Para-Methoxyamphetamine
NEXMS	Needle Exchange Monitoring System		

PMW	Peer Mentoring Wales	SMT	Substance Misuse Toolkit
PNC	Police National Computer	SMNPB	Substance Misuse National Partnership Board
POM	Prescription Only Medication	SOCA	Serious Organised Crime Agency
PSHE	Personal, Social and Health Education	SPCR	Surveying Prisoner Crime Reduction
PSNI	Prison Service Northern Ireland	SPS	Scottish Prison Service
PuP	Parents under Pressure Programme	SQ	Standard Questionnaire
PWID	People Who Inject Drugs	SROI	Social Return on Investment
RBP	Reckitt Benckiser Pharmaceuticals	SSO	Suspended Sentence Order
RCGP	Royal College of General Practitioners	ST	Standard Table
RCT	Randomised Controlled Trial	STI	Sexually transmitted infection
RIOTT	Randomised Injectable Opiate Treatment Trial	SWAP	Structured Weekend Antidote Programme
SALSUS	Scottish Schools Adolescent Lifestyle and Substance Use Survey	TB	Tuberculosis
SCDEA	Scottish Crime and Drug Enforcement Agency	TCDO	Temporary Class Drug Order
SCJS	Scottish Crime and Justice Survey	TDI	Treatment Demand Indicator
SDA	Severe Disability Allowance	THN	Take-Home-Naloxone
SDD	Smoking Drinking and Drug Use Survey	TOP	Treatment Outcomes Profile
SDF	Scottish Drugs Forum	TV	Television
SDMD	Scottish Drug Misuse Database	UAM	Unlinked Anonymous Monitoring
SFAD	Scottish Families Affected by Alcohol and Drugs	UCL	University College London
SIB	Social Impact Bond	UK	United Kingdom
SMAF	Substance Misuse Action Fund	USA	United States America
SMAH	Substance Misuse and Associative Health	VCT	Voluntary Confidential Testing
SMART	Substance Misuse and Ageing Research Team	VFTF	Voices from the Frontline
SMMGP	Substance Misuse Management in General Practice	VSA	Volatile Substance Abuse
SMR	Special Mortality Register	WEDINOS	Welsh Emerging Drug and Identification of Novel Substances
		WHO	World Health Organisation
		WNDSM	Welsh National Database for Substance Misuse
		YPBAS	Young Persons Behaviour and Attitudes Survey

List of Standard Tables

NUMBER	TITLE	SOURCE
ST01	Basic results and methodology of population surveys on drug use	England and Wales – <i>Crime Survey for England and Wales (CSEW)</i> ; Scotland – <i>Scottish Crime and Justice Survey (SCJS)</i> ; Northern Ireland – <i>Northern Ireland Crime Survey (NICS)</i> ; <i>Drug Prevalence Survey</i>
ST02	Methodology and results of school surveys on drug use	England – <i>Smoking, Drinking and drug use amongst school children in England</i> Scotland – <i>Scottish Adolescent Lifestyle and Substance Use Survey (SALSUS)</i> Northern Ireland – <i>Young Persons Behavioural and Attitudes Survey (YPBAS)</i> Wales – <i>Health Behaviour in School Age Children Survey (HBSC)</i>
ST05	Acute/direct related deaths	General Mortality Registers (GMRs) for England and Wales, Scotland and Northern Ireland
ST06	Evolution of acute/direct related deaths	General Mortality Registers (GMRs) for England and Wales, Scotland and Northern Ireland
ST07	National prevalence estimates of high risk drug use	Home Office; National Health Service (NHS) Information Services Division (ISD) Scotland; Department of Health Social Services and Public Safety Northern Ireland (DHSSPSNI); Welsh Government; Public Health England (PHE)
ST08	Local prevalence estimates of high risk drug use	Home Office; National Health Service (NHS) Information Services Division (ISD) Scotland; Public Health England
ST09	Prevalence of hepatitis B/C and HIV infection among injecting drug users	Public Health England (PHE); Health Protection Scotland (HPS); National Public Health Service for Wales (NPHSW); Communicable Disease Surveillance Centre Northern Ireland
ST10	Syringe availability	Injecting Equipment Provision (IEP) in Scotland Survey, National Health Service (NHS) Information Services Division (ISD) Scotland; Northern Ireland Needle and Syringe Exchange Scheme; Harm Reduction Database (HRD), Public Health Wales
ST11	Arrests/reports for drug law offences	Ministry of Justice; Scottish Government; Northern Ireland Office; Northern Ireland Police Service (NIPS)
ST12	Drug use among prisoners	Scottish Prison Service
ST13	Number and quantity of seizures of illicit drugs	Home Office; UK Border Force; Scottish Government; Northern Ireland Police Service (NIPS)
ST14	Purity at street level of illicit drugs	National Crime Agency (NCA)
ST15	Composition of tablets sold as illicit drugs	National Crime Agency (NCA)
ST16	Price in Euros at street level of illicit drugs	National Crime Agency (NCA)
ST24	Access to treatment	National Drug Treatment Monitoring System (NDTMS) in England; Welsh National Database for Substance Misuse (WNDSM)
SQ25	Universal prevention	Consultation with relevant UK government officials
SQ26	Selective and indicated prevention	Consultation with relevant UK government officials
SQ27	Treatment programmes	Consultation with relevant UK government officials
SQ28	Social reintegration	Consultation with relevant UK government officials
SQ31	Treatment as an alternative to imprisonment	Consultation with relevant UK government officials
SQ32	Policy and institutional framework	Consultation with relevant UK government officials
ST34	TDI data	National Drug Treatment Monitoring System (NDTMS) in England; the Scottish Drug Misuse Database (SDMD), the Welsh National Database for Substance Misuse (WNDSM); and the Northern Ireland Drug Misuse Database



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UK Focal Point on Drugs
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Skipton House
80 London Road
London
SE1 6LH



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