



# Younger drug users assessed by DIP teams in non-intensive areas; characteristics and implications for service delivery

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## Introduction

The Drug Interventions Programme (DIP) is a Home Office initiative intended to reduce the impact of drug-related crime on the community. By directing drug misusing offenders out of crime and into treatment, it aims to break the cycle of drug use and re-offending. DIP forms a critical part of the Government's 2002 Updated Drug Strategy, in which plans were laid out for the programme under its previous title, the Criminal Justice Interventions Programme (CJIP) (Home Office, 2002a). CJIP was designed to ensure continuity of care between custody and the community by joining up prison, treatment and aftercare services. Its case-management approach was intended to ensure seamless, tailored support and treatment for drug misusing offenders from the point of arrest through sentencing, to prison release and beyond. Initially launched in April 2003 as a three-year initiative in areas of high acquisitive crime (intensive areas), the programme was implemented in all remaining Drug (and Alcohol) Action Team areas in May 2005 (non-intensives). Home Office statistics suggest that as the number of clients accessing treatment through DIP has increased acquisitive crime has reduced, although it is not possible to imply causality at this stage. After the introduction of DIP in 2002/3, acquisitive crime nationally was reduced by 20%. Approximately 3000 drug-misusing offenders enter treatment through DIP every month, which is on track for attaining the Government target of engaging 1000 drug misusing offenders into treatment every week by 2008 (Home Office, 2008a).

To date, little work has been done examining the characteristics of clients involved with DIP as most information collection and publications have focused on performance, as is to be expected considering the level of investment into DIP. This has meant that a valuable source of information has, to some degree, been neglected. Despite the fact that it has rarely been used to do so, the monitoring system put in place for DIP can provide a wealth of information regarding client characteristics. Every client entering DIP for the first time or re-entering the programme after a period of absence will be assessed and a record of this assessment will be taken on a Drug Interventions Record. Information collected includes:

- Age
- Gender
- Ethnicity
- Illicit drug use
- Injecting behaviour
- Sharing behaviour
- Alcohol use
- Drug treatment contacts
- Accommodation status
- Offences leading to criminal justice contact

Data from these forms are collated on a Home Office designed web based system. The intensive areas enter this data themselves whilst the non-intensive areas submit their forms via regional data collection points. The Centre for Public Health is the regional data collection point for the Eastern, Yorkshire and Humber, West Midlands and North East Government Office areas as well as for Merseyside and Cheshire, half of the North West Government Office region. As such, the Centre has access to a substantial amount of data regarding clients entering DIP in the 31 Drug (and Alcohol) Action Team areas covered by these regions (21% of the D(A)ATs in England).

This report is the first in a series aiming to examine the data collected to highlight emerging trends in client characteristics and provide early warning of potential areas for service development that will be required to account for changes in the types of clients accessing DIP. This report will focus on the age of clients, more specifically the differences between clients who were *under 25* and those who were *25 and over*, at the time of their DIP assessment. This is of critical importance as clients *under 25*, one of the key focus groups in the original models of care document, retain particular emphasis in the 2006 updated version of the guidance (NTA, 2006) and action with young people remains one of the four strands of the Drug Strategy (Home Office, 2008b). In addition, one of the key drug strategy targets that has formed a Public Service Agreement is to 'Reduce use of Class A drugs and the frequent use of any illicit drug amongst all young people under 25, especially the most vulnerable young people'.

Recent policy initiatives have moved the examination of 'young persons' drug use more towards under 18 year olds, particularly with the introduction of the Young Persons Substance Misuse Strategy by the Department for Education and Skills and the Home Office in 2005. Whilst this focus is essential in order to promote early

intervention with individuals who may develop highly problematic drug use in the future, the period between 18 and 25 is a vital transitional period where clients may move from being dealt with as a 'youth' through drug treatment and criminal justice agencies to being dealt with as an adult. It is also the period where individuals will reduce their dependence on their family and will have greater independence regarding life decisions. The NTA have highlighted the importance of making sure that drug users in contact with services approaching 18 should have a transitional care plan laid out to ease their passage into the 'next stage' of their treatment journey (NTA, 2005). It is also important because there is no definite point of transition from youth to adult either on an individual level or organisationally with Youth Offending Teams and Institutions, Drug Treatment Services, the Police, Connexions and the myriad of other assorted agencies dealing with young drug users having different age ranges for their involvement with clients.

Examination of the characteristics of younger drug users in comparison to their older counterparts can provide key indications for planning service delivery as client requirements may be very different. It can also indicate emerging trends in drug use or early warning regarding potential public health issues. Some research and monitoring systems have identified substantial differences in clients' characteristics dependent on age. The Home Office's National Arrestee Survey, a nationally representative survey of randomly selected arrestees in custody suites across the country, surveyed 7,535 individuals in 60 custody suites in 2004. Of the arrestees interviewed 41% were aged between 17 and 24 years, 30% aged between 25 and 34 years, with 29% aged 35 or over. Offenders *under 25* who had used heroin, crack or cocaine in the past year were more likely to self report committing acquisitive crime in the past twelve months than their older counterparts who had used these drugs. Offences committed by arrestees under and over 25 were similar with shoplifting, burglary and assault being the three most common offences among individuals who admitted heroin, crack or cocaine use in the past year. Use of cannabis and cocaine in the last month was higher among arrestees *under 25* than those *25 and over*. In contrast, individuals between 25 and 34 were more likely than those *under 25* to use heroin and crack. In addition, arrestees between 25 and 34 used heroin more frequently than their younger and older counterparts and were more likely to have injected drugs at some point in their lifetime. Under 25 year old arrestees who had used heroin, crack or cocaine in past year were also slightly more likely than their older counterparts to have been arrested in the previous 12 months (Boreham et al, 2007).

The British Crime Survey, whilst not a survey that provides information specifically regarding problematic drug use, can provide some useful information regarding drug use in the overall population. The 2005/6 survey revealed that individuals *under 25* had higher levels of use of any drug in the past year than their older counterparts and that people between 20 and 24 had the highest levels of use of Class A drugs in the past year. In addition, the proportions of people *under 25* using cocaine increased between 1998 and 2004/5. However, there was a decrease in this age group of clients using amphetamines, solvents and hallucinogens (Roe and Man, 2006). The increasing levels of use of cocaine were also highlighted as a key trend in the 2005/6 UK drug situation report with data from the British Crime Survey used to demonstrate that over half of the estimated current (last month) users of cocaine in the country were between 16 and 24 years old (Eaton et al, 2006).

Other patterns emerge when clients in contact with structured drug treatment are considered. A recent report examining structured drug treatment contacts in the North West of England in 2005/06 revealed that female clients made up a larger proportion of the *under 25* year old population in treatment than they did of the *25 and over* treatment population (Khundakar et al, 2007).

The principle aim of DIP is to reduce drug related crime through the provision of appropriate treatment and case management support. The work of DIP with *under 25* year olds is critical when it is considered that research has shown that offenders *under 25* (although not specifically drug users in this case), are more likely to re-offend than their older counterparts after a prison sentence or community order of some sort (Cunliffe and Shepherd, 2007).

The evidence above highlights how essential it is that any drug using offenders under the age of 25 that come into contact with DIP are dealt with as effectively as possible. This report is intended to provide some analysis to inform effective service delivery with clients between 18 and 25.

## Methodology

Data for assessments completed by DIP teams in 06/07 was used for all analyses. Any clients under 18 were removed from analyses, as were any clients that reported that they had not used illicit drugs in the month prior to their assessment. All 31 D(A)AT areas for which the Centre for Public Health acts as a collection point were included. Two areas, Wirral and Sefton, have a slightly different status to the others as they conduct drug testing on arrest and as such can apply legislation around

required assessments laid out in the Drugs Act 2005, despite the fact that they are not officially designated as intensive areas. Clients were only included in analyses if they reported using drugs in the past month and for alcohol responses only if they reported that they had used alcohol in the last month. It is important to note that not all of the clients included will have gone on to be taken onto the DIP caseload as there are a number of alternative assessment outcomes. These outcomes include the decision by the worker that no further intervention was required or a refusal by the client to engage in further intervention. In addition, clients may have been transferred to prison or to their D(A)AT area of residence prior to being taken onto the DIP caseload. In

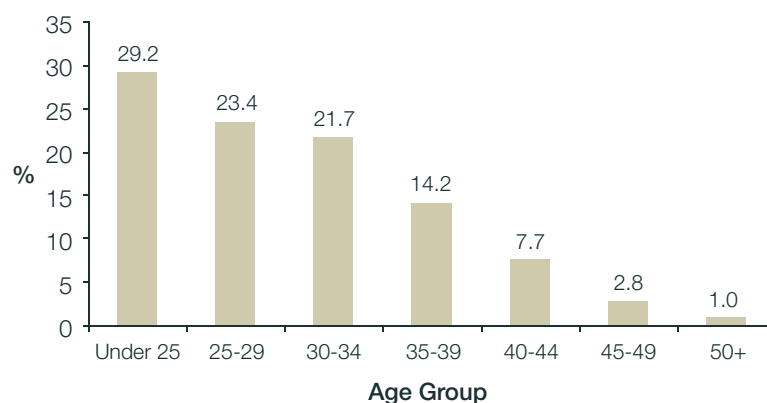
both these cases it would be hoped that the client would then receive the required treatment in these locations. Finally, in some cases clients may have had appointments made for them to attend follow up appointments which they failed to attend.

Analyses were conducted using SPSS and Epi Info. Cross tabulations were performed on key indicators and Chi-square tests were utilised to determine the significance of any differences between *under 25* year olds and clients *25 and over*.

## Findings

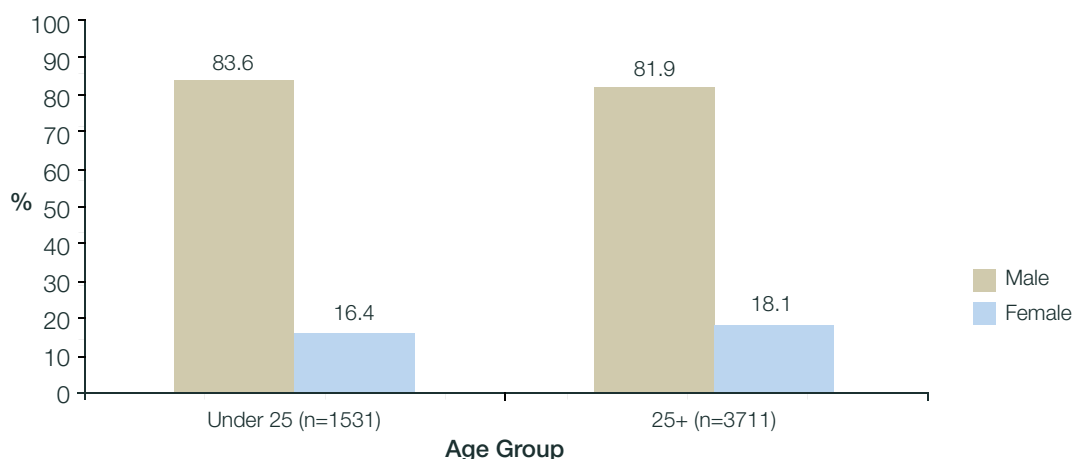
### Demographics

**Figure 1: Age of Clients Assessed (n=5242)**



Clients under the age of 25 were the largest group assessed in this sample of non-intensive areas in 06/07 (Figure 1).

**Figure 2: Age Group by Gender**



There was no significant difference in the gender split of under 25 year old clients compared to their older counterparts ( $\chi^2=3.00$ ,  $df=1$ , ns). Approximately eight in ten clients assessed in both cases were male (Figure 2).

**Table 1: Age Group by Ethnicity**

Ethnicity	Under 25 (n=1527*)		25+ (n=3699**)	
	n	%	n	%
Asian or Asian British	9	0.6%	33	0.9%
Black or Black British	9	0.6%	43	1.2%
Chinese or other Ethnic Group	3	0.2%	2	0.1%
Mixed	39	2.6%	48	1.2%
Not Stated	4	0.3%	16	0.4%
White	1463	95.8%	3557	96.2%

\* The ethnicity of four under 25 year old clients assessed was not recorded

\*\* The ethnicity of 12 25+ clients assessed was not recorded

Both sets of clients were predominantly from a white ethnic background (95.8% of clients under 25 and 96.2% of those 25 and older). The next most common ethnicity in both groups was mixed. Whilst the ethnicity profile

was similar in both groups clients from a mixed ethnic background were significantly more highly represented in the under 25 year old group ( $\chi^2=10.42$ ,  $df=1$ ,  $p<0.005$ ) (Table 1).

## Drug Use

**Table 2: Self Reported Drug Use**

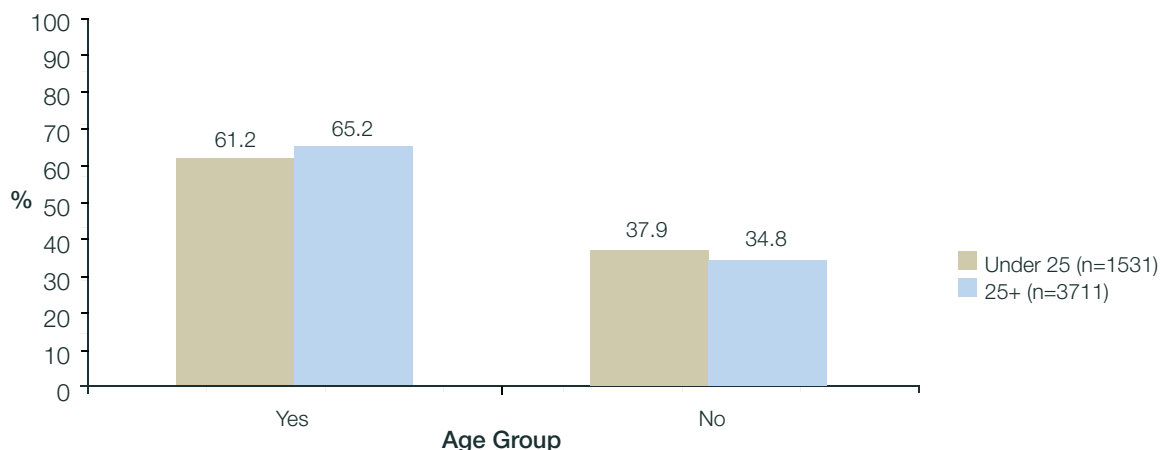
Drug	Under 25 (n=1531)		25+ (n=3711)		$\chi^2$	p
	n	%	n	%		
Amphetamines	148	9.7	278	7.5	6.87	<0.01
Benzodiazepines	151	9.9	477	12.9	9.19	<0.005
Cannabis	676	44.2	847	22.8	239.23	<0.001
Cocaine	590	38.5	655	17.7	261.09	<0.001
Crack	404	26.4	1532	41.3	103.23	<0.001
Ecstasy	185	12.1	121	3.3	153.50	<0.001
Heroin	702	45.9	2798	75.4	426.40	<0.001
Methadone	78	5.1	457	12.3	61.65	<0.001
Other	53	3.5	126	3.4	0.01	ns

NB/ As clients can report the use of more than one substance figures will add up to more than 100% of the sample

Drug use profiles in the two groups were quite different. Whilst heroin was the most common drug of use in both groups the percentage of *under 25* year olds using it in the previous month (45.9%) was significantly lower than among the *25 and over* group (75.4%) ( $\chi^2=426.40$ ,  $df=1$ ,  $p<0.001$ ). In addition, rates of crack, illicit methadone

and benzodiazepine use were significantly higher in the *25 and over* group. In contrast, clients *under 25* were significantly more likely than their older counterparts to report the use of cocaine, cannabis, amphetamines and ecstasy (See Table 2 for Chi square and significance values).

**Figure 3: Poly-drug Use**



Poly-drug use was defined as the self reported use of more than one drug in the month prior to assessment. Whilst clients under the age of 25 were significantly less likely to report poly-drug use the difference was not substantial ( $\chi^2=4.63$ ,  $df=1$ ,  $p<0.05$ ).

**Table 3: Drug Combinations**

Drug Combination	Under 25		25+	
	n=1531	%	n=3711	%
Uses heroin, methadone, crack or cocaine	1301	85.0	3420	92.2
Used Opiates (heroin or methadone) and cocaine (powder or crack)	348	22.7	1514	40.8
Cannabis only	125	8.2	114	3.1
Cocaine only	193	12.6	203	5.5
Stimulants only	286	18.7	384	10.3

The considerable differences between the two age groups in their drug use profiles, as seen in the previous two tables, continue when drug use combinations are examined. Rates of use of heroin, methadone, crack or cocaine in both groups were very high, however, they were significantly higher among 25 and over clients ( $\chi^2=62.45$ ,  $df=1$ ,  $p<0.001$ ). The differences were even more pronounced for the use of opiates in conjunction with cocaine or crack, with four in ten 25 and over clients (40.8%) using this combination compared to 22.7% of

under 25 year old clients ( $\chi^2=154.47$ ,  $df=1$ ,  $p<0.001$ ). Both age groups had relatively few clients who were using cannabis only although there were significantly more cannabis only users among the under 25 year olds ( $\chi^2=64.60$ ,  $df=1$ ,  $p<0.001$ ). The under 25 year old age group also had a significantly greater proportion of cocaine only users than in the older age group ( $\chi^2=67.03$ ,  $df=1$ ,  $p<0.001$ ) and use of stimulants alone was more commonly reported in this group ( $\chi^2=67.51$ ,  $df=1$ ,  $p<0.001$ ).

**Table 4: Age Group by Self Reported Weekly Spend**

Weekly spend	Under 25*		25+**	
	n	%	N	%
0-50 (n=1287)	410	31.9	877	68.1
51-100 (n=895)	275	30.7	620	69.3
101-250 (n=1373)	411	29.9	962	70.1
251-500 (n=1004)	266	26.5	738	73.5
501-1000 (n=495)	132	26.7	363	73.3
More than 1000 (n=134)	28	20.9	106	79.1

\* Estimate of weekly spend not provided for nine under 25 year old clients

\*\* Estimate of weekly spend not provided for 45 25+ clients

For both groups of clients the most common range of weekly expenditure was between £101 and £250 followed by £0 to £50. However there was a significant difference between the levels of expenditure between the two groups ( $\chi^2$  trend=13.31, df=4, p<0.001). Examination of the proportions of clients spending under

£100 and over £100 per week revealed that generally clients *under 25* years old were spending less than their older counterparts. Four in ten *25 and over* clients (40.8%) spent under £100 per week on drugs compared to 45.0% of clients under 25, a significant difference ( $\chi^2=87.12$ , df=1, p<0.001) (Table 4).

**Table 5: Weekly Spend by Drug Used (under 25s only)**

Drug	£0-£50		£51-£100		£101-£250		£252-£500		£501-£1000		More than £1000	
	n	%	n	%	n	%	n	%	n	%	n	%
<b>Amphetamine (n=148)</b>	35	23.6	37	25.0	43	29.1	23	15.5	6	4.1	4	2.7
<b>Benzodiazepines (n=150)</b>	26	17.3	20	13.3	44	29.3	32	21.3	21	14.0	7	4.7
<b>Cannabis (n=676)</b>	202	29.9	151	22.3	177	26.2	93	13.8	42	6.2	11	1.6
<b>Cocaine (n=586)</b>	227	38.7	94	16.0	137	23.4	75	12.8	41	7.0	12	2.0
<b>Crack (n=400)</b>	23	5.8	52	13.0	116	29.0	107	26.8	83	20.8	19	4.8
<b>Ecstasy (n=185)</b>	49	26.5	45	24.3	51	27.6	22	11.9	15	8.1	3	1.6
<b>Heroin (n=700)</b>	76	10.9	115	16.4	236	33.7	176	25.1	84	12.0	13	1.9
<b>Methadone (n=77)</b>	12	15.6	12	15.6	16	20.8	23	29.9	10	13.0	4	5.2
<b>Other (n=48)</b>	9	18.8	15	31.3	16	33.3	5	10.4	6	12.5	1	2.1

Much of the evidence presented points to a different, possibly less problematic profile for *under 25* year old clients, with greater levels of cannabis and cocaine use but lower levels of heroin and crack use than their older counterparts. Further investigation of this point was carried out by examining the weekly spend on drugs of clients under the age of 25 in more detail. This analysis

revealed that *under 25* year old clients using cocaine, cannabis and amphetamines had generally lower levels of expenditure than their counterparts using heroin, crack or methadone. It should be remembered that clients in each drug use category may have used other drugs as well so when text refers to cocaine users these clients are possibly not users of cocaine exclusively (Table 5).

**Table 6: Drug Administration Behaviour and Treatment Contacts**

	Under 25 (n=1531)		25+ (n=3711)	
	n	%	n	%
<b>Ever injected</b>	560	36.6	2355	63.5
<b>Injected in past month</b>	402	26.3 (71.8% of those ever injected)	1451	39.1 (61.6% of those ever injected)
<b>Ever shared*</b>	333	21.8	1048	28.2
<b>Shared in last month*</b>	187	12.2 (56.2% of those ever shared)	341	9.2 (32.5% of those ever shared)
<b>Been in treatment in the past 2 years</b>	542	35.4	2153	58.0
<b>Currently in treatment</b>	162	10.6 (29.9% of those in treatment in past 2 years)	1031	27.8 (47.9% of those in treatment in past 2 years)

\* Please note that sharing as recorded on the DIR may not solely be injecting paraphernalia, it is all drug using paraphernalia.

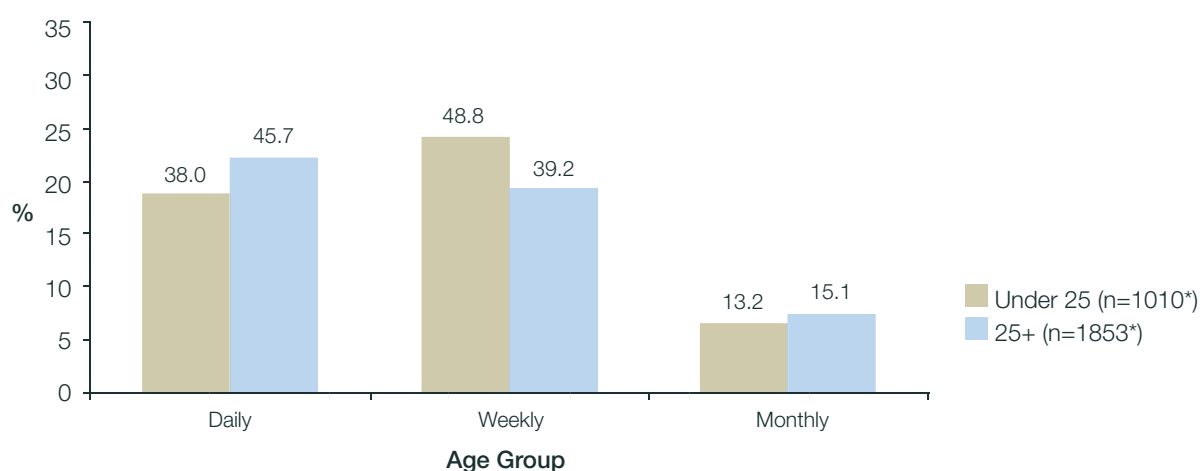
Self reported injecting behaviour in the two age groups was substantially different. Rates of lifetime injecting were significantly higher among *25 and over* clients ( $\chi^2=317.30$ ,  $df=1$ ,  $p<0.001$ ) as were rates of injecting in the past month ( $\chi^2=78.22$ ,  $df=1$ ,  $p<0.001$ ). Importantly though a larger proportion of *under 25* year old clients who had injected in their lifetime were still injecting (71.8%) than among *25 and over* clients (61.6%). A slightly different pattern was seen for the sharing of drug using paraphernalia. Whilst *25 and over* clients were significantly more likely than their younger counterparts to have ever shared equipment ( $\chi^2=23.53$ ,  $df=1$ ,  $p<0.001$ ) this pattern was reversed for current sharing with *under 25* year olds significantly more likely to have shared equipment in the past month ( $\chi^2=10.95$ ,  $df=1$ ,  $p<0.001$ ). A third of the older client group (32.5%) who had ever shared equipment were still sharing whilst 56.2% of *under 25* year old clients who had ever shared equipment were still sharing.

As might be expected older clients were more likely to have been in treatment in the past two years than their younger counterparts ( $\chi^2=221.91$ ,  $df=1$ ,  $p<0.001$ ) and they were also more likely to currently be in treatment ( $\chi^2=182.42$ ,  $df=1$ ,  $p<0.001$ ). Of the *under 25* year olds who had been in treatment in the past two years three in ten were still in treatment. Among *25 and over* clients this figure was substantially higher at 47.9%. Further analysis revealed that 18.4% of the current injectors among the *under 25* year olds were in treatment at the time of their DIP assessment. This is compared to 26.7% of the *25 and over* current injectors.

## Alcohol Use

Of the 1,531 *under 25* year olds in the sample, 1,023 had drunk alcohol in the past month (66.8%), a larger percentage than among *25 and over* clients, 1,885 of whom had drunk alcohol in the past month (50.8%).

**Figure 4: Frequency of Alcohol Use**



\*Information not available for 13 clients under 25

\*\*Information not available for 32 25+ clients

A higher proportion of *25 and over* clients than *under 25* year old clients reported drinking on a daily basis whilst this trend was reversed for weekly drinking.

**Table 7: Self Reported Weekly Alcohol Unit Consumption**

Units/wk	Under 25 (n=983*)		25+ (n=1800**)	
	n	%	n	%
0-25	443	45.1	891	49.5
26-50	246	25.0	402	22.3
More than 50	294	29.9	507	28.2

\*Information not available for 40 clients under 25

\*\*Information not available for 85 25+ clients

Whilst the categories given on the DIR do not allow for direct comparison, the quantities of alcohol consumed by a large proportion of individuals in both age groups are well above the maximum weekly recommended intake levels for both men (21 units) and women (14 units). Clients *under 25* were significantly more likely to consume 0 to 25 units a week than their older counterparts ( $\chi^2=5.01$ ,  $df=1$ ,  $p<0.05$ ).



**Table 8: Offence or Reason for Contact with Criminal Justice System**

Offence	Under 25 (n=1488*)		25+ (n=3493**)	
	n	%	n	%
Assault	148	9.9	215	6.2###
Breach	62	4.2	124	3.5
Burglary	193	13.0	436	12.5
Criminal Damage	47	3.2	50	1.4###
Domestic Violence	14	0.9	43	1.2
Driving Offences	43	2.9	143	4.1#
Fraud/Deception	13	0.9	53	1.5
Failed to attend court	4	0.3	43	1.2##
GEFT	19	1.3	14	0.4###
Handling	21	1.4	44	1.3
Harassment	7	0.5	5	0.1
Misuse of Drugs Act	121	8.1	762	21.8###
Non payment of fines	9	0.6	15	0.4
Public Order	29	1.9	70	2.0
Recall	10	0.7	13	0.4
Robbery	63	4.2	115	3.3
Sex	10	0.7	22	0.6
Theft from a vehicle	33	2.2	54	1.5
Theft of a vehicle	117	7.9	91	2.6###
Theft other	105	7.1	268	7.7
Theft Shop	332	22.3	1116	31.9###
Warrant	26	1.7	70	2.0
Weapons/Firearms	23	1.5	37	1.1
Other	47	3.2	177	5.1##

\* Information was not available for 43 clients assessed

\*\* Information was not available for 218 clients assessed

# significant at the p<0.05 level, ## significant at the p<0.005 level, ### significant at the p<0.001 level.

The offences or reasons for contact with the criminal justice system that led to involvement with the DIP team were similar for both age groups. However, a number of significant differences did arise including a significantly larger proportion of criminal damage, theft of a vehicle, going equipped for theft (GEFT) and assault offenders among the *under 25* year olds. In contrast, clients who were *25 and over* at the time of their assessment were more likely than their younger counterparts to have been arrested for shoplifting, Misuse of Drugs Act offences, driving offences or for the variety of offences that made up the ‘other’ category.

## Discussion

This study has highlighted some considerable and important differences in the profiles of *under 25* year olds and *25 and over* clients who are being contacted by the DIP teams in the 31 non-intensive D(A)ATs that were included in the analyses. There was evidence that a substantial proportion of the *under 25* year clients could be considered less ‘problematic’ than their older counterparts. This is evidenced by the significantly lower levels of self reported weekly expenditure on drugs, the lower use of heroin and

crack and higher levels of cannabis, cocaine and ecstasy use among the younger clients assessed. Findings are very similar to those from the Home Office’s arrestee survey (Boreham et al, 2007). This is not to say that cannabis, cocaine and ecstasy can not lead to or be involved in problematic use patterns but the indications (levels of expenditure on drugs, administration route, treatment contacts etc) are that for a substantial proportion of young people in this sample this was not the case. Despite this, these individuals are offending and therefore action is required. The question is whether DIP is the place for this action. If their drug use is at a relatively low level as indicated by their expenditure then is their offending directly related i.e. are they offending to raise money to buy drugs or are their drug use and their offending two unrelated elements of a range of risk behaviours that they take part in? If the second premise is true, involving these clients in treatment may tackle their drug use and help them to reduce or abstain but it is unlikely to have a direct effect on their offending, therefore failing in DIP’s primary aim to reduce offending by channelling clients into treatment. An examination of the specific needs of young male prisoners in Britain has highlighted that they use a wide range of substances but that the reasons and patterns of their drug use are complex and may not be rectified by a

concentration purely on treating drug use. A wider approach is advocated looking at lifestyles and environment (Home Office, 2002b), a suggestion corroborated by this current piece of work. If these clients are to be channelled into DIP then the emphasis must be placed on the 'wraparound' services that DIP provides or refers to and adequate resources must be allocated to these elements of the service.

There is a presumption that needs examination from the paragraph above. Should we assume that there is appropriate treatment available for these individuals? Do these D(A)Ts have treatment that will be effective in addressing the use of cannabis and cocaine? Treatment services have had some issues adjusting to the high levels of crack use that have emerged in many areas of the UK in the past decade but whilst clinically many crack users have different medical needs to primary opiate users, for the most part the crack using clients coming into contact with structured drug treatment are likely to present with similar social issues, e.g. severe health issues, accommodation problems and drug use and offending patterns that have removed them from what could be classed as 'normal' social functioning. It is not clear whether this is the case with the group of younger clients identified in this study and treatment would need to be responsive to the different needs of this group. Furthermore, whether the existing treatment centres are the place for these individuals to receive the support they require is questionable. There are two issues to consider. Firstly do agencies want to bring users who might be 'recreational' into the same agencies as individuals who are entrenched in their drug use and offending, therefore increasing the potential for the younger users to get pulled into a more problematic use pattern? Secondly will the younger less problematic group be willing to engage in a service that they view as being populated with 'smackheads', as they might see them. So there is a paradox, the format and clientele of current services may deter this younger group from engaging but if they do engage there are substantial risk factors (Melrose et al, 2007, Parker, 2007, Social Exclusion Unit 2005, Ridenour et al, 2003). This situation presents a substantial challenge for treatment providers and commissioners.

It is important to recognise that the monitoring data do not suggest that there are no problematic drug users in the sample of *under 25* year olds being contacted by the DIP teams in the non-intensive areas. There are still substantial proportions of *under 25* year olds using heroin and crack and spending substantial amounts of money on drugs, suggesting a more direct link to their offending. These individuals may be suitable for the interventions provided by traditional treatment services therefore it is critical that they are channelled into treatment effectively and as quickly as possible. This is particularly true as a recent analysis of Tier 3 and 4 treatment outcomes for clients under and over 25 in the North West of England revealed that across the region individuals discharged from treatment during 2005/06 aged *under 25* were significantly more likely to have completed treatment successfully than their older counterparts (Khundakar et al, 2007). This emphasises the need to

ensure that clients are engaged as early in their drug use career as possible if successful outcomes are to be optimised, especially as evidence suggests that treatment engagement acts as a protective factor against overdose. Stewart et al (2002) evidenced a reduced rate of non-fatal overdose among clients treated in residential and community settings. The reduction was associated with reduced frequency of drug taking and injecting. The protective effect of treatment on fatal overdose has also been evidenced among Swedish injectors (Fugelstad et al, 1995). However, paradoxically previous methadone detoxification or criminal justice based treatment has also been associated with increased risk of overdose due to the effects of lowering tolerance and the risk this can present following disengagement from treatment (Seal et al, 2001). If clients are to be successfully engaged, services must be adaptive to their needs and this paper provides some indications as to the direction services for drug users in this transitional phase should be taking.

Some of the interpretation above draws on the use of weekly expenditure as a simple proxy measure of how chaotic or problematic a person's drug use is. However, there are a number of caveats that must be considered in this assumption. Firstly, a drug user's problems will expand well beyond the amount that they have to spend to fund their habit every week. In addition, there is dramatic variation across areas in the price of drugs (Drugscope, 2006). The price of drugs will also vary as a function of their availability, an individual's familiarity with their drug dealing network, the ability to obtain 'multi-buy' deals and the provision of drugs through trade for goods or services. There is also a considerable variability in the purity of drugs that may be sold for the same price (Johnson and Golub, 2007). Finally, reports on weekly expenditure on drugs will be distorted if the individual is involved in drug dealing themselves. Despite this the use of this indicator has some substantial merits when considering drug users within the criminal justice system. Clients having to spend large amounts of money every day on their drugs are unlikely to be able to afford to pay for that utilising their own sources of income and often the way to augment this income would be through crime. Evidence from previous research has supported this conclusion suggesting that a large proportion of drug users' money is obtained through illegal activity (Jones et al, 2007, Godfrey et al, 2002, Coid et al, 2000, Hearnden and Harocopos, 2000, Parker and Bottomley, 1996, Jarvis and Parker, 1989).

One area of service delivery that this work has highlighted for particular examination is injecting and drug using equipment sharing among younger problematic users. Whilst a lower proportion of clients under the age of 25 were currently injecting than their older counterparts, it was still a substantial proportion and in fact a greater proportion of clients who were *under 25* who had ever injected were still injecting. This is probably evidence of the fact that they have not had the same time as the older users to move out of injecting but it also reflects the fact that early intervention either has not taken place or has not been effective in tackling their injecting behaviour. There is a wealth of evidence that highlights the risk of injecting in overdose

(Gossop et al, 1996, Stewart et al, 2002) and age has been highlighted as a factor in the risk of fatal and non-fatal overdose. A study in San Francisco looking at risk factors for non-fatal heroin overdose found that injecting was significantly associated with the occurrence of non-fatal overdose and that the highest risk was with clients in the 20-24 years age range (Ochoa et al, 2005). As non-fatal overdose has been proved to be associated with the risk of future fatal overdose this is worrying if the trend of continuing relatively high levels of injecting among the group of *under 25* year olds included in current study continues. In a sample of 459 Glasgow drug injectors in treatment, investigation revealed that younger drug users had a higher risk of mortality than their older counterparts (Frisher et al, 1997). Peak time in terms of risk of overdose in the San Francisco study was 6-7 years after the initiation of injecting so it is important that behaviour is altered before reaching this point.

Other risk factors for overdose have also been identified in British drug users. Among a sample of 312 current injectors, risk factors for overdose included the age at which users started injecting, the use of alcohol, poly-drug injection and also being female. The longer individuals had been injecting the lower their risk of overdose (Powis et al, 1999). The risks associated with poly-drug use (heroin use in conjunction with other drugs) have also been emphasised both in the Gossop et al 1996 study, a study with 276 Glasgow based injectors (Taylor et al, 1996), in an Australian drug using population (Darke et al, 2005) and has also been seen in the National Treatment Outcome Research Study (Stewart et al, 2002). Use of alcohol and benzodiazepines in particular has been identified as a contributory factor in studies of heroin related overdoses (Darke and Ross, 1999, Darke et al, 1996, Darke et al, 2000, Strang et al, 1999, Coffin et al, 2003, Seal et al, 2001, McGregor et al, 1998). Rates of poly-drug use and alcohol use were relatively high among the *under 25* year old group in this study. Involvement with the criminal justice system and in particular having spent time in prison are also suggested to be predictors of overdose (Darke et al, 2005). As the clients we are examining in this report have been sampled from an offending population the risk factors for the younger, poly-drug using, heroin injecting group begin to accumulate. It is unfortunate that the monitoring system during this time period did not provide information regarding the length of time that the clients had been using drugs or had been injecting as there is some debate as to whether it is age or in fact length of drug using or injecting career that is an influence on the risk of overdose (See Darke and Zador, 1996 for a review of evidence on overdose).

The higher rates of current sharing among clients under 25 years old when compared to their older counterparts is an alarming trend for the potential spread of blood borne viruses. Hepatitis C is currently the most significant infectious disease facing those who inject drugs in the UK; its prevalence is increasing and estimates suggest that 42% of current injectors show signs of being infected with the virus (HPA et al, 2007). Considering both hepatitis C and

hepatitis B, evidence suggests that injecting drug users are at a greater risk of infection in the first year of injecting compared to experienced injectors, highlighting the urgent need to target interventions to reduce the transmission of blood borne virus transmission to those who are just beginning to inject (Sutton et al, 2006). Investigations among intravenous drug users in Amsterdam found that whilst age was not a predictor for HIV seroconversion recent onset of injecting was (Fennema et al, 1997).

In conclusion, this piece of work has provided some valuable indicators as to the issues posed for criminal justice, drug treatment agencies and their partners in tackling the needs of 18 to 25 year old drug users entering the criminal justice system. In particular there are substantial questions to be asked regarding the efficacy and appropriateness of traditional treatment approaches with a substantial section of younger users coming into contact with DIP teams. In addition, it would appear that there is some significant work required with younger 'problematic' clients around injecting, sharing and treatment engagement in order to ensure that there are not serious ramifications a number of years down the line for the health of this group. The impact of the potential problems on the health service should not be underestimated.

There is inherently a reliance on self report with the majority of monitoring systems and it should be acknowledged that this research relies solely on this for its information. However, the strength of the significance of findings in many areas suggests that conclusions can be drawn with some confidence. It should also be remembered that the clients analysed in this paper represent just a proportion of those contacted in 06/07 across the country. The future inclusion of the other non-intensive areas and the more urban intensive areas would provide a more complete understanding of the emerging trends and issues.

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