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DAAT**

Web-based learning tool.

Course Information page

Why a web based learning tool?

Norfolk DAAT have developed web – based learning as a means for expanding access to a range of materials covered in existing DAAT Courses. Places on the DAAT courses are often over-subscribed and so by developing a technology based solution to these problems the DAAT can offer the learning to a wider audience.

The course learning materials that you will find on the following pages, will help you to develop knowledge and understanding for a number of DANOS units, and will enable learners to build up a portfolio of learning. Please note this course is designed to encourage self directed learning there is no provision for online support by phone, email or by post.

Aims of this web-based course

- To use technology to share a scarce resource among geographically disbursed learners
- To deliver information and Continuing Professional Development opportunities to a wider learning constituency, including underserved groups.
- Through the use of the materials on these pages students will receive quick feedback on their performance and it is hoped that this will improve the learning experience making it enjoyable and meaningful for learners.
- The course has been designed to enable people to stop and start their learning at times that suit them. The downloadable reflective learning logs help learners to reflect on their learning.
- The printable question and answer sheets enable learners to build a portfolio of their learning.

Learning outcomes. By the end of this course participants will be able to;

- Differentiate between drugs and alcohol myths and realities.
- Explain the spectrum of drug use.
- Explain how drugs are classified.
- Name examples of treatment providers in Norfolk
- Summarise the key strands of national drug/ alcohol strategy.
- Describe the relationship between criminal justice and substance misuse.

Contact us details.

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Please Register: In order that we can gain an idea of how widely this resource is being used, please let the DAAT know that you have started the course by emailing michael.hutchinson.dat@norfolk.gov.uk

Course content:

Outlined below is the course content.

1. Myths and realities.
2. A to Z of terms.
3. Drugs and alcohol.
4. Signs, symptoms and frequently used terms
5. National / local trends.
6. Problematic, recreational and experimental drug use.
7. Drug, set and setting. (The drug, the mindset and the setting in which the user has his/her experience)
8. Classification of drugs
9. Drugs and the law.
10. Scale of effect.
11. The role of the DAAT and National Drug and Alcohol strategies.
12. Criminal justice and substance misuse.
13. Treatment – local services.
14. Care planning
15. Finish

To start the course and to start building your portfolio of learning, please answer the following quiz questions:

Doing this will enable you to establish a base line profile. Please print out the question sheet and write your answers in. You will return to these questions at the end and be able to see how much you have learnt over the period of taking this course.

Exercise 1. Drug and Alcohol myths and realities quiz.

Please print out the Multiple-choice questions on the next page.

No/	Question	Multiple choice	Your answer
1	What age can you legally buy alcohol?	16 years	
		17 years	
		18 years	
2	Is it an offence to be drunk and incapable or drunk and disorderly in a public place or on licensed premises?	Yes	
		No	
		Depends how old you are	
3.	Alcohol travels in the body by:	The urine	
		The bloodstream	
		The nervous system	
4.	How many 'units' of alcohol does a 500 ml can of Super (lager) contain if the ABV is 9% ?	2.5 units	
		3.5 units	
		4.5 units	
5.	What are the safe drinking guidelines for men?	2-3 units, per day with a couple of alcohol free days	
		3-4 units , per day with a couple of alcohol free days	
		5-6 units, per day with a couple of alcohol free days	
6.	What are the safe drinking guidelines for women?	2-3 units, per day with a couple of alcohol free days	
		3-4 units , per day with a couple of alcohol free days	
		5-6 units, per day with a couple of alcohol free days	
7.	How many units of alcohol can the liver process per hour?	One unit	
		Two units	
		Three units	
8.	Drugs like heroin which slow down the central nervous system to suppress neural activity in the brain are called	Hallucinogens	
		Stimulants	
		Depressants	
9.	Drugs like LSD which alter your perception, the way you see, hear, or feel, are called	Hallucinogens	
		Stimulants	
		Depressants	
10	Drugs like cocaine which speed up the central nervous system to increase neural activity in the brain are called	Hallucinogens	
		Stimulants	
		Depressants	

An A-Z of terms

2. A to Y (Z) of terms

Below you will find a brief alphabetical list of drugs and related terms, many of these will be used in this course. Take a few minutes to read through them and then answer the questions at the foot of the page.

A

Alcohol – a depressant drug, it is a substance that affects the way the brain and the body functions.

Amphetamines – are synthetic stimulant drugs, used to suppress appetite, control weight, and treat disorders including narcolepsy and ADHD. In powder or pill form they are a class B drug in the UK.

ACMD – The Advisory Committee on the Misuse of Drugs, they advise the Home Office on drug related matters.

B

Benzodiazepines (benzos) – a type of tranquilliser.

Buprenorphine is an opiate used to treat drug users. The risk of overdose is said to be less than with methadone.

Barbiturate – central nervous system depressants. Barbiturates are synthetic drugs, which used to be regularly prescribed for anxiety, depression and insomnia. They are highly dangerous (risk of overdose) and they are only now prescribed for very serious insomnia. (MODA class B drugs)

BBV – Blood borne virus.

C

Cannabis – is a naturally occurring drug made from parts of the cannabis plant. It is a mild hallucinogen and often gives sedative like effects.

Cocaine – a powerful stimulant, and a class A drug under the Misuse of Drugs Act.

Crack - is a smoke able form of Cocaine, a stimulant drug.

D

Depressant - Drugs which slow down the central nervous system to suppress neural activity in the brain

Diamorphine - Heroin

DAAT or DAT – Drug (and Alcohol) Action Teams were set up in 1995. They are local teams (which include Police, Probation, Education, Local treatment providers, Social services) to deliver the Governments drug strategy on a local basis.

Detox – or Detoxification describes the way in which drugs such as opiates (heroin or methadone) are eliminated from the body. This will be done with the help of a doctor and / or a specialist drug worker.

E

Ecstasy – has both stimulant and hallucinogenic properties. The tablets are usually swallowed although some people do smoke or snort them. The effects take about half an hour to kick in and tend to last between 3 to 6 hours, followed by a gradual comedown. Most commonly viewed as a clubbers drug.

Source Frank

F

Fungi – this large genus includes some hallucinatory mushrooms, magic mushrooms & fly agaric.

Frank - a free confidential drugs information and advice help line for young people (24 hours a day)

Forensic services – Forensic psychiatric services specialise in the treatment and assessment of people with mental health disorders undergoing legal or court proceedings or who have offended.

G

GHB – is a central nervous system depressant and a class C drug under the Misuse of Drugs Act. .

H

Heroin - Heroin is a very strong painkiller, it is a natural opiate made from morphine, which comes from the opium poppy.

Hallucinogen – drugs which alter your perception, the way you see, hear, or feel

HIV - Human Immunodeficiency Virus, people with HIV have HIV infection, some of these people will develop AIDS as a result of their HIV infection.

I

INCB – The International Narcotics Control Board is the independent control organ that monitors the implementation of the United Nations drug control conventions (see below)

J

Juniper berry used as a flavouring in gin

Jellies – slang for Tranquillisers, manmade drugs produced to treat anxiety, depression and insomnia.

K

Ketamine – a class C drug under the misuse of drugs act.

Kief (hashish)

L

Laudanum – a (19th c) tincture of alcohol and opium (opium dissolved in alcohol)

LSD – a hallucinogen and a class A drug under the Misuse of Drugs Act.

M

Methadone - Methadone is a synthetic opioid, it is used medically in the treatment of heroin addiction.

Methamphetamine - Methylamphetamine (commonly referred to as methamphetamine) is one of a group of a psychostimulant drugs called amphetamines that act on the brain and nervous system.

MDMA – also known as ecstasy, a class A drug.

Misuse – for the purposes of this course, this refers to illegal or illicit drug taking or alcohol consumption that leads a person to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption and or dependence. Drug misuse is therefore drug taking that causes harm to the individual, their significant others or the wider community. By definition, those requiring drug treatment are drug misusers.

MODA / Misuse of Drugs Act 1971 – the act prohibits certain activities in relation to 'controlled drugs'. In particular the MODA is concerned with manufacture, supply and possession.

MOC - Models of care 2002 and updated 2005, sets out national frameworks for the commissioning of adult substance misuse treatment that are expected to be available in every part of England to meet the needs of diverse local communities.

Motivational Interviewing - Motivational interviewing is a directive, client-centered counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence.

N

Narcotic – a drug that affects the mind

Naltrexone - Naltrexone blocks the effects of heroin and other opioids.

Nicotine - is a stimulant drug, which increases the pulse rate and blood pressure.

NTA – Created in 2001 the National treatment Agency is a special health Authority which aims to increase the availability, capacity and effectiveness of treatment for drug misuse in England.

NSF - National service frameworks (NSFs) are long-term strategies for improving specific areas of care (see MOC)

NAHRSE – the National Alcohol Harm Reduction Strategy for England.

O

Opium – a drug produced from the opium poppy.

Opiate – drugs derived from opium, for example morphine and codeine

Opioid – An opioid is any agent that binds to opioid receptors, for example heroin, methadone, morphine and codeine.

OTC -Over the counter

P

Polydrug - Polydrug use is the use of more than one substance, it is a common pattern among alcohol and drug users.

Psychoactive or psychotropic drugs – act on the central nervous system where they alter brain functions, which result in temporary changes in perception, mood, consciousness and behaviour.

Physically / psychologically dependant - Physical dependency means that your body has become so used to a drug that you get physical withdrawal symptoms if you stop taking it. Psychological dependency means that you take the drug because it has formed a large part of your life, and you take it to make yourself feel good. You may feel that you cannot stop taking the drug, even though you are not physically dependant. Some drugs can make you both physically and psychologically dependent. Source NHS Direct.

Q

Qat (Khat) A plant that contains the stimulant ephedrine.

R

Ritalin - is a central nervous system (CNS) stimulant. It has effects similar to, but more potent than, caffeine and less potent than amphetamines

Rehab/rehabilitation – any service, residential or community based, that aims primarily to help people stay alcohol and drug free. (Source Exchange The Rehab Handbook)

S

Stimulant - drugs that act on the central nervous system and increase brain activity.

Speed (slang for Amphetamine sulphate) is a central nervous system (CNS) stimulant.

Subutex - is a long-acting opiate that you take as a pill that dissolves under the tongue.

Structured day care – ‘Structured Day Programmes provide intensive community-based support, treatment and rehabilitation. They should offer clear programmes of defined activities for a fixed period of time with specified attendance criteria - usually four to five days a week.’ (Source: NTA: Models of care for the treatment of drug misusers)

T

THC - Tetrahydrocannabinol is the main psychoactive (see above) substance found in the Cannabis plant.

Tackling Drugs Strategy – the Governments 10 year drug strategy that focuses on four specific areas of activity. Young People, Communities, Treatment and Availability.

Tolerance - describes the need to consume more of a substance to achieve the same effect produced originally by smaller amounts.

U

UN International Drug Conventions – The earliest being in 1912, the three major current international drug control treaties (1961, 1971 & 1988) are mutually supportive and complementary. The first two treaties aim to ensure the availability of narcotic drugs and psychotropic substances is for medical and scientific purposes only, and to prevent their diversion into illicit channels. The last convention is concerned with trafficking, including provisions against money laundering and the diversion of precursor chemicals.

V

Valium (Vallies) - a type of tranquilliser

Veronal (a barbiturate)

W

Wine – is produced by the fermentation of fruit, typically grapes. Most wines have an ABV or alcohol by volume of between 10 –13%.

X

X see ecstasy or MDMA

Y

Yage or Ayahuasca - native Amazonian names for the jungle vine Banisteriopsis Caapi. It contains dimethyltryptamine (DMT) a hallucinogenic drug.

Exercise 2 : Now that you have read the A-Z of terms, print out the sheet below and ask yourself the following six questions; try to do this without looking back at the answers, when you have finished go to the next page to reveal the answers.

Question number	Question	Your Answer
1	What do the Advisory Committee on the Misuse of Drugs (ACMD) do?	
2	What are Psychoactive or psychotropic drugs?	
3	What is the 1988 UN Drug Convention principally concerned with?	
4	What is the role of the DAAT (or DAT) ?	
5	What is the key piece of UK legislation in relation to controlled drugs?	
6.	What is the aim of the NTA?	

Drugs and Alcohol

Classifications

As we have seen in the earlier exercise, the Misuse of Drugs Act prohibits certain activities in relation to “controlled drugs”, in particular their manufacture, supply and possession. The penalties applicable to offences involving the different drugs are graded broadly according to the harmfulness attributable to a drug when it is misused.

The drugs are classified in three categories; Class A, B or C substances. For example heroin is a class A drug and cannabis is a class C drug, shortly to become class B again.

Exercise: Shortly you will be asked to complete a task, this will ask you to consider legal drugs like alcohol and tobacco as well as illegal drugs. You will be asked to rank the top five from the list (see below)

When doing this you should consider each drugs addictive qualities, social harm and physical damage, once you have done you will be asked to rank the substances, where number one is the most harmful.

This exercise is simply for you to reflect on the information you have been given, and draw some conclusions. **Here is some more information to help you with your task.**

Heroin – A powerful depressant drug, physical dependence, and tolerance are associated with this drug. Withdrawal symptoms follow when use is stopped. Health problems usually result from adulterants, injecting, poor diet and a loss of appetite for food.

Alcohol: A legal drug, long term, heavy drinking can be very damaging to the body. Physical dependence and tolerance develop so people drink more and suffer withdrawal symptoms when they stop drinking.

Cocaine: A powerful stimulant drug, psychological dependence is associated with cocaine use. There are known associated mental health problems (including depression and paranoia) linked to heavy use of this drug.

Methadone: Users of Methadone mixture will develop physical dependence and will experience withdrawals if they stop using it. Tolerance to methadone builds slowly. Methadone even if taken for many years causes no direct physical damage. Source - The methadone handbook

LSD: A hallucinogenic drug, there is no evidence of LSD use leading to physical dependence or fatal overdose. Some LSD users experience what is known as ‘flashbacks’ where a ‘drug induced trip’ is re-experienced some time afterwards.

Ecstasy: A stimulant drug with hallucinogenic effects, psychological dependence on the feelings of use can develop. Longer-term health effects are still unknown. Deaths associated with use are usually associated with overheating.

Tobacco: The main active ingredient is nicotine, a stimulant drug, tolerance develops quickly and regular, long-term smoking greatly increases the risk of a number of serious diseases. Smokers experience withdrawal symptoms when they stop.

Barbiturates: Rarely prescribed nowadays, these drugs slow down the central nervous system. Tolerance and physical dependence develop with regular use. Users suffer withdrawal symptoms when they stop. There is a high risk of overdose when using this drug as a lethal dose level is very close to a normal dose level.

Whilst these figures do not take into account the scale of use, they clearly indicate the health problems associated with the use of legal substances like alcohol and tobacco.

Table 1 Drug-related deaths in England and Wales 2000 to 2004

Cocaine	575
Amphetamine	384
Ecstasy	227
Solvents	246
Opiates (heroin, morphine & methadone)	4,976
<i>Alcohol</i>	25,000 - 200,000 approx.
<i>Tobacco</i>	Half a million approx (UK)

Drugscope <http://www.drugscope.org.uk/resources/faqs/faqpages/how-many-people-die-from-drugs.htm>
accessed 07/05/08

Exercise 3: Now that you have consider all the information have a go at the exercise, print out the sheet and fill in your answers.

Ranking	Drug
1	
2	
3	
4	
5	

Drug effects

The legal classification of drugs, Misuse of Drugs Act 1971, is one way in which drugs are classed, another is by the effects they have. This is why we have the terms depressant, stimulant and hallucinogen. In the exercise below there is a list of commonly used drugs.

Exercise 4: Please print out and complete the following exercise.

In the column beside the drug please indicate the group that you think the drug fits into.

There are a few that fit in more than one category if you think they fit into more than one category tick the boxes that you believe to be right.

Drug	Effect	Your answer
Heroin	Depressant	
	Stimulant	
	Hallucinogen	
Cocaine	Depressant	
	Stimulant	
	Hallucinogen	
Alcohol	Depressant	
	Stimulant	
	Hallucinogen	
Cannabis	Depressant	
	Stimulant	
	Hallucinogen	
Ecstasy	Depressant	
	Stimulant	
	Hallucinogen	
Amphetamine	Depressant	
	Stimulant	
	Hallucinogen	
Solvents	Depressant	
	Stimulant	
	Hallucinogen	
Benzodiazepines	Depressant	
	Stimulant	
	Hallucinogen	

Signs, symptoms and frequently used terms

Introduction:

A question that is frequently asked is, what are the signs and symptoms of someone that has taken an illegal drug?

The lists that are offered will usually include mood swings, a change in appearance, tiredness to name a few. There is a danger in having lists like these and that is that other things, unrelated to drug use may cause these behaviours or appearances. The best advice is, if you are worried and think someone is acting outside their usual behaviour then talk to them to find out more.

When working with drug using clients workers must seek information on current practice that might lead to danger, and harm, in the next few paragraphs we will look at some of the key things to look for.

Mixing drugs:

Mixing drugs raises the risks as there is no way to accurately predict how a combination of drugs, including alcohol and prescription and or over the counter (OTC) medicines, will affect any individual. These complex interactions will involve considerations of what is in the system already, the purity of the drug taken, the dose of the drug taken, and any existing medical condition. In light of the risks, mixing drugs should be avoided; here are some of the most dangerous combinations.

1. **Alcohol and cocaine** used together is dangerous, when the two are taken together; they form a compound called Cocaethylene, which is associated with an increased risk of liver damage and premature death.

2. **Cocaine and heroin:** Injecting a mixture of **cocaine and heroin**, known as a 'Speedball' is one of the most dangerous mixtures and it can be potentially deadly. Here the stimulant drug cocaine raises the heartbeat, as these effects wear off, the heroin will in turn slow the heart. This can result in severe respiratory depression, as one drug wears off and the full effects of the other are experienced in isolation.

3. **Heroin/alcohol/benzodiazepines:** Heroin is a depressant drug, which slows the activity of the central nervous system (CNS) when heroin is mixed with alcohol or benzodiazepines the depressant effects are magnified, especially breathing and respiration, as is the risk of an overdose.

Possible indicators of danger and harm can include mode of usage, for example injecting. Injecting drugs is always risky, drug using injectors should never share, lend or borrow injecting equipment, if you would like to find out more go to the Exchange Supplies website www.exchangesupplies.org and follow the links for the 'guide to safer injecting'

The Safer Injecting Handbook is a user's guide to reducing harm related to injecting. The handbook covers everything from vein collapse to hepatitis C, to cleaning injecting equipment and deep vein thrombosis.

The five rules for safer injecting are;

Injecting drugs is always risky / never share, lend or borrow injecting equipment, this includes, needles / Syringes / Spoons or other cookers / Mixing equipment /Filters /Water / Ascorbic or citric acid

Use the smallest needle possible to inject

Use the smallest amount of water possible

Don't inject on your own

Dispose of your used equipment carefully. HIT [no date] A guide to safer injecting. Liverpool:HIT

Injecting tablets: Drugs that are injected usually tend to be heroin, amphetamines, cocaine or sedative and tranquilliser tablets. There are special risks around injecting tablets. If you hear that people are injecting tablets advise them of the risks, these include vein damage resulting from build up of un dissolved tablets. Chalk from tablets is a major cause of collapsed veins, leading to infection, deep vein thrombosis and potential loss of limbs. You may suggest that if clients still wish to take them, they swallow them with a hot drink instead of injecting them. Taking tablets in this way will slow down the time taken for the drugs to act but the effect will be similar. The same advice is true for Temazepam, which is a dangerous drug to inject.

Exercise 5: Please print out and complete the following exercise.

Question	Your Answer
Q1) Drug combinations, what compound is formed when cocaine and alcohol are taken together?	
Q2) Why are injecting tablets so potentially dangerous?	
Q3) Why is injecting street drugs dangerous?	
Q4) Why is alcohol and heroin such a dangerous combination?	

REFLECTION

Having reached this point it is a good time to look back and reflect on your learning so far; below you will find a reflective learning form. Please take a minute to fill it in, you may wish to print it out place it in your portfolio.

Reflective Learning Log.

1. Norfolk DAAT Web based learning course
Name:
Date:
2. a) What have you learnt so far? b) What strengths do you already have in relation to the learning? c) What have been the most useful/important pieces of learning for you? d) What insights have you gained from this activity?
3. How will you apply the learning to your work?
Signed:
Date:

Frequently used terms:

There are a great many terms used to describe a range of drug taking or drinking behaviours, you will come onto the terms used to describe **drug taking behaviours** later on, but here are some frequently used **alcohol terms**.

Hazardous drinking (World Health Organisation)

Drinking more than recognised sensible levels but not experiencing harm

> 5 units/day for men;

>3 units/day for women

Harmful drinking (WHO)

Drinking more than recognised sensible levels and experiencing harm

Alcohol dependence (WHO)

Drinking more than recognised sensible levels and experiencing harm and symptoms of dependence

Binge drinking

“ a man who regularly drinks 10 or more units in a single session, or a woman ... 7 or more units...”

(Royal College of Physicians)

8 or more units on a single occasion for men,

or 6 or more for women (National Alcohol Harm Reduction Strategy for England)

Alcohol misuse

Taken to include binge drinking,

“Heavy drinking” (50+ units/week in men; 36+ in women)

Abuse and misuse: there is a lack of consensus about the definition of terms used to describe alcohol consumption behaviours. Misuse appears to describe excessive use rather than inappropriate use linked to time of day or setting (abuse)

5. National / local drug and alcohol trends.

Agencies working in the substance misuse sector use data to try to build up a picture of what is happening on a local and national level. Data is collected to find out which drugs are being used, how and in what circumstances; whether there are any groups, which are more or less at risk than others; and how far need is being met.

The sensitive and sometimes illegal nature of substance misuse complicates this picture. There is no one data source, which tells us everything we need to know. National research such as the University of Manchester's Drug Treatment Outcomes Research Study contribute greatly, as do items of regularly collected data such as hospital admissions relating to drug overdoses, numbers entering treatment, and people convicted of drug offences. However while these can be useful, they only cover relatively small sub-groups of the overall substance using population. The best picture can usually be built by combining sources of data, and by always bearing in mind their limitations

2007 / 8: The following is a breakdown of the main drug that the adult (over 18) clients presented to Norfolk treatment agencies in 2007 - 2008 with. It's important to note that these figures relate to drug users in treatment and not the general drug using population, for whom we would expect to see a different picture.

Heroin	65%
Methadone	8%
Other opiate	4%
Benzodiazepines	1%
Amphetamine	3%
Cocaine	4%
Crack	3%
Ecstasy	1%
Cannabis	8%
Other drug	1%
Prescription drugs	2%

Drugs and crime.

There are strong links between drugs and crime as these Home Office statistics, focusing mainly on class A drug use, illustrate. That said it has to be stated that the vast majority of illegal drug users do not commit criminal offences, beyond their drug usage.

- 1) Three quarters of crack & heroin users claim to be committing crime to feed their habit.
- 2) 75% of persistent offenders have misused drugs and
- 3) Arrestees who use heroin and or cocaine commit almost 10 times as many offences as arrestees who do not use drugs.
- 4) Between a third and a half of acquisitive crime is estimated to be drug related.

1.2.3 2002 Updated National Drug Strategy - Home Office.

4. 2008 National Drug Strategy – Home Office.

Treatment.

Treatment works and is cost-effective, treatment targets for DAAT areas have been set to increase the participation of problem drug users in drug treatment programmes and to increase year on year the proportion of users successfully sustaining or completing treatment programmes.

- for every £1 spent on treatment, at least £9:50 is saved in crime and health costs. Treatment breaks the links between drug misuse and crime. Source: Home Office.
- Norfolk DAAT area had 2674 clients in treatment during 2006/07
- Norfolk DAAT area has a 77% retention in treatment against a national target of 75% National Drug Treatment Monitoring System 1st drug of choice

The National Drug Treatment Monitoring System (NDTMS) relates to the process of collecting, collating and analysing information from and for those involved in the drug treatment sector.

Harm Reduction / Minimisation

This philosophy recognises that many people are not at this time able to stop using drugs, it therefore focuses on harm reduction strategies, such as the issuing of clean needles and the prescribing of methadone. As the Fraser report* states, *this is not to condone drug taking but simply to acknowledge that it takes place, and therefore the pragmatic response is to provide information and advice about minimising risks.*

***Drugs in Scotland: Meeting the challenge, report of Ministerial Drugs Task Force, Scottish Home Office & Health Department, October 1994.**

This strategy is a public health approach to dealing with drug related issues that aims to reduce drug-related harm while also promoting abstinence, linked to this are targets to reduce the number of drug-related deaths.

The European Monitoring Centre for Drugs and Drug Addiction or EMCDDA defines drug-related death, as ***specifically those deaths that are caused directly by the consumption of drugs of abuse.***

The number of drug related deaths in Norfolk (both male and female) between 1996 and 2003 were;

1996 – 19 people
1997 – 27 people
1998 – 24 people
1999 – 32 people
2000 – 24 people
2001 – 26 people
2002 – 23 people
2003 – 16 people.

These figures relate to the number of deaths where the death certificate records a death which is 'caused directly by the consumption of drugs of abuse. These deaths occur generally shortly after the consumption of the substance(s)'

It should be noted that this definition systematically excludes many types of death, which could be thought of as drug related, for example: infections caused by the injecting of drugs of misuse; respiratory problems caused by the smoking of crack cocaine; accidents caused by intoxication. There may also be drug related deaths where it is not apparent to the person writing the death certificate that drugs are involved, in these cases the deaths will not be entered into the official drug related death statistics.

Alcohol: Data and trends

The Alcohol Harm Reduction Strategy for England begins by saying “ millions of us enjoy drinking alcohol with few, if any, ill effects. Indeed moderate drinking can bring some health benefits. But, increasingly, alcohol misuse by a small minority is causing two major, and largely distinct, problems: on the one hand crime and antisocial behaviour in town and city centres, and on the other harm to health as a result of binge drinking.”

Splitting those two problem areas, listed below are a few national statistics that illustrate the scale of the problem:

Crime and anti social behaviour.

- In nearly half (48%) of all violent incidents, victims believed offenders to be under the influence of alcohol.
- This figure rose to 60% in cases of 'stranger violence'.
- The offender was least likely to be perceived to be under the influence of alcohol in the case of muggings (17%).

Source: British Crime Survey 2004/05.

- There were around 1.2 million incidents of alcohol-related violence in 1999 (defined as assaults, robbery and snatch thefts in which the victim considered the perpetrator to be 'under the influence' of alcohol).

- A quarter of those were domestic assaults between partners, relatives or household members.
Source: British Crime Survey 2000

Harm to Health

- Alcoholic liver disease. The numbers admitted to hospital in England with alcoholic liver disease has more than doubled in 13 years. Between 1989 and 2003 admissions increased by 116% in men and 108% in women. London's St George's Hospital & the Office for National Statistics 2005
- In 2005 - 4,160 people in England and Wales died from alcoholic liver disease. Safe, Sensible and Social. Next steps in the National Alcohol Harm Reduction Strategy England 2007
- 27% of men and 14% of women drink more than 21 and 14 units of alcohol per week (the recommended safe sensible guidelines) 100% proof Alcohol Concern
- 2001 Alcohol deaths - The deaths of almost 6,000 people, 3,800 men and 2170 women, were directly attributable to alcohol. Four times the number of deaths directly related to drugs. Alcohol Concern 2003

The picture in Norfolk

The national picture
2003, there are between
200,000 and 300,000
children of drug users in
England and Wales.

The national picture
327,000 problematic
drug users in England.
UK Drug Policy
Commission.

3,718 children have
parents with a drug
Problem *1*

8,200 people are
estimated to be problem
drug users

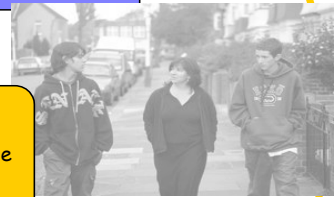


7,360 people aged
16-24 have used a
class A drug in the
last year.*2*

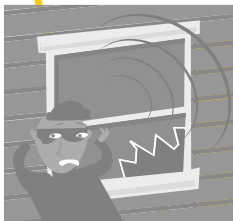


284 drug related
and **2720** alcohol
related anti social
behaviour incidents
are reported in a
year

271 people
in a year are
charged
with posse s-
sion of class
A drugs




There are
33,943
crimes of
burglary,
robbery or
theft in a
year




29 People will die of a
drug related death -
*Based on 2001 ONS
statistics*



KEY

 = data extrapolated
from national figures

 = data from local
sources

The national picture
1,506 people died in
England (2005)

Exercise 6: Please print out and complete the following recap exercise.

Question	Your answer
Q1) What does EMCDDA stand for?	
Q2) Alcohol question - the numbers of people admitted to hospital in England with alcoholic liver disease in the last 13 yrs has?	
Quadrupled	
Trebled	
Doubled	
Stayed the same	
Q3) What percentage of crack and heroin users claims to be committing crime to feed their habit?	
25%	
50%	
75%	
100%	
Q4) What is the estimated figure of problem drug users in Norfolk?	
5000- 6000	
6000 - 7000	
7000 - 8000	
8000 - 9000	
Q5) What is the estimated figure of numbers of children in Norfolk that have parents with a drug problem?	
1000-2000	
3000-4000	
5000-6000	
7000-8000	

Problematic, recreational and experimental drug use.

Understanding drug use:

Just as in the alcohol field, where there are a number of terms used to describe levels of alcohol use, moderate, harmful, hazardous, the drug field also uses a number of terms to describe patterns of use, for example recreational, experimental and problematic drug use.

These terms can be useful in understanding different drug using patterns and the associated risks.

Drug abuse – this term has largely been replaced by the term Drug Misuse that is understood to mean the use of illegal drugs and the misuse either deliberate or unintentional of prescribed drugs and substances such as solvents.

Experimental, Recreational, Dependant and Problematic.

Any drug use whether a drug is used once as an experiment, or used occasionally at a specific time in a specific way, clubbing at the weekend for example, carries risks.

The four terms you will come across are Experimental, Recreational, Problem and Dependant use.

These terms embrace the full range of drug taking behaviours from experimental sometimes called novice use, through to recreational or regular use, problematic use to dependant use, where securing adequate supplies of the drug have become the main focus of the individual.

Experimental use

Experimental use, is often short-term and often a group activity. As the term implies, the use tends to be exploratory in nature, with the individual 'trying' a particular substance. This may be a single experience or may be repeated. Availability and current fashion are factors that will feed into the experimental use.

At this stage, lack of knowledge about the effects of the drug being taken carries a specific risk.

Recreational use

Recreational use refers to the use of drugs where enjoyment is a key factor. Here the recreational or casual user will be taking drugs to have fun, to enhance their experience, the drug is being used as a way of achieving this. Enhanced social interaction is the aim. Use is regular and the user feels their use is controlled rather than dependant, with them deciding where, when and how the drug is used.

Problem drug use

Any person who experiences or causes social, psychological, physical or legal problems relating to their self-administration of a drug, including any form of drug use that involves injecting.

From the DAAT Commissioned UEA Crack Cocaine Needs Assessment (2003):

Dependent use

Dependent use, as the term implies is where the users are physically or psychologically dependant on their drug use. Where the user has lost control of their drug use. Obtaining the drug has become more important to the user than either the purity of the drug or the quality of the experience. This is more likely to be as a result of long-term activity, and here the drug use will often be accompanied by emotional, psychological and social problems. It is important to stress that problem users are a small part of the overall drug using population.

Physical and psychological dependence

Drugscope give the following definitions for physical and psychological dependence.

Physical dependence, when someone has taken drugs in quantity for a time and comes to rely on the use of them in order to feel well and for their body to function 'normally'. It usually happens when the body has built up a **tolerance** to the drug and in its absence, physical withdrawal symptoms appear.

Psychological dependence is when the user experiences an overwhelming desire to continue with the drug experience. This can be because of the pleasurable effects and the desire to keep experiencing them. It can, however, also represent some sort of psychological crutch. The drug experience can become a way of blocking out reality, making life bearable, and a way of facing the world. Without the crutch life seems worthless. It can happen with any drug or any activity, which takes over a person's life including eating, sex, work, or jogging.

www.drugscope.org.uk

Problem use

As we have seen already, problems can accompany a number of these patterns of use, it is not necessarily the frequency of the use, which is the main issue or problem, but the effects that the drug taking has on the life of the user and or those about them.

Exercise 7: Please print out and complete the following exercise.

Please read the following short case studies and select the pattern of use that you believe best describes the way drugs are being used.

Tom: Tom meets up with his friends after school. They often gather under the old bridge by the river. Here they will usually share cigarettes, someone always has a pack, and drink the odd bottle of cider or can of lager if they can get an older brother to buy it for them.

Tom’s friend has suggested they try inhaling solvents, he has seen friends after they inhale and they are ‘a real laugh’ he has often wondered what it would be like to try it. Tonight he is going to find out for himself.

Please tick the box you think best describes Tom’s pattern of use.

Experimental	
Recreational	
Dependant	

Yasmin: Yasmin is planning her night out with her friends; she’s been waiting all week for this. A few drinks at Glenn’s house first to loosen up, a couple of joints to loose the stress of a hard week at work and they will all be ready for the City. They will be out for hours yet and after the vodka shots she may need something to boost the energy level a little, that’s ok Jon always has something on him. She is determined to enjoy this evening; it will be another week before she and her friends can do it again.

Please tick the box you think best describes Yasmin’s pattern of use.

Experimental	
Recreational	
Dependant	

Rob: Rob is a sales rep; he has a company car and a large sales area. Rob also buys over the counter cough medicine, it contains opiates and by drinking it he can feel ready for the daily challenge. Targets are tough and he needs to meet them. He has been doing this for a couple of years now and doesn’t like doing cough medicine, but the way he sees it at least he isn’t one of those drug users he sees in the city. To get the hit he needs to buy a number of bottles and buying them all from one source, would risk arousing suspicion. The result is that he needs to spend some time and cover a number of miles each day visiting different chemists in order to secure his daily supply.

Please tick the box you think best describes Rob’s pattern OTC drug use.

Experimental	
Recreational	
Dependant	

Exercise 8: Please print out and complete the following reflective exercise.

Can you identify what / if any problems may be experienced by Tom, Yasmin and Rob?

Tom	
Yasmin	
Rob	

Drug, Set and Setting

Drug, set and setting are terms used to describe the context for drug experiences. Andrew Tyler, author of *Street Drugs* argues that the impact of a drug is not fixed, it depends on dose, expectations, the mental and physical condition of the user and the setting in which it is taken. Tyler A (1986) '*Street Drugs*' London Coronet

Drug: The first thing to be considered is the drug itself, the purity of the drug and the strength of the drug. Next there is the dosage taken, the frequency of previous use, which may lead to tolerance, which may lead an individual to higher dosage in order to achieve the same effect. If the individual takes a break from using and then resumes this could lead to overdose, as the tolerance may have been reduced in between times.

In addition there may be risks associated with the procurement, the buying of the drug, the preparation of the drug for use and the method of use, injecting for example or combining several drugs, or as seen earlier multiple depressants or stimulants and depressants in combination.

Set: The mindset the person brings to the drug experience, their moods or previous experience, their knowledge of drug effects, their expectations. All these may affect how the person feels and whether the experience is viewed positively or negatively.

Setting: The environment, both physically and socially. Where the drug is taken, who with, if alone and injecting drugs, there will be no one to assist if you overdose.

Drug levels of risk: As you will have seen from the explanations above, drug risk can be seen as the result of complex interactions between the drug, the set and the setting.

Exercise 9: Please print out and complete the following exercise.

Substance misuse workers will always try to work with their clients in order to minimise dangerous, or harmful behaviour and practices, from a harm reduction perspective, abstinence is the ideal goal. However sometimes that goal is unrealistic and that makes harm reduction even more urgent.

Reflecting back on the information you have read so far, take a few minutes to write down your answers to the following questions. Once you have finished you will find the answers on the following page. Think how harm can be reduced in the following scenario?

Jon:

Q1) It is Friday, Jon is due out of prison today. He has been serving two years and before he went to prison he was injecting six times per day. You are the prison drugs worker, he has an appointment with a local drug service on Monday, but you are concerned that Jon may lapse over the weekend.

What key piece(s) of information would you give Jon before he leaves prison?

Q2) Jon is going back to his hometown and you are worried that he might be mixing with his old drug using friends. From previous work with Jon you are familiar with his drug preparation practices. There are five rules for safer injecting what are they?

The five rules for safer injecting are;
1
2
3
4
5

Q3) Knowing he has an appointment on Monday, Jon has asked you about substitute prescribing options, what can you tell him about the following?

Methadone.
Naltrexone.
Subutex.

These next two sections look at the way drugs are classified, by their effects and by their legal status.

8. Classification of drugs.

As we have seen already, all drugs can be loosely fitted into three main categories: -

- 1. Stimulants:** - drugs that act on the central nervous system and increase brain activity.
 - 2. Depressants:** - drugs that act on the central nervous system and slow down brain activity.
 - 3. Hallucinogens:** - drugs that act on the mind, distorting the way users see and hear things.
- Sometimes a fourth category, deliriant, is added to cover the effects of glue and aerosol use. The effect of solvents is of a depressant nature; but most other depressants are long lasting in their impact on the body, which is different to the sudden and short lived effects that solvents have, which is very different.

9. Drugs and the law

The Misuse of Drugs Act 1971 is the legal instrument by which the government prosecutes individuals for possession, supply or manufacture of controlled substances. The MODA is split in the ABC classification system.

The Commons Select Committee on Science and Technology Fifth Report explains the background to the ABC system and how the act came about:

The ABC classification system "was designed to make it possible to control particular drugs according to their comparative harmfulness either to individuals or to society at large when they were misused". The ABC system has its origins in the Misuse of Drugs Act (MDA) 1971, which introduced the concept of 'controlled drugs' and (as amended) constitutes the main piece of legislation regulating the availability and use of these drugs. The purpose of the Act was to provide a coherent framework for drug regulation, which, until then, had been covered by the Drugs (Regulation of Misuse) Act 1964 and the Dangerous Drugs Acts of 1965 and 1967.

The United Nations' Single Convention on Narcotic Drugs 1961 and its attempts to establish a Convention on Psychotropic Substances (eventually ratified in 1971) formed an important backdrop to the UK's efforts to rationalise its legislation in this area. James Callaghan, the then Home Secretary, told Parliament in 1970 that in developing the ABC classification system the Government had used the UN Single Convention and guidance provided by the World Health Organisation to place drugs "in the order in which we think they should be classified of harmfulness and danger". Even at that early stage, the Government said that drugs would be classified "according to the accepted dangers and harmfulness in light of current knowledge", with provision "for changes to be made in [...] the light of scientific knowledge".

The Misuse of Drugs Act did not specify why particular drugs were placed in Class A, B or C but did create an Advisory Council on the Misuse of Drugs (ACMD) to keep the classification of drugs under review.

The Select Committee on Science and Technology Fifth Report (2006) [online] Available from <http://www.publications.parliament.uk/pa/cm200506/cmselect/cmsctech/1031/103105.htm> [Accessed 09/10/06]

Examples of Class A,B & C drugs.

The following list from Drugscope gives an example of current class A, B and C drugs:

Class A: These include cocaine and crack (a form of cocaine), ecstasy, heroin, LSD, methadone, magic mushrooms and any Class B drug which is injected.

Class B: These include amphetamine, barbiturates, and codeine.

Class C: These include mild amphetamines, anabolic steroids and minor tranquillisers and **cannabis (in resin, oil or herbal form)** Cannabis is shortly to be reclassified as a Class B drug.

Note:

Barbiturates – once prescribed for anxiety, depression and insomnia they are rarely seen these days.

Minor tranquillisers – benzodiazepines replaced barbiturates, they are better known by their brand names such as Librium, Temazepam and Diazepam.

www.drugscope.org.uk

10. The Scale of Effect Exercise (Recap)

As we have seen already, all drugs can be loosely fitted into three main categories

Stimulants.

Depressants.

Hallucinogens.

Within those categories some drugs will be stronger than others. There are also some drugs that cross those neat definitions by straddling more than one category.

Exercise: From the list below place the 15 drugs in the appropriate column and in order of strength, with strongest to the top, those that have more than one type of effect may fit in between or even across all columns.

1. LSD
2. Cannabis
3. Magic Mushrooms
4. Methadone
5. Caffeine
6. Ecstasy
7. Amphetamines
8. Cocaine
9. Crack
10. Ketamine
11. Tobacco
12. Solvents
13. Heroin
14. Alcohol
15. Benzodiazepines

Exercise 10: Please print out and complete the following exercise.

- LSD
- Cannabis
- Magic Mushrooms
- Methadone
- Caffeine
- Ecstasy
- Amphetamines
- Cocaine
- Crack
- Ketamine
- Tobacco
- Solvents
- Heroin
- Alcohol
- Benzodiazepines

	DEPRESSANT		HALLUCINOGEN		STIMULANT
STRONGEST 					

Exercise based on work by Kevin Flemen and reproduced by permission.

11. The role of the DAAT

In 1995 the first National Drug Strategy 'tackling drugs together' was launched by the Conservative Government. The strategy focused on crime, young people and public health. The strategy recognised the need for increased collaboration between a wide range of services involved with drug misusers. It was as a result of this strategy that DAT's or drug action teams came into being.

There are currently 149 DAAT's in England covering the whole country and they are tasked with coordinating the implementation of Government Drug strategy. To do this, the DAAT bring together representatives of local agencies, Police, Health, Probation, Social Services, Education, the Prison Service, as well as local Treatment Providers, the DAT partnership. The DAAT submit annual Adult and Young Peoples treatment plans.

In 1998 a 10 year strategy 'tackling drugs to build a better Britain' was launched, it was this strategy that established the four specific areas of activity mentioned above. Young People, Communities, Availability and Treatment. Each of these four areas had a programme of action and performance targets.

Standing alongside the National Drug Strategy is the National Alcohol Harm Reduction Strategy for England this was launched in 2004, at that point those DAT's that hadn't already incorporated alcohol within their remit, were encouraged to do so and expand the acronym to reflect their larger role. Like the National Drugs strategy the Alcohol strategy has four main themes.

1. Education and communication
2. Improving health and treatment
3. Crime and disorder and
4. Supply and Industry responsibility.

The 2004 Alcohol strategy can be downloaded or viewed on the www.strategy.gov.uk website.

Drug strategy: In 2002, and mid way through 'tackling drugs to build a better Britain', an updated version of the strategy, now simply called 'Tackling drugs', was launched. This put a stronger emphasis on the most dangerous drugs, the most damaged communities and on the individuals whose addiction is considered most harmful to both themselves and others within the community. There was also a stronger emphasis on education, enforcement, prevention and treatment.

In November 2004 the Government published Tackling Drugs. Changing Lives, which set out progress made in delivering the Drug Strategy and planned action for the period to 2008.

In 2008 the new ten year strategy was launched. The 2008 ten year strategy can be downloaded or viewed on the <http://www.drugs.gov.uk> website.

The 2008 strategy highlights four key strands of work.

- Preventing harm to children, young people and families affected by drug misuse.
- Protecting Communities – through tackling drug supply, drug-related crime and anti social behaviour.
- Delivering new approaches to drug treatment and social reintegration.
- Public information campaigns, communications and community engagement.

Exercise 11: Please print out and complete the following exercise.

Question	Your answer
Q1) Multiple choice, when did DAT's come in being?	
1995	
2004	
2006	
Q2) What does the acronym DAAT stand for?	
Drug and Alcohol Action Team	
Drug and Alcohol Abuse Team	
Drug Action and Abuse Team	
Q3) What was the name of the first drug strategy?	
'Tackling drugs together'	
'Tackling drugs to build a better Britain'	
'Tackling drugs'	
Q4) Having looked at the 2008- 18 National Drug strategy (hyper link above) can you fill in the missing words for the four strands of work within the Drug Strategy?	
Preventing harm to	
Protecting Communities	
Delivering new approaches to	
Public information campaigns	

12. Criminal justice and substance misuse

Action to reduce the supply and availability of illegal drugs is a key part of the National Drug Strategy 'Tackling drugs together'. It is also an obligation under the International Drug Conventions to which Britain is a signatory. The cultivation, production, trafficking and distribution of drugs are one part of the story. Drug related acquisitive crime, or crime committed to fund a drug habit whether it is, theft, burglary, fraud or shoplifting is another. Lastly there are other categories of drug related crime and these would include, drink or drug driving and violent offences while under the influence of drugs. Before going on to look at Drug and Crime statistics it is important to point out that the vast majority of illegal drug users do not commit criminal offences (beyond their drug usage).

Drugs and Crime - Drugscope

Some statistics about Drugs and Crime.

- 250,000 of a total using population of 4 million – more than 6% of the total – are dependent users of heroin, crack/cocaine and other drugs.
- A minority - 100,000 people - finance their use through crime.
- A proportion of this group are responsible for large amounts of acquisitive crime, NOT violent crime.

Alcohol and Crime – Home Office

Before looking at alcohol and crime statistics it is important to point out that there is no direct pharmacological link between alcohol and violent behaviour but it is more likely that alcohol increases aggression by influencing the social and cognitive processes. According to Home Office statistics alcohol is implicated in:

- 40% of violent crime.
- 78% of assaults.
- 88% of criminal damage.

It is important to note that drugs and/or alcohol act as catalysts to crime rather than primary causes of crime, per se. The underlying causes of crime are many and varied and hotly disputed by criminologists. There is general agreement, however, that offending behaviours are usually in place before people begin using drugs and/or alcohol. The Home Office suggested in a recent report (The Road to Ruin) that:

- Average age of onset for truancy – 13.8 years.
- Average age of onset for crime – 14.5 years.
- Average age of onset for drugs (general class B& C drugs) - 16.2 years.
- Average age of onset for drugs (hard class A drugs) – 19.9 years.

Criminal justice interventions “Out of crime, into treatment”

The Drug Interventions Programme is a critical part of the Government's strategy for tackling drugs. It began in 2003 as a three-year programme to develop and integrate measures - known as “interventions” - for helping adult drug-misusing offenders out of crime and into treatment. Source www.drugs.gov.uk

This initiative involves criminal justice, treatment agencies and other services working together to provide a tailored solution for adults who commit crime to fund their drug misuse - particularly those who misuse Class A drugs.

Police Custody

To look at the role that the Police play please go to the website listed below. This will take you to the Home Office Police custody web pages, these will explain, drug testing, conditional cautioning and Prolific and Other Priority Offenders (POPO)

www.drugs.gov.uk/drug-interventions-programme/strategy/police-custody/

Arrest referral

Arrest referral, now part of the pre sentencing arm of the DIP in Norfolk, is one of a series of criminal justice interventions that seeks to identify problem drug-using offenders in the criminal justice system (CJS) and refer them to treatment. For further information on the range of interventions for moving an offender away from drug misuse and into treatment. please go to the website

<http://www.drugs.gov.uk/drug-interventions-programme/strategy/courts-and-probation/>

This will take you to the Home Office Courts and probation web pages, these will explain Restriction on Bail and Custody Orders.

DTTO/DRR

The Drug Rehabilitation Requirement (DRR) has evolved from the Drug Treatment and Testing Order (DTTO) to bring those Orders within the Criminal Justice Act (2003) provisions.

Its aim remains to bring persistent and dependent drug-misusing offenders into a closely supervised multi-agency programme of treatment, in order to effectively break the links between their drug misuse and their offending.

An order can last a minimum of 6 months and up to a maximum of 3 years, within a Community Order with a Supervision Requirement. The treatment requirement included in the order can specify either residential or non-residential treatment, or a combination of the two over specified periods, and has recently added the option of an added requirement to attend the Offender Substance Abuse Programme (OSAP), run by the Probation Service. Source www.nordat.org.uk

Offender Substance Abuse Programme (OSAP) Run by the Probation Service OSAP is a specialised programme designed to raise awareness of the link between substance misuse and offending and to equip offenders with the skills to enable them to reduce or stop substance misuse, thus reducing offending.

Alcohol Treatment Requirements

These are similar to DRRs but focus upon alcohol.

Acceptable Behaviour Contracts and Anti-Social Behaviour Orders.

These can be used to ameliorate the impact of substance misuse upon the community, such as geographic prohibitions on street drinkers, beggars and sex workers.

Conditional Cautioning

These are used by the police for minor alcohol related offences whereby a condition can be imposed that someone attends an alcohol awareness session.

Prison and CARATS

Prison offers a prime opportunity for encouraging drug misusers to engage in treatment and support processes. The Prison Service has in place a framework of treatment and support to address a wide range of drug misuse problems.

The foundations of the prison drug treatment framework are the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) services. These meet the non-clinical needs of the great majority of prisoners, providing low threshold, low intensity drug services. The CARAT team works closely with the DIP team.

Source www.drugs.gov.uk

For further information on prison interventions please go to the website www.drugs.gov.uk and follow the links to the Home Office Drug Intervention Programme pages.

DIP

The Drug Intervention programme (DIP) workers work with clients who have a history of Class A drug use, where that use is closely connected to offending, where the individual has consented to engage with the

programme and is to be released from prison to a local address. Their role begins before release to help them plan for their release. Upon release they will help the client find accommodation, access housing benefit, get a referral to a helping Drug or Alcohol agency, secure a GP and find work.

YOT

The Youth Offending teams (YOTs) are key to the success of the youth justice system. There is a YOT in every local authority in England and Wales. They are made up of representatives from the police, Probation Service, social services, health, education, drugs and alcohol misuse and housing officers. Each YOT is managed by a YOT manager who is responsible for co-ordinating the work of the youth justice services. Because the YOT incorporates representatives from a wide range of services, it can respond to the needs of young offenders in a comprehensive way. The YOT identifies the needs of each young offender by assessing them with a national assessment. It identifies the specific problems that make the young person offend as well as measuring the risk they pose to others. This enables the YOT to identify suitable programmes to address the needs of the young person with the intention of preventing further offending.

For further information on the work of the YOT please go to the website
www.youth-justice-board.gov.uk/ and follow the links to the YouthOffendingTeams.

Exercise 12: Please print out and complete the following exercise.

Why do people commit crime? Before answering this question you may wish to look at the Home Office Crime Reduction website www.crimereduction.gov.uk

The reasons why people commit crime can be grouped under three main headings,

1. Gain or need 2. Society/experience/environment 3. Beliefs

Question	Your answer
Q1) Under the three headings take a minute to fill in as many reasons for why people commit crime as you can.	
Gain or need	
Society/experience/environment	
Beliefs	

Exercise 13: Please print out and complete the following exercise.

Q) Why do people misuse illegal drugs, take a minute to fill in as many factors as you can why people may take drugs.

Question	Your answer
Q1) Why do people misuse illegal drugs, take a minute to fill in as many factors as you can why people may misuse illegal drugs.	

If we were to pose the question about reasons why people misuse alcohol? You will see there are a number of similarities with why people misuse illegal drugs.

- Age
- Gender
- Geography
- Adolescent drinking
- Socio-economic group
- Social exclusion – homeless, prison, dual diagnosis

As before it is important to note that some or all of these factors may be significant to some degree. It is also important to note that many of these factors will interact and through that interaction their significance be amplified.

In Summary

The reasons why people commit crime and the reasons why people misuse drugs and/or alcohol are many and complex. Where a person is misusing drugs and/or alcohol and involved in an offending lifestyle, it is important that there is a holistic response that meets the full range of their needs. Drug and/or alcohol treatment in isolation is unlikely to lead to significant reductions in offending, significant improvements in health, or significant social improvements.

Exercise 14: Please print out and complete the following exercise.

Question	Your Answer
Q1) According to Home Office figures what is the average age for the onset of crime?	
Q2) Again according to Home Office figures what is the average age for the onset for drugs (general)	
Q3) According to Drugscope how many dependant heroin, and crack/cocaine users are there in England and Wales?	
Q4) Alcohol is implicated in what percentage of criminal damage.	
Q5) What does the acronym DIP stand for?	
Q6) What does the acronym PPO stand for?	

13. Treatment – local services

The term treatment covers a range of interventions, which are intended to address an identified drug related problem or condition relating to a person's physical, psychological or social (including legal) well-being.

Structured drug treatment follows assessment and is delivered according to a care plan, with clear goals, which is regularly reviewed with the client. It may comprise a number of concurrent or sequential treatment interventions.

The NTA's models of care, see below, organises the full range of treatment services relevant to drug treatment into four tiers.

Source: Drugscope druglink guide to UK drug policy

Tier 1

Non-substance misuse specific services

eg. Primary Care (family doctors [GPs], pharmacists, dentists and midwives), A&E, Social Services, Probation, Housing and Homelessness, Psychiatric

Tier 2

Open access drug misuse services

eg. Drug related advice and information, open access drop in, motivational interviewing, outreach, needle exchange, low threshold prescribing

Tier 3

Structured community-based specialist drug misuse services

eg Drug specialist care planning and coord, care planned counselling, structured day programmes, community detox, prescribing, DTTOs, structured aftercare, liaison, general healthcare eg BBV vaccinations.

Tier 4a

Residential substance misuse specific services

eg. Inpatient drug detox and stabilisation, residential rehab, specialist drug and alcohol residential units eg mother and baby

Tier 4b

Highly specialist non – SM services

Eg specialist liver disease units, forensic services, psychiatric units, HIV units

Models of care (MOC)

The MOC strategy document sets out a National framework for developing local systems of effective drug misuse treatment in England.

Models of care for the treatment of adult drug misusers has the same status, in terms of local planning and delivery, as a national service framework (NSF).

NSFs are evidence-based strategies setting out national standards of care that patients can expect to receive from the NHS in major care areas or disease groups

MOC aims to provide an *integrated* treatment system for adults (18+)

Gives seamless care pathways over 4 tiers

A client centred approach. (Reflect their individual needs)

http://www.nta.nhs.uk/programme/national/docs/MoCDM_update_2005.pdf

Local services:

For a copy of the Norfolk Drug and Alcohol service directory please go to the NORDAT website, www.nordat.co.uk

14.Care planning

Care planning and care coordination are key elements in an integrated system of treatment for drug and alcohol misusers. The Models of Care 2002 stated that all those who enter structured drug or alcohol treatment services should receive a written care plan, agreed with the client and subject to regular review.

a) What are care plans?

A care plan is a written strategy to provide care services to an individual or family, the care plan is drawn up following an assessment. The aims of care planning and care co-ordination are to:

- develop, manage and review documented care plans
- ensure that drug and alcohol misusers have access to a comprehensive range of services across the four tiers of local drug treatment systems
- ensure the co-ordination of care across all agencies involved with the service user
- ensure that there is continuity of care and that clients are followed throughout their contact with the treatment system
- maximise client retention within the treatment system and minimise the risk of clients losing contact with the treatment and care services
- re-engage clients who have dropped out of the treatment system
- avoid duplication of assessment and interventions
- prevent clients 'falling between services'.

b) The care plan details the essential steps in the care of a drug and alcohol misuser and describes the drug and alcohol misuser's expected treatment and care course.

A care plan is structured, often multidisciplinary, and is task-oriented. The care plan must do the following:

- set the goals of treatment and milestones to be achieved (taking into account the views and treatment goals of the drug and alcohol misuser, and developed with their active participation)
- indicate the interventions planned and which agency and professional is responsible for carrying out the interventions
- make explicit reference to risk management and identify the risk management plan and contingency plans
- identify information sharing (what information will be given to other professionals/ agencies, and under what circumstances)
- identify the engagement plan to be adopted with drug and alcohol misusers who are difficult to engage in the treatment system
- identify the review date (the date of the next review meeting is set and recorded at each meeting)
- reflect the cultural and ethnic background of the drug and alcohol misuser, as well as their gender and sexuality.

c) Care plan reviews:

A care plan should be reviewed and evaluated at regular intervals and at the request of a member of the care team, the service user or their carer. The date of the next review meeting is set and recorded at each meeting. In reviewing the care plan the following is assessed:

- the relevance of the care plan
- the effectiveness of care plans/outcomes
- any unmet needs
- client satisfaction with the care.

Source: NHS NTA Models of Care for the Treatment of Adult Drug Misusers. Oct 2002

Exercise 15: Please print out and complete the following exercise.

Care plan Exercise:

Question	Your answer
Q1) Which document written in 2002 stated that all those who enter structured drug or alcohol treatment services should receive a written care plan?	
Q2) List any two of the aims of care planning and care co-ordination.	
Q3) Why are care plans reviewed?	
Q4) A care plan is structured , often multidisciplinary, and is task-oriented. The care plan must detail the essential steps in a clients treatment can you list any two of those steps?	

If you are a service provider

If you are a service provider and would like to learn more about Care planning the NTA have developed a Care planning [e-learning tool](#) designed for your use. The course is designed to ensure that service providers are up to date with best practice in care planning.

The course covers areas including the client treatment journey, key working, confidentiality and consent, developing a care plan, risk assessment, goal setting and harm reduction.

<http://www.nta.nhs.uk/frameset.asp?u=http://www.nta.nhs.uk/publications/clinical.htm>

15. And finally to finish the course, please answer the following questions:

This exercise enables you to return to your original profile in order to show how your learning has progressed since you began this course.

[Drug and alcohol myths and facts quiz.](#)

No/	Question	Multiple choice	Your answer
1	What age can you legally buy alcohol?	16 years	
		17 years	
		18 years	
2	Is it an offence to be drunk and incapable or drunk and disorderly in a public place or on licensed premises?	Yes	
		No	
		Depends how old you are	
3.	Alcohol travels in the body by:	The urine	
		The bloodstream	
		The nervous system	
4.	How many 'units' of alcohol does a 500 ml can of Super (lager) contain if the ABV is 9% ?	2.5 units	
		3.5 units	
		4.5 units	
5.	What are the safe drinking guidelines for men?	2-3 units, per day with a couple of alcohol free days	
		3-4 units , per day with a couple of alcohol free days	
		5-6 units, per day with a couple of alcohol free days	
6.	What are the safe drinking guidelines for women?	2-3 units, per day with a couple of alcohol free days	
		3-4 units , per day with a couple of alcohol free days	
		5-6 units, per day with a couple of alcohol free days	
7.	How many units of alcohol can the liver process per hour?	One unit	
		Two units	
		Three units	
8.	Drugs like heroin which slow down the central nervous system to suppress neural activity in the brain are called	Hallucinogens	
		Stimulants	
		Depressants	
9.	Drugs like LSD which alter your perception, the way you see, hear, or feel, are called	Hallucinogens	
		Stimulants	
		Depressants	
10	Drugs like cocaine which speed up the central nervous system to increase neural activity in the brain are called	Hallucinogens	
		Stimulants	
		Depressants	

Now compare your score with your first score, has there been any change?

Now that you have finished the course it is good practice to take a few minutes to reflect once again on your learning, please take a minute to fill out the reflective learning log.

1. Norfolk DAAT Web based learning course
Name:
Date:
2. a) What have you learnt?
b) What have been the most useful/important pieces of learning for you?
c) What insights have you gained from this activity?
3. How will you apply the learning to your work?
4. What further learning needs do you still need to consider and how do you plan to do achieve them?
Signed:
Date:

Lastly the course is always under review and the DAAT would like to hear any comments you have about the course if you would like to share those thoughts with us please email

Michael.Hutchinson.dat@norfolk.gov.uk

To close the course take a minute to revisit those original objectives do you think you achieved them?

Learning outcomes	Fully	Partially	Not at all
Differentiate between drugs and alcohol myths and realities.			
Explain the spectrum of drug use			
Explain how drugs are classified.			
Name examples of treatment providers in Norfolk			
Summarise the key strands of national drug/ alcohol strategy.			
Describe the relationship between criminal justice and substance misuse.			

Reading and Useful Hyperlinks to other materials

Additional documents/sites:

Home Office - The road to ruin? Sequences of initiation into drug use and offending by young people in Britain <<http://www.homeoffice.gov.uk/rds/pdfs2/hors253.pdf>>.

NTA - Drug misuse treatment and reductions in crime: findings from the National Treatment Outcome Research Study (NTORS) *Professor Michael Gossop* http://www.nta.nhs.uk/publications/docs/rb8_final.pdf

NACRO - Policy Report - Drugs and Crime from Warfare to Welfare (2003) Dr Marcus Roberst - <http://www.crimereduction.gov.uk/drugsalcohol71.htm>

Home Office (Crime Reduction) - Crime Reduction Toolkits (Alcohol Related Crime and Communities Against Drugs in particular) - <http://www.crimereduction.gov.uk/toolkits/index.htm>

Home Office (Crime Reduction) - Reducing the Availability of Illegal Drugs - <http://www.homeoffice.gov.uk/drugs/drugs-misuse/reducing-availability/?version=1>

Joseph Rowntree Foundation - A national survey of problem behaviour and associated risk and protective factors among young people - <http://www.jrf.org.uk/knowledge/findings/socialpolicy/432.asp>

Portman Group - Keeping the Peace - A guide to the prevention of alcohol related disorder - http://www.portman-group.org.uk/uploaded_files/documents/35_49_KeepingthePeace.pdf

Scottish Executive - Liquor Licensing and Public Disorder: Review of Literature on the Impact of Licensing and Other Controls, and Audit of Local Initiatives - <http://www.scotland.gov.uk/cru/resfinds/crf68.pdf>

Youth Justice Board - Risk and Protective Factors - <http://www.youth-justice-board.gov.uk/Publications/Downloads/Risk%20Factors%20Summary%20fv.pdf>

National Probation Service - <http://www.probation.homeoffice.gov.uk>