Drug use in vulnerable young people • New projects • Methamphetamine • Preventing drug use and violence in recreational settings • Evidence update • Cannabis gateway theories • Ex-users as educators • Volatile substance abuse
Volatile Substance Abuse is implicated in the deaths of 72 young people a year, more than the combined total of all the other common illicit recreational drugs. Yet despite this, little is known about effective interventions to prevent use, and there is a lack of understanding about the role that volatile substances play in young people’s lives. Read more on page 31.

Written and edited by Dr Harry Sumnall, Kimberley Edmonds, Lisa Jones, Lynne Wilkinson, Jim McVeigh, and Professor Mark Bellis. Additional contribution to cannabis gateway article by Dr Jon Cole (j.c.cole@liv.ac.uk).

The bulletin is also available on-line (http://www.cph.org.uk/publications) & printed copies are available on request from the NCCDP.
Welcome to the third edition of Drug Prevention; the quarterly news review from the Collaborating Centre for Drug Prevention. We hope the publication helps to keep those working in, commissioning and developing strategy for the prevention of drug use informed of developments in what is a rapidly changing and expanding field. This quarter we examine prevention developments at the European level and, closer to home, review initiatives to support families, address the needs of children of drug using parents and explore links between drug use and violence especially in night life settings. Articles also include work on forecasting problematic drug use, the emergence of new drugs (e.g. methamphetamine), cannabis as a gateway drug and volatile substance abuse. We hope these publications encourage a broad view of substance use incorporating illegal drugs, alcohol, tobacco, pharmaceuticals, solvents and legal highs. Without such a perspective, gains in one area can often mean individuals simply moving from one substance to another without necessarily any real health gain. Equally, while Drug Prevention focuses specifically on substance use issues, a key part of sustaining reductions in drug use is understanding what alternatives for pleasure and entertainment are affordable and available to those most at risk. Drug Prevention aims to help inform you on both the details of specific drug related interventions and on the location of drug prevention initiatives in a broader suite of programmes addressing ill health and inequalities. We hope you enjoy this issue and, as ever, welcome all feedback and suggestions for future editions.

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Find out more about the NCCDP
www.cph.org.uk/nccdp
The NCCDP undertakes reviews of government sponsored research, and evaluation of drug prevention interventions, and the facilitation of evidence based practice. The first update has now been published and focuses on drug prevention among vulnerable groups of young people, and considers how this relates to current government policy and guidance. These findings are considered within the context of relevant policy, in particular the Updated Drug Strategy (Home Office, 2002), Every Child Matters: Change for Children Programme (DfES, 2004) and the Department of Health Choosing Health agenda (DH, 2004). The full report is available on request from NCCDP, or can be downloaded from www.cph.org.uk/publications.

Population description and drug use

The population described are young people (under 25) considered to be at increased risk of involvement in drug use, and in particular, patterns of use having detrimental effects on life. These risk factors are strongly interconnected and are seldom found in isolation.

Several studies have sought to identify ‘at risk’ groups (see for example Lloyd, 1998). The specific groups considered in this report were identified through the literature:

- Children whose parents misuse drugs
- Young offenders
- Cared for children
- Homeless young people
- School excludees
- Sexually exploited young people
- Young people from Black and Minority Ethnic communities (BME)

The carers of young drug users were also considered as they were seen to hold a pivotal role in a young person’s life.

It is important to note that although this approach may be a useful tool in service delivery, inclusion within one or more of the indicated groups is not seen as a pre-cursor to problematic drug use. These groupings are not exclusive and many young people will be part of multiple groups or transfer between groups. Sub-sets of particularly vulnerable individuals will exist within these groups.

Data from the Youth Lifestyle Survey 1998/99 indicated that drug use was more prevalent, drugs were more accessible and monthly use of class A drugs was higher among young people that would be considered as ‘vulnerable’ than among the general youth population (Goulden & Sondhi, 2001). Whilst level of drug use cannot be directly associated with problematic use, heavy use and early initiation are both considered to be risk factors for future problematic use. Drug use prevalence is generally shown to be lower among young people from BME backgrounds in general surveys. However, this population is included as a vulnerable group due to suspected under reporting, indications of increasing use and barriers to engagement with services.

Accurately assessing drug use behaviours among these groups is difficult due to the
heterogeneity and hidden nature of these populations, who may have disengaged with services. As reliable data is sparse and samples varied no attempt was made to compare the drug use of different groups. In general, however, drug use among vulnerable young people may be characterised by poly drug use with some evidence of existing stigma around injecting, particularly among those from BME backgrounds (Melrose, 2004; Borrill et al., 2003).

The relationship between these vulnerable young people and their drug use is very complex. Among young people in care, for example, important issues impacting upon drug use included parental/carer use, challenging life events and transition from care (Ward et al., 2003). There is some evidence that the prolificacy of young offenders is significantly associated with drug use (Goulden & Sondhi, 2001). However it is also suggested that their drug use is not necessarily problematic or linked to their offending (Hammersley et al., 2003). Involvement in drug use and sex work may be mutually reinforcing, especially if ‘trapping factors’ are present (including early initiation, involvement in street sex work and experience of additional risk factors) (Cusick et al., 2003).

It is important that all drug use is considered within the context of the wider problems facing these young people, compared to other events in their lives young people may see their drug use as a relatively minor challenge (Ward et al., 2003).

Home Office Findings 254 (Becker and Roe, 2005) describes drug use among vulnerable people using 2003 Crime and Justice Survey data, but was published after completion of this review. The report can be accessed at http://www.homeoffice.gov.uk/rds

**Approaches**

Overall there is a lack of robust government sponsored evaluations of drug prevention interventions among vulnerable young people, although some potentially useful approaches were highlighted in the literature.

**Training of staff**

Training of non drugs specialists (e.g. youth workers, teachers in pupil referral units) in drug misuse issues could facilitate earlier identification of problems and more effective responses, for example training of care workers (Bauld et al., 2004). Training for all professionals working with children to enable them to identify, assess and respond to the needs of young people with substance use problems is detailed in the green paper Every Child Matters (DfES, 2004).

**Use of communications**

FRANK is the national drugs information campaign and an important element in the Updated Drug Strategy (Home Office, 2002), however little robust evidence is available to assess it’s effectiveness. Material was widely recognised by one sample of homeless young people but they preferred one-to-one contact to internet or phone based support (Frontline, 2004).

**School based approaches**

Despite the highlighted importance of school attendance and drugs education, there was a lack of robust evaluation of school based targeted drug prevention work. Interventions such as the Behaviour Improvement Project (BIP) aim to increase school attendance which is considered a protective factor against drug use. Pupil referral units are in a good position to deliver targeted drugs education to those in need. Guidance on drugs issues within schools (DfES, 2004) advises teachers to pay specific attention to the drugs education of those at risk from exclusion and those that have been
drug prevention interventions targeted at vulnerable young people. Longitudinal evaluation methodologies and the inclusion of long term (post initiative) follow up within evaluations would help to assess impact. Research focusing specifically on the relationship between vulnerabilities and drug misuse is also limited. A longitudinal approach examining the changing nature of vulnerability in young people generally, and in particular its association with drug use over time, may be best placed to fill this gap. Identifying specific needs and drug related behaviours could contribute to the tailoring of existing approaches.
Implications and recommendations

Although some recommendations made are specific to certain populations, some are applicable to all vulnerable young people.

The emphasis should be on a multi-agency approach as this population often face multiple problems and come into contact with a range of agencies. Tackling drugs issues in isolation is less likely to be successful.

In order to facilitate multi-agency working, training is needed for all non-drug specialist professionals working with vulnerable young people. This training should also be linked to systematic assessment of substance misuse needs when a young person comes into contact with a service.

In order for this to be successful recruitment and retention of staff needs to be improved, particularly in relation to projects subject to short term funding, the Positive Futures scheme and the dearth of drugs workers from BME backgrounds.

Drug prevention interventions must be relevant to the age and knowledge level of the audience. The messages delivered should be non-didactic and drug use should not be represented as deviant. Harm minimisation may be the most appropriate approach among some groups who do not consider their drug use to be problematic. Particular focus should be given to those aged 11-14, particularly those that are at risk of exclusion from school.

References


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As reported by the BBC\(^1\), methamphetamine use has been identified as a major problem in the US and a recent report indicated that of 500 law enforcement agencies questioned across 45 states, over 50% perceived it to be their largest drug problem (Kyle and Hansell, 2005). This followed reports that sub populations of the gay community in the UK were using the drug\(^2\).

**METHAMPHETAMINE**

- Class B drug, Class A if prepared for injection
- Amphetamine derivative, quicker onset and longer lasting than amphetamine sulphate (*speed*)
- Stimulant drug that affects the central nervous system
- Releases high levels of serotonin, noradrenaline, and dopamine creating feelings of euphoria or an “intense rush” depending on how the drug is used
- Can cause a variety of cardiovascular problems, elevates body temperature and can cause convulsions
- Chronic users may suffer from anxiety, confusion and insomnia, and may display symptoms of psychosis
- Drug of dependence
- Neurotoxin in experimental animals

**Forms**
- Pill - *yaba*
- Powder - *meth, crank, pico*
- Crystal (methamphetamine hydrochloride) - *ice, crystal meth*

**Methods of use**
- Oral
- Intranasal
- Injection
- Smoking

Methamphetamine is mainly produced in South East Asia and North America (UNODC, 2005) and consequently these areas and neighbouring countries have seen an increase in the use of the drug over the past decade. The National Survey on Drug Use and Health for 2003 in the US (NSDUH, 2003) showed that around 5% of the US population have used methamphetamine in their lifetime. Use was highest amongst 18 to 25 year olds, with 1.6% reporting use in the last year and 0.6% reporting use in the past month. Recent data from Australia (NDSHS, 2005) suggests that approximately 10% of the population there have ever used methamphetamine, with around 3% using in the last 12 months. Methamphetamine use was highest in the 20-29 age group. However, some age groups have shown a decline in use of the drug between 2001 and 2004 (14-39 year old males and 14-19 year old females). Methamphetamine production in Europe is on a relatively small scale, with only the Czech Republic and the Russian Federation reporting significant levels of production in 2003 (UNODC, 2005). Use of methamphetamine is rare in the United Kingdom, and data on its use is not specifically recorded in the British Crime Survey. However, methamphetamine use may be captured within amphetamine use in general, which has gradually decreased over
the last few years, particularly in young people (aged 16 to 24 years).

Due to a lack of information on the use and supply of methamphetamine in the UK it is unclear if the drug is growing in popularity in this country. However, two recent pieces of research give some insight into trends in methamphetamine use in the UK within specific populations. Unpublished research (Bolding et al., 2005), undertaken by Bolding and colleagues at City University in London, reported that of 750 gay men questioned, 21% reported ever using methamphetamine. However, few reported using the drug frequently, with only 1% reporting that they used the drug one or more times a week. In an annual dance music magazine-based survey, McCambridge and colleagues (McCambridge et al., 2005) identified that there had been an increase in the number of people currently using methamphetamine in ‘dance contexts’ in the UK, between 2000 and 2003. From the data collected for 2003 (n=850), around 7% of people reported ever using the drug and 2% reported current use. Mean age of first use was 22 years.

It is difficult to judge whether these findings provide an ‘early warning’ of wider methamphetamine use in this country. Firstly, the two populations studied are more likely to use and experiment with recreational drugs than the general population. Secondly, there is the possibility that these findings over represent the number of methamphetamine users. Due to the nature of the illicit market some users may believe, or be led to believe by dealers, that they have purchased methamphetamine, rather than a new formulation, or high quality, amphetamine sulphate. However, it is also possible that some users (and dealers) are unaware that they have purchased methamphetamine, which would lead to an under representation of use.

References


Footnotes
1 http://news.bbc.co.uk/1/hi/world/ americas/4654503.stm
2 http://news.bbc.co.uk/1/hi/uk/4604047.stm

User-focused information about methamphetamine can be found at http://www.erowid.org/chemicals/meth/meth.shtml; and http://www.tweaker.org
The Advisory Council on the Misuse of Drugs report into the needs of children of problem drug users, “Hidden Harm”, indicated that 200,000 to 300,000 children in England and Wales came from families where one or both parents had serious drug problems. Only 37% of fathers and 64% of mothers from these families were still living with their children. Most children not living with their parents lived with other relatives (ACMD, 2003).

Grandparents often lack knowledge about their rights and responsibilities, have access to very little information on drugs, are unaware of sources of help or support, and often want guidance about the day-to-day practicalities of living with children/young people (Family Rights Group, 2001). At the same time, research points to the benefits for young people who are raised by grandparents, as opposed to being in foster care or children’s homes (ibid).

As part of the project’s focus, Mentor carried out a needs assessment. From one to one interviews it was found that whilst grandparents acting as kin carers wanted their grandchildren to grow up with as normal a life as possible, children and the grandchildren were seen as different, they therefore felt different and inevitably tried to conceal from the world the differences that made them stand out. Where the family had difficulties with drugs the children are seen as a threat by other parents and even to some extent schools because of what they know or may have seen; the family is then forced into secrecy. With diminishing health, finances and energy, grandparents have to cope with the increasing demands for these things from the grandchildren they save from a life in the care of strangers. The social, health and financial structures that have been crafted to support stranger care is of little value to many grandparents because local social services have discretionary powers about helping kinship care. Financial and staff restraints often push the needs of this highly marginalised group into the background, fear of losing the children keeps them there. They ask so little yet they need so much, and they save the country billions of pounds. They get little help for the real sacrifices they make. It is never their fault although they carry guilt and the shame like a burden.

The Mentor UK Grandparents Project will allow us a unique opportunity to make a real difference to the lives of vulnerable members of our society that have become almost overlooked. To find out more about the Mentor UK Grandparents Project contact Ray Timms ray.
Family, Prevention and Support Programme
ADFAM, UK

A programme to fund pilot projects around the country aims to tackle the thorny subject of families and the prevention of substance use, writes Eva Geser

Adfam is the national charity supporting the needs of families affected by substance use and has secured funding from the Department of Health (via the National Drugs Prevention Development Unit), to source and evaluate projects across England and Wales dealing with how families can improve the likelihood of children avoiding drug use – in particular, problematic drug use.

Over a period of one year, Adfam will select and fund six projects across the country, to develop innovative substance use prevention and education programmes with families in community settings. Programmes are being targeted specifically to address issues related to diversity in parenting, vulnerability to substance misuse, how best to engage families in prevention work, as well as develop quality standards, resources and training programmes with family members.

With careful planning and selection, the programmes will address the needs of families in circumstances and communities that have traditionally been seen as difficult to attract to, or include in, drugs prevention and education work, e.g. foster carers, young parents and Black and Minority Ethnic (BME) families. Projects will run from September 2005 and will be externally evaluated after 12 months of operation.

Evidence from around the world suggests that building on family strengths, family cohesion and communication protects young people against substance misuse in later life. Aspects of family life, including the building of close and caring relationships, consistent monitoring and supervision of young people’s behaviour and the clear communication of family norms, expectations and values, build resilience to risky behaviour in young people. Supporting families in developing their strengths, awareness, support for one another and care and guidance for young people, are key challenges for prevention work.

Many service providers recognise that family vulnerability and stress, parental attitude and use of drugs and alcohol, increases the risk of young people’s drug misuse. Increasingly, examples of innovation and good practice in this field of prevention do exist, including long-term therapeutic prevention work with families and short-term drug awareness and parenting programmes in school and community settings. Developing a consistent framework for prevention work with families, and the professional skills of organisations to
facilitate programmes effectively, are important next steps.
Ensuring programmes meet the range of family needs and experiences is also important; families vary in their understanding, views and approaches to parenting, family life and substance use. Engaging with this range of values, approaches and experiences involved in parenting and substance use is key to prevention work with families – respecting the differences and finding ways to communicate to all groups is essential if we are to move the field of prevention forwards.

The notion of ‘preventative parenting’, which is becoming an important part of the Government’s drug strategy, can be a challenge for service providers, especially voluntary groups and NGOs such as Adfam, to endorse. It is important to take a positive view on parenting, so that families do not feel stigmatised from accessing services that may help them when there is a drug problem. It is important to work with the evidence that supporting families in drug prevention and education in meaningful, targeted ways could certainly improve outcomes and reduce the chances of many young people taking up drug use.

Working especially with vulnerable families, including young people, in ongoing programmes that meet practical needs, motivations and interests is an important challenge. The role of mentoring, peer support and involving extended family members in informal, community-based programmes are all potential areas to explore. This latest project creates opportunities for local organisations to deliver services that they know their communities need.

Sharing the results of the projects and learning from the delivery is the next vital step forward. After all, ultimately it’s not just about educating families – it’s up to us as service providers to learn too.

For more information about this programme, please contact Eva Geser, the Programme Coordinator at Adfam, on 020 7202 9433 or email e.geser@adfam.org.uk

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Preventing Harmful Substance Use: The Evidence Base for Policy and Practice
Tim Stockwell, Paul Gruenewald, John Toumbourou, Wendy Loxley (Editors)

The prevention of harm from drug use, both legal and illegal, is a major concern to government departments and clinicians throughout the world. Recently, much new research has been conducted regarding global levels and patterns of drug-related harm, on common risk factors with other social problems (e.g. mental health, crime) and on the effectiveness of a wide range of intervention strategies. Preventing Harmful Substance Use offers comprehensive and up-to-date advice on the prevention of drug and alcohol abuse. Contributors provide science-based reviews of knowledge on their areas of expertise, and make clear recommendations for the future of prevention policy and practice. A final section draws the work together and offers a framework for an integrated science of prevention.

John Wiley & Sons 2005 494pp
0470092289

Mind-Altering Drugs: The Science of Subjective Experience
Mitch Earleywine (Editor)

This volume provides a review of the subjective effects of drugs and the dominant theories behind these effects, which is intended to help inform readers about the experience of intoxication and help researchers learn from studies in other disciplines. This book provides a clear description of the theories and techniques behind the investigations of intoxication and how subjective experiences relate to dependence potential, which should help people make an educated decision about drug use, help researchers identify ideal ways to assess a drug's subjective effects, and help clinicians understand their substance abusing clients better by providing insight into the intoxication that they seek.

Oxford University Press Inc, USA 2005 412pp
0195165314

Troubled teens: Multidimensional Family Therapy
Howard Liddle

This book details the multidimensional family therapy (MDFT) approach for adolescent drug and behaviour problems. Clinically, the treatment incorporates family therapy, drug counselling and individual therapy traditions. Theoretically, the model weaves together ecological and developmental conceptual frameworks. The approach uses the research-derived knowledge base about how adolescent drug and behaviour problems form, and how protective factors can encounter these problems to inform assessment and intervention. Four focal areas organise the treatment: the individual functioning of the adolescent; the parent(s); the family interaction; and the individual family members in relation to extrafamilial sources of influence. There are simultaneous interventions with the individual teenager, the parent(s), the family's interaction and with persons and systems of influence outside the family.

W.W. Norton & Co 2005 320pp
0393703401
The Council of Europe’s ‘Responses to violence in everyday life in a democratic society’ project (2002-2004) was established in response to concerns about violence and its effects in Europe. In partnership with other international organisations and NGOs, its primary objective was to help decision-makers and other protagonists involved to implement comprehensive policies for combating violence while respecting human rights and the rule of law. The focus was on transversal efforts to prepare and disseminate useful implementation tools that were easily available to all who need them. One key strand was the link between substance use and violence. This topic is of particular importance because prevention strategies which have an effect upon violent behaviours may be adapted towards drug use (and vice versa), as both involve complex behaviour change and have cross influencing effects (e.g. experiencing violence can lead to substance use).


Night-time entertainment venues such as cafés, bars, nightclubs and discotheques are frequently the scene of violence. Violent incidents occur both in and around licensed (alcohol selling) premises and levels of this
violence are often disproportionately high on weekend nights (Kershaw et al., 2000; Ireland and Thommeny, 1993). In the UK, for example, one in five violent incidents occur in or near a pub, bar or club, rising to one in three incidents of violence between strangers (Kershaw et al., 2000). Furthermore, levels of public violence are associated with the number of pubs and clubs concentrated in an area, with increases in the number of drinking establishments having been accompanied by increases in levels of violence (e.g. Norström, 2000; Brown, 2002). Alcohol- and drug-related violence in nightlife can take several different forms. This includes; aggression and violence where one or more of those involved are under the influence of alcohol or other drugs (Wells and Graham, 2003); the use of alcohol and drugs to facilitate sexual assault (ElSohly and Salamone, 1999); and violence associated with drug dealing (O’Neill, 2001).

There is little empirical evidence available on the specific association between drug use and violence in nightlife. However, there are links between drug use and violence; for example, approximately one in five incidents of violence in the UK are related to drug use (Kershaw et al., 2000). High levels of recreational drug use among young people attending nightclubs suggest that use of drugs in nightlife may play a role in night-time violence. Drug related violence in nightlife may occur through the effects of drugs on users, such as increasing aggression or vulnerability among users. Different drugs have different effects, and some may be more related to violence than others; nevertheless drug dealing activity involving any illicit substance may also lead to violence in night-time settings.

Research in Emergency Departments has found associations between violence and drug use, with those presenting with violent injuries (Macdonald et al., 1999), and those reporting current or past-year violence (Cunningham et al., 2003) being more likely to use drugs. Some recreational drugs used in nightlife are particularly associated with violence, such as cocaine (Davis, 1996). Use of cocaine among young people in several European countries appears to be increasing (e.g. EMCDDA, 2004), and greater use of cocaine in nightlife may contribute to higher levels of aggression in night-time settings. Increasing use of methamphetamine in nightlife in Australia has been associated with higher levels of night-time violence (Dillon, 2002). Ecstasy use has also been found to be associated with violence; in a study of men who have sex with men, those who used ecstasy were more likely to be victims of domestic violence (Klitzman et al., 2002).

Whilst research in the Netherlands suggested that the consumption of alcohol was a poor predictor of violence among pub-goers; the consumption of alcohol and drugs in combination was slightly more likely to predict
 violence (Korf et al., 2001). Violence in nightlife can result from drug dealing and feuds between rival drug gangs. Rivalry between British drug gangs inadvertently employed to maintain safe environments in the nightlife resort of Ayia Napa, Cyprus, for example, led to incidents of violence in the town at night (O’Neill, 2001). Door supervisors themselves may be involved in drug dealing, for example by supplying drugs to customers themselves or by permitting drug dealers to operate on the premises. However, door supervisors may also be the victims of drug dealer violence, sometimes being forced to allow drug dealers to operate on the premises through intimidation by criminal gangs (Morris, 1998).

Concerns about drug facilitated sexual assault (DFSA) and drink spiking have increased in recent years, and bars and clubs are perceived as being locations in which drugging occur (Sturman, 2000). While there is some evidence that drugs such as gammahydroxybutyrate (GHB) and flunitrazepam (Rohypnol; ‘roofies’) have been used in cases of DFSA (Schwartz et al., 2000), alcohol is by far the most frequently detected substance in victims (ElSohly and Salamone, 1999).

Preventing drug related violence

Reducing access to drugs in nightlife would help reduce levels of drug use at night and hence drug-related harms, including drug-related violence. Attempts to clamp down too harshly on the use of drugs in clubs are...
likely to make participants in certain cultures (e.g. dance music cultures that are specifically associated with drug use) eschew licensed venues in preference for environments where drug use, drug dealing and related violence may continue unchecked and safety is more difficult to ensure (Advisory Council on the Misuse of Drugs, 1994). However, there are a number of ways in which the availability of drugs in bars and clubs can be reduced. Although many drug users will purchase their drugs before going out, others may rely on availability of supplies in nightclubs or may accept drugs offered to them in nightlife settings without having planned to take drugs. Spontaneous use of drugs may occur when people’s perception of risk is reduced through alcohol. This is of particular note as research has found that concurrent use of alcohol and cocaine produces higher levels of aggression than use of either substance alone (Pennings et al., 2002).

The types of drugs used in nightlife may influence levels of drug dealing in bars and clubs owing to the different duration of effects observed between drugs. For example, whilst the effects of ecstasy last several hours and users may only take it once during the night, cocaine has a shorter span of effect and may therefore be used several times in a night. Hence where cocaine is used in nightlife there may be more demand for drugs in nightlife and therefore more drug dealing activity in bars and clubs. Reducing drug dealing in nightlife would reduce potential for violence and intimidation associated with dealing activity. Since certain drugs (e.g. cocaine) are more strongly associated with violence than others, efforts to reduce drug use in nightlife should focus on those that cause the most harm. The Home Office Safer Clubbing guidance provides a range of advice on addressing drug use in nightlife (Webster et al., 2002). Implementing a search policy upon entry to bars and clubs can help identify drug dealers, allow drug supplies to be confiscated and deter people from bringing in drugs. The use of Closed-Circuit Television cameras (CCTV), security patrols and washroom supervisors inside bars and clubs can also help identify and prevent drug dealing and use. Providing venues with safe locations to store confiscated drugs can help prevent rogue staff from becoming involved in drug dealing themselves and prevent innocent staff from being penalised for possession of drugs they have confiscated from a customer. In the UK, for example, many late night venues are provided with a drug safe for depositing confiscated drugs that can only be accessed by police (Hughes & Bellis, 2003). In Amsterdam, police and club owners have made an agreement to place a ‘drug box’ at the entrance of clubs. Visitors can put both weapons (including knifes etc.) and drugs in it before being searched by the door staff, with clubs delivering the contents of the box to police. Individuals who do not take the opportunity to dispose of drugs or weapons and are then found to be in possession of them are refused entry to the club and, in the case of drug dealers, reported to the police (Korf, 2003).

Staff training can raise awareness of drugs issues among workers, enabling them to identify signs of drug use and drug dealing and respond to drug-related harms (e.g. in Denmark, the ‘Nul Tolerance’ project provides staff in bars and clubs with information on drugs and dealing with drug induced problems; in Italy the ‘Popper’ project raises awareness of staff in bars and clubs of drug and alcohol issues and how they can influence youth behaviour; Biffi and Lemera, 2002). Staff training in dealing with customers who commit crime, and conflict management can reduce violence between staff and customers who are caught using or dealing
drugs on the premises.

The formulation of a house drugs policy can ensure that all staff are aware of their responsibilities, know how to deal with drug-related incidents and have set procedures to follow when people are caught drug dealing (Webster et al., 2002). Drugs policies should be devised in consultation with police and local authorities to ensure that action taken by management is legal and safe. For example, there must be a clear method of handling confiscated drugs and handing these over to police, and an agreed procedure for dealing with drug dealers found operating on premises and reporting such individuals to police. In order to encourage venues to operate drugs policies, efforts must be made to ensure that venues confiscating drugs from customers are not penalised for drug use on their premises and that those operating responsible drugs policies are not stigmatised by the public as being associated with drug use.

Information campaigns to raise awareness of the harms related to alcohol and drug use may encourage some people to reduce their intake, although there is little evidence to suggest that these work in isolation (Canning et al., 2004). Such information should include the health effects of substance use, related risk behaviours, and methods of reducing harm associated with use. Preferably, outreach workers should be available onsite to assist users how to expropriate the advice effectively. In particular, information should raise awareness of the increased vulnerability to violence through alcohol and drug consumption (e.g. in UK, the Crystal Clear campaign raised awareness of the links between alcohol and glass-related violence in nightlife and encouraged people to take responsibility for their actions). However, research into awareness and implementation of harm reduction measures by drug users in nightlife found that, although there was widespread knowledge of harm reduction measures, these were not always implemented and were often negated by other risk behaviour (Webster et al., 2002). Hence, raising awareness of potential harms will not necessarily encourage people to change their behaviour. Despite this, people need to be aware of the risks associated with substance use and methods of protecting their own health and that of others. Information on personal safety and transport availability in nightlife should also be widely available to enable people to plan safe journeys home and hence reduce their vulnerability to violence upon leaving bars and clubs. More information at: http://www.coe.int/T/E/Integrated_Projects/violence/

References


Dillon P (2002) Personal communication


Korf DJ (2003) Personal communication


In recent articles in the Irish national press (e.g. ‘Pills will kill’: Irish Daily Mirror p. 17, 21 Jun 2005), it was reported that a new type of ecstasy tablet, Snowballs, “three times stronger than regular ecstasy” had been implicated in the death of a male clubber. Warnings were issued by drug campaigners who believed that further deaths would result. This followed other high profile cases such as the death of Lorna Spinks in 2001, which was reported in the national media as the result of ingestion of Euro tablets, which were “of exceptionally high strength”1. In 2000, after Dutch police received an ecstasy tablet containing strychnine, a warning, released by the Chief Medical Officer for cascading to health professionals2, soon appeared in health centres and doctor’s surgeries around the country.

Campaigners argued that by releasing these warnings young people would be persuaded not to take ecstasy. However, in the case of Lorna Spinks it later transpired that the tablet implicated in her death only contained 150 mg MDMA, around twice the usual street dose, and Dutch police later admitted only a single tablet containing strychnine was received, suggesting that this was a one off case. The USA website, Ecstasy Data (http://www.ecstasydata.org), which publishes the relative constituents of tablets, showed that submitted samples of Snowball tablets contained MDMA or the dissociative DXM (dextromethorphan hydrochloride). Scientific research into the content of ecstasy tablets has found that the amount of MDMA tablets contain varies widely, even within identically branded tablets (Cole et al., 2002). In addition, a large percentage of tablets do not only contain MDMA, but certain other controlled drugs such as amphetamine and MDE or non-controlled drugs such as ketamine and ephedrine3.

Publicising the emergence of potentially dangerous variations or preparations of drugs may serve as important warning systems, but because of its very nature, the illicit drug market is not homogenous and great regional and local variations exist. If these types of approach are to have an impact upon behaviours then intelligence must be locally driven, perhaps as a result of analysis of local seizures. Importantly, users must be supported in use of this information and to plan appropriate personal responses, as knowledge-based interventions alone have been shown to have no effect upon drug using behaviours (Canning et al., 2004; Parkin and McKeeganey, 2000).

Footnotes
1 http://news.bbc.co.uk/1/hi/uk/1320949.stm
2 http://www.info.doh.gov.uk/doh/EmBroadcast.nsf/0/e0a328bd5028cbdc80256d ad0044ec67?OpenDocument
3 It is important to note that despite popular opinion, heroin, crushed glass, or ‘rat poison’, have never been found in tablets

References


Drugs Futures 2025?
The latest report from Foresight, the Government’s science-based think tank, provides independent evidence through ‘horizon-scanning’ of what future scientific advancements may uncover in the next 20 years. Drugs Futures 2025? is based on a series of scientific reviews authored by some of the UK’s leading researchers. Topics include such areas as psychological treatments of substance misuse, the ethical aspects of new scientific developments, and the history and future of psychoactive substances. All offer exciting insights into potential developments in the field, but one of the most contentious pieces of work comes from Professor Neil McKeganey and colleagues. In their review of the sociology and substance abuse they explore a number of scenarios covering possible increases in the prevalence of problem drug use. These range from a high-prevalence scenario of around 1 million problem drug users by 2025, to a medium-prevalence scenario of around 750,000 problem drug users, a low-prevalence scenario of around 500,000 problem drug users, and a final reducing-prevalence scenario of around 300,000 problem drug users. They conclude that on the basis of the longer-term trend of problem drug use of the last 40 years, the number of problem drug users could increase three-fold to the 1 million level by 2025. In response, a Government statement preceding the review argues that these predictions do not match Government data, which indicate that the proportion of 16-24 year olds reporting that they have ever taken any drug has fallen by 13% in comparison to 1998 and the proportion reporting that they have ever taken class A drugs has fallen by 24% in comparison to 1998. The data are used to suggest a recent decrease in levels of use of certain illicit drugs, which would subsequently lead to a reduction in the number of problematic drug users in the future. More information on the Foresight 2005 project and its publications can be found at http://www.foresight.gov.uk/Brain_Science_Addiction_and_Drugs/index.html

Drug Education in schools
In a recent analysis of drug education in 60 primary and secondary schools in England and Wales, it was concluded that the quality and effectiveness of drug education had improved since 1997. However, there were particular gaps. Whilst pupils’ knowledge and understanding of illicit drugs had increased there was little consideration of associated behaviours, and the role of alcohol and tobacco in the recreational pharmacopoeia. Furthermore, many pupils reported that their needs were not being met by secondary schools at an appropriate level of detail and individuality. Many primary schools had failed to implement updated drugs curricula and policy. Specific recommendations included:

• schools should ensure that they have a teacher and a governor with specific responsibilities relating to the provision of drug education

• secondary schools who use all teachers to teach about drugs should evaluate the quality of their teaching with particular care

• secondary and special schools should consider involving specialist drug and youth works in teaching about drugs

• schools should ensure pupils have access to up-to-date information on local and national helplines and other drug services.

At the end of June 2005, 22 experts from 16 member states and Norway gathered at the EMCDDA headquarters in Lisbon in order to finalise and fine-tune an EMCDDA project which is aimed at providing a Prevention and Evaluation Resource Kit (PERK) to professionals and local decision makers across the European Union.

PERK has a seven step structure which compiles basic but evidence-based prevention principles, planning rules and evaluation tips. It promotes the notion that prevention planning and evaluation are intertwined, so that intervention, and essential research on it, should not be separated. This is especially important with a view to the modern and more realistic concepts of theory-based evaluation: “what works with whom in which context”? For this purpose, evaluation must be closely interlinked with project planning and implementation and not be a separate research study. The latter would rather reproduce black box effects, where inputs and outcomes are achieved, without explaining how they were achieved and under which conditions they could be replicated. Therefore PERK supports its users strongly in defining and establishing working hypotheses and in controlling context (social, normative, cultural) factors.

For the implementation, PERK compiles components that have proved to work in prevention, but it also presents (and comments upon) those components, which are popular but without any proof of effectiveness, like isolated information provision, or affective education. In this respect, PERK has been created in order to put an end to the notion that everything in prevention is a matter of opinion and perspective: there is nowadays sufficiently strong evidence and theory base for practitioners and stakeholders to know what prevention is and what it shouldn’t be called. Among the experts from such different cultural backgrounds as Lithuania and Portugal, Greece and Finland, there was a high level of agreement upon the contents of PERK, reducing concerns about the cultural limitation of prevention strategies; there does exist a common understanding of what is good prevention work, both content wise and in terms of project design across the European Union. PERK is merely compiling these key principles and permitting fast and easy access to the underlying evidence base through the online provision of research articles (abstracts), grey literature (pdf-files), practice examples (selected projects from EDDRA, see http://eddra.emcdda.eu.int), evaluation indicators (see http://eib.emcdda.eu.int), and links to important sources for science-based prevention like the NCCDP. The integration of experts and initiatives with similar aims as the NCCDP is especially important as this allow for continuous multi-lingual updates of the PERK tool: new articles and evidence can be uploaded and made available especially for those who have less access to scientific journals and grey-literature.

PERK invites users to follow a guided tour through the available knowledge base in prevention and therefore to gather – or revise – ideas and suggestions on how to plan and design an intervention and its evaluation, always depending on the available resources and the setting.

It is hoped that this leads in the long run to a common European canon on what is good professional prevention work. This might help member states to quickly develop quality standards for prevention projects and also training requirements for those working in prevention. In any case, it will result in Europeans having a common set of concepts (e.g. universal, selective and indicated prevention), while debating on and comparing prevention work across countries.

PERK is now under revision in order to integrate the proposals from the various experts and will be launched on the EMCDDA website www.emcdda.eu.int at the end of September.

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Recent estimates indicate there are 359,000 children currently experiencing parental drug use in the UK (Barnard and McKeganey, 2004). The Advisory Council on the Misuse of Drugs’ (ACMD, 2003) Hidden Harm report and the Government’s delivery plan (see NCCDP Bulletin 2) prioritises establishing an ‘evaluation of interventions aimed at improving their health and well-being in both the short and long term’. Personal Services Society (PSS) IMPACT began in January 2004 and aims to work with both the children of drug using parents and the parents/carers themselves. The proposed evaluation aims to assess the success of the PSS IMPACT scheme.

PSS IMPACT centres upon prevention by working with young people who are negatively affected by their parent’s problematic drug and alcohol use. The project provides a package of support, which aims to help them cope with their environment and help them develop for their future lives. This includes recreational activities; issue based group work (e.g. drug and alcohol use, sexual health, keeping safe); one to one support; residential weekends; and therapeutic and practical support.

The project has been developing since its onset and now adopts a holistic family approach to service delivery, addressing children’s needs in the context of their social, economic and home environment. The work of the project centres upon two out of the six key messages published by the Hidden Harm enquiry (ACMD, 2003):

- Parental problem drug use can and does cause serious harm to children at every age from conception to adulthood.
- The number of affected children is only likely to decrease when the number of problem drug users decreases.

The proposed evaluation, which is currently being undertaken, sets out a number of means by which to measure success. The evaluation is separated into two sections. Section A assesses the structures and processes of the service. This includes how the project has established models of working with children of drug using parents, the creation of new inter-agency working relationships and how the project has targeted the families it aims to support. Section B focusses upon the impact of the project and uses qualitative research methods to establish whether the project has really made a difference to the lives of families that have been supported. A range of methods are being used to gauge how users view the scheme, whether it has impacted upon their lives and the degree to which the project has achieved the aims and objectives it has been working towards.

It is important in projects like this that a single researcher conducts the evaluation work. This aims to ensure consistency and also ensure that the young people are not constantly faced with strangers. It is also important that the researcher attends a number of sessions prior to the study commencing in order to become familiar with staff, children and their families. Key topics of investigation are described in the box overleaf.

Examples of good evaluation:

NE choices; a multicomponented drug prevention programme for adolescents
http://www.drugs.gov.uk/ReportsandPublications/DPASPublications/1033750747

Evaluation of the US National Youth Anti-Drug media Campaign 2002
http://www.mediacampaign.org/publications/westat5
Section A

- To document the programme approach an overview of staff skills, resources and internal structures will also be outlined and assessed
- To appraise the project aims and objectives among key stakeholders secondary analysis service level documentation and semi structured interviews will be discussed and assessed
- Assessment of referrals and targeting will be documented and assessed. Demographics of young people and families on the scheme will be reviewed to establish whether present service users match the intended target group criteria of the scheme. A quantification of the proportion of young people on the scheme that are affected by the projects focus issues will be provided
- To gauge levels of awareness of Integrated Children’s Service plans the projects’ level of engagement with other agencies and its involvement in the development of information sharing processes (commonly known as IRT) and Common Assessment Frameworks (CAF) across Children’s Services

Section B

- To assess perceived need and utility of the service, staff and agencies making referrals will be interviewed to discuss their views
- Perceived benefit for families will be investigated. Children will be invited to participatory workshops where their views on the scheme, how they feel they may have benefited from the support provided and what could be improved will be collected. Views and experiences on a range of issues will be explored such as; self esteem; health; friendships; school attendance; views on drug use; drug awareness; hopes for the future; depression/anxiety etc. Parents and carers of the young people will be invited to participate in a short semi structured interview. The interview will aim to gauge what parents feel are the benefits of participation, why their family attends, and how they feel the project could be improved
- All young people involved in the evaluation will be asked to potentially participate in a longitudinal study in order to investigate long term impacts of participation

Two part evaluation structure of the Personal Services Society Impact Evaluation
**Common Assessment Framework**

Halton Drug Action Team are working in partnership with the Integrated Services team and Healthwise to deliver universal training to use the Common Assessment Framework (CAF) as a screening tool for young people. The aim of this training is to ensure that those who work with children and young people within co-located multi-agency teams and Children’s Centres can identify additional needs and intervene much earlier to help children and young people.

The CAF is a nationally (England) standard approach to conducting an assessment of the needs of a child or young person and deciding how they should be met. It has been developed for use by practitioners in all agencies so that they can communicate and work more effectively together. It will support earlier intervention by providing a tool to enable practitioners in universal, as well as targeted or specialist services, to assess needs at an early stage. It aims to become the main method whereby needs are assessed by agencies, reducing the number and scale of specialist assessments.

The CAF is geared towards the practical delivery of support. The Common Assessment Framework is fundamental to the Every Child Matters agenda and the development of Children’s Trusts.

The implementation of CAF as a screening tool for substance misuse will play a major part in improving services to children, young people and families.

The training for all universal services will provide an insight into how the Every Child Matters agenda can increase the quality of assessments whilst reducing the number of assessments being carried out separately by different services, which can cause young people to be in a situation where they are constantly being asked for the same information. Using the CAF as a screening tool will de-stigmatis e substance misuse and will put the young person at the centre of service delivery, addressing all their needs.

With similar concerns in mind, HIT have developed, on behalf of Wirral Drug and Alcohol Action Team, The Wirral Identification & Screening Tool (TWIST), which will enable workers who do not have specialist substance misuse knowledge to identify young people who may be at risk from substance misuse and to refer them to the most suitable agency that will meet their needs. The use of this tool will allow efficient use of existing services and cut down levels of inappropriate referrals.

The TWIST tool is designed to be effective when used by a broad range of tier 1 workers, who will receive training relating to drugs awareness issues and the procedures involved with screening young people. As well as the development of the TWIST tool HIT will also promote the use of this tool, and deliver training to those groups of workers who will use it.

We hope to write about screening approaches (particularly for Tier 1 workers) in the next issue of the bulletin. If you would like to share your experiences and approaches, then please contact the NCCDP team.

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The debate whether cannabis is a stepping-stone or gateway for use of other illicit drugs is a long standing one (Kandel et al., 1992). This has resurfaced in the UK with a recent BBC Panorama investigation which presented unpublished data from researchers based at the Karolinska institute in Sweden suggesting that adolescent rats exposed to THC showed changes in part of the brain called the nucleus accumbens, which contributes to experiences of drug reward. It was reported that such rats showed increased propensity to self-administer heroin in adulthood. This data was presented by the programme as demonstrating strong links between cannabis use and other drugs in humans.

The relationship between cannabis and other drug use has been examined in a number of epidemiological, behavioural, genetic and animal research studies, and recent papers have added to debate on whether this relationship is causal, supporting a cannabis gateway effect, or non-causal, supporting a random effect. Hall and Lynskey (2005) have thoroughly reviewed the literature and present three main hypotheses that attempt to explain how the relationship between cannabis use and other drug use may arise:

1. Cannabis and other illicit drugs are supplied through the same market and hence cannabis users may have greater access to a range of illicit drugs than non-users.

2. Early cannabis users have certain characteristics that predispose them to using other illicit drugs.

3. The pharmacological effects of cannabis increase a user’s likelihood of using other illicit drugs.

Illicit drug market exposure

Socio cultural theories suggest that the progression from one drug to the next is a consequence that cannabis and other illicit drugs are sold on the black market (de Kort and Kramer, 1999), so cannabis users will be exposed to other drugs through these markets or through shared peer networks. Whereas historically, cannabis has been smuggled into the UK by criminal networks, much of the available drug is now homegrown, often on a small scale for use by individuals or friends (Hough et al., 2003). Hence, there is often a clear separation of small scale dealing of recreational drugs such as cannabis and other drugs. In young people, there is a relationship between the age of first opportunity to use a particular drug (i.e. age when a drug was first offered) and the actual age of first use (Kenkel et al. 2001; Morral et al. 2002; Van Etten and Anthony 1999). Hence drug availability and behavioural economics (how the individual responds to economic decision making surrounding drug choice) are also contributory factors predicting initiation, choice, and maintenance (Vuchinich and Heather 2004).

In a secondary analysis of US household and arrestee data Golub and Johnson (2002) concluded that there was no relationship between sequence of cannabis use and subsequent initiation of other drugs. Progression of substance use after young adulthood (e.g. 25 years old) was also found to be quite different than the sequences observed in teenagers (ibid). Most individuals also seem to discontinue drug use in their mid to late twenties, coinciding with dedication to career and family, or if they no longer desire the effects that drugs produce (Chen and Kandel, 1998). This means that most drug using careers are resolved without exposure to drugs such as heroin and crack cocaine.

In the general population there seems to be a random propensity to use drugs (Morral et al., 2002). In simple terms this means that some individuals will use harder drugs such
as heroin regardless of their prior use of soft drugs such as alcohol, tobacco or cannabis. According to this interpretation, there probably is no ‘gateway effect’.

**Genetic and personal predisposition**

Behavioural genetic studies have examined whether shared genes and environmental factors may explain the relationship. Twin studies from Australia suggested that individuals with early onset of cannabis (<17 years old) had odds of other drug use (including sedatives, hallucinogens, psychostimulants, and opioids), alcohol dependence, and drug abuse/dependence that were 2.1 to 5.2 times higher than those of their co-twin, who did not use cannabis before age 17 years. These findings remained after controlling for other known risk factors such early-onset alcohol or tobacco use, parental conflict/separation, childhood sexual abuse, conduct disorder, major depression, and social anxiety (Lynskey et al., 2003). Fergusson and colleagues (2002) reported a strong association between frequency of cannabis use and use of other drugs that varied with age, i.e. earlier age of cannabis onset was associated with higher risk.

It is important to note that population risk factors such as these serve to alert drug professionals to potential problems rather than substituting for evaluating individual needs.

**Pre-clinical behavioural pharmacological investigations**

The best way to study the effects of one drug upon another is in pre-clinical animal models, however it is important that a certain degree of caution is exerted when extrapolating these results to humans. There is considerable evidence that exposure to one drug of abuse can affect the response to a different drug of abuse at a later date. Usually this is through cross tolerance (where the response to the different drug is reduced) or cross sensitisation (where the response to the different drug is enhanced). Both of these effects will make the consumer vulnerable to consuming more drug than those who weren’t exposed. However, it is important to note that many other non-drug factors can also produce similar effects. For example, animals exposed to the metal lead self-administer more cocaine than those who aren’t (Burkey et al., 1997). The overall picture from this literature is that the use of any drug at an early age is likely to alter the response to other drugs at a later age and cannabis is no exception.

It is important that this literature is not taken at face value as indicating a deterministic causal chain between the use of one drug and the use of another. Animal experiments cannot model the complex social interactions and pressures that are brought to bear on young people when they are confronted with the opportunity to use controlled drugs. The altered responsiveness to novel drugs will only become apparent if those drugs are used and this may never happen as that decision may not be taken.

**Summary**

Although a large body of research exists exploring whether there is a causal relationship between cannabis use and subsequent use of other illicit drugs (the gateway theory), the findings are far from conclusive. Epidemiological, behavioural, and genetic studies appear to indicate that although non-causal factors may account for some of the reasons cannabis users may progress to other drugs, there remains an association if these factors are controlled for, pointing towards a causal relationship. This is especially true for young initiates.

Animal studies indicate that there are some potential mechanisms for this, but it is unlikely that these mechanisms are truly deterministic.
in nature. It is much more probable that there is an interaction between multiple causal mechanisms that lead from cannabis use to other controlled drugs. Drug prevention policies in many countries are founded on the principle that cannabis use may lead to other illicit drug use. Investigation of this relationship may help to target these strategies most effectively.

**Footnotes**

1. Suggests that progression from one substance to the next is inevitable
2. Suggests that the transition from one type of drug to the next takes place in stages and is progressive, but not inevitable
3. For a programme transcript see [http://news.bbc.co.uk/1/hi/programmes/panorama/4109554.stm](http://news.bbc.co.uk/1/hi/programmes/panorama/4109554.stm)

**References**


**Table 1** (and next page) Recent research on cannabis gateway theory. References are listed on page 37.

Cannabis users who previously used either alcohol or tobacco were eight times more likely to have an opportunity to try cocaine compared to those who had no history of alcohol, tobacco or marijuana use. In addition, cannabis users with a cocaine exposure where approximately 15 times more likely to use cocaine than those with no history of cannabis use, including when users with behaviour characteristic of “active cocaine-seeking” were excluded.

Behavioural genetic studies

Lynskey et al. (2003) Examined whether the association between early cannabis use and subsequent progression to other drug use and drug abuse/dependence persisted after controlling for genetic and shared environmental influences in a sample of young adult same-sex twin pairs, who were discordant for cannabis use.

Early initiation of cannabis use (before age 17 years) was associated with a significantly increased likelihood of other drug use and drug abuse/dependence. This relationship persisted after controlling for known environmental factors.

Agrawral et al. (2004a, 2004b) Assessed the relationship between early cannabis use and subsequent use and abuse/dependence of other drugs in a population-based sample of male and female twin pairs.

There was a strong association between early cannabis use and other drug use and other drug abuse/dependence. Early cannabis use in one twin was significantly associated with other drug use in the second twin.

Animal studies

Ellgren et al. (2004) Rats were exposed to a cannabinoid receptor agonist during adolescence and then administered with amphetamine in late adolescence. Dopamine levels and behavioural responses were monitored.

There was no sensitisation to the effects of amphetamine on dopamine levels or behavioural response in rats pretreated with cannabinoids.

On the 27th June, the Council of the European Union adopted the new EU drugs action plan. This forms an integral part of The Hague Programme, addressing security and criminal justice in the EU. The strategy aims to provide a framework for preventing and reducing drug use, dependence and drug related harms to health and society. It calls for coordinated mechanisms to ensure regional, national, and international activities are complementary within the EU and with international partners such as the United Nations. Impact assessment will be carried out in 2008, and if interim success is agreed, a final evaluation of the strategy and its impact will be delivered in 2012.
The main objectives are coordination [of responses to drug use within the EU]; demand reduction; supply reduction; international cooperation; and information, research, and evaluation. Specific references to prevention and education are detailed in the box below.

There is a particular focus on the need to identify vulnerabilities to drug use, and the development of targetted, evidence-based approaches (see article on drug prevention in vulnerable young people on page 4). Underpinning this, the Action Plan highlights effective evaluation as the key to obtaining evidence on successful approaches. For more information please visit http://www.emcdda.eu.int/index.cfm?Fuseaction=public.Content&nNodeID=10360&sLanguageISO=EN

<table>
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<th>Objective</th>
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<td>Improve coverage of, access to and effectiveness of drug demand reduction measures</td>
<td>Improve coverage of, access to, quality and evaluation of drug demand reduction programmes and ensure effective dissemination of evaluated best practice</td>
<td>2007</td>
<td>Quantitative and qualitative analysis of access to and effectiveness of drug demand measures. Drug use and risk perception on drugs in the general population and school studies</td>
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| Improve access to and effectiveness of school-based prevention programmes | i) Ensure comprehensive effective and evaluated prevention programmes on both licit and illicit psychoactive substances, as well as poly drug use, are included in school curricular or are widely implemented  
  ii) Support joint prevention programmes of public services, school communities, and relevant NGOs | 2007      | Number of member states having implemented comprehensive effective programmes on prevention in schools; percentage of pupils reached |
| Set up, deliver, and improve selective prevention and new ways of reaching target groups | Develop and improve prevention programmes for target groups, and specific settings, taking into account gender differences | 2008      | Availability of prevention programmes; number of member states having implemented programmes in the work place; number, coverage, and evaluated effectiveness of prevention in recreational settings |
| Improve methods for early detection of risk factors and early intervention | i) Detection of risk factors related to experimental drug use  
  ii) Provision of training for professionals who come into contact with potential drug users | Ongoing   | Member states report on risk factors; estimated percentages of professionals receiving training; number of early intervention programmes and estimated population reached |
Volatile substance abuse (VSA) could be described as “the forgotten drug”. VSA gets a fraction of the attention of illegal drugs, yet it results in more deaths of young people aged 10-16 than all illicit drugs. Volatile substances are legally available and easily accessible even to very young children.

Misunderstood

There are many misconceptions about VSA, including a notion that the practice is rare. A Department of Health survey (Smoking, Drinking and Drug Use among Young People in England in 2004) which questioned just under 10,000 pupils aged 11-15 found that 6% had used volatile substances within the last year. Young people are more likely to use volatile substances than any illegal drug apart from cannabis (11% in the last year).

Even more concerning, at age 11 and 12 misuse of volatile substances was more common than use of all illegal drugs (age 11, 4% had used volatile substances in the last year, compared to 1% having used cannabis; for 12 year olds the figures were 5% and 2% respectively).

VSA is also often considered a trivial issue. However, despite a fall in deaths in 2001, the number of deaths of school age children still exceeds those from illegal drugs. Over the last 10 years, there have been an average of 72 deaths per year from VSA. Since 1971 more than half (51%) of these deaths have been young people under the age of 18, with 12 children aged 10-14 dying through VSA in 2002. The youngest recorded death was a child of 7 years old. These children have lost out on the largest part of their life and we have lost their contribution to society.

In comparison there were 1,565 deaths related to the misuse of illegal drugs in England and Wales in 2002. Of these deaths, 63 (4%) were aged under 20.

Ignored

Misconceptions about VSA may be considered understandable as reports of VSA deaths seldom attract much media attention, often with no more than a few column inches in the local press. The recent death of Cali Chambers, a 12 year old girl in Essex, after inhaling a cannister of butane gas received just brief reports in a couple of papers. The lack of media coverage of this death, or the many other similar deaths, is in stark contrast to the high levels of media concern triggered by some drugs related deaths, such as the deaths of Rachel Whitear or Leah Betts. It appears that VSA deaths do not generate the same anxieties amongst the media and parents. The reasons for this are unclear.

Vulnerable

As with other drugs, there are strong associations between measures of vulnerability in children and their use of volatile substances. Research shows high levels of use amongst those who had been excluded from school or were truant, young offenders and homeless rough sleepers. Re-Solv also has over 600 press reports of court cases over a 10-year period where VSA has been mentioned. This list includes a significant proportion of very serious crimes such as murder, rape, or arson. A full analysis is currently being undertaken.

Young people who experiment with volatile substances may be more vulnerable to using illegal substances. The Department of Health’s 2001 survey of substance use found that those who had taken volatile substances by the age of 13 were over twice as likely than those who had not, to have taken Class A drugs in the last year (16% compared with 7% respectively). Two US studies, found a much higher correlation when looking at later problematic drug use, one finding that young people with a history of inhalant use by the age of 16 were over nine times more likely to begin heroin use by the
age of 32.

Education about VSA

There has been very little research that has specifically looked at the impact of education around VSA, despite differences in behaviour regarding VSA and the use of illegal drugs.

It is becoming increasingly clear that if education is to be effective young people need to have a key role in its development. The UN Convention on the Rights of the Child (Article 12) states that children and young people have the right to express their views freely and to have their opinions taken into account in all matters affecting them.

Re-Solv’s Youth Liaison Project provides an essential direct link with young people. The project has asked over two thousand young people about their experiences of drug education and in particular about volatile substances.

The findings suggest that young people want to be given it straight.

“I think education about sniffing should show the true dangers of it no matter how shocking they may be and start at an early age.”

There is an interesting tension between the views of the young people and the accepted norms of substance abuse education. Re-Solv believes that this is worth exploring in detail as it may provide greater insight and clarity as to what works.

Young people appear to favour use of ‘scare tactics’ or ‘fear arousal’; in fact, they express a range of complex views about what has an impact on their attitudes and behaviour. The work of Donovan and Henly (2000) may throw some light on this issue. Their review of published papers found contradictory findings about the efficacy of such approaches. They distinguish between approaches that highlight a threat, which can be effective, as opposed to approaches where the emphasis is on generating the fear response.

A key finding of our work has been to highlight the value of humour. Humour has some big advantages when talking about these issues, it grabs young people’s attention and they appear to retain the information longer. Most importantly, humour diffuses fear but also enables young people to talk about and think through the risks, including death.

Egg roulette is one example of a means to deliver a serious message in a humorous way. The activity uses five hard-boiled eggs and a raw egg, with obvious consequences and is used to open up discussion about risk taking behaviour. Egg roulette is one of the activities within a pack called “A Loaded Gun” which was distributed to every secondary school in the UK.

A further example is the recently launched, “Hazard Crew” a group of seven characters devised with the help of Aardman animations (producers of “Wallace and Gromit”). Each character is used to highlight a different issue. These packs have also gone out to schools.

The national response to VSA

There has been little attention to VSA within strategic policy documents. While, Tackling Drugs to Build a Better Britain includes mention of VSA, solvent abuse receives no consideration...
in the Updated Drug Strategy (2002). The one indirect reference explained that some D(A)ATs include VSA within their remit. As the strategy sets no targets for volatile substance abuse, it is unsurprising that there have been few examples of action in this area by Drug (and Alcohol) Action Teams.

However, participation in consultation activities has meant that VSA is included in a number of other guidance and minimum standards documents. For example, the report Drugs Guidance for Schools (Department for Education and Skills, 2004) makes clear distinctions where appropriate between illegal drugs and volatile substances.

The Department of Health released a Framework for VSA in July 2005. The Framework was publicly announced by David Hanson, the Prime Ministers Parliamentary Private Secretary and ex director of Re-Solv at Re-Solv’s 2004 AGM. VSA has been under-recognised as a cause for concern and a coordinated, comprehensive and adequately resourced response is welcomed. The Framework is based around four themes, better education, dealing with VSA better locally, minimising the opportunities for abuse and research.

Hopefully, this will help VSA to achieve greater prominence on the National agenda. It has unique characteristics, which are not fully recognised or addressed within the existing framework. Re-Solv would like to talk with any groups or individuals who have a concern about VSA or would like to develop the debate.

We can be contacted through our helpline on 0808 800 2345 or via our website at www.re-solv.org. The website has a “VSA alert” service highlighting new and current research, issues and events as well as a free on-line training course for professionals. Re-Solv has a range of resources and offers training services.

References


Johnson EO, Schutz CG, Anthony JC, Ensminger ME (1995) Inhalants to heroin: a prospective analysis from adolescence to adulthood. Drug and Alcohol Dependence 40 (2) 159-165


Young people, when asked about who they want to visit their drug education lessons often say they want to hear from ex-users (McKeganey et al., 2003). They feel that unlike with their teachers and other expert visitors they will get an ‘authentic’ voice on the experience of using and trying to overcome drug misuse.

The DfES guidance to schools (DfES, 2004) makes it clear that schools need to think carefully about the suitability of meeting this desire for authenticity:

Without sensitive handling they may arouse interest or glamorise drug use or describe experiences which young people may find it hard to relate to. In some instances they may unwittingly imply that their own drug use represents a ‘safe limit’ that can be copied. If they are to be involved, this should be because they are skilled in facilitating pupil learning and not simply by virtue of their status as a former user (DfES, 2004).

Many schools already use bodies like Narcotics Anonymous (NA) to provide ex-users as expert visitors to schools. NA is clear what they want to achieve by visiting schools; for example, explaining what a 12 step programme is and raising the profile of NA for those who may want to use the service. NA have told the Drug Education Forum that they don’t do “war stories” as part of their presentations, however, not all ex-users are as disciplined. The following comes from a report of a presentation by Mike Gunn, a comedian and ex-user funded by the Arts Council to work in schools:

After the hour-long show, the 16- and 17-year-old students are left in no doubt about Gunn’s life. They listen intently to his stories of psychosis, visits to mental hospitals and eventual recovery. He confesses that at one stage of his drug addiction, he had a hole in his arm big enough to stick a match into, and says: “I would inject anything from red wine to heroin into my arm, I was so desperate (The Guardian, 2005).

Most young people don’t use drugs (SHEU, 2005) and very few of those who do will go on to become problematic users in the way Mr Gunn describes, and so it is unclear how this sort of presentation fits in with the aims of drug education which are “to develop their [pupil’s] knowledge, skills, attitudes and understanding about drugs and appreciate the benefits of a healthy lifestyle, relating this to their own and others’ actions” (DfES, 2004).

Schools need to become much clearer about why they are inviting expert visitors in to talk to young people, how what they are going to say fits in with their programme and the ethos of drug education. Leaving it to chance or not being clear with visitors about how their contribution fits with the wider learning young people are doing about drugs and life skills means that opportunities are lost to make the most out of the skills that visitors can bring to drug education.


It wasn’t funny at the time, Guardian 25 January 2005


Mike Gunn’s website: http://www.mikegunn.co.uk

Andrew Brown: def@mentoruk.org
Web Links

Weblinks

Ongoing drug related internet directory. Please send your links to the e-mail address on the contents page. Note that inclusion does not mean endorsement of content.

Information

Tackling Drugs Home - www.drugs.gov.uk

Wired for Health - www.wiredforhealth.gov.uk - health information related to the National Curriculum

The Vaults of Erowid - www.erowid.org - documenting the complex relationship between humans and psychoactives

FRANK - www.talktofrank.org - UK Government Drugs Information pages

Drug Slang - www.drugs.indiana.edu/slang/SearchSlang.aspx - (USA) street drug slang

Medical Dictionary - cancerweb.ncl.ac.uk/omd - online medical dictionary

NPHL - www.nphl.nhs.uk - National Public Health Language Thesaurus

Organisations and Research Centres

NICE - www.nice.org.uk - National Institute for Health and Clinical Excellence

Turning Point - www.turning-point.co.uk - Social care for individuals with substance misuse problems

DARE - www.dare.com - Drug Abuse Resistance Education

JRF - www.jrf.org.uk - Joseph Rowntree Foundation

Action on Addiction - www.aona.co.uk - Seeking new ways to prevent substance misuse

Mentor Foundation - www.mentorfoundation.org - International Prevention Organisation

DrugScope - www.drugscope.org - Independent UK drug centre

ADFAM - http://www.adfam.org.uk - support for families facing drug and alcohol problems

Addaction - www.addaction.org.uk - drug and alcohol treatment charity

SDF - www.sdf.org.uk - Scottish Drugs Forum

NIDA - www.international.drugabuse.gov/home.html - NIDA’s International Programme

National Open College Network - http://www.nocn.org.uk - provides accreditation for adult learning (e.g. drug awareness programme)

Centre for Ethnicity and Health - http://www.uclan.ac.uk/facs/health/ethnicity/index.htm - based at UCLAN

MAPS - www.maps.org - Psychedelic and Marijuana Research

NCCDP - www.cph.org.uk/nccdp - NCCDP website

Evidence, Knowledge, and Evaluation

DEPIS - 199.228.212.132/doh/depisusers.nsf/Main?readForm - Drug Education and Prevention Information Service

EDDRA - www.eddra.emcdda.eu.int - Exchange on Drug Demand Reduction Action

Evidence into Practice - subsites.nigz.nl/
Drug Prevention Quarterly

Web Links

systeem3/site2/index.cfm - European Project for evidence based practice

Microgram Bulletin - www.usdoj.gov/dea/programs/forensicsci/microgram/bulletins_index.html - Forensic science publication of the DEA

PubMed - www.pubmed.org - free access to over 15 million citations for biomedical articles

Health Promis - healthpromis.hda-online.org.uk - national public health database for England

ACYS - www.acys.utas.edu.au - Australian Clearinghouse for Youth Studies

PREVLINE - www.health.org - SAMHSA’s Alcohol and Drug prevention information

DrugInfo Clearinghouse - http://www.druginfo.adf.org.au/ provides information on drugs and drug prevention to the community

Cannabis gateway references continued from page 29:


www.cph.org.uk/nccdp